We appreciate our volunteers and member agencies for their dedication to public safety.
“Translational science” is all the work that goes into ensuring that research is put to use—that it actually goes out and serves the professionals, communities, and individuals it is intended to serve. That can mean anything from engaging more professionals in doing research, to actually “translating” scientific findings into more approachable forms.

**Middle East NAVIGATOR**
Dubai, United Arab Emirates
Feb 2018 — 45 Attendees

**Asia NAVIGATOR**
Kuala Lumpur, Malaysia
Mar 2018 — 350 Attendees

**US NAVIGATOR**
Las Vegas, Nevada
Apr 2018 — 1532 Attendees

**UK NAVIGATOR**
Bristol, England
Sep 2018 — 160 Attendees

**Australasia NAVIGATOR**
Sydney, Australia
Nov 2018 — 98 Attendees

**Euro NAVIGATOR**
The Hague, Netherlands
Sep 2018 — 165 Attendees

**China NAVIGATOR**
Jinan, China
Oct 2018 — 491 Attendees

**Dispatcher of the Year Recipients**

**Middle East** - Loai M. Ghazy Alrefai  
**Asia** - Nur Azwany Binti Aziz  
**US** - Kelly Cayer  
**US** - Margaret Dohrman  
**Euro** - Michael Strobl  
**UK** - Nikki McAuley  
**China** - Yue Weiqi  
**Australasia** - Natasha Ellis
“Translational science” is all the work that goes into ensuring that research is put to use—that it actually goes out and serves the professionals, communities, and individuals it is intended to serve. That can mean anything from engaging more professionals in doing research, to actually “translating” scientific findings into more approachable forms.

With Standards 10, the IAED™ is introducing a strengths-based approach to case review feedback, intended to facilitate a more positive QA/QI process.

In a bold response to recent catastrophes and countless other emergency events, Fire Priority Dispatch System™ v7.0 (Fire 7) includes six new Chief Complaint Protocols unavailable in any other protocol system.

IAED recognizes emergency dispatchers who have recently helped successfully deliver a baby. The Academy sends them a mug and posts their pictures on social media.
Dear IAED members, volunteers, and friends:

I extend my warm greetings and sincere thanks to each of you as we conclude another successful, memorable year.

It continually astounds me to see and hear about your dedicated efforts and passion for helping to move this industry forward. In your daily work, you interact with people who face life-and-death situations. Yet, you respond calmly, professionally, and with excellence. On behalf of everyone at the IAED, I commend you.

It’s customary to turn the page to a new year and reflect on accomplishments of the past. In 2018, we not only saw more growth, but we also saw changes—positive change that wouldn’t be possible or relevant without you.

The Academy now has more than 66,000 members, an increase of around 3,000 from last year. We now have a total of close to 111,000 certifications as well as more than 226,000 total members trained to date. The Academy has a presence in 46 countries and has a membership comprising 21 languages with more to come soon. These numbers are reflected in our NAVIGATOR conferences, held around the world in seven locations, as well as in our ACE program, which has swelled to 244 total agencies. We welcomed 45 new ACEs in 2018!

This past year, we rolled out the Supervisor Portal, which allows communication center leaders to track employees’ Continuing Dispatch Education progress and to assign courses. We also unveiled the Performance Standards 10th Edition, the Medical Transfer Protocol Suite™ (MTPS™), and Advanced SEND.

In addition, you’ve flocked to the College of Emergency Dispatch. We surpassed the 18,000-user mark, collectively completing more than 172,000 lessons. We’ve also increased our public outreach and public relations efforts, which have helped us develop key relationships and increased our visibility worldwide. Numerous television, newspaper, and online stories have mentioned or highlighted the Academy, the Protocols, and our members across the globe.

The list goes on and on, but you bring these accomplishments to life. Thank you for everything you do. Each one of you matters to us and plays a crucial role in the lives of many.

With gratitude,

Jerry Overton
President
The following U.S. patents may apply to portions of the MPDS or software depicted in this periodical: 5,857,966; 6,010,451; 6,053,864; 6,076,065; 6,078,894; 6,106,459; 6,607,481; 7,106,835; 7,428,301; 7,645,234; 8,066,638; 8,103,523; 8,294,570; 8,335,298; 8,488,748; 8,494,868; 8,713,761; 9,319,859; 9,516,166. The PPDS is protected by U.S. patent 8,396,191; 8,670,526; 8,873,719. The FPDS is protected by U.S. patent 8,417,533. Other U.S. and foreign patents pending.

Protocol-related terminology in this text is additionally copyrighted within each of the IAED’s discipline-specific protocols. Original MPDS, FPDS, and PPDS copyrights established in September 1979, August 2000, and August 2001, respectively. Subsequent editions and supporting material copyrighted as issued. Portions of this periodical come from material previously copyrighted beginning in 1979 through the present.

Follow IAED on social media.
Heidi started in late 1993 in police dispatch and meandered down the career path of calltaking, backup fire dispatch, statistician, SARA TITLE III assistant, supervisor, and finally shift manager for the Harford County Department of Emergency Services in Maryland (USA). What an adventure!

HEIDI DIGENNARO
12 | GUEST WRITER

Art is a software instructor and IAED™-certified EMD-Q® instructor for Priority Dispatch Corp. He has been a fire and EMS dispatcher for 20 years and is a former air medical dispatcher. He currently works at Union County Regional Communications in Westfield, New Jersey (USA).

ART BRAUNSCHWEIGER
13 | FROM THE EMD SIDE

Sherri is the training and operations manager for Waukesha County Communications, Wisconsin (USA), a combined dispatch center in southeastern Wisconsin, just west of Milwaukee, a land where the beer runs freely and locals proudly stack cheese on just about everything and call it great. You can contact Sherri at 262-446-5085 or by email at sstigler@waukeshacounty.gov.

SHERRI STIGLER
14 | LEAN IN

Mike began his journey in the field as a campus safety dispatcher for Azusa Pacific University (California) for a year before transferring schools. After graduating from the University of North Dakota (USA), he transitioned to working for Rural/Metro ambulance as a system status controller, where he still continues to work part time. Mike was the Rural/Metro transportation coordinator based at Palomar Medical Center before coming to FirstWatch.

MIKE THOMPSON
16 | ACADEMY ANALYTICS

During his more than four decades in EMS, Mike's credentials include street paramedic, writer, conference speaker, and multi-decade associate professor. As a consultant Mike has worked with EMS, fire, and public health in 48 of the 50 states and throughout the world. His expertise includes EMS Street Survival, Patient Centered Leadership, and Effective Quality/Performance Improvement. He is the improvement guide at FirstWatch.

MIKE TAIGMAN
16 | ACADEMY ANALYTICS

Follow IAED™ on social media for amazing dispatcher stories and news, ACE announcements, prizes, and more!

Facebook and LinkedIn: International Academies of Emergency Dispatch Twitter: @TheIAED
ICE CREAM AT BREAKFAST
Journal dishes out variety

Audrey Fraizer

There’s bound to be something in this issue to satisfy everyone’s tastes and, for starters, we have ice cream.

Ice Cream for Breakfast Day is the first Saturday in February. Florence Rappaport created this holiday in the 1960s in Rochester, New York (USA), to entertain her small children on a snowy day when they couldn’t go outside.

A “Dispatch Cat” named Charlie will never get certified, but that doesn’t make him any less important at Medstar Ambulance Inc., Spara, Illinois (USA). “I introduce him as ‘support services personnel,’” said Dispatch Manager Trecia Hanna. “He provides therapeutic love when needed and often provides comic relief.”

Two sheep tanneries, a woolen mill, a soap factory, and a brewery dominated the open landscape north of Salt Lake City, Utah (proper). To the south was a baseball field and an Episcopal Chapel. The Church of Jesus Christ of Latter-day Saints’ Temple and Assembly Hall dominated a single square block downtown kitty-corner to ZCMI. Gaynor Electric Fire Alarm was contracted to place 30 public fire alarms to alert the city’s single fire station. The city was “heartily” recommended to all fire insurance companies, and the city map was stamped for approval by the Sanborn-Perris Map Co., Limited, New York City, New York (USA) (November 1889).

Kendra Smith, a Communications Training Officer at Harnett County Sheriff’s Office in Lillington, North Carolina (USA), went from using a pen and paper to using Microsoft DOS and, taking yet another leap, managing multiple screens during her (so far) 20-year career in emergency dispatch.

144 Notruf Niederösterreich is the main emergency dispatch center in Lower Austria, one of Austria’s nine states. “Notruf” means “emergency call” in German—which they speak in Austria—and “Niederösterreich” means “Lower Austria.” Together it means “144 Emergency Call Lower Austria.”

Gathering information is a big part of our jobs at the Journal along with talking to people and arranging the pieces into an essay. Senior Designer Serina Nelson has an equally good time in complementing our words with her tremendous visual effects. It’s our hope and intention that readers enjoy the results as much as we enjoy putting each issue together for you.

By the way, if you’re interested in your locale’s fire rating (Sanborn maps, circa 1867 to 1977), check out the Library of Congress holdings at loc.gov/collections/sanborn-maps.

THE SKINNY
One of the best things about humans is that we love celebrating things. Oh, it’s the anniversary of your nation’s birth? Have the day off work, and set off some fireworks. It’s the day of your birth? Have some cake with fire on it! Want a day to remember the dead? We’ve got scads—one with candy, one with flowers, and one with skulls. We have national and religious holidays for just about everything.

