The American Heart Association:
- Jeff J. Clawson, M.D.

National Recognition for EMDs

I recently returned from three fascinating days at the American Heart Association's Emergency Cardiac Care (ECC) Standards Revision Meeting in Dallas, Texas. I want to share my experience and some exciting new information about the meeting. In the long run it is certain to effect the world of emergency medical dispatching.

Approximately every five years, the Emergency Cardiac Care Committee, meets to consider, debate, explore, and recommend directions for research and improvement of the CPR, BLS, ACLS, PALS, and other lesser known but important standards. This large group meets in general sessions during which there are presentations by panels of experts in various areas of current interest. Each panel has had preparatory "preliminary fact finding sessions" to hone the issues and focus on consensus, where possible, on myriad issues and controversies in ECC. I was honored to be a member of the "Citizen Response to Cardiac Arrest" panel. One particular area of interest was in the "emerging" role of the medical dispatcher within the "Chain of Survival's" first link—Early Access.

In the past, the key performer in this link was widely viewed as the citizen or lay person. All attention was focused on reaching, stimulating, and training the citizen/lay person to act correctly in the face of a nearby emergency. In 1991, one of the key members of the ECC Committee recommended to the chairman of what was to be my panel, that significant input might be elicited from the public safety dispatch community regarding the new concept of "Phone first, Phone fast." continued on page 6

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From the President's Desk:

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

"Isn't the AMPDS an unnecessary burden?"

Not long ago, a representative from a large EMS agency in California asked me a poignant question. It went something like, "our urban response times average under five minutes, so why do we need to provide Pre-Arrival Instructions? Additionally, if we adopt the MPDS, won't we have to hire more dispatchers to cover the increased time they will be spending on the phone?" In essence, I was being asked, "why does any agency need the MPDS? Doesn't it just add an additional and unnecessary burden on our dispatchers?" I consider this an intriguing question, the answer to which I feel should be shared with the entire body of NAEMD-certified dispatchers.

Regarding the need to increase dispatcher coverage when implementing the MPDS, I can say unequivocally that no dispatch center that I am aware of has ever been forced to increase dispatchers as a result of implementing the MPDS. Once the MPDS is phased into standard dispatch operations, the provision of an additional dispatcher is unlikely.

"No dispatch center that I am aware of has ever been forced to increase dispatchers as a result of working the MPDS"

Many dispatch centers, in their new-found zeal to "save choking babies" may sometimes give inappropriate, unnecessary, and even dangerous PALS before establishing a firm idea of the real problem. They are on thin ice if someone questions their judgment, which is likely since crises and deaths are always fair game for disgruntled citizens.

Thirdly, average response times are just that..."average". For every one under five minutes, one is over. For every near "still alarm", there is a ten or eleven minute response. The average and below only insure quick responses to the "average" cases. It is the moral responsibility of any dispatch center to provide a "zero minute response time" to all patients. What happens if a first responder gets stopped by a train on a critical case that would have had a 3.5 minute response. Legally you wouldn't have a leg to stand on in court with the national standard as well.

"when a law suit happens it's usually an isolated one-time occurrence, but it's for million-dollar stakes"

PALS will not add an extra time burden to the dispatchers. To use the Los Angeles Fire Department as an example, it was proven during their MPDS implementation that the interrogation time actually dropped enough to allow the inclusion of all PALS, making the new call processing times equal with their pre-existing average of 72 seconds on all calls. Additionally, the time to dispatch on critical (time/pace priority) cases like cardiac arrest, choking, etc., was significantly shortened because the MPDS protocol identifies the most important things first and deals with them. In these cases, a maximum response is dispatched before asking questions that verify the need for telephone treatment sequences. The MPDS in my Los Angeles example did not change the call waiting time (in the queue) either. They averaged 7.0 seconds both before and after implementation.

The associated issue of "short response times" was one of the questions I had to deal with in the implementation of the MPDS in Salt Lake City over 13 years ago. Both dispatchers and administration initially stated essentially that, "We will be there before PALS can be performed or have any effect". There are four problems with this logic.

First, the national standard of care now states that "Pre-Arrival Instructions are a mandatory function of each EMD in a medical dispatch center. Standard medically approved telephone instructions by trained EMDs are safe to give and in many instances are a moral necessity" according to the NAEMSMP and ASTIM (copies of both of these standard documents can be obtained by contacting the NAEMD).

