Annual EMD Conference

Dawn of the Dispatch Decade

The last 15 years have been replete with incredible advances in the provision of Emergency Medical Services to our communities. Since Gage and Desoto first graced our television screens with their handsome and professional demeanor, increased public awareness and expectation have played an important role in driving these advancements. Today, shows such as CBS' "Rescue 911" continue to remind us of the grave responsibility we have of providing modern pre-hospital care. Millions of dollars have been devoted to training pre-hospital care providers and to equipping their emergency vehicles with the necessary equipment to provide the best service possible. We have seen the advent of pre-hospital thrombolytic therapy, intraosseous infusion, automatic defibrillation, and many other exciting technical leaps, all with one common goal in mind... to help reduce morbidity and mortality of patients in the pre-hospital care system.

Recently, the communications center has been more fully recognized as an integral part of the pre-hospital care team. Agencies face mounting difficulties in their delivery of pre-hospital care as EMS becomes increasingly sophisticated and complex. Pressure from municipal government to allocate resources in a safe and efficient manner becomes even more problematic.

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THE DAWN OF THE DISPATCH DECADE

October 28 & 29

San Diego, California

Third Annual International Emergency Medical Dispatch Conference

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From the President’s Desk: Poison Control & the EMD

Jeff J. Clawson, M.D.
President, NAEMSD

Since the beginning of the Poison Control Center (PCC) concept in 1953, the role of these expert information and treatment resources has expanded as they became better understood. Regional PCC’s began forming in the 1970’s, staffed with toxicologists (experts in the pharmacology of poisons). A process called “Home Care” for handling childhood poisonings has proven effective by these Regional Poison Centers.

The Medical Priority Dispatch System (MPDS) currently includes one response level that does not fit into any of the standard 4-tier response categories. Ingestions (non-intentional poisonings) in children age 1 to 11 are referred by direct electronic telephone transfer to the regional PCC and no mobile response is initially sent. After evaluation by the PCC “interrogator”, the patient may be referred to an E.R. Rarely, response by EMT’s or paramedics will be initiated by the PCC if necessary. This referral “response” by dispatch is called the Omega (Ω) response.

Referral of this category of callers by medical dispatchers to a Regional PCC is very safe and highly effective, both from the economical and medical standpoint. In 1983, the Journal of Pediatrics published a study by Chafee-Bahamon and Lovejoy called “Effectiveness of a Regional Poison Center in Reducing Excess Emergency Room Visits for Children’s Poisonings.” The following are excerpts that will interest the Emergency Medical Dispatcher (also see diagram):

“Findings of this study indicate that, like reported poisonings incidents, the majority of pediatric emergency room visits for poisonings are not severe enough to warrant hospital care. Moreover, the overwhelming majority of poisoning visits are from persons who do not contract a poison center medically effective. Each year in the U.S., there are 850,000 acute poison exposures in children under age 5 alone. This study indicates that 23% (195,000) either go directly to the E.R. or call 9-1-1. While many parents wisely call the PCC directly, those who call 9-1-1 and report a conscious and breathing child, without priority symptoms, should be immediately electronically transferred to the PCC. A joint written policy with your Regional PCC outlining the mechanical procedures involved, should precede this activity and be approved by your Medical Director. Follow-up reports from PCC to the dispatch center on patient outcome can be routinely obtained. In summary, this innovative association of PCC with medical dispatch centers is safe and without question medically appropriate.

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as budgets continue to shrink, while at the same time public awareness and expectations of EMS are heightened. The public has acknowledged the importance of telecommunications professionals and have a higher expectation of them when they make telephone contact. We are truly witnessing the “Dawn of the Dispatch Decade” as municipal and public awareness recognizes the increasing importance of Emergency Medical Dispatch. The events of next 10 years will serve as the template for the safe and efficient provision of EMS in the 21st century.

With this in mind, we have designed the Third Annual International Emergency Medical Dispatch Conference to provide presentations intended to answer common questions and to leave the participant with “tools they can use.” This conference is intended to assist the Emergency Medical Dispatch administrator, manager and dispatcher in achieving their operational goals.