There’s a lot of talk about some holidays, like Christmas and Valentine’s Day, being too commercialized. You don’t have to love the highly publicized holidays to love holidays in general. Some of my favorite holidays are the obscure ones that somehow work their way into our lives, like National Pancake Day or “I Love Yarn” Day. I wouldn’t normally care about World Donut Day, but if Krispy Kreme is going to give me a good deal on a dozen delicious donuts, count me in. Sometimes it’s nice to have an excuse to do something you don’t always do. It’s also nice to have something to celebrate during the long winter or summer months (depending on where you live) to break up the monotony.

So in case you don’t feel like celebrating Valentine’s Day on Feb. 14 but still want to party, here are some other February holidays you can observe instead.

Ice Cream for Breakfast Day is the first Saturday in February. Florence Rappaport created this holiday in the 1960s in Rochester, New York (USA), to entertain her small children on a snowy day when they couldn’t go outside. Ice cream might not be super enjoyable for those of you living in places where February is a winter month; you Southern Hemisphere folk might enjoy it a little more. But really, do whatever you want. That’s the point of made up holidays. Dig into that Ben and Jerry’s!

Chinese New Year is on Feb. 5, ushering in the Year of the Pig. If your Chinese zodiac sign is the pig—aka you were born in 1947, 1959, 1971, 1983, or 1995—you might want to lay low this year, as the year of your zodiac sign is traditionally your most unlucky year. See if anyone is holding a Lantern Festival near you.

Feb. 17 is Random Acts of Kindness Day in the U.S. Who doesn’t like the feeling of helping someone in a small yet significant way? Let someone go ahead of you in line, or write a compliment on a sticky note and give it to a co-worker.

And last but not least, Feb. 27 is International Polar Bear Day, which is designed to raise awareness of the impact of global warming on polar bear populations. Do something that’s good for the environment, like recycling, and then treat yourself by watching videos of baby polar bears.

I hope this gets you through the month, which always feels far longer than it actually is, even in leap years when we get the extra day. And don’t forget to mark your calendars—National Public Safety Telecommunicators Week is April 7–13. Love and appreciation are coming your way!
Hi,

I’m working on writing a Medical Protocol 7: Burns (Scalds)/Explosion (Blast) CDE lesson (78b). More specifically, I’m writing the “Selecting the Correct Chief Complaint” section and came across a situation that I’m not sure how to address, but would like to explore out of curiosity.

There is a recent phenomenon called “The Deodorant Challenge” where kids/teens spray deodorant from an aerosol can directly onto their own or another person’s skin. It is reported that the result of doing this is second- or third-degree burns (https://youtu.be/OM64aGFyVY). If an EMD received a call regarding a patient who suffered burns (cold burns) from this challenge, how would the call be coded? Or, what would the Chief Complaint be? Would it be considered a burn (Protocol 7), cold exposure (Protocol 20 for frostbite), or psychiatric (Protocol 25)? Let me know your thoughts.

Thank you!
Jennifer Taylor
Instructional Writer/Proofreader
Curriculum Department
Priority Dispatch

Jennifer,

This is certainly a “burn” (also known as an aerosol or cryogenic burn) that may even have some later complications due to the chemicals involved, not simply the cold vaporization. I would keep it on Protocol 7: Burns (Scalds) as this is now even better evaluated by the Advanced Burn Calculator, which handles smaller burn areas. With a dollar to soup can lid size burn on an arm, leg, or other surface (other than the face), whether 2nd or 3rd degree, prehospital care is still only supportive and, from an ER doc’s perspective, would be a “Don’t call 911; drive them slowly in to me or see your doc today.”

I think that the issue of the chemicals involved is still probably not well known and, like a spider bite, may cause more necrosis of tissue in the long run. Before I saw the pics, I thought they would be 1st and 2nd degree, but I was surprised that most of them were really 3rd degree for most of the center of these burns. Additionally, I would suggest that flushing with tepid (neutral temperature) water might be helpful in reducing the chemical residue sitting on the burn area—as an educated guess (I have since found that flushing with lukewarm water is advised). This thing can also occur with other aerosol medications, air fresheners, etc.

All said, I would only consider modifying or expanding the protocol level if this ill-conceived phenomenon becomes a 911 reality, not a “what-if” situation.

Certainly, it’s an interesting issue to consider … Regards, Doc

P.S. Deodorant Challenge? This thing is going to stink more now, not less, having had deodorant applied in this crazy way. Do I smell the fresh scent of pseudomonas in the air? ...

A research paper published in the Annals of Emergency Dispatch and Response (AEDR) merely quantifies what Jeff Clawson, M.D., always knew: Consistent application of an evidence-based process at the dispatch level reduces litigation involving issues that can adversely affect outcomes—and also induce wrongful death/injury allegations, associated court cases, and liability.

The research, years in the making, characterizes the most common types of events, actions, and omissions that lead to lawsuits in the dispatch center. A secondary objective looked at which of these actions led to successful suits and the practices that can help guard against successful litigation.

To conduct the study, researchers scanned publicly-available records and databases for dispatch-related litigation, selecting 82 cases, dating from 1980 to 2015, and categorized them by type (medical, police, fire) and the dispatch-related issue (such as false assurances that help was on the way). The date and place of occurrence were also noted. Legal outcomes were identified, when available, from city, state, and federal court databases.

Multiple (two or more) calls was found as the most common dispatch problem, as illustrated in the lawsuit Lam vs. City of Los Angeles (1987). In this case, the first call to report a patient’s breathing problems was met with the dispatcher suggesting the patient breathe into a paper bag to relieve the symptoms of “hyperventilating.” A second call resulted in a second dispatcher diagnosis of “food poisoning” and the recommendation to transport the patient to a doctor. The patient collapsed and died on her way to the car.

Customer service issues or mishandled calls and failure to provide PAIs and PDIs were the other most commonly found dispatch errors. Implicit in all was the expectation that the dispatcher would collect all the relevant caller-critical information and pass it to responders, which did not happen, for example, in Clay vs. City of Chicago (1987). In this case, 31-year-old Nancy Clay died in a fire because dispatchers failed to communicate to the responding personnel conditions of the incident, Clay’s location in the building, or that she was trapped. Even after a second call from Clay, now clearly dying as she pleaded for help, dispatchers failed to communicate her condition and known location in the building.

Wrongful death was the most common allegation when filing a case and was the type of case most often reaching a settlement. In Hutcherson vs. City of Phoenix (1990), for example, the jury awarded plaintiffs $1.7 million citing the lack of protocol use and resultant improper call prioritization that cost the lives of Chiquita Burt and her boyfriend. In this case, Burt called for help, knowing her ex-boyfriend was on his way to her apartment with malicious intent. The dispatcher decided the call was a non-emergency routine call. Twenty-two minutes after the call was made, the ex-boyfriend broke into the apartment, killing Burt and her current boyfriend before turning the gun on himself.

Other common allegations resulting in litigation included negligence, misconduct, the plaintiff’s emotional distress/suffering, and lack of due process, civil rights, or equal protections under the law.

With each case, courts increasingly applied generally accepted and disseminated standards of care when reaching their decisions; the failure to meet clear and enforceable standards on the part of the defendant led to adverse findings against the individual or agency. These standards were publicly available as early as 1994, when the National Institutes of Health published an EMD Position Paper citing the use of protocols, provision of pre-arrival instructions, and maintaining certification through continuing dispatch education as critical components of effective emergency dispatch practice.

As the authors concluded, “Agencies without the recommended practices in place should be prepared to defend their practices in court—and in the court of public opinion.”


You will also find the Research Brief, which outlines the Standard of Care and Practice for Emergency Dispatch, available at aedjournal.org/is-there-a-standard-of-care-and-practice-for-emergency-dispatch. The Research Brief quiz is available on the College (learn.emergencydispatch.org) for CDE credit.
59.5% of the 79 cases in the case study had been initiated by medical problems.

$1 MILLION is the U.S. median settlement awarded to each victim.

20.3% of the cases involved domestic violence or trouble breathing.

92.4% involved one or more victims who died at the scene or within 24 hours.

36.7% of the cases cited customer service issues.

78.5% of initial calls were made by a first- or second-party caller.
Looking Forward by Looking Back
How your past shapes your future

Heidi DiGennaro

Emergency dispatchers have a hard job. You know this; you hear it from someone who watches you work during a tour and says, “I couldn’t do your job.” Yet we are often the first ones criticized when there’s a mistake—gotta be dispatch’s fault. The hours can be bad, the pay never enough, and there should be “putting up with crap” additional compensation. Benefits range from awful to great. Yet we stay for a variety of reasons.

When the years pass and suddenly days go by with the speed of minutes and you see your work anniversary coming up, it’s a shock. You look at the new people coming in full of enthusiasm, wide-eyed, energized, and slightly terrified, and you wonder if you ever were like that. You were but time, repetition, and incidents have jaded you.

This isn’t a job where you walk out at the end the same person you came in. This job changes you. Your personality, your outlook on the world, your priorities. It starts out with passion and fire, tempers to a slow burn through the years, and becomes a nice little fireplace to keep you warm and satisfied. When the fire cools, whether you’re at the end of your “time served to retirement” or you need to leave, you wonder what you’ve accomplished.

