Service & Support

Here we Grow...

* Robert L. Martin, Executive Director

In an effort to provide better service and support for its certified EMDs, the Academy has expanded significantly in the past few months. We have moved to a larger office space, added a toll-free 800 phone number, implemented a more efficient computer database and hired additional staff to assist with record-keeping.

To reach the Academy toll-free, dial 1-800-960-NAEMD (6236). The Academy’s street address remains the same, at 139 E. South Temple in Salt Lake City. Our new offices are Suite 530. All currently certified EMDs should have received with this newsletter a “business card magnet” listing our new address and phone number.

Currently, Academy office staff is comprised of the following dedicated individuals:

- David Garcia, Manager
- Amy Ehr, Service & Support
- Karen Argyle, Data Processing
- Scott Hauert, Curriculum
- Fred Hurtado, Editor
- Bonnie Williamson, Finance
- Robert Martin, Exec. Director

The office staff works closely with Dr. Clawson, the Board of Directors, and the College of Fellows. Through the College of Fellows the Academy can address itself to scientific issues related to dispatch. The College is currently comprised of 41 EMS experts, with specific specialties or interest in EMD.

Appointment to the College is given by special invitation and voting. Three new members were recently appointed. They are:

- Gilles Bastien, MD, Ph.D., of Montreal, Canada
- David Massengale, EMT-P, of Sacramento, California
- Mikel Rothenberg, MD, of Cleveland, Ohio

Dr. Gilles Bastien is the Medical Director for Urgences-Sante, Montreal, Canada. He was instrumental in beginning a comprehensive EMD program that will soon be extended to the entire Province of Quebec. He is an EMS and Education specialist. In addition to his MD, Dr. Bastien holds six other academic degrees, including a Ph.D. in Education from Montreal University.

Mr. David Massengale has worked in EMS & Fire Dispatch since 1973. He is currently a Paramedic, Field Training Officer, and Lead Instructor for Sacramento County, California State Highway Patrol and for the NAEMD. He has instructed EMD certification courses throughout California and across the U.S.

Dr. Mikel Rothenberg is an expert in EMS education and writing. He received his MD degree from the University of Colorado and is currently an Emergency Physician at Lutheran Medical Center in Cleveland, Ohio. Dr. Rothenberg is the author of several textbooks and articles related to EMS, ACLS, and Risk Management. He is a contributing editor for JEMS, EMS Insider, and Prehospital Care Reports.

We are honored to welcome these three outstanding individuals as members of the Academy’s College of Fellows. With insight from all the Fellows, the Academy is unique in being able to provide a scientific, systematized forum and format for continuous professional EMD protocol review and improvement.

Maintaining the MPDS protocols is only one function of the College. Our goal with the Academy is to provide an International clearing house of information relative to EMD, including Quality Assurance and Improvement programs, Continuing Dispatch Education, and the development and support of uniform EMD practice standards. We value input from all certified dispatchers and appreciate your continued dedication to professionalize EMD.

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Rural Dispatch

• Jeff J. Clauson, M.D.
  President

Following the recent release of the version 10.1 updates to the Advanced MPDS, and the associated endorsement by the Academy’s College of Fellows, several people have commented to me on how well the MPDS maintenance program works. A few mentioned that the MPDS is a “Cadillac” dispatch system, the best of the best, but hindered with the stigma of being too expensive or unattainable for a small rural dispatch center with limited personnel, equipment and budget.

Actually, the Advanced MPDS was designed specifically for the small dispatch center, where resources are limited and money is tight. In these situations the MPDS provides systematic direction to the dispatcher(s) rather than forcing them to “reinvent the wheel” every time an Emergency Medical call is received. The system just happens to work exceptionally well in larger centers also.

Press coverage and discussion of recent high-profile MPDS installations in municipalities such as Montreal and Cleveland, can sometimes give the impression that installation in smaller dispatch centers goes unnoticed or underappreciated. This is certainly not the case.

We recently received a letter from Ruth Maxwell, an EMD for Ketchum Communications in Ketchum, Idaho. Ms. Maxwell’s situation is a perfect example of the MPDS working well in a small, rural center. She writes, “I wanted to comment on one of the questions in the Spring ‘93 Q&A Column. The last question addressed the dilemma of a single station dispatcher with simultaneous emergencies. Our procedures are in line with your response and I hope to take it a little further.”