In October, we will bring together in one location, a dozen top individuals in the EMS communications industry that have the answers you seek. Topics and discussions will be presented ranging from how to fund and implement 9-1-1, to the challenges faced in providing EMS dispatch during the San Francisco earthquake and Hurricane Hugo. Other subjects will include:

- “Dispatch Liability and Risk Management”
- “The Nuts and Bolts of Full Time Q.A. in EMD”
- “Interpersonal Communication Skills for Dispatchers”
- “Excellence in Leadership for the EMD Administrator”
- “Disaster and Critical Incident Communications”
- “Secondary PSAP and EMD in the Private Sector”
- “EMD in the Dominion of Canada”

and much more. Each presentation will be an informative overview of practical issues and their applications, directly from the acknowledged experts in each field. The conference participant will leave with valuable information, knowledge and skills (tools you can use) that will assist in developing a practical, safe and efficient EMS communications and deployment system. Join us in San Diego at the La Jolla Marriott, October 25-27 for the EMD Certification course, and October 28-29 for the Conference, as we usher in the 90’s with the Dawn of the Dispatch Decade. Follow the instructions in the accompanying brochure to register.

The MPDS and Medical-Legal Danger Zones

- Scott A. Hauert

Dr. Clawson’s Medical Priority Dispatch System (MPDS) has been developed and refined over the last 12 years to, in a nutshell, provide two basic functions. First, to assist callers with pre-arrival instructions prior to pre-hospital care providers arriving at the scene; and second, to help the dispatcher determine appropriate levels and configurations of response based upon the answers they receive to certain medically approved key questions.

Many individuals and EMS agencies have expressed certain concerns surrounding the legal implications of implementing the MPDS and of providing pre-arrival instructions. Unfortunately, we do live in a very litigious society, and these concerns warrant an explanation.

According to a recent survey (JEMS 1989), 61% of all services providing medical dispatch are using some sort of a pre-arrival system. Of that 61%, 69% are ad-libbing and 31% are using protocols, a much safer way to operate from a legal standpoint. Of the dispatchers providing pre-arrival instructions, 34.2% are EMT’s, 5.4% are paramedics, 22.5% are EMDs, and an astonishing 37.8% have no training at all. In our experience, we have seen those dispatch centers who have EMD trained personnel and are using a protocol system, incur much less attention from the legal community than those without. Some of the most common questions and misconceptions regarding the legal hazards of providing such an additional level of service include:

1. Are we practicing medicine over the phone?
2. Can we be found negligent should a patient die?
3. What if we’re too busy to give pre-arrival instructions?
4. Do we have a duty to provide this additional service?
5. Is this call screening?
6. How can we protect ourselves from litigation?

There will be extensive responses to these issues at the Conference this October, here I will attempt to only briefly answer these questions and allay any misconceptions of those who are justifiably concerned. Those who wish additional information on these subjects, or have other related questions, should feel free to contact either myself or one of the National Academy’s Regional Instructors.

To begin with, are we practicing medicine over the phone? The answer is clearly no. Pre-arrival instructions (continued on Page 4)
Danger Zones...
(continued from Page 3)
(or post-dispatch suggestions) are designed to do three things: to provide immediate assistance through the caller when certain emergency conditions are present; to protect the patient and caller from potential hazards; and to protect the patient from well meaning bystanders who may unknowingly provide incorrect treatment. The MPDS does not prescribe any medical procedure that would cause harm or injury to the patient or place the dispatcher outside their realm of expertise. The instructions and advice consist of simple first aid “do’s and don’ts.” By using appropriate key questions, the dispatcher is able to identify the problem generally (not diagnose), identify the presence of “priority symptoms” and respond to those symptoms with simple, non-invasive, first aid procedures.