Look back at the calls where you had an impact, calls that shaped you, and calls that scared you. See them for the building blocks that formed you. Sometimes you may not even know the impact you had, but in some way, every single time, you mattered. You made a difference somewhere, whether it was to soothe a terrified caller whose baby had a febrile seizure, the lost or broken-down motorist who reached out to you for help, or the field provider you repeated the address to. You sent them what they needed. Yeah, you took their insults and their “Send somebody now!” comments in stride. Sometimes it was insulting but, hey, you’re a professional. You smiled and gritted your teeth, kicked the trash can, and finished the call. That transfer to the records department could be the difference in someone winning an argument with their insurance company.

Still, time marches on and all the mundane tasks start to weigh on you. You get an armor that screams, “Been there, it sucked; I’m still here, and don’t mess with me.” Under your breath, you’ve shouted your thousandth “Ma’am” or “Sir,” and it doesn’t blip your blood pressure. Or maybe it does.

Look back at what you’ve done to look forward to what you can become. What’s in the past cannot be changed. You can change yourself.

I’ve done it myself. Recently I was called one of the most positive people someone knows because I’m always looking for the good or the humor. It surprised me because I had once considered myself a cynical type of person. Yes, the job changes you and the longer you do it, the more you change until you have to draw a line. I drew mine; I’m going to look for the good and the humor. I’m going to smile because having been through some of the worst of the worst, it’s easier for me to smile than to be bitter. I don’t need to carry the negativity with me along with the 10 pounds I’m constantly trying to lose.

By looking back and seeing how things shaped you, you can see how to change them or use them to define going forward. This isn’t the job for everyone, and you should congratulate yourself for being one of the elite—the emergency dispatcher.
CHANGING TIMES

It’s a new, more forgiving era of call review

Art Braunschweiger

Q is changing and for the better. If your call center has switched to version 10 of the ED-Q™ Performance Standards released at the NAVIGATOR conference last year, you might have noticed that Q seems to be more forgiving. Here’s what’s changed and why—and what you need to know.

ED-Qs are tasked with ensuring that the protocols are used correctly and giving you feedback on how to use them better and more effectively the next time. Protocol users often chafe at being reminded that we need to read protocol questions and instructions exactly as written, subject to certain allowable enhancements.

But word choice matters. There’s no guarantee that asking a question your way is going to be as effective as the way that’s been vetted by the IAED’s Council of Research and Council of Standards. For that reason—up to now—if you inadvertently changed the wording of a protocol question or instruction and were more than two words off, even if you didn’t change its intent or the meaning, it was considered as having been asked or given incorrectly. That was termed an “insignificant error” and was weighted as a Minor deviation from standards.

The problem is, we’re human. We subconsciously alter certain words and phrases to more closely match our own habits of speech. Sometimes we can control that tendency, but not always, especially if we need to give more attention to caller management or protocol navigation.

A key concept emphasized now in ED-Q certification courses is trending. Now we focus more on performance over time and in which direction it’s going. When something needs correction but isn’t critical to the outcome of the call, it’s reasonable to build in a grace period. Based on that philosophy, under the Performance Standards 10th Edition there are no more “insignificant errors.” Instead, if you alter the wording of a protocol question or Pre-Arrival Instruction (PAI) without changing its meaning or intent, it’s now evaluated as “Not As Scripted (NAS)” and is not considered a deviation. But this new standard has opened up a Pandora’s box of misunderstanding. Pay close attention: It does not give you latitude to alter the protocols as you choose. Instead, it buys you time to change what may be a largely subconscious habit and time for your Q’s to provide feedback to help you make that change.

AQUA® 7 Ascent—the latest version of the Priority Dispatch® call review software—tracks all occurrences of “Not As Scripted” over a look-back period determined by your agency. The NAS look-back period can be anywhere from 90 to 365 days. Over that time period, AQUA tracks the number and percentage of times a specific protocol question or PAI has been evaluated as Not As Scripted. The ED-Q sees this information every time “NAS” is checked and over time can see whether you’re trending toward improvement. If not, and the alteration in wording continues to occur more than occasionally, the Q can evaluate subsequent occurrences as asked incorrectly.

The new “Not As Scripted” flag should be regarded as an attention-getter. Take advantage of it. Training yourself not to stray is the best way to protect yourself and ensure you’re being as effective as you can with the protocols.
Few groups of people share like emergency dispatchers do. We share space, keyboards, headsets, food, and air with our pod mates. One minor cough, a little sore throat, and the next thing you know, strep is running rampant. A stomach flu going around? You'll see a constant parade of people jockeying for a place in line at the restrooms. Time to pull out Protocol 26. Given how great we are at “sharing,” it’s really no surprise why we always seem to get sick in the dispatch center.

Reality is that as long as we are exposed to people, we are exposed to viruses. We can’t dispatch in a bubble, and we can’t avoid communicating with co-workers. So, at some point, we will undoubtedly pick up some nasty bug in the center. There are ways, however, to reduce your chances of getting sick. Read on!

Get a shot
Prevention is always key, and the best way to protect yourself against influenza is by getting vaccinated on an annual basis. Big, strong emergency dispatchers afraid of needles? Talk to your health care provider about a nasal spray option. Take advantage of the free or reduced cost options your agency might offer.

Keep your distance
Do the best you can to avoid close contact with others when either you or the other person is sick. Of course, I kind of giggled at that because in most instances we are a pretty cozy group.

Cover up
Cover your mouth and nose with a tissue or sneeze into your sleeve. Viruses are released into the air via droplets. People sneezing and coughing are the main ways that diseases are spread to others, so it’s very important to cover your mouth and nose with a tissue when sneezing or coughing. If the sneeze is coming before you have a chance to cover, sneeze into your bent elbow/sleeve, and get to a restroom to wash your hands with soap and water and/or sanitizer.

Clean up
Avoid touching your eyes, nose, and mouth with unwashed hands. This is how bugs are spread, and to make sure you’re not aiding and abetting, keep hand sanitizer, tissues, and bleach wipes in every pod. Wipe down workspaces between shifts, before and after. A word of caution on this one; check your systems after the wipe down. Vigorous wiping can unseat, unplug, and otherwise undermine equipment.

Stay home
This is probably the hardest thing for us to do. Why? Because we are programmed to be team players. Most of us would come into work rather than call in sick and, consequently, create a situation where others have to stay late or come in early because of our absence. Don’t even think about it. Learn to resist that lean and really consider whether you are “fit for duty.” I’m sure you will agree that miserable people do not make the best emergency dispatchers, and can, in fact, do more harm than good. The flu, fevers—anything contagious—and incapacitating pain (e.g., a migraine) impact your ability to do your best for the people you serve and protect.

Prevention is key
Remember that promoting healthy lifestyles and eating habits does make a difference in your ability to stave off bugs. Eat healthy foods. Drink plenty of water. Exercise. Get sleep. Stay positive. People who take care of themselves have a better chance of staying healthy and pose less risk to their co-workers.

Do your part to keep yourselves and your center healthy. Develop those good cleanliness habits, and encourage others to do the same. Keep sharing with each other ... just don’t share the bugs!
BREATHING NORMALLY
What to do if the answer is clearly not true

Brett Patterson

Brett:
A question I hope you can help me with:
Caller is continuously relaying the EMD questions to a patient who is next to him.

"Is she breathing normally? <question is relayed to the patient, who gives an extensive and clearly audible answer>
Caller: "No, she's not."

"Does she have difficulty speaking between breaths?" <again, question is relayed, and the patient answers extensively in full sentences>
Caller: "Yes, she is having difficulty speaking between breaths."

In this case, the answer given does not seem to correlate well with the situation on scene. Should the EMD err in favor of this patient and choose "Yes" when prompted for difficulty breathing between breaths? Or should the EMD choose "No" as this is clearly the case?

Universal standards 17 suggest that the question to which an answer is already clear, need not be asked. But it does not handle the situation where the question is asked but the answer is quite clearly not true.

I'm inclined to err in favor of the patient, who might be forcing us to get an ambulance sent but doesn't need one. But it doesn't feel quite alright to do so ...

Hope you can help me out here.

Thanks in advance,
Harm van de Pas, M.D.
Medical Director
Brabant Noord Dispatch Center
Netherlands

Hello Harm:
These situations put the EMD in a difficult spot.

We recently added a Rule to Case Entry (v13.1) that allows some EMD discretion when dealing with first-party callers and INEFFECTIVE BREATHING terms, but this was restricted to first-party callers where assessment is more obvious. With second-party callers, once an answer has been given, no matter what we hear in the background, we are placed in a bit of a quandary. In a court of law, the opposing attorney refers to this as “Asked and answered!”

What we advise is to enter what the caller has answered. However, if the answer is obvious before the question, there is no need to ask the question. If the patient is speaking in full sentences and we know absolutely that the full sentences are being spoken by the patient, then there is no need to ask about difficulty speaking between breaths.

I was recently asked if the results of the Breathing Verification Diagnostic Tool could be used to downgrade a call in which an ECHO-Level code was selected due to the use of an INEFFECTIVE BREATHING term at Case Entry. This seems straightforward and prudent when the EMD is using the tool in good faith to monitor the patient’s breathing in Case Exit. However, the potential for EMDs to use the tool to confirm INEFFECTIVE BREATHING because they doubt INEFFECTIVE BREATHING is very concerning.

So while your scenarios are innocent enough, and likely clinically accurate, we don’t want EMDs to get in the habit of “testing” the caller’s answers or doubting the integrity of the caller. These practices have proven to be very dangerous over the years.