Ketchum Communications is a single station center and we feel that we have as good a solution as possible. Our policies include that no caller gets put on hold or disconnected without first obtaining the location and call-back number. Along with this policy is that we stay on the phone with calls providing PALS until responders arrive (assuming that caller’s safety is secured). There is always a dilemma with simultaneous calls. Should a second 911 call come in during an emergency, dispatchers will answer the second call to determine its seriousness (it may be necessary to put the first emergency on hold for a very short time). Using their good judgement, the dispatcher then attempts to answer the most life-threatening call. If both calls are high priority, the dispatcher will use our second phone to maintain both calls at the same time. It is theoretically possible to provide PALS to both callers at the same time and in extreme cases I would definitely attempt this.”

Thank you Ms. Maxwell for sharing your intelligent insight. The National Academy of EMD applauds the efforts of everyone providing effective DLS, whether from small or large centers.

MPDS Q&A.

• Scott A. Hauert
  Director of Curriculum

This issue’s column is dedicated to a letter we received from Santa Cruz County in Watsonville, California. During their review, Santa Cruz brought up the following very interesting questions.

Q. Key Question #6 on the Convulsions/Seizures Card #12 (which reads “Is the epileptic or ever had a seizure before?”) does not provide the dispatchers any response to the caller’s answer. What should the response be if the answer is yes or no? Our Q.A. committee believes that the response to a first time seizure should be a high priority.

A. This key question is to provide en route “big picture” information for the responders and does not affect the level of response nor PDLs. Emergency medical standards do not create any different prehospital urgency to a first-time seizure unless it is continuous or recurs.

The difference regarding “first-time” seizures is the in-hospital (and neurological) workup of the patient to determine the underlying cause. This does not mean that it is a prehospital emergency, as nothing will be specifically done to the patient unless warranted by the presence of mitigating priority symptoms. The Key Questions of pregnancy, diabetes, recent trauma, and cardiac history are special indicators prompting a higher response.

Q. Rule A on the Falls/Back Injuries (traumatic) Card #17 reads “Always consider that the patient’s fall may be the result of a medical problem (fainting, heart arrhythmia, stroke, etc.)” The dispatchers suggest that Card #17 should shunt to those conditions.

A. This suggestion is consistent with Rule A, however, “fainting” already shunts to Protocol #31. For stroke and heart arrhythmia’s first, a stroke would be a secondary dispatch diagnosis and would, even if the patient was not alert, result in at best a CHARILE level response code instead of a DELTA level on Protocol #17. The PDLs for both protocols are essentially the same. Second, Heart Arrhythmia’s are difficult to determine at dispatch and a shunt to a “Shunt” card – Heart Problems – would be inappropriate given the fact that a lower response could occur even in the presence of priority symptoms such as “not alert” or “abnormal breathing.” Secondary determined problems are established as “Go To” shunts only when they identify a category that would be responded to, or interrogated in a unique way within another protocol. In general, protocol “jumping” is discouraged as a definitive Chief Complaint is more often the correct one and leads to less confusion in processing.

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Continuing Dispatch Education

By now, all licensed Advanced MPDS users should have received their new version 10.1 updated protocols. Along with the updated cards, came a memorandum detailing each change. This is an important document for Continuing Dispatch Education. Keep track of time spent reviewing the new protocols. Going over these changes with a local dispatch supervisor or administrator will count for between 2 and 4 hours of CDE toward each dispatcher’s recertification.

Recent Research

Robert L. Martin

A large portion of the responsibilities of the EMD relate to determining appropriate resource utilization in response to emergency calls. This can be correlated with “sending the right thing, in the right way, at the right time, in the right configuration.” In properly fulfilling these responsibilities, the trained and certified EMD can be part of the solution to the growing problem of EMS misuse.

The Annals of Emergency Medicine recently published an interesting study conducted by Eric Brown, MD, and Jody Sindle, Ph.D., both from Yale University, entitled “The Emergent Problem of Ambulance Misuse” (Annals, 22:4, April ’93). This study then concluded that “Ambulance misuse is common in the studied community and may be related to the broader problem of the provision of care to the poor or otherwise underserved.” The study used a sample set of 373 records of patient transport and treatment at the Emergency Department of a 175-bed community hospital in central Connecticut.

Among other issues, the study examined retrospectively whether or not ambulance use was necessary. The study found that “36 patients (55.4%) had appropriately used an ambulance, and 61 patients (44.6%) had done so inappropriately.” The study deemed ambulance use as unnecessary if “the patient’s presenting complaint was nonemergent, the patient was ambulatory, and the patient was not ultimately hospitalized.”

Also cited was the overall rate of EMS misuse, which based on research the authors believe to be between “40% to 50%.”