In answer to the negligence question, I will quote James O. Page, who stated that “A patient who is breathless and pulseless can not be made worse, therefore, there can be no negligence for a good faith attempt that fails or leaves a person better off.” In time-life priority situations such as cardiac arrest, choking, and childbirth cases, the dispatcher using the MPDS stays on the phone with the caller and instructs or coaches them to do something positive for the patient during the response time lag that proves fatal in so many cases. The alternative is for the caller to stand by and watch the patient needlessly die. Even if the caller accidentally breaks a rib or bruises the patient’s abdomen while administering CPR, for example, the only other option would be death. Can the dispatcher be held liable? No.

But what if we’re too busy? This is also a valid question. Time has shown, however, that the majority of instructions relayed by the dispatcher using the MPDS can be done briefly and the caller told to call back if other problems arise. We often have cases come in that require no instructions at all. The amount of time spent on the phone by dispatchers does not increase as result of using the

is not held to the same standard as one who is faced with no such emergency, based on a principle of reasonableness.

The question of our duty is a frequent one. We believe that we do have a duty to provide this additional level of care based upon a number of factors. Duty is defined as the responsibility to act or perform in a similar fashion as another similarly trained dispatcher would under the same or similar circumstances. “Changing social conditions lead constantly to the recognition of new duties” (ref: Prosser, Law of Torts, Third Ed.). We have been witnessing a changing social condition in the field of EMD for several years. EMD is a changing and dynamic industry and according to a number of nationally recognized entities and expert opinions, the duties of the EMD have also been changing.

In studying past law suits that have been filed against dispatch agencies, we have identified a number of common factors. These we call the “dispatch danger zones” and they are discussed in detail during the National Academy’s EMD certification course. They include call screening or no send policies, mechanisms by which large municipalities screen calls for validity and the dispatcher is left to decide whether to send help or not. We have seen that dispatch diagnosis is tantamount to dispatch malpractice and should not be used. The impetus for this type of program comes from the need to reserve valuable resources for those who actually need it. We have found that through proper questioning, based upon medically approved protocols, the dispatcher can confidently make a decision on who goes, how many go, how they go, and when they go. This is one of the empha-

THE DISPATCH DANGER ZONES
1. No send policies.
2. Delayed responses.
3. More than one call for EMS.
4. Omission of pre-arrival instructions.
5. Dispatch Diagnosis.
6. Failure to follow established protocols.
7. No protocols to follow.
8. Failure to verify address and call back number.
9. “Let me talk to the patient.”
10. Problems at shift change.
11. Attitude problems.
12. Pre-conceived notions and imposed negative personal impressions.
13. Mistranslation and/or misinterpretation of chief complaint (not seeing the forest through the trees)
sis’ of medical priority dispatching: sending the right thing at the right time in the right way. Call prioritization is not to be confused with call screening. The point with the MPDS is that everyone gets appropriate on-scene help based on their chief complaint and other symptoms present. The protocols have enjoyed over 10 years of refining and field testing. During that time we know of no litigation that has been brought against an agency that is correctly using the system. There is no other comparable system anywhere.

Finally, I will address the question of how to protect ourselves from litigation. First, and most obviously, we must avoid the dispatch danger zones. By providing proper training for EMD personnel, this can be achieved. Knowing why the dispatchers should do something gives them the power to do it. Conversely, knowing why not to do something empowers you with the ability to avoid behavior that may put both dispatcher and patient at risk.

Having strong medical control assists the dispatch agency in providing a safe environment for the health of the system and to nurture and maintain safe practitioners. Proper record keeping is a must to thwart unfounded litigation, as is proper supervision and team building to establish a loyal labor force. Other recommendations from the National Academy include the establishment of a risk management and quality assurance program to ensure the proper application of the MPDS.

The National Academy is committed to assist dispatchers and their agencies through its conferences, seminars, EMD training, testing, and National Certification programs. Fellows of the Academy are also available for on-site EMD systems evaluation, consultation, and MPDS implementation.

Scott A. Hauert is the Director of Training for the National Academy of EMD and has worked with Dr. Clawson for over 12 years.