Ideally, we need to develop reliable evaluations/diagnostics that can substitute for the questions we have consistent over-triage issues with. If we can crack those alertness and difficulty breathing nuts, we’ll take specificity to new heights in dispatch.

Brett A. Patterson
Academics & Standards Associate Chair, Medical Council of Standards International Academies of Emergency Dispatch
FEEDBACK TIPS
Not all feedback is created equal

Mike Thompson, Mike Taigman

Have you ever stayed in the guest bedroom at a friend's house? Maybe in a country house in one of those bedrooms that was converted from a garage where they have a shower that was clearly installed as an afterthought? Stepping groggily into the shower to clean up before breakfast you reach in and turn the hot water knob a lot and the cold up a little. After a few seconds you stick your hand in to find that the water is arctic cold. You reach in and turn the hot water all the way up and wait for what feels like an hour, but is only seconds, and try it again. The water is still cold for a frozen daiquiri. So you reach in and turn the cold all the way off and make sure that the hot water is turned all the way up. It's still freezing cold. Figuring that the hot water must be broken you take a deep breath, brave the cold water, and go for the gold in the world's fastest shower competition. Then, like a light switch, the water turns scalding hot. Leaping from the shower hoping to keep it to only second-degree burns you reach back in through the cloud of steam and turn the hot water down halfway and the cold water back up. It's still as hot as a ghost pepper so you crank the hot all the way off. Then it switches from scalding to freezing again. Have you had a shower experience like this?

When we've described this to audiences full of EMS and fire leaders most of them raise their hands when we ask if this has ever happened to them. What makes it difficult to get the right water temperature in some showers is that the hot water heater is located on the other side of the house—a long way from your guest room. When you take an action, like turning on the faucet, it takes a long time for the message to be sent across the house, for the hot water heater to receive the message, and to respond by sending hot water all the way back across the house to your shower. This delay between action and feedback makes it very difficult to fine-tune a warm, comfortable shower.

Leadership author Ken Blanchard said, “Feedback is the breakfast of champions.” Here are a few things to consider when thinking about feedback systems for you and your team.

Measure what you want more of
One school of thought says, “What gets measured gets done.” So if you measure mistakes you’ll get more mistakes; if you measure successes you’ll get more successes. For example, it may be more effective to measure the
percentage of cardiac arrests identified by arriving EMS crews that were recognized as cardiac arrest by the EMD than it would be to track the percentage where the arrest was missed.

Focus on improvement rather than judgment

Having a communication center culture where people use feedback to shorten their total time in ProQA® is healthier than a culture where people are afraid that they will get in trouble if their time is too long. Accountability to the people you serve and to each other is different than accountability to arbitrary goals. A goal of the fastest possible hands-on-chest time for cardiac arrest cases is more powerful than if we want hands-on-chest in 35 seconds or less. There is a delicate balance between looking at your actual performance, and working to improve and focusing on goals. The benefit of an improvement focus is that it deals with actual performance and allows for quantum improvement that might be better than the number stated in a goal. The advantage of having a goal is that people like to have a target to shoot for. The most effective approach may be a blend of both.

Clarity of purpose

It’s important for leaders to make it clear what they hope followers will do with the performance feedback they provide. An ambulance service was hoping to decrease hospital turnaround times for their crews. They decided to provide performance feedback by publishing average weekly turn times by crew names with the longest at the bottom of the list and the shortest at the top of the list. A line in magic marker was drawn across the list one-third of the way down. In green ink a big “Thank You, Well Done” was written in the top third. On the bottom two-thirds, written in red ink, was a big, “If you’re down here, try to be up here next week” with a big red arrow pointing up.

A few crews were arriving at the hospital, finding any open bed, and dropping their patient without a report just to get a short turnaround time. Clearly this is not what their leaders hoped would happen. It’s important to be clear why the feedback is being provided and what you hope people will do, feel, or think when they see it.

Be careful with comparison

There’s a natural tendency that lives deep in the DNA of many emergency communication center leaders. It’s the impulse to use data for comparison-based feedback. In the quality improvement world this is referred to as benchmarking. If you’re using comparison feedback for genuine improvement that’s great. If it is being used as some kind of crazy competition or to make people feel bad for not being up to snuff, it’s time to rethink your strategy.

Effective leadership involves a blend of art and science. Using accurate and helpful improvement systems yourself and providing them for your team delivers the best opportunity to optimize performance. Academy Analytics was created to make feedback fast, easy, and effective. Go to academyanalytics.info for more information.

Faster is usually better

Near real time individual, shift, and system performance feedback can be a powerful tool for fine-tuning individual performance. For example, an EMD finishing a CPR call gets instant feedback on the dashboard for how long it took to get hands-on-chest. This allows the EMD to reflect on the call and make micro adjustments to improve the next one.

Faster is better except when it isn’t

Often when making a change to improve a practice, policy, protocol, or procedure it’s important to “let the data run” for a while before assessing the effectiveness of the improvement. If you’ve added EpiPen assistance to your Pre-Arrival Instructions and the first case or two cause frustration for the EMD, it would not be helpful to rewrite the instructions without having more experience with the new approach. We will talk more in a future column about the value of tracking improvement data/feedback over time.
Two decades ago LaWanda Rauss was a recruit answering calls and dispatching response for the St. Louis Fire Department (SLFD), Missouri (USA).

She had put in close to 10 years as a paramedic for the same fire department, shifting to dispatch because, like a lot of people, she was ready to come indoors. Emergency dispatch was not a 180-degree turn in her public safety career, but rather, offered some of the same attractions such as helping people both physically and emotionally.

“[In the street] you had to be the calm in the chaos, and it’s the same in dispatch,” said Rauss, Senior Fire Equipment Dispatcher and QA/QI Officer. “You must be the one able to keep the calm in any situation.”

Two decades ago, the busiest firefighting units in the city averaged nearly two-thirds fewer calls than they do today on an annual basis. Rauss answered 911 calls over the telephone, wrote down the basic information—what happened and where—and sent response. The trip tickets were filed and archived for medical and fire related calls in drawers and cabinets similar to the card catalogues libraries once used for books.

Population growth is not the sole factor for the increasing number of calls. Firefighters everywhere have taken on a variety of additional responsibilities. St. Louis is no exception, and the same principle applies to emergency dispatch.

Rauss recalls the learning curve of CAD operations and the Medical Priority Dispatch System™ (MPDS) when it was introduced in 1998, and an ACE medical accreditation that has since expired and she’s now intent on renewing.

“I always thought ACE was a good thing,” she said.

Then things happened to interrupt the accreditation, such as turnover of key players and a shuffling of priorities.

At the close of the century, IT was facing the Y2K millennium bug that threatened havoc in computer networks (a daunting issue for emergency communication). Soon afterward, emergency communication centers incorporated the additional oversight and assistance of the U.S. Department of Homeland Security, established following the terrorist attacks on New York City’s twin towers. Training never ends, and last year the St. Louis Office of Emergency Management required job-specific courses in response to flooding of the Meramec River in spring 2017 that shut down portions of interstates and damaged hundreds of homes and businesses.

Other major incidents in the St. Louis area pushed the envelope of fire, police,
and EMS and demanded dispatch play a more centralized and integrated role in coordinating response. For example, a crew of radio dispatchers from St. Louis County emergency communications were deployed to Ferguson (a north suburb of St. Louis County) following the fatal shooting of the unarmed 18-year-old Michael Brown, an African-American, by a white police officer on Aug. 9, 2014. Riots by people outraged by the young man’s shooting and the grand jury’s decision not to indict the officer escalated into a national emergency. SLFD did not send dispatchers to the incident; however, it did increase staffing due to the demands of the riots and sent fire apparatus to the scene as a mutual aid assist to Ferguson.

“National Guard was protecting our building,” Rauss said. “Responders went out in crews.”

There’s always the pressure of environmental threats, particularly in a city contiguous to two of the largest rivers and watersheds in the United States, the Mississippi and the Missouri. Spring can be hazardous. Torrential rainfall during the last weekend of April 2017 led to record flooding and the governor declaring a state of emergency for large sections of the state.

Slow down for a minute. Don’t get the wrong impression.

The city at the eastern edge of Missouri is also a great place to live and visit. It is home to many contemporary and historic attractions. The internationally recognized 630-foot Gateway Arch, completed in 1965, stands as a monument to westward expansion. The Missouri Botanical Garden, founded in 1859, offers 79 acres of gardens and a geodesic dome conservatory. The St. Louis Zoo is nothing like the exhibit featured at the 1904 World’s Fair. Areas added over the past century offer landscapes closer to the relationship the animals have with their natural environs.

St. Louis is a sprawling urban center, with daytime commuters and tourists tripling the city’s number of actual residents (about 320,000). The population is predominantly African-American (49.2 percent) and white (43.9 percent). An estimated 70,000 Bosnians live in the metro area, the largest population of Bosnians in the United States and the largest Bosnian population outside their homeland.

It’s a city of people who love a celebration. The 11-day Soulad Mardi Gras features live music and tons of the iconic beads tossed during the opening Grand Parade to the closing nighttime parade when the event wraps up on Fat Tuesday. The 40th Annual St. Patrick’s Day Run draws upward of 10,000 participants following a five-mile route through downtown streets. Thousands upon thousands of people attend the two-day Pride Festival in June, and the whole time something big is happening, you can be assured of smaller events scheduled simultaneously.

“We’re always busy,” Rauss said. And during these major events, SLFD dispatchers are on scene staffing the command post.