Second, the time of response is somewhat irrelevant regarding the use of the MPDS since the provision of PALS or Dispatch Life Support of any kind is predicated on the fact that one has to determine which cases require telephone intervention or advice and what exactly is the right thing to tell them. In essence, the MPDS is the Primary (Entry protocol) and Secondary (Key Questions) Survey. Proper assessment is always necessary prior to formulation and then delivering appropriate care. It is extremely important to follow a standard protocol at dispatch.

"Dispatch centers in their new-found zeal to "save choking babies" may sometimes give inappropriate, unnecessary, and even dangerous PALS before establishing a firm idea of the real problem"
Letters

Q. Where's my respect?

I was fortunate enough to attend an EMD course in Charleston, S.C. taught by Scott Hauert. The course was very enlightening in my opinion and I am looking forward to attending anything that the NAEMD has to offer.

I am a dispatcher for a Communication Center in South Carolina. We dispatch for 27 Fire Departments, 10 EMS Units County Rescue, and 3 small town Police Departments. We consist of 8 full time dispatchers whom are all Academy-Certified EMDs and 4 part time dispatchers. We are presently working on a CAD System and also handle NCI/C for the police departments. Our county hopes to also have 911 within the next two years.

In the past I worked in the field with EMS for about five years. I know exactly what it is like to respond to a call and not know what to expect when you arrive. I guess I've seen a little of everything that can happen to EMS workers on a call. We pride ourselves in doing the best job possible for our friends in the field as well as for the people of our county, but we seem to be encountering problems.

The field EMS system in our county doesn't seem to think that we are capable of prioritizing calls and dispatching the proper equipment to where it is needed. In my opinion, they feel that the need to decide what units go where should be theirs. It seems that they do not want to accept the possibility that we can do our job. The attitude we get is that they are in the field and know more about what is happening than we do. We can't seem to get the point across that we are on-line with the people needing help and are asking key questions so that we can tell them as close as possible what the situation is.

I was reading an article in the Summer, 1991, NAEMD Journal titled Dispatch - The Voice of EMS and came across a very interesting statement that in my opinion is our EMS's assumption of dispatchers. It stated, "A few years ago, the dispatchers' job was simply to keep track of the ambulances in service, get the patient's address, and put the two together." I agree that that assumption is wrong. We do the very best job possible at all times.

After speaking with several of the EMS supervisors and our supervisor we still come back to the same situation. My question is: How do we get EMS to understand that we too are trained professionals and can be trusted in what information we relay to them and assure them that the response we are sending is adequate?

—Name withheld

A. Right here!

I can feel your frustration and will attempt to answer the basic question that you posed. Although many individual dispatchers have taken it upon themselves to obtain EMD training, that, in and of itself, is not sufficient to convince other elements of EMS that you are "trained" professionals whose information and unit response selection can be trusted. Our experience in over 3000 cities has demonstrated to us that there must be a systems approach to the implementation of Medical Priority Dispatch.

Individual training that cannot be used because of existing or antiquated dispatch policies is an exercise in futility. The systems approach dictates that it is not only the dispatchers that must be educated. Elected officials, management and supervisory per-

“Individual training that cannot be used because of existing or antiquated dispatch policies is an exercise in futility”

sonnel, and field responders must also be provided with education and information that dispels the myths regarding EMD. Political jurisdictions must then make a conscious policy decision to change emergency medical dispatch methodology and seek expert guidance to assist them in addressing the issues that the policy decision raises.

On a national level, dispatchers have been recognized as a key element of the EMS system. The National Association of EMS Physicians (NAEMSP) and the American Society of Testing and Materials (ASTM) have taken official positions on the need for training emergency medical dispatchers in standardized interrogations, pre-arrival instructions, and pre-determined unit responses. There have been a number of articles in JEMS and other EMS journals that have supported the evolution and advancement of the medical dispatch science.

“Recently published studies... have clearly demonstrated that trained EMDs who use medically appropriate pre-determined protocols can prioritize EMS calls”

Nevertheless, it takes time for advancements in technology to disseminate throughout the United States.

We have found that in many cases the adoption of the Medical Priority Dispatch System has been facilitated by EMS field responders and dispatchers themselves. By providing information that is in the literature they have piqued the interest of policy and decision makers in their individual locales. It is becoming increasingly apparent that those systems that have not kept pace with advances in the dispatch science are incurring huge risks both from a patient care and medicolegal perspective.