The other end of the phone

Robert L. Martin

Life is a battlefield. Each human being comes into this world and faces his own struggle. Some people struggle longer than others, some stronger, some with more ferocity. Some choose to face their struggles head-on; others try to ignore them or maybe scotch around them, but still the battles rage within us. There are victories and defeats, great joys and deep sorrows.

Each battle will eventually end, but the war will continue as long as there are people on planet Earth.

Our battles are dotted with many fears: failure, inadequacy, the unknown, helplessness. I may witness a tragedy in progress and not be able to prevent it, or may find myself on the other end of an emergency phone call when someone desperately needs my help... situations such as these can cause severe apprehension. On the other end of the phone anything could happen; a man may die, a woman may burn to death, a child may drown, and sometimes all I can do is LISTEN TO IT HAPPENING! I can try to be prepared. I can learn, or recommend, or instigate dispatch protocols to follow that are designed to cover every conceivable event or emergency. I can install multi-million dollar dispatch systems or pride myself in the achievements of the past or the expectations for the future. But when something goes dreadfully wrong, I may ask myself if I am really doing anybody any good, especially myself, by what I do for a living.

I may be a fire chief and feel the weight of “responsibility” for my crew, for their mistakes as well as mine. I may be a field paramedic or EMT, arriving at a scene “too late” to do anybody any good. I may be a bystander, stepping out of the ice-cream shop on the corner just in time to witness that child being struck down by a speeding car... the one that didn’t stop... the one that I should have gotten the license number from but didn’t. I may be a dispatcher, a trained and certified EMD, who wasn’t, who couldn’t have ever been prepared to listen to a tortured burn victim screaming in my ear “Can’t you do something?” I may feel like there was “something else” I should have done. If only I’d... Maybe if... What if...

Each of our lives impacts so many others’ lives, and we can never fully foresee the reasoning behind what happens in the battleground. We may question if there is reasoning behind any of it, but it does no one any good to dwell on fear, failure, or inadequacy. I praise those valiant EMD’s who face their fears every day. Some say it’s “human nature” to not want to be involved, to not want to take the risks, to say “it’s not my problem” or “that would never happen to me or my family”. I want to say thank you to those who have dared to take the risk, dared to make a difference, even when on the other end of the phone anything could happen.

(continued on Page 6)
The other end of the phone
(continued from Page 5)

This last December in Johnson City, Tennessee, David Davis dared to make a difference. Only a few weeks after attending the EMD Conference and Certification Course in Orlando, Florida last year, his EMD skills were put to the ultimate test in the battlefield. The John Sevier Center, an aging ten story hotel being used as a retirement center, caught fire. The building was home to 145 elderly residents, and having been built before sprinklers were required, it had no sprinkler system. The fire started on Christmas Eve... in sub-freezing temperatures. The first emergency call came in at 17:11 and before it was over, 16 people had died and several others had been rushed to hospitals, including 25 firefighters who were treated for smoke inhalation, hypothermia and frostbite.

David corresponded with the National Academy several times after the fire, wanting to share information with other EMD's and to express his thanks for the training he had just received. He wrote "...had it not been for the EMD program, I would not have done as well 'under the guns' as I did. I learned to keep my head, gather information and relay this information to the proper EMS units. God bless you all and I hope an incident doesn't occur again like this in our city". Mr. Davis relayed that a total of 35 ambulance and rescue units responded, along with a med-flight helicopter, 2 haz-mat trucks, 25 off-duty police officers, as well as city and regional fire departments.

Newspaper articles outlining the fire relayed that virtually every available emergency vehicle and crew in Upper East Tennessee was sent to the fire scene, some responding from as far as seventy miles away. Also responding were Civil Defense and the Red Cross. Several area stores and hotels also opened their doors to provide all the help and shelter from the cold they could.

Bobbie Hall was the fire dispatcher and David was at the medical console. Dallas Penley was the call taker and Pat Shipley the shift supervisor. Charlie Baines, the sheriff's dispatcher, spoke with a lady in room 803 who eventually died, despite all his efforts to get someone in close enough to rescue her. The fear level rose. The frustration level rose. It took over 7 hours and the efforts of many people struggling hard in the battlefield to finally bring the searing blaze under control.