EMS merged into the fire department in April 1997, and although they share the same floor in the fire administration building, they are housed in spaces separated by a foyer. All calltakers and dispatchers are cross-trained (to answer calls and work the radio), but they work either in SLFD fire communications or SLFD EMS communications. The Metropolitan Police Department, which is in a different location, operates the city’s PSAP and fields calls requesting response from police, fire, and ambulance. All calls requiring fire department or ambulance assistance are transferred to the SLFD communication center. Both centers use the MPDS.

Rauss’ QA/QI management position was created to get everybody in EMS and fire dispatch “on the same page” for eventual re-accreditation. She reviews calls, does a lot of one-on-one training, and found time in November to take a tactical dispatch course.

The cooperation it takes to keep St. Louis rolling emphasizes the change Rauss most appreciates in emergency dispatch. It has little to do with technology, call volume, or job security.

“We’re being recognized for what we do,” Rauss said. “From the start, I got that dispatchers were the true first responders. We are the initial contact.”

Their motto—Justifiably Proud—says it all.

“At the end of the day, people need help, and there has to be someone there to do that,” Rauss said. “The public always appreciated us, but inside it was overlooked. That’s changing. We’re heading in the right direction.”

Sources
LAND OF MOUNTAINS
Lower Austria does it all

Becca Barrus

If you are an English speaking person, chances are you’ve mixed up “Austria” and “Australia” at some point in your life. After all, they sound so similar! They’re basically the same word, give or take a few letters. While they sound alike, however, they are still different places with unique customs, histories, and spoken languages. For clarity’s sake, Australia is located in the Southern Hemisphere, surrounded by the Indian and Pacific Oceans, and is home to the Great Barrier Reef, the Sydney Opera House, and kangaroos. Austria is located in the Northern Hemisphere, surrounded by other European countries, and is home to the Alps, the Vienna State Opera, and 144 Notruf Niederösterreich.

144 Notruf Niederösterreich is the main emergency dispatch center in Lower Austria, one of Austria’s nine states. “Notruf” means “emergency call” in German—which is what they speak in Austria—and “Niederösterreich” means “Lower Austria,” so together it means “144 Emergency Call Lower Austria.” What does the 144 stand for? Rather than use 112, like most of Europe, Austria uses 144 as the standard emergency number. But 112 is still an emergency number; it’s routed to the police instead of to emergency medical services.

In an article she wrote for EMS World, Susan Ottendorfer, the medical director for 144 Notruf NÖ, explained that there are three national emergency numbers, which children learn in kindergarten. 144 is for medical emergencies, 133 is for police, and 122 is for fire.¹

Not only do they dispatch for emergency medical, police, and fire calls, 144 Notruf NÖ also dispatches for Mountain Rescue, Cave Rescue, Water Rescue, Helicopter Emergency Service (HEMS), Patient Transport (taking non-emergency patients to and from medical facilities), all K-9 search and rescue units, and Psy (mobile psychological interventions after traumatic incidents).

But they don’t just dispatch—they use the Emergency Communication Nurse System™ (ECNS™) to handle non-emergency medical calls and many other miscellaneous hotlines.

While you can be routed to one of the individual help lines if you call 144, some have their own numbers that get you directly to the help you need. For instance, if you were in need of help for a water rescue, you would call 144, but if you were stranded in the mountains, you would call 140. If you had a medical question or a low-acuity problem, you would call 1450 to be connected with an Emergency Communication Nurse (ECN). If your medical problem was more urgent but still not emergent, you would call 141 to be connected with a doctor or pharmacist.
This last service is particularly helpful on nights, weekends, or public holidays, when regular doctors’ offices are closed.

All of these numbers end up in 144 Notruf NÖ, which is very unusual for Europe. Callers don’t necessarily have to choose the “correct” number because the calltakers will direct their calls accordingly.

“They are the gatekeepers—or rather, the gate openers—to the health system,” said Stefan Spielbichler, head of public relations at 144 Notruf NÖ.

All told, 144 Notruf NÖ dispatches for 26 individual agencies and over 1,100 individual resources, including more than 800 ambulances and 16 helicopters. In 2017, these helicopters made 31,880 trips combined, answering an average of 86 calls a day. As of 2017, one of the helicopters has been able to make medical calls at night due to being equipped with night vision goggles.

The ground they cover is considerable in both size and population. Lower Austria is the largest state in Austria in terms of area—it comprises 19,178 square kilometers (11,916 square miles), although 144 Notruf NÖ’s service area is only 11,922 square kilometers (7,408 square miles). They do, however, serve all 1.6 million Austrians that fall under their jurisdiction.

Included in the physical area they serve are rural regions around Vienna, flatlands in the east, the River Danube, and the Alps. The Alps provides a specific set of potential emergencies: namely, lost or injured hikers and lost or injured spelunkers. Due to booming numbers of people going off trail skiing in the winter and a high amount of hikers and cragsmen in summer, there are numerous calls for the mountain rescue service all year round. In 2017, 1,300 mountain rescue volunteers handled 682 calls, saving 706 people in some complex operations.

Between all the services they render and the ground they cover, the agency deals with roughly 1.5 million calls a year (or 4,300 calls a day).

Such a large workload demands a large staff to handle it. 144 Notruf NÖ’s staff is made up of 163 individuals, of which 106 are calltakers/dispatchers and 17 are ECNs. The rest of the staff is made up of supervisors, quality managers (QMs), IT personnel, and administration.

The main shifts at the Lower Austrian dispatch center are 12-hour shifts, one from 6:00 a.m. to 6:00 p.m. and the other from 6:00 p.m. to 6:00 a.m. There are additional shifts where emergency dispatchers come in to help during time frames that consistently experience high call loads.

There is only one dispatch agency in Lower Austria, located at four centers situated in different areas of Lower Austria—one in St. Pölten, the state’s capital, one in Korneuburg, one in Mödling, and one in Zwettl. They are all connected to one central system.

144 Notruf NÖ has used the Advanced Medical Priority Dispatch System™ (AMPDS™) since 2003. They became a medical Accredited Center of Excellence (ACE) in 2009, being the first central European dispatch center to do so. Even now, some 10 years later, they are one of only 10 total accredited centers in Europe.

“It’s fairly easy to become an ACE,” said 144 Notruf NÖ’s CEO and IAED™ Accreditation Board Chair, Christof Constantin Chwojka, “but it’s tough to remain so for many years.”

One of the things that motivated the center’s staff to earn and maintain accreditation is their dedication to providing the best possible service for the caller, according to Spielbichler.

“Every dispatch center’s aim should be to become an ACE,” he said. “It is an unparalleled aid in providing the best care for the population you serve, as well as making use of available resources effectively so as to ensure the optimal outcome in emergency situations.”

They are currently working toward becoming an ECNS ACE.

In addition to being an ACE, 144 Notruf NÖ has also earned the European Emergency Number Association (EENA) PSAP certification, making them the only agency worldwide to have earned both distinctions.

To learn more about 144 Notruf NÖ, visit notrufnoe.com.
A LOOK BACK

Emergency dispatch as a profession over the years

Becca Barrus
There are some jobs that seem like they’ve been around forever, like farming. As soon as humans figured out that cultivating land was more efficient than hunting and gathering, we had farmers. On the other hand, there are jobs that seem like they were born yesterday, like social media coordinators. If you traveled back in time even 15 years ago and told someone you were a social media coordinator, you’d get a blank look. Not so if you said you were a farmer.

The profession of emergency dispatch is somewhere between those two ends of the spectrum, maybe a little closer to social media coordinator than farmer in terms of how long it’s been around. However, the longevity of a profession is by no means an indication of its value to society.

This feature is a perspective on the profession of emergency dispatch from four people who have been aiding their communities for over 15 years.
KENDRA SMITH

Kendra Smith is a Communications Training Officer at Harnett County Sheriff’s Office in Lillington, North Carolina (USA). She started working as an emergency dispatcher 20 years ago when a friend of her husband’s introduced her to the profession.

One of the very first medical calls she took on her own—without the aid of a trainer—was for a little boy who was crossing the street from his grandparents’ house to his parents’ house and was struck by a car and killed instantly.

“I can still tell you the child’s name 20 years later,” Smith said. “It stuck with me.”

When asked what things have changed in the emergency dispatch field since she started, Smith said it’s mainly been technology. She went from using a pen and paper to using Microsoft DOS to multiscreen consoles that are almost entirely automated. As far as her own center goes, the number of emergency dispatchers on shift has had to grow to keep up with the call volume growth. There are now six-person shifts as opposed to the two-person shifts she started with.

In the future, Smith would like to see more higher education opportunities that are specific to telecommunicators. While majors such as emergency management with a minor in communications are nice, it would be great to see the profession recognized in academia.

Also in the vein of education, Smith would like to see more public education about emergency dispatchers, although she realizes that funding isn’t always available for that sort of thing. Harnett County Sheriff’s Office held its first Citizen’s Academy this past year where they had citizens go through a basic law enforcement course and take a tour of the sheriff’s office. It was a real eye-opener for the participants, who had no idea about everything that happens in the background of an emergency call.

“I wish most people knew we aren’t just answering telephones,” Smith said. “There’s so much more being performed simultaneously.”

Smith wishes first responders knew that too—emergency dispatchers aren’t just talking to them. They’re doing so much at once, and a little bit of patience while they gather all the information goes a long way.

