New International Advances:

**EMD in Italy**

*Gianluca Ghiselli, M.D.*

Emergency Medical Dispatch is now being used in Italy too. Collaboration of work on the translation of the entire Medical Priority Dispatch System (MPDS) began about two years ago, when the first agreements were signed. Interest in the system then progressively increased after the first translated protocols were presented at a European EMS Conference in Abano Terme, in Northern Italy.

Finally, in April of 1995, the complete MPDS was officially presented to all national territories during a special meeting in the City of Udine (pronounced oo-din-ay). Udine then became one of the first cities in Italy to formally establish an EMS Dispatch Center.

In May, 24 Italian dispatchers completed the Academy EMD Certification Course—the first to be certified in Italy. Udine went on-line with the MPDS the 1st of September.

The development and adoption of the MPDS in Italy also includes an experimentation phase conducted in the City of Bologna, the site of Italy’s first dispatch center, which should be completed before the end of the year. During this phase, translation of the ProQA EMD software will also be completed.

Other Italian regions have also shown considerable interest in the MPDS and are considering its adoption. Foremost among these cities is Rome, in the Region of Lazio.

Dr. Ghiselli is an emergency medical physician from Luca, who is currently the foremost authority on EMD and MPDS implementation in Italy.

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**Obvious Death and the EMD**

*Jeff J. Clawson, M.D.*

The phone rings...unconscious and not breathing. As EMS guru, Jim Page, most eloquently stated: “the ultimate contingency” has just occurred. What could be simpler for the trained EMD? This scenario will generate the highest level of single patient prehospital response in nearly every system within the civilized world. But in 24% of all cases coded as cardiac arrests (Code 9), the decision is not quite that easy. At least not initially. These cases were those determined to be “obvious deaths” using the Advanced MPDS (9-B-1).

Obvious death situations are when the traumatic method of death is apparent, or when the patient has passed away—not just prior to the call—but often hours before. The caller responds to the entry questions: “unconscious, not breathing.” Death, simply defined, meets this description. In many of these cases, death has occurred long before, while the possibility of any resuscitative help has clearly past.

Over the past five years, significant changes have occurred in EMS in the handling of out-of-hospital death. Even more dramatic are the changes in attitude toward death and resuscitation that have swept the American public. While EMS systems dramatically struggle with the “correctness” of precluding “at scene” resuscitation without the approval of a physician, the average American, Canadian, and especially the European citizen, appears to be a quantum level ahead. We in public safety have been trying to catch up ever since.

During the public’s honeymoon with technology (which not surprisingly paralleled the honeymoon for emerging EMS systems), many believed that paramedics armed with fantastic machines could routinely snatch life from (continued on page 3)
From the President's Desk

EMD Changes the World... one step at a time

Alexander Kuehl, MD, MPH, FACS

Emergency Medical Dispatch is changing the world. Has everyone noticed? A simple idea with far-reaching meaning has grown to affect the thinking of the entire, global EMS community. Who would have thought?

In late September I had the opportunity to spend two weeks in the Republic of China (Taiwan), assessing the status of EMS on that island community of some 20 million people. Recently, national legislation was enacted there that formalized a "basic" emergency medical technician level and an "intermediate" level. Like many other jurisdictions around the world, the prehospital system in Taiwan is not exactly leaping to introduce sophisticated medical interventions that are not proven for use in the field.

About the time I concluded that I was probably the only one actually learning anything from my trip, I gave a presentation on Prearrival Instructions and Priority Dispatch. By the response of my audience, I realized that the simple but brilliant logic of the MPDS "cards," or rather the EMD "vision," was once again capturing the imagination of the medical leadership of an entire EMS community.

In Taiwan, virtually all the physicians read and speak English, at least for
(continued on page 6)

I realized that the simple but brilliant logic of the MPDS "cards," or rather the EMD "vision," was once again capturing the imagination of the medical leadership of an entire EMS community.

From the field...

MPDS Q&A

Central vs. Peripheral Injuries

Steven M. Carlo, Vice President

Someone's been stabbed! Someone's been shot! Send an ambulance right away? With high-emotion stab/gunshot incidents, the mechanism of injury itself often implies a life-threatening crisis. We should send an immediate DELTA-response... or should we?