Recently published studies by Dr. Kallsen in Fresno County, California and Dr. Pepe in Houston, Texas have clearly demonstrated that trained EMDs who use medically appropriate pre-determined protocols can prioritize EMS calls. They can effectively and efficiently send the right thing, to the right place, at the right time, in the right way. By "the right way" I mean Red Lights and Sirens (RLS) or non-RLS. This particular issue is one developing area of EMS litigation.

—Jeff J. Clawsen, M.D.
Teamwork Works

The next time you see geese flying along in a V formation, you might be interested to know what science has discovered about why they fly that way. As each bird flaps its wings, it creates an uplift current for the bird immediately following. By flying in a V formation, the flock adds at least 71% greater flying distance than if each bird flew on its own.

People who share a common direction and have a sense of community can get where they are going quicker and easier because they are travelling on the thrust of one another.

Whenever a goose falls out of formation, it suddenly feels the drag and resistance of trying to go it alone, and quickly gets back into formation to take advantage of the lifting power of the bird immediately in front.

If we have as much sense as a goose, we will stay in formation with those who are headed in our same direction.

When the lead goose gets tired, it rotates back on its wing and lets another goose take over the lead.

It pays to take turns doing hard jobs.

When geese are in the V formation, they are constantly honking from behind to encourage those up front to keep up their speed.

What are we saying when we honk from behind?

Finally, when a goose gets sick or is wounded and falls out, two geese fall out of formation and follow it to the ground to help and protect it. They stay with it until it dies or is able to fly. And only then, do they launch out to rejoin their group or another.

Introducing...

Robert L. Martin has replaced Mike Jessop as the NAEMD’s Executive Director. Robert is the co-author of all Medical Priority’s advertising, promotional literature and training materials and has worked closely with Dr. Clawson since the NAEMD’s inception in 1988. Prior to that time he was an independent computer consultant and manager of his own secretarial and graphic design service. He is a member of the Pi Kappa Alpha Fraternity, has been recognized by Outstanding College Students of America and this year will graduate in Marketing from the University of Utah. In addition to his administrative role, Robert will continue to coordinate the writing, technical development, design, layout and publication needs for the NAEMD, including the maintenance and internal logic consistency of the Advanced Medical Priority Dispatch System. If you have technical questions about the Advanced MPDS, the NAEMD’s College of Fellows, official publications or the overall function of the NAEMD itself, please direct your call to Robert.

David T. Garcia is the NAEMD’s new Manager. David is now responsible for coordinating all the records and certifications for the Academy. For the past two years, David worked as office manager for a Computer-Aided Dispatch company in Sacramento, California. He acted as liaison between several EMS, Police and Fire Communications Centers and has excellent management and organizational experience. If you have questions about course registrations, test scores, retesting, certification, recertification, or general management issues, please direct your call to David.

Scott A. Hauert has been working as the NAEMD’s “Director of Training.” To clarify the National Academy’s role, his title has recently been changed to Director of Curriculum. This change is to emphasize the importance of the material taught during an NAEMD-sponsored certification course. Also, the NAEMD does not conduct its own “training” per se, it only endorses curriculum that meets certain content standards and provides student testing and a National Registry for EMD Certification. Scott is one of the original NAEMD founders. He currently serves on the Board of the Utah State Emergency Medical Training Council, and the Salt Lake EMS/InterHospital District Council. He is a member of the Board of Directors of the Utah Heart Association, and is a past President of the Utah Association of EMTs. He has personally recruited and trained the complete NAEMD staff of instructors. As an accomplished lecturer and writer, Scott has travelled all over North America. If you have technical questions about course curriculum and content, on-site comprehensive EMD consultations, or quality assurance and risk management programs, please direct your call to Scott.

Founded in 1988, The National Academy of Emergency Medical Dispatch is a non-profit organization dedicated to furthering the advancement of Emergency Medical Dispatch in the U.S. and throughout the world. Its membership has grown steadily from its beginning to more than 5,000 individuals today, representing more than 1,700 progressive Emergency Medical Service agencies.
The NAEMD's College of Fellows

The NAEMD is comprised of Nationally Certified EMD's, and medical control and administrative personnel. The College of Fellows is the standard-setting body of the NAEMD, working closely with the Board of Directors. The College of Fellows' purpose & Mission Statement is:

"To conduct an on-going review of the current standards of care and practice in Emergency Medical Dispatch and evaluate the tools and mechanisms used to meet or exceed those standards."