It’s difficult to go 20 years in any profession without being changed, and emergency dispatch is no different. Smith said her perspective of herself has changed over the years. When she started her career, she had been a stay-at-home mom for years. Transitioning to working outside the home was not an easy thing for her—Smith had lost some self-esteem and identity in the process, but she built it back up.

“Knowing that your job directly helps save and protect people’s lives is a huge confidence boost,” she said.

Smith sees it with new hires all the time. “They aren’t sure who they are, where they want to go, or if they can do this, but eventually the cocoons open and the butterflies spread their wings. There are still days that are difficult and make you question everything about who you are and what you’re doing; however, with the right training and coaching, you can grow more than you ever thought you could.”

CRISELDA YANEZ

Criselda Yanez is a dispatcher/calltaker at Medcare EMS in McAllen, Texas (USA). Her interest in the field of public safety began some 20 years ago when she wanted to know how she could help her chronically ill daughter (who has since passed away) when something went wrong. Yanez initially started off as an EMT, and the agency she worked for often had EMTs handle the dispatching side of things. Then one day the supervisors asked if she would help cover the phones, and she decided to stay for good.

Making the switch from EMT to emergency dispatcher wasn’t easy. When Yanez began answering emergency calls, her center didn’t have a protocol that allowed her to give instructions to callers on how to perform CPR or control bleeding. All she could do was ask for the address and phone number and send an ambulance on its way. Since 1998, Medcare EMS has been using the Medical Priority Dispatch System™ (MPDS®), and emergency dispatchers are better able to help callers before the first responders get to the scene.

“I like helping people,” Yanez said. “I feel confident that I can help the patient if the caller listens to and trusts me.”

One thing Yanez likes about the changes in emergency dispatch during her career is the access to voice print—a system that transcribes what’s being said over the phone in real time. It’s a huge aid in allowing her to review her own calls and being able to learn from what she’s done right. If she misses a number in an address or phone number because someone was screaming for help, she has the ability to go back and double-check.

Like Smith, Yanez would like to promote emergency dispatch as a profession more among community members. She lives in a small town in south Texas, and yet there’s still not a lot of awareness of all the ways emergency dispatchers can aid the community. She said it would help to go into schools and teach kids what to expect when they call 911.

Educating the first responders would be
helpful as well. She wishes first responders knew how difficult it is to be an emergency dispatcher. Yes, first responders are the first people to arrive on the scene, but it’s the emergency dispatchers who have to hear all the screaming as the seriousness of a situation takes hold. She believes that if first responders would shadow emergency dispatchers for 24 hours, they would begin to understand what emergency dispatchers go through every day.

Yanez knows this job is not for everybody. You’ve got to be able to put yourself in the caller’s position, something that comes naturally to Yanez since she called 911 frequently to get help with her daughter’s seizures. She knows what it’s like to answer questions when it feels like help is taking forever to arrive. Working as an emergency dispatcher has given Yanez an acute sense of compassion.

DAVID POLLITT SR.

David Pollitt Sr. is Acting Shift Supervisor at Wicomico County Emergency Services in Salisbury, Maryland (USA). As of November 2018, he has worked in emergency dispatch for 35 years. He’s always had a strong desire for public service, as evidenced by his becoming an EMT when he turned 16 and becoming a member of the volunteer fire department not long after that. A family friend suggested that he apply to become an emergency dispatcher, and, after a few hiccups, he began his long career—two years before 911 became the area’s standard emergency number.

Pollitt’s first impression of the job left him overwhelmed. There was a wealth of knowledge he didn’t know about the county he’d be dispatching for—roadways, landmarks, business locations, etc. Additionally, each of the 13 fire departments his agency dispatched for had their own rules that he had to keep straight. During his very first shift, he handled a call for a natural cover fire that required eight fire departments from two counties and states to be on location.

When he started, emergency dispatchers used punch cards to keep track of units and two-channel low-band radio systems for communicating. Now, they have computer technology for keeping track of Calls for Service, ANI/ALI, geographic information system (GIS), internet mapping, and a 50+ channel digital radio and alerting system. Talk about growth! Some things stay the same, though—are you annoyed by all the accidental calls coming in from cellphones? An earlier version of that was people calling 911 from payphones and then running away.

“Public education is a big thing for me,” Pollitt said. To him, it seems like the community doesn’t understand
why emergency dispatchers ask all the questions they do. They think emergency dispatchers are delaying the response's arrival when that is not the case, which can be frustrating for both the caller and the emergency dispatcher.

It isn’t just the public Pollitt would like to see educated. He thinks that first responders would benefit from coming into the dispatch center to get a taste of what emergency dispatchers experience. Don’t shoot the messenger, he said. Emergency dispatchers can only provide as much information as they’re given.

All in all, Pollitt sees his decision to become a dispatcher/calltaker as the best decision he could’ve made those 35 years ago.

DANA PRZYBYSZEWSKI

Dana Przybyszewski is a Master Dispatcher for Howard County Police in Ellicott City, Maryland (USA). She’s spent her 15-year career between Howard County, Intrado, Inc. (now known as West Corporation) in Longmont, Colorado (USA), and Loveland Police Department in Loveland, Colorado.

Before Przybyszewski was an emergency dispatcher, she was a preschool teacher, although she was no stranger to emergency response since three of her brothers were police officers. Her mom was also a big fan of emergency responders—at least the ones on “Rescue 911,” which was part of Przybyszewski’s introduction to the profession as well.

“My first thought was, ‘Wow, this isn’t like on TV,’” Przybyszewski said. When she applied for the job, she had to do a four-hour sit-in and immediately knew that it was something she wanted to do. That knowledge was solidified when she took a call where CPR had to be administered over the phone after a drowning and saved a child’s life for just a little longer.

Her goal, like the others highlighted in this article, is to help the citizens. Even though she’s not the person who pulls up on scene to pull someone from the fire, she’s the person who tells the first responders where they need to go. Przybyszewski loves working with the police and fire departments and knowing that when she leaves work, everyone went home safe. This is her main goal.

At Howard County, police officers do come into the dispatch center and sit in on some calls for an hour as part of their training. However, Przybyszewski noted that they often only come during slow times—which means some police officers don’t get the real feel of what emergency dispatchers do during an incident. She understands that police officers are putting their lives on the line for members of the community, but emergency dispatchers contribute in a big way as well. She said that everyone she works with goes into each shift with the attitude of giving it 100 percent.

When asked if her perspective of herself has changed over the years, Przybyszewski’s voice got choked with emotion as she said her career changed who she is. The last 15 years have brought all sorts of personal changes to her life; between those and the events she’s gone through at work—such as the death of a police officer and a firefighter, a mall shooting, and the death of several co-workers—her perspective of the world and of people have changed. Things affect her more now. Some calls are easier than others, she readily admits, but after hearing thousands of calls over her 15 years, she’s realized something.

“I’m not weak,” she said. “I’m a human being.”

All together

The career of every emergency dispatcher isn’t going to look the same and yet the core remains constant. People get into this profession and stay because they want to help people. How they help the community might change—like Yanez and Pollitt, they might go from first responder to first, first responder or vice versa—but the desire is always there. Just as the technology and awareness of 911 has changed over the years, perhaps one day the community will recognize emergency dispatchers for the service they provide and the responsibility they shoulder.
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Emergency dispatchers must develop and use a variety of skills

Josh McFadden

Emergency dispatcher. Emergency telecommunicator. Communication specialist. The men and women who handle emergency calls are known by different titles. But no matter what title you have at your agency, one thing is for sure: This job isn’t for the faint-hearted. It’s not a position in which the average person can simply walk into and succeed without possessing and cultivating certain skills, talents, and attributes, either.

Unfortunately, many members of the public don’t realize this. Uninformed individuals may think of emergency dispatchers as clerks or as workers in a common call center, answering the phone, pushing buttons, and quickly passing the matter off to someone else.

Whether you help desperate people with medical, police, or fire needs, your role is critical in the chain of patient care. In fact, as the first, first responder, everything begins with the emergency dispatcher. In the most recent edition of “Principles of Emergency Medical Dispatch,” authors Jeff J. Clawson, M.D.; Kate Boyd Dernocoeur, EMT-P; and Cynthia Murray point out: “The EMD is the sole authority over an emergency scene until the first responding crew can make initial assessments and establish scene control. (In essence, the ‘scene commander’ until
someone physically reaches the scene.) Until that moment, the EMD knows more about the scene than anyone else in the emergency care pipeline. Through telephone interrogation, the EMD can continually access patient information. This information is then used to select the appropriate response for each call. Unsafe situations can be identified and relayed almost instantly to responding crews. Additionally, the EMD can provide directions to the caller about what to do, or what not to do, on the patient’s behalf.¹

The opening chapter of “Principles” also informs us of the numerous duties emergency dispatchers have and how they are critically linked to callers, ambulance services, air transport, fire and rescue services, and hospital and secondary care. Some of the many duties EMDs, EPDs, and EFDs have involve the following:

- Telephone interrogation
- Triage
- Dispatch Allocation and Field Communication
- Logistics Coordination
- Resource Networking
- Life-Impacting Via Telephone Instructions

That’s a lot of pressure. It’s no wonder emergency dispatchers need a litany of skills to meet these expectations and demands. What are some of these specific skills? How can you put them to use in your work and keep them sharp? If you aren’t born with these talents, how can you develop them?