In examining MPDS protocol #27 (Stab/Gunshot Wound), it's fairly easy to understand why a "NON-RECENT" wound, where 6 hours or more have passed since the incident or injury occurred, is classified with a lower Determinant than DELTA. However, I'm sometimes asked to justify why a "peripheral" injury that just occurred, especially a gunshot wound to the lower leg (for example), is only classified as a BRAVO.

Well, a brief article and statistical abstract we recently came across may help explain why a single peripheral injury does not represent an immediate life-threat.

The abstract was published in the 1994 Summer Edition of Update Neurosurgery, The Newsletter of The American Association of Neurological Surgeons and Congress of Neurological Surgeons. It looks at records taken from the Charity Hospital of New Orleans. A note for EMD historians in the readership: this is the hospital where Jeff Clawson interned.

What I found most unique about the abstract was the mean age and sex for assault (versus suicide) patients—Males of 27.6 years of age. The study looked at regions of the body and single wounds as opposed to multiple wounds and found that penetrating head wounds represented 49% mortality, thorax with 30.3% mortality, abdomen 14.3%, neck 5.8% and extremities finished with an extremely low mortality rate of just 0.6%.

This abstract is a good independent validation of Academy statistics for stab and gunshot wounds. These statistics bear out the DELTA response for central wounds and should come as no real surprise for the field responders among us.

Why is a peripheral injury only classified as a BRAVO?

... extremities finished with an extremely low mortality rate of just 0.6%

Reference; Update Neurosurgery, Summer 1994, Vol. 1, No. 2
Obvious Death...
(continued from page 1)
the jaws of death. They also believed that they always
should. In time, the imposed necessity for resuscitating
"all comers" became a disillusionsment for many
EMS providers. Wondering why your system
could only resuscitate between 5 to 10% of
its cardiac arrests while grumbling about
the validity of
"Seattle statistics"
only added to the
apparent guilt.
Tabletop discussions
about all too common
"bad outcomes" were of-
ten peppered with com-
ments about the creation
of all those "vegetables"
and "gorks". The prob-
lem was often blamed on
medical control physicians
and nurses who seemed to be robotically required
automatic resuscitative action on the part of scene
personnel facing insurmountable odds in resuscitating
what they saw as essentially non-viable patients.
This "never say dead until they are in front of a
Doc" was referred by ambulance personnel trans-
porting these expired patients to Charity Hospital during
the 1970s as "a DOA for an AOD" (any old Doc).
This attitude of those in medical oversight positions
was often justified blaming the litigious nature of
today's society (i.e., "If we don't try, the family will
sue us" logic).

The Advanced
MPDS describes
obvious death as a
general condition
requiring local
medical oversight
to define, then authorize
recognition of
certain specific
conditions.

We've been
essentially told
that if EMS fails to
attempt resuscitation,
roving bands of
starving plaintiff's
attorneys will befall
your otherwise
pleasant day...

...well,
fortunately,
this is just
not true.

The Obvious Death Additional Information Protocol, taken from the Advanced/MPDS, Ver. 10.2, ©3/95.

OBVIOUS DEATH Situation, Classification
Local Medical Control must define and authorize (X) any of the patient conditions below before the OBVIOUS
DEATH determinant can be used. Situations should be unquestionable and may include:
- Decapitation
- Decomposition
- Explosive gunshot wound to the head
- Incineration
- NON-RECENT expected death
- NON-RECENT traumatic death
- Severe injuries obviously incompatible with life
- Submersion (≥24 hrs)

Approved signature of local Medical Control Date approved

The protocol poses an additional key question if death is suspected: "Tell me why do you think she's
dead?" This question should be asked in a respectful
tone to gain greater knowledge of the situation at
hand. Since this is what we call in medicine a "rule
out" decision, any information not compatible with
an obvious death situation would cause a regular car-
diac arrest response based on a 9-D-1 code.

An emerging problem directly related to the
management of death at dispatch is the situation of
a non-obvious (recent) but expected death. In essence,
someone whose death was anticipated due to a
terminal condition but in which resuscitation
is not desired. Currently the MPDS does not directly
account for this particular situation.
We recently received a letter from a center in the Midwest describing problems caused by the coroner's legally imposed requirement to notify law enforcement. This was resulting in subsequent EMS responses to Hospice centers. We responded as follows:

"It seems the problem is not with the notification of the law enforcement agency per se, but with the subsequent dispatch of public safety personnel of any type to the scene where the patient was expected to die under the care of family or hospice. This activity, when the patient is truly terminal and DNR, is an intrusion into the very philosophy of hospice and home death at the worst possible moment. It is no wonder the hospice people have become so agitated.