The National Academy salutes all the brave men and women who dared to get involved in the struggle, take a risk and make a difference. These people had prepared themselves enough, through proper field and dispatch training, that they didn't take uncalculated risks, they effectively saved lives.

Robert L. Martin is the Production Director for Medical Priority Consultants, Inc. and works as Dr. Jeff Clawson's administrative assistant.

RESCUE 911 NEEDS YOUR HELP!

For those of you who attended last year's EMD Conference in Orlando, Florida, you will remember the excellent presentation by Arnold Shapiro, the Producer for the CBS television show "Rescue 911". Dr. Clawson, who is the Medical Consultant for the series, has been asked by Mr. Shapiro to solicit the help of the National Academy's Certified Dispatchers in finding exceptional stories that can be used on the show. Contact us if you have any ideas!

Dispatch case of the quarter...

BLOOM COUNTY

by Berke Breathed

Kids say the darnest things

• Jim Meeks

I remember many years ago when I was not very old, watching the "Art Linkletter Show," a daily talk show. My favorite part was when he interviewed kids. Some of the best laughs on his show came from their responses to his questions. One of his favorite questions was to ask them what they thought a particular word meant. After a few great laughs, he would always finish up with "Kids say the darnest things." I always thought more of his show should be spent with kids.

In our profession, we sometimes rush through the interrogation of young callers because they are upset and are, on occasion, hard to get information from. We may have led ourselves into the belief that it's a lot easier to get the general idea of a problem from a youngster and then "send out the marines" than it is to put on our brakes and try to work with them on their level. After all, time is critical, right?

At a recent dispatch-related training course in Utah, Linda Hargaden, a dispatcher with Provo City Police Department, presented a lesson plan on the topic of communication with children. Linda related two incidents that had occurred in her jurisdiction and prompted her to look at Priority Dispatching with a new perspective.

One incident occurred on a highway in a busy canyon near the city of Provo. A man and his 9 year old son were driving down the canyon into Provo. They were from out of town and not very familiar with the area. The father happened to be allergic to bees. They were stopping for soft drinks and enjoying their trip through the mountains when, unknown to the father, a bee had flown into his soft drink can. As he took a drink, the bee stung him inside his mouth. They pulled off the road to a phone booth, not knowing exactly where they were, and dialed 9-1-1.

To make a long story short, the father began to have difficulty breathing soon after calling for help and very shortly was unable to talk. The next voice on the line was a very scared, almost inaudible squeak of "Hello?" Rescue crews were already on the way so the dispatcher wanted to find out how the boy's father was doing. She followed her priority card and asked the young man if his father was conscious. "What?" he responded. "Is your father conscious?" she asked again. "Uh, yeah, I think so" the boy said. "What is your father doing now?" "He looks like he's sleeping," responded the boy.

Eventually, rescue crews arrived and the patient was revived. "He looks like he's sleeping" can give a fairly clear idea of what the situation might be, but to a young child, "Is he conscious?" may have no meaning.

In another incident related by Linda, a 10 year old hemophiliac boy was alone. Somehow, he had cut himself and was bleeding seriously. He called 9-1-1 and said "Hello, I'm a hemophiliac and I'm bleeding." The dispatcher asked the boy where he lived. The patient's response seemed well practiced as he repeated his address. Dispatched units arrived but found no one at the home. While the units responded, the boy continued to bleed until losing consciousness. By the time the call was traced and units sent to the correct address, the boy had passed away.

What went wrong? The investigation revealed that the boy had responded correctly when asked what his address was, but the boy was in fact staying at a grandparent's house when the accident occurred. No one was at fault. A normal question under normal circumstances, but answered from the understanding of a child.

Linda further illustrated her point by "interviewing" her seven year old daughter, Tammy, and asking her to define a word or phrase that would be common in our normal conversations as EMDs. Tammy's interpretations were very enlightening as shown in the accompanying table. A question that may be perfectly understandable from our point of view as adults, may not have found its way yet into a small child's vocabulary.