**Multitasking**

Merriam-Webster gives a simple definition for the term multitasking: “The ability to do several things at the same time.” Does that not fit with what an emergency dispatcher does? You take phone calls, gather critical information from callers and patients, input the information into ProQA® and follow the Key Questions and instructions from the software and cardsets, coordinate efforts with responders, use mapping software to identify locations, and the list goes on. Sometimes, you must jump from one task to another at a second’s notice. Sometimes, you literally do more than one of these at a time without hesitating.

People who can’t focus on multiple duties simultaneously will struggle in this role.

If you want to get more comfortable with multitasking, there are some strategies you can try. Writing for the popular business magazine “Entrepreneur,” Nadia Goodman suggests using downtime to review new information. You may not get much downtime in the comm. center, but she suggests taking the time to “review it later that day. Reread it while you walk between meetings or commute home, and explain it back to yourself to make sure you understand it.”²

“Business Insider” reports that only 2 percent of humans can excel at more than one task at the same time. Citing a study from psychology professor David Strayer, from the University of Utah (USA), the other 98 percent of people actually get worse at tasks when they try to multitask.³ Piggybacking off of Strayer’s study, a research team at the University of Queensland (Australia) found that people are destined to perform terribly at multitasking. Their study, which involved doing two tasks at the same time, revealed that while participants struggled initially, repetition for three days showed marked improvement at both activities.⁴ This suggests that at a job like emergency dispatching, where multitasking is inevitable and required, early failures don’t mean you’ll never catch up. Keep at it, and it should eventually become a strength.

**Empathy, sympathy**

Seasoned emergency dispatchers have heard just about everything over the phone: calls for ridiculous reasons, hysterical callers, inconsolable callers, combative callers, irrational callers, and so on. Regardless of what the caller is saying or doing on the other end of the line, the customer service skills of empathy and sympathy are essential.

Though callers’ attitudes and behaviors may frustrate you at times, it would be foolish to say things such as “deal with it,” “quit overreacting,” or “this isn’t a big deal.” As Art Braunschweiger taught in a Journal article from our March/April 2018 publication titled “Treating Callers Like Real People,” emergency dispatchers must “talk to people like real people ... [a]ll too often the emergency dispatcher becomes impatient or irritated with the caller, and the call goes downhill from there.” He gave an example of a colleague who spoke with empathy to a caller whose baby was having
a seizure and used the following words: “Listen—I know this is scary. Trust me, I know this is scary. But you have to calm down so we can help your baby, okay?”⁶

Emergency dispatchers must act quickly and efficiently under the most stressful situations imaginable. In the midst of it all, you must remain calm, polite, and sympathetic—putting yourself in the caller’s position. In the section “Caller Management Techniques” of “Principles,” the authors emphasize, “Remember that it is unprofessional to broadcast opinions about the caller, the caller’s problem, or anything else through inappropriate words or tone of voice. The EMD who sounds sarcastic or overburdened is prone to act on that frame-of-mind rather than on the basis of the situation at hand. Remember, callers aren’t usually the patients, they are customers. Treat them well. While we can’t save everyone, we can help everyone.”⁷

The question is, can you learn the skill of authentic empathy and sympathy? An article from NBC News explores this topic. In it, author and researcher Roman Krznaric says people can develop this skill. He points out that, “Fifty percent of our empathic capacities are genetically inherited, and the rest we can learn.” The same article quotes author Judith Orloff, M.D., who runs an empathy training program. She says improving empathy for others “can be as simple as getting people into the habit of asking others how they are and actually listening to the answer.”⁸

Bryan Kramer, a CEO and author, writing for “Forbes” magazine, acknowledges that becoming more empathetic doesn’t happen overnight. He said it has a lot to do with your attitude. “Empathy is about acknowledging biases and genuinely imagining and trying to feel what it’s like to be in someone else’s shoes,” he said. “You’re putting yourself right there, in the thick of the emotion. This can be incredibly difficult to do time and time again, but it gives a unique perspective that can lead to positive action-taking. Feeling empathy comes more naturally to some people, but mostly, it can be a choice. You can choose to start seeing things from other perspectives and seeing things with their eyes.”⁹

**In-depth medical training**

For many EMDs, it’s common to give instructions on how to help a choking patient, how to perform CPR, or how to stop bleeding. Does it matter much if the EMD knows how to do these lifesaving actions themselves? Ruel Kapunan, an ETC Instructor and Advanced EMD Instructor from Pilipinas911 in the Philippines, says it’s absolutely critical that emergency dispatchers not only know how to relay these steps but to know how to perform them personally.

Kapunan oversees a Stop the Bleed Program in his community. Many emergency dispatchers take the course, which, among other things, teaches participants how to properly use a tourniquet, how to apply direct pressure, and how to pack a wound. He gives emergency dispatchers the course after they have taken the Emergency Telecommunicator Course.

“I think it’s a good skill for the emergency dispatcher to have,” he said. “I think it helps dispatchers become confident giving bleeding control instructions. Also, it gives students a better understanding of shock, which becomes the issue with uncontrolled bleeding.”

Kapunan even has a Facebook group for the program, which has been going strong for nearly a year and has around 1,200 members.

**Stress management**

Everyone feels stress at work or at home from time to time. Emergency dispatchers, however, bear much more of this than many people.

In 2013, “Business Insider” published a list of 600 different stressful jobs in the United States. Emergency dispatcher made its appearance at No. 13.¹⁰ This shouldn’t surprise anyone that works in the field. The job has grueling hours, often low pay, high turnover, and puts workers in constant contact with emotionally charged people on the worst days of their lives.

Calls such as the death or injury to a member of the EMS team, scenes with significant media coverage, death or injury to a child, or a call from a family member

**Dealing with stress in a positive manner is crucial for career success.**

- Take time off
- Take a vacation
- Take time for yourself
- Meditate
- Increase exercise
- Develop outside friends and interests
- Apply self-programming and rebalancing
- Trecia Hanna, Dispatch Manager at Medstar Ambulance Inc. in Sparta, Illinois (USA), said her center has a “Dispatch Cat” named Charlie. She said his presence can relieve stress much. I introduce him as ‘support services personnel,’” she said. “He provides therapeutic love when needed and often provides comic relief.”

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Tresca Brown, an emergency dispatcher with Glynn Brunswick 911 in Brunswick, Georgia, USA, suggests that volunteering in health care facilities can help emergency dispatchers cope with stress overload. Specifically, she recommends spending time with little ones.

“Babies—holding babies, rocking babies, loving babies,” she said. “If you are in a large area, hospitals need volunteers in the NICU and pediatric units for that. Smaller areas can check with day care centers or church nursery volunteering. It reminds me that everyone started out sweet and innocent.”

Like other skills, cultivating the ability to cope with stress and anxiety requires simply doing something. In this case, commit to exercising, follow through with vacation plans, or go out of your way to reconnect with friends. Balancing your demanding work duties with personal time will go a long way toward helping you feel refreshed and rejuvenated at work.

Pre-dispatch education

Fortunately, comm. centers can do an amazing job of training new emergency dispatchers. Current staff members get valuable feedback as well as one-on-one communication and guidance. The IAED™ provides vast resources of training, certification, and continuing education.

Andre Jones, Assistant Executive Director of Communications at Hamad Medical Corporation – Ambulance Service in Doha, Qatar, said it’s also helpful if emergency dispatchers have a varied skillset before they even apply for their positions.

“The career needs educated people when they come in, and then they can receive training on agency-specific policies, procedures, and protocols,” he said. “We train them, but we make the assumption they have the skills based on an interview or a test, and it is only after they are hired that we learn they don’t have the skills necessary to succeed. Education comes first, in my opinion.”

Jones, who started his dispatching career at age 17 on a university campus, said this education largely comes from work history. He urges recruiters and comm. center managers to look for candidates who have previously worked in stressful environments and in places that demanded multitasking and strong interpersonal interaction. Then, the in-depth training comm. center management provides can augment what a new emergency dispatcher already knows and has learned.

“When we provide specialized training in our centers, it should be to focus or enhance those skills that already exist,” he said.

The best of the rest

The list of important skills for this profession could go on and fill the entire issue of this publication. Because every day—every call—presents a different scenario and a countless array of challenges, it’s impossible to have too many abilities in your repertoire. You may have found that skills such as listening, self-confidence, self-control, patience, integrity, and decision-making are indispensable in your daily roles.

Jones mentioned a handful of other skills that complement the robust training that an emergency dispatcher receives. These include:

- Analytical skills
- Communication skills
- Coaching
- Coordination
- Collaboration
- Basic computer skills
- Emotional intelligence
- Conflict resolution
- Resilience
- Adaptability

If you find that you’re lacking in any of the areas we’ve mentioned or discussed in this article, seek to improve. Talk to your manager, or look for resources from the IAED. Remember, too, that skill development is a lifelong pursuit, no matter what stage of your career you find yourself.

Sources

5. See note 1.
7. See note 1.
11. See note 1.
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ART AND SCIENCE
How a complaint description becomes a Chief Complaint

Brett Patterson

A Chief Complaint may be described as the reason a caller is seeking help. The Chief Complaint may or may not be accurately expressed by the caller for various reasons, including a tendency to self-diagnose, a lack of knowledge concerning clinical or situational priorities, multiple/concurrent problems, or emotional distress, among other factors.

Case Entry Question 3, “Okay, tell me exactly what happened,” was designed to solicit a complete complaint description from the caller that can then be interpreted by the trained EMD to determine an accurate Chief Complaint.