On the other hand, the coroner is completely correct in requesting 'notification' in these situations in order to make reasonable decisions if and when further inquiry or involvement is appropriate—which I imagine it is not in the majority of such cases. Failure to so notify violates what we call 'the no surprise rule.' Obviously, the coroner, through the notified law enforcement agency, should appropriately not respond when it can be reasonably determined that scene evaluation and further inquiry into the facts surrounding such a death is unnecessary given the totality of the known facts."

With growing interest in correct, early management of this problem, the Academy is discussing authorizing of a special study utilizing a modification of the Cardiac Arrest protocol (#9) to examine feasibility of an alternate response approach in expected death situations.

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**Protocol #9, Key Questions, ver. 10.2, ©3/95.**

In summary, the obvious death situation provides an EMS system the opportunity to practice ethically correct medicine. The trained EMD can first carefully evaluate the situation, determine the true chief complaint (non-resuscitatable death), and then respond in an appropriate manner. In the case of an actual obvious death, the friend and family become our true patients. This protocol allows us to treat both them and their departed loved one with more dignity and respect. ı

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1. Tell me what happened.
   a. (If witnessed arrest) Did s/he choke on anything first?
      1. Y
         a. Go immediately to PDIs
      2. N
         a. (If suspected death) Tell me why do you think s/he's dead?

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1 Cleveland (Ohio) EMS Dept., 1994 AMPS Statistics from the ProQA Master Dispatch Analysis program.

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Emergency Dispatch 9-1-1 Day: Utah Program

- Jan M. Buttrey

It’s been a milestone year for EMD in the State of Utah; culminating with Governor Mike Leavitt declaring Monday, September 11th, 1995, as “Emergency Dispatch 9-1-1 Day.” This declaration follows in the spirit of “9-1-1 Emergency Number Day,” originally dedicated for September 11th by President Ronald Reagan.

This recognition of State dispatchers is significant because after two years of trying and lobbying, long and hard, dispatchers throughout the State were finally able to convince the 1995 Utah legislature to establish an official “public safety dispatcher” certification. This recognition will require 40 hours of additional training, above and beyond standard EMD certification. This is just one more step in achieving full recognition for the vital and essential role dispatchers play in all emergency services—whether Police, Fire, or EMS.

During the Summer of 1979, I had the opportunity and privilege of working with Dr. Jeff Clawson to develop the original EMD course curriculum.

Earlier this year... The State of Utah officially recognized EMD training approved by the National Academy as meeting local State program requirements.

That September, with the support of federal funding, we held the first EMD course in the State of Utah. What a thrill it has been for me to see this program grow and mature into a fully functioning professional designation. The programs' success has proven what we believed in the beginning: that the dispatcher is the backbone of the entire EMS function and fills a role all too often forgotten.

Utah was the first state to establish an official EMD certification program (in 1983), and officially recognize that level in administrative rule and statute. Earlier this year, in a similar forward-thinking action, Utah officially recognized EMD training approved by the National Academy as meeting local State program requirements. By acting on these things at a State-level, Utah has ensured a progressive medical dispatch program even though EMD is not mandated. We have found the dispatchers themselves reach out, and want to be recognized as the professionals they are.

Jan M. Buttrey is the Director of the State Bureau of Emergency Medical Services and the Utah EMS for Children Grant Program. She holds a Masters Degree in Business Administration, and is the former Special Projects Director and Wasatch Front Regional Coordinator—all part of the Utah Department of Health.

DISPATCH! Newsletter
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ATTENTION Dispatch Agencies
Want help tracking CDE & recertification? At your request we can provide quarterly combined mailings, with updated lists of EMDs at your agency, together with their recertification dates and required forms. This enables a local liaison to track your records. Contact the Academy if you want to start this combined program, or if you have other questions or concerns about continuing education or recertification.

Governor Mike Leavitt signs “9-1-1 Day” Declaration, surrounded by (left to right): Alan Fletcher, Medical Priority President; Judy Sampson, State Trauma Nurse Coordinator; Jolene Whitney, State Director of EMS Systems Resource Program; Robert Martin, Academy Executive Director; Sheryl Morrey, Medical Priority Client Rep.; and Susie Cozakos, Dr. Jeff Clawson’s Executive Assistant.