Protocol must always be strictly adhered to and we must never try to substitute our own words for protocol, but if the emergency caller seems confused, child or not, we may need to put ourselves into their shoes and rephrase our technical instructions and questions to be more on their level. We will want to be acutely aware of these callers' special needs. Consider also the situation of mentally handicapped persons or foreign speaking people. They may easily become frustrated trying to understand us.

Quoting from Card G of the new 1990 MPDS, "CPR instructions should be read directly from the PAI (Pre-Arrival Instruction) card and not ad libbed or paraphrased, no matter how well you understand CPR yourself. However, this does not preclude the careful practitioner from enhancing, not replacing, the PAI protocols when common sense requires it." This statement can easily be extended to apply not just to CPR, but to any instructions you may be relaying to a caller (especially a child) who seems confused or is not fully comprehending the meaning of what you are trying to tell them.

The point of all this is that kids do say the darnest things. In moments of fear or uncertainty, they may be afraid of not giving enough information or of telling us that they don't understand our question. They may answer without really knowing what was asked. All they do know is that they need our help. We're employed in a public service operation and there's an awful lot of "public" out there to serve!

Jim Meeks is an EMT-P with the Salt Lake County Fire Department, a certified EMD, and a regional representative faculty member of the National Academy.
1990 Regional EMD Certification

The list shown below is current, and reflects changes since last publication. Additional courses may be added and/or individual agencies may be sponsoring an on-site certification course in your area. Questions regarding an on-site course should be directed to either Scott Hauert, National Director of Training, or Diana Clark, Sales Manager.

NASHVILLE, TN
July 19-21

NAPLES, FL
July 20-22

LAS VEGAS, NV
July 25-27

AKRON, OH
July 30-August 1

ROCHESTER, NY
August 3-5

MINNEAPOLIS, MN
August 8-10

SASKATOON, SASK.
September 10-12

EDMONTON, ALB.
September 19-21

SYRACUSE, NY
October 2-4

BOSTON, MA
October 10-12

SANFORD, FL
October 18-20

SAN DIEGO, CA
October 25-27

COLUMBUS, OH
November 1-3

KANSAS CITY, MO
November 6-8

ATLANTA, GA
December 3-5

NOMINATIONS for 1990 EMD of the Year Awards

Academy-certified EMDs are urged to nominate their co-workers whose professionalism is worthy of consideration by the Academy for one of the 1990 "EMD OF THE YEAR" Awards. Please keep these awards in mind as you work this summer.

You will find included with this newsletter a form to use for your nominations. Follow the instructions on the form and please return it to the Academy office no later than August 31st. The awards will be presented at a special ceremony at the upcoming Conference in San Diego, California.

Be expecting to receive conference registration materials in the mail soon.

New Academy PATCHES and PINS available

Academy-certified EMDs can now order additional insignia patches and lapel pins through the NAEMD. We have ensured the very best possible quality for the Academy insignia patches and pins. The lapel pins are done in red, white and gold, and are hard-fired cloisonne (enamel) metal, laser etched for durability. The patches are 5 color (red, white, gold, blue and black), and are heavily stitched cloth embroidery with 100% thread coverage.

Each item is only $5.00 plus 10% to cover shipping and handling to Academy-Certified EMD's only. An order form has been included with this newsletter. Please call if you would like us to send you additional forms. All payments must be made by a check or money order, payable at a U.S. bank in U.S. funds, with an order form attached. We regret that we are not able to process these orders over the phone or by a P.O. number.

As part of your certification fee with the National Academy, you are entitled to receive one free patch upon being accepted.

To help ensure the integrity and exclusivity of the NAEMD Certification patch, please order patches only for yourself and not for other, non-certified individuals. You may, however, order additional pins bearing the National Academy insignia for as many other people as you so desire. Call with questions.

1989-90 Academy Directory

As promised, the new National Academy of EMD — Directory of Certified Members is now available. Anyone who is currently certified with the Academy can request a free copy of this directory by contacting the NAEMD.