The College of Fellows (with its members listed at left) is a unified international scientific body of experts and maintains the integrity and credibility of the Advanced MPDS protocols. This is done through a pre-established process of reviewing and, where appropriate, approving proposed modifications and improvements to the protocols. Without such a process, an insightful user cannot possibly share findings with every other dispatch center in the world, nor is there any to validate local findings or ideas. After approval of a modification to the protocols, a new protocol card or computer disk will be sent to all licensed users.

Just as the American Heart Association controls the standards of CPR, BLS, & ACLS, The NAEMD's College of Fellows maintains the standards and integrity of the Advanced MPDS protocols and curriculum, as well as all aspects of Dispatch Life Support. Through application and adherence to the scientific method of review and voting by the College, the protocol remains unified and standard and not subject to arbitrary, anecdotal modifications that are not medically nor legally supportable. The built-in Determinant coding system with its 227 sub-determinant codes, allows comparative study and science across jurisdictions, boundaries, and borders. Changes or modifications to the printed or computerized protocols not authorized by the NAEMD are expressly prohibited under the license agreement and copyrights. Note that the actual Responses based on the codes, however, are always locally developed and implemented by the user agency.

Through the College of Fellows (see the Organizational Chart below), the Advanced MPDS will be properly maintained and its accuracy assured for the important dual purposes of:

1. Improving patient care, and
2. Maximizing the efficiency of EMS systems.

Given the fact that the tool EMD's are trained to use (the Protocols) is designed to help people in their moment of crisis, and in some cases actually provides remote, dispatcher-directed life-saving interventions, there is no other medically correct, morally responsible way to do it.
National Recognition for EMDs

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Doing one minute of CPR on an apparent cardiac arrest victim prior to activating the EMS system has been the standard for some years.

Through discussions with panel members, interest in the role of the trained Emergency Medical Dispatcher was initiated officially at the AHA. It made sense to them that, regardless of the citizen's training status, their skill retention, or even their fear, the EMD could be the professional "constant" by teaming with the caller to aid the victim. While this realization by such an important organization as the AHA is quite late in coming (from a historical perspective) it is happening at a very opportune time, for quite different reasons from those which might seem obvious.

In order for the AHA to rely on the medical dispatcher to "be there" for the "phone first" caller (when the callers go to the phone significantly earlier in the arrest crisis) the experts wisely asked if the EMS "infrastructure," as they put it, was in place and ready to function for anyone calling 911 or another emergency number.

As much as I would have liked to have given them a big grin and a thumbs up, I had to sigh and report that from what we know about the EMS "infrastructure" in America at present, less than 20% of dispatch centers offer any form or sort of telephone aid. What is even more sobering is that less than 5% of American dispatch centers provide PALS from scripted, medically approved protocols after formal, standardized training in Emergency Medical Dispatching. "Who ya gonna' call?" if you discover an unresponsive person in collapse, unfortunately, is still dispatchers who have no emergency medical training (as opposed to certified EMDs) in the vast training and protocol wasteland of public safety answering points worldwide.

The good news is that it appears the AHA's ECC will strongly and officially support not only the presence of a universal 911 number, but the formal training of EMDs and their use of medical protocols, including medically approved scripts for airway control, foreign body obstruction relief, and cardiac arrest treatment by telephone. In addition, they appear to be on the brink of endorsing two medical dispatch "national standard" documents: The National Association of EMS Physicians' "Position Paper" on EMD and ASTM's F 1258-90 "Standard Practice for EMD." By quoting that, "Pre-arrival instructions are a mandatory function of every medical dispatcher in a medical dispatch center" and "Standard, medically approved pre-arrival instructions given by trained dispatchers are not only safe to give but in many instances are a moral necessity," such long-needed allied medical support will clearly place the most influential medical specialty group in history, squarely behind the thirteen year medical dispatch "movement." The AHA will have not only validated the medically trained dispatcher's role in the Chain of Survival, but will have strongly locked in the now unstoppable process of making the trained EMD a universally found "first" first responder.

I think the point was successfully made that training dispatchers in CPR is not enough. That practice provides only the "illusion of pre-arrival instructions" for cardiac arrest victims. The accurate, consistent, verified-as-medically-necessary certified EMD "invasive" procedures, such as CPR and foreign body obstruction relief thrusts, are what must be routinely provided where possible and appropriate by trained and certified EMDs.