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Changing the World

(continued from page 2)

medical purposes. This is true over much of the world. However, it was very apparent that the fire dispatchers would need to communicate with the field units and families in Taiwan. Luckily, all Chinese dialects are written using the same characters; so, in theory, a single Chinese translation should be usable (with slight regional modifications) for another quarter of all the folk on this planet.

During the 13 hour flight back to New York, I reflected on why the excellent and dedicated medical advisors in Taiwan had not previously "discovered" the value of Prearrival Instructions and Priority Dispatch. Eventually, I realized that like many other prehospital directors, most had never been inside a dispatch center.

Just before I fell asleep, I smiled as I remembered looking back at an International Academy of EMD insignia I had left prominently emblazoning the "interventional passengers in transit area" at Narita (Tokyo) Airport. I just can’t wait for those next steps!

The World’s Largest EMS Registry

(continued from page 4)

(1) those whose certification was current, and
(2) those whose certification had expired for more than 6 months. Of those members with current certification, 81% were working for a center licensed to use the MPDS. Of those who lapsed, only 58% said their employer (or previous employer) was MPDS licensed.

In the current group, an overwhelming 96% felt that earning their National EMD certification was beneficial. Even in the lapsed certification group, 66% said it was beneficial, 28% were neutral, and only 6% said "not."

It was also interesting to note in the current group that 84% felt the Academy’s fees were reasonable for the benefits provided. The respondents rated the most important Academy benefits as:

(1) National recognition with an "EMD" credential
(2) Access to a toll-free information line,
(3) Access to data about EMD providers across the country and/or around the world,
(4) Receipt of a personalized Certificate/Diploma, and
(5) Receipt of a quarterly newsletter.

We’re proud to be part of such a positive movement! The Academy staff salutes the daily efforts of our certified EMD membership in helping provide the best quality prehospital care possible.

Upcoming Courses

For more information on these and other approved EMD Certification Courses call Medical Priority (801) 363-9127:

Nov. 15-17 Dartmouth, Nova Scotia, CANADA
Hosted by: Metro & District Ambulance
Nov. 22-24 Banff, Alberta, CANADA
Hosted by: Parks Canada
Dec. 8-10 Regina, Saskatchewan, CANADA
Hosted by: Regina EMS
Nov. 3-5 & 17-19 Salinas, California
Hosted by: Monterey County EMSA
Nov. 7-9 Marion, North Carolina
Hosted by: McDowell Technical College
Nov. 9-11 Yuba City, California
Hosted by: Yuba City Police Dept.
Nov. 10-12 Amherst, New York
Hosted by: Twin City Ambulance
Nov. 15-17 Reno, Nevada
Hosted by: Mercy Ambulance
Nov. 15-17 & 29-Dec. 1 St. Charles, Illinois
Hosted by: Kane County Emer. (ETSB)
Nov. 16-18 Walterboro, South Carolina
Hosted by: Colleton County Sheriff’s
Nov. 17-19 Shelbyville, Indiana
Hosted by: Shelby County Sheriff’s
Nov. 18-20 Plano, Texas
Hosted by: Garland Police Dept.
Nov. 19-21 Las Vegas, Nevada
Hosted by: Las Vegas Fire Dept.
Nov. 27-29 Salt Lake City, Utah
Hosted by: Medical Priority
Nov. 27-29 Belleville, Illinois
Hosted by: S.I.M.E.C.
Dec. 1-3 Bakersfield, California
Hosted by: Sandoval County EMS
Dec. 4-6 St. Louis, Missouri
Hosted by: Central County Emer. 911
Dec. 4-6 St. Joseph, Michigan
Hosted by: Berrien County 911
Dec. 4-6 Bernalillo, New Mexico
Hosted by: St. Paul, Minnesota
Hosted by: St. Paul Fire Dept.
Dec. 8-10 Erie, Pennsylvania
Hosted by: EmergencyCare, Inc.
Dec. 11-13 Akron, Ohio
Hosted by: Safety Comm. Division
Dec. 14-16 Port Huron, Michigan
Hosted by: St. Clair County 911
Dec. 16-18 Modesto, California

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