Another report of interest to EMDs was published recently by Jill J. Clark, et. al., of the Center for Evaluation of EMS in Seattle, Washington (Annals, 21:12, December 1992). For the study, entitled “Incidence of Agonal Respirations in Sudden Cardiac Arrest,” the authors reviewed 445 nontraumatic out-of-hospital cardiac arrests that occurred before arrival of EMS at the scene. Using the authors’ review criteria, agonal respirations occurred in 40% of the cases. Among witnessed arrests, they occurred 55% of the time.

With such a common incidence of agonal activity in cardiac arrest victims, the implications for the EMD while giving pre-arrival instructions are important to consider.

The authors encourage EMDs to “be aggressive in encouraging bystanders to perform CPR when descriptions of agonal activity are reported.” The study concludes with the warning that, “the presence of agonal respiratory activity may prevent bystanders from initiating CPR, may prevent dispatchers from properly identifying the problem, and may prevent dispatchers from providing CPR instructions. Dispatchers must be aware of the frequency of this occurrence...if signs of agonal activity are present in the unconscious patient, dispatchers must proceed without delay with delivery of CPR instructions.”

The Academy encourages each EMD to be aware that a lay person may easily interpret agonal respirations as “breathing difficulty” and may report an unconscious person as “breathing” if such respirations are present. This is partly why Axiom 1 on the Cardiac Respiratory Arrest protocol (#9) and Axiom 5 on the Unconsciousness/Fainting protocol (#31) both read that “Funny noises” reported by the caller generally means that patient is unconscious with an uncontrolled airway and often represents agonal (dying) respirations at the beginning of a cardiac arrest. This is also why Rule A on the Breathing Problems protocol (#6) reads that, “Difficult breathing is an Advanced Life Support (ALS) problem until proven otherwise.” An “uncertain” answer to the breathing question, often associated with arrest situations witnessed by second-party callers, should always prompt an “arrest-level” response at the outset and continued evaluation of the patient for verification of life signs.
MPDS Q. & A., continued

Q. As a training problem and for practical use, the dispatchers are having difficulties in defining the terms “Alert”, “Difficulty Breathing”, and “Abnormal Breathing”. Do you have any prepared definitions for these terms or any explanations that would help in this regard?

A. Currently there are no “official” definitions of these terms, however, I can offer some clarification. “Alert” in our opinion means “awake and oriented.” In most cases, this can be presumed to mean that they can “talk normally” with one main exception. Some individuals with a specific type of stroke affecting their speech formulation center can be totally alert and oriented but unable to effectively speak. That is why Key Question #1 is worded as “Is she alert (awake)?” rather than “Is she alert (able to talk)?”

As Dispatch Axiom #4 on Card #31 implies, if there is any doubt as to whether a patient is “alert” due to lack of understanding on the part of the caller, the dispatcher should ask if they are “able to talk”, then “awake” or even “with the program”, “making sense”, or a more descriptive phrase. However, if doubt remains after dispatcher-directed attempts at clarification, apply the Second Law of Medical Dispatch — “When in doubt, send them out,” or (more medically speaking) “Always act in the direction of patient safety.”

“Difficulty breathing” and “abnormal breathing” are answers to oppositely directed questions that have, however, the same medical dispatch meaning. That is, any state different than normal, unlabored breathing. In a nutshell, advise your EMDs to go with the answer received to the questions that can generate these answers and don’t try to second-guess the caller. An example from a recent case we reviewed was a first-party caller that when asked if he was breathing normally, stated, “Well, not exactly.” From both a medical and a legal point of view, a dispatcher should assume that the answer is “No” even though retrospectively it might not pan out to anything really bad. In this particular example, this 36 year old male with a chief complaint of possible food poisoning, arrested 3 minutes after arrival of the ALS crew from an acute MI. Probably the next 5 or 10 patients with the same type of answer would not, but then medicine is based on statistical probabilities, and the dispatch standard of care and practice is to assume that what the caller says is correct and not a lie.

We appreciate the thoughtful, intelligent questions provided from trained system users. We would like to hear from any NAEMD-certified dispatcher regarding how the MPDS has had an impact on dispatch operations in your agency. Keep those letters coming.

Advertise your EMDs to go with the answer received...don’t try to second-guess the caller...assume that what the caller says is correct and not a lie."

**Newly Accredited EMD**

"Center of Excellence"

Cleveland EMS recently completed steps necessary for their Accreditation as a Center of Excellence. Pictured at the award ceremony (from left to right) is the Chair of Cleveland’s Physician/EMS Advisory Board: David Lehtinen; Clerk of Council, Artha Woods; Safety Director Carolyn W. Allen; Assistant Chief Mark Ricciutii; Mayor White; Councilman Polensek; and Commissioner Bruce Shade. The NAEMD congratulates the entire Cleveland EMS organization for their Accreditation and continued efforts to provide the best level of service possible for their citizens. ■