The nation-wide publicity dispatchers have been given on Rescue 911 is a positive first step. The public's developing perception of the dispatcher as an EMS professional has had both good and bad side effects. First, it has created a hero image of dispatchers which is a far cry from the "clerk" mentality held by so many citizens and even dispatch employers. However, this new "hero" status has, in another way, created a new monster. As one dispatcher put it, it is now "cool to save choking babies." The public, and many medical dispatchers themselves, see the ungodly, ad-lib provision of CPR from a dispatcher who has been "certified in CPR" as completely adequate. Nothing could be further from the truth. Quality assurance-based studies have shown that dispatchers not following scripted protocols will omit over 50% of the verification and treatment steps in a given PAI procedure. If a doctor was that inefficient, it is not likely that his patients would return for more inconsistent and fragmented care—if they survived. If you don't believe this, try to tell someone, over the phone, how to tie their shoes—something everybody knows how to do themselves. Non-visualy instructing it and doing it promptly (even when no crisis is present) is nearly impossible off the top of one's head—and so it is for important pre-arrival instructions.

In addition, TV has given the public the widespread expectation that the EMD will "tell them what to do" until the paramedics or ambulance arrives. Recent nationally aired cases of mothers holding dying babies while pleading

"Dispatchers not following scripted protocols will omit over 50% of the verification and treatment steps in a given PAI procedure"

with dispatchers for help (specifically CPR) was not lost on the viewing public. Their developing expectation is for modern emergency medical dispatch, while the current reality throughout most of the nation, from a medical dispatch perspective is "pre-historic."

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“The American Heart Association has just jump-started the process to fix this ‘weak link’...and it may just be the single most important ‘defibrillation’ in their history”

issue, rather than a funding/taxation issue, I believe the case for negligence (duty) becomes even stronger.”

Enter the AHA. All public safety agencies providing medical dispatch services must realize that they are about to enter a new epoch of expectation based on evolving standards of duty, practice, and care in medical dispatching. The AHA has just jump-started the process to fix this “weak link” in the infrastructure of prehospital care, and it may just be the single most important “defibrillation” in their history.

AMPDS Burden?

from place the unit “went out”, etc., etc.,). It is wise not to rely heavily on response times as they can give a false sense of security in many situations.

Dispatch is the “jewel upon which the watch of EMS turns.” In both its manual flip-card version and now fully automated “ProQA” software, the AMPDS provides a systematic and time-proven standard of care, fully supported and maintained by the NAEMD’s College of Fellows. It used to be that dispatch was not observed effectively and that EMS dispatch could be disregarded as an equal to law enforcement and fire dispatching in the same center. This is just not the case anymore. Now that there is a proven, reasonably simple way to be state-of-the-art in medical dispatching, it makes no sense not to do it.

What I Love About This Job

by Toni Wolff
Alachua County Sheriff's Office, Gainesville, Florida

“Mary? Mary! Mary, listen to me.
You're going to have to calm down and listen to me
if we're going to help your baby.
Are you listening?
Good.

Now, I'm going to tell you how to give Mouth-to-Mouth.
Place your hand under the baby's neck and shoulders
and slightly tilt the head back.
Completely cover the baby's mouth and nose with your mouth.
Then, blow two soft puffs of air into the lungs
Just like you're blowing up a small balloon.
Watch for the chest to rise with each breath.
When you've done this, come right back to the phone.
Go do it now.
Go ahead, Mary, you can do this.

He's crying? Good, Mary, that's great!
As long as he's crying, he's breathing!
Isn't that the most wonderful sound you've ever heard?
You did great, Mary.
Just let him cry, honey,
Let him cry.

The ambulance is there?
Okay, let them take over.
What?
Oh, no Mary! You were just great!
Go ahead and cry.
You've earned it!
You were just wonderful!
Oh, you're welcome, Mary,
I'm glad I could be here to help.”

I love reaching out,
 Holding on,
 Being strong and capable
 And a safe place
 In a dangerous world.

I love the moment when hysteria breaks and reason returns,
 And I'm able to help a stranger
 Whose world has been disrupted,
 Shattered,
 Perhaps forever.

I love stretching
 Growing,
 Extending beyond my own limits
 To meet someone else’s need,
 Being the person I've always hoped I was.

I love taking a chance,
 Breaking down the walls
 I've so carefully built,
 and finding the world a better place
 Because I cared.
Q.A. Coding Dilemma...

Ted Stockwell
Cleveland Emergency Medical Services

I am writing this report to explain the slight delay of the dispatch of an emergency call yesterday. After receiving the call and giving the appropriate PDI's I had just flipped closed my card file unaware that my hand was still on the board, the cards crashed down upon my left hand trapping it (22). Startled and in pain I jumped back tripping and falling (17) over my chair. My right hand, still holding my dispatch card came up suddenly and the corner of the card impaled my right eye (16). Some time during the fall I accidently knocked over my cup of coffee, which incidentally I only drank half of because I realized that I had putroach poison (23) instead of coffee-mate in it. The coffee spilled into my console shorting it out and when I put my hand out to stand back up I received a continual shock (15) until the capacitors overloaded and blew up (7) causing me to be thrown backwards landing with my head in the cleaning lady's bucket of pure chlorine (8). My head was so completely stuck in this full bucket I couldn't get it out and being full of chlorine caused me apparently to drown (14). I say this because I awoke to find a pretty girl performing chest compressions on me (9). I waited to let her know I was awake until after she gave me a few more breaths. Apparently I responded too enthusiastically because she slapped me (4) several times across the face knocking loose a tooth which fell back into my throat causing me some trouble breathing (6) until I gasped and inhaled the tooth and occluded my airway (11). I choked for a few minutes until it finally came up and before spitting it out I accidently swallowed it. I know I swallowed it because I could feel it rolling around in my stomach, a most irritating feeling (1). To be honest with you I was starting to get a headache (18), a feeling that I quickly lost when I noticed the police dog that had somehow gotten into the EMS side of the dispatch center was chewing rather angrily on my left leg (3). I grabbed the first thing I could find to defend myself with—a CO2 fire extinguisher. I discharged the extinguisher onto the dog and consequently onto my leg giving myself a rather solidly frozen knee joint (20). This last incident was more complicated by the fact that I have an odd allergy (2) to German Shepherds, and since this dog was of that breed I found myself breaking out in hives. The reactions usually do not progress more than that but one of the hives was unusually scary looking and I promptly fainted (31). I awoke quickly however to notice that I had some slurred speech and difficulty using my right hand. The doctor who later examined me stated the slight stroke I had suffered (28) would leave no permanent damage. It was then when I noticed my pen had gone through my hand (27) and was causing a very serious amount of bleeding (21). Ignoring the pain I again got up and walked over to the radio operator to give her my current dispatch ticket. I started feeling the tightness in my chest (10) that I first experienced when the doctor first told me I was a diabetic (13). He also told me the heart attack (19) I just suffered was only a minor one. I was almost to the console when I felt the old familiar twinge of back pain (5) that I often have stemming from an old football injury. That's when I fell again, not passed out or tripped—I don't know (32) what was wrong—but I was able to get back up. That is until I had the seizure (12). It was over quickly though and I was just about to hand my ticket over when the truck came crashing through the wall of our center (29). All I suffered was a broken leg (30) and slight aggravation of my hemorrhoids (26). The radio operator however was not so lucky, as soon as she dispatched the ambulance on my assignment she felt her first labor pain (24). I must be crazy (25) to work here!

National EMD Certification Courses

Through Medical Priority Consultants, the NAEMD regularly sponsors National EMD Certification Courses at various training sites across the country. Medical Priority can arrange for these courses to be sponsored on-site by your individual agency. These courses offer 24 hours of comprehensive, professional EMD training, recognized with an official NAEMD Diploma and Certificate (upon successful completion of the examination and initial application).

The following 1992 courses are currently scheduled:

**JULY**

10-12 Birmingham, AL
(Suburban Ambulance)

10-12 Youngstown, OH
(American Ambulance)

17-19 Flint, MI
(SWM Systems)

24-26 Vicksburg, MS
(Vicksburg Fire Dept.)

29-31 Las Vegas, NV
(Las Vegas Fire Dept.)

30-1 Heber, AZ
(Heber-Overgaard Fire Dept.)

**AUGUST**

13-15 Concord, NC
(Centralina Council of Govts.)

19-21 San Marcos, TX
(San Marcos Police Dept.)

28-30 Sanford, FL
(Seminole County EMS Acad.)

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