The objectives associated with determining an accurate Chief Complaint include the discovery of any potential safety issues, any significant Mechanism of Injury (MOI), and the identification of priority symptoms and/or conditions that can be used to select a Chief Complaint Protocol. The selection of an appropriate Chief Complaint Protocol then helps to meet the primary objectives of the MPDS: safety, response allocation, patient care, and information for responders.

Understanding exactly what is happening, or has happened, at a given scene is essential to accomplishing the above objectives. For this reason, Case Entry Question 3 is perhaps the most important question in the MPDS. Because callers may not understand the EMD’s objectives or priorities, they may not initially provide a complete or accurate complaint description, making a second or clarifying attempt at asking this question mandatory. Most often, simply repeating the phrase “… tell me exactly what happened” is enough to obtain the information necessary to identify a Chief Complaint. However, if this does not work, rephrasing or otherwise attempting to find out exactly what triggered the call for help...
is compulsory. Cutting the caller off at Case Entry Question 3 is self-defeating as an inaccurate result is far worse than sacrificing a few seconds to get it right.

The Chief Complaint Selection Rules, found primarily on the Case Entry Protocol but also on various Chief Complaint Protocols, are designed to guide the EMD by setting some basic priorities. In particular, once a Chief Complaint is identified, these Rules ensure that safety, MOI, and priority symptoms are always considered when selecting a Chief Complaint Protocol. In other cases, a Rule may ensure a specific condition or situation is addressed accordingly on a specific Chief Complaint Protocol, i.e., that hazardous materials are addressed on Protocol 8: Carbon Monoxide/Inhalation/HAZMAT/CBRN, or that the apparently non-breathing seizure patient is evaluated on Protocol 12: Convulsions/Seizures before response assignment and caller instruction.

Our first Case Entry Rule is perhaps the most easily understood because safety is always our first priority. If the caller’s complaint description identifies any safety issues, the EMD must choose the Chief Complaint Protocol that best manages those issues. This applies even to those cases where another Chief Complaint Protocol may seem more appropriate for the caller’s concern, or even the patient’s care. A basic premise is introduced here: More than one Chief Complaint Protocol may address a safety issue, a mechanism of injury, or a priority symptom. All EMDs should be familiar enough with the MPDS to know the basic functions of each protocol.

Our second Case Entry Rule is designed to identify specific MOIs addressed by the MPDS. This is because significant MOIs can cause undiscovered (occult) injuries that may not be noticed by the caller or patient but require a certain level of response to address the potential injury. The classic example is LONG or EXTREME falls. While a caller may be concerned about a particular injury, perhaps a broken leg that

Protocol 30: Traumatic Injuries (Specific) would address, Protocol 17: Falls is most appropriate because it will prioritize the call based on the MOI alone, if necessary. In MEDICAL cases, Case Entry Rule 5 was designed to establish priorities when multiple complaints are expressed in the caller’s complaint description. Generally speaking, we want to know the primary reason the caller decided to call for emergency help. This is called the foremost symptom. In many cases, knowing why the caller is seeking help right now is enough to determine the Chief Complaint. Second, we want to make sure priority symptoms are not missed because lay callers may not understand their clinical significance. For instance, while a patient’s belly may hurt worse than her chest, the chest pain is obviously the clinical priority in the pre-arrival environment.

However, in order to appropriately apply these Rules and ensure the selection of an appropriate Chief Complaint Protocol, we must first obtain a complete complaint description, and then formulate an accurate Chief Complaint that we can apply our Rules to. To do this, we must consider the clinical and situational scenario presented to us and also have a thorough knowledge of the content and capabilities of our Chief Complaint Protocols. Let’s illustrate this concept by using a few examples.

A very emotional mother dials 911 after her 12-year-old son is exposed to a known allergen, say peanuts. Her Chief Complaint description includes both difficulty breathing and allergic reaction. If we strictly apply Case Entry Rule 5 to the complaint description alone when considering a Chief Complaint Protocol, we might select Protocol 6: Breathing Problems and, therefore, miss Key Questions and instructions very important to this case. However, if we consider this scenario clinically, we understand that the difficulty breathing is being caused by an allergic reaction. If we consider the scenario’s physical circumstances, we note that the child was exposed to a known allergen. With this information, we can now formulate an accurate Chief Complaint description: allergic reaction. And, knowing that Protocol 2 will address both the allergic reaction and the priority symptom of difficulty breathing, we can apply our Rules and select an appropriate Chief Complaint Protocol—Protocol 2: Allergies (Reactions)/Envenomations (Stings, Bites). This example clearly illustrates the basic premise we made earlier: More than one protocol may address
a particular priority symptom—we are not always limited to a Chief Complaint Protocol with the same name as the priority symptom.

Let’s look at another scenario that’s not so cut-and-dry. An elderly woman calls and states: “My husband just fell in the kitchen.” With this information alone, an EMD may initially think about the fall (MOI) when considering which Chief Complaint Protocol to select. However, because we know nothing about the circumstances of this fall, the prudent EMD asks again, “Tell me exactly what happened” to which the caller replies, “He was in the kitchen doing the dishes, and I heard him fall from the living room. Now he’s not responding to me!”

In this case, the complaint description contains a mention of fall. However, the complete scenario—the sudden, unexplained collapse of a previously normal patient—strongly suggests sudden cardiac arrest. The trained EMD understands that a ground level fall is very unlikely to cause unconsciousness, but the sudden collapse and unresponsiveness is highly indicative of cardiac arrest, followed by stroke or seizure. So, while the complaint description made mention of possible TRAUMA, the Chief Complaint is most likely MEDICAL.

Let’s look at one more case. A 65-year-old man calls and, in answer to Case Entry Question 3, states: “I was just watching television when I got this terrible, ripping pain between my shoulder blades. And when I tried to get up, I felt faint and had to sit back down. It’s really hurting badly now.”

In this case, the patient’s foremost complaint is ripping back pain, but there is also the mention of a priority symptom. However, the EMD understands that this sort of non-traumatic back pain, coupled with the patient’s age, fits the definition of SUSPECTED aortic aneurysm addressed on Protocol 5: Back Pain (Non-Traumatic or Non-Recent Trauma). Additionally, the near-fainting symptom, also suggestive of aneurysm, is addressed in the CHARLIE level of Protocol 5. Therefore, in this case, the caller’s complaint description matches the Chief Complaint determined by the EMD—non-traumatic back pain. And the Chief Complaint Protocol selected, Protocol 5, addresses both the SUSPECTED aortic aneurysm and the associated priority symptom of near fainting.

One of the most misunderstood concepts of the MPDS is the application of the Chief Complaint Selection Rules. Specifically, the literal interpretation of the Rules versus their actual intent, i.e., the “letter versus the spirit of the law.” And nowhere is this more apparent than in the selection of a Medical Chief Complaint Protocol, especially when priority symptoms are involved.

In v12.2 of the MPDS, the wording of the “Chief Complaint Selection Rules” was altered slightly to differentiate the caller’s complaint description from the actual Chief Complaint determined by the EMD. This was done because the caller’s chosen description of events doesn’t always accurately reflect the Chief Complaint and, subsequently, there is a tendency for EMDs to select a Chief Complaint Protocol based on keywords heard in the complaint description, rather than considering the entire description as a whole. Let’s call this tendency the “trigger finger” approach to Chief Complaint Protocol selection. Perhaps the most common and notable example of the trigger finger approach involves the selection of Protocol 31: Unconscious/Fainting (Near), when unconscious, fainting, or near fainting are not even part of
the complaint description. How does this happen? It happens when the EMD’s interpretation of the complaint description is incorrectly decoded based on the perceived notion that all forms of a decreased level of consciousness (a priority symptom) are best handled using Protocol 31. And this is quite simply not the case.

While it is certainly true that unconsciousness, fainting, and near fainting are all forms of decreased level of consciousness, it is not true that all remaining forms of decreased level of consciousness are appropriately addressed using Protocol 31. In fact, many MPDS Chief Complaint Protocols address varied levels of consciousness while also addressing the multi-varied complaints associated with a decreased level of consciousness.

Protocol 31 is designed to deal with the unconscious state when no specific cause is addressed on another protocol (think anaphylaxis, seizure, diabetic problem, stroke, and the many TRAUMA protocols where the Unconscious Determinant Descriptor and associated DLS Links appear). It also deals with the episodic events of fainting and near fainting, both of which are specific medical events. What it was not designed to do is deal with more specific causes of decreased level of consciousness that are addressed on other Chief Complaint Protocols, like the ones mentioned above.

So why does this inappropriate Chief Complaint selection process continue to happen? The most likely culprit is a trigger finger approach that relates all non-traumatic level of consciousness issues with Chief Complaint Rule 5: “If the complaint description appears to be MEDICAL in nature, choose the Chief Complaint Protocol that best fits the patient’s foremost symptoms, with priority symptoms taking precedence.”

When read literally, this Rule seems to direct the caller’s mention of any priority symptom to the Chief Complaint Protocol associated with that mention. Literally, all MEDICAL complaint descriptions that include chest pain should be handled using Protocol 10, any MEDICAL complaints involving breathing problems require the use of Protocol 6, all MEDICAL bleeds should be taken care of with Protocol 21, and all MEDICAL patients with any decreased level of consciousness should be handled with Protocol 31. However, when presented this way, most would agree that this is not an absolute, nor was it intended to be. In fact, these conditions sometimes relate directly to more specific Chief Complaint Protocols and are far better addressed as such.

So, what is the purpose of these Chief Complaint Selection Rules? How do the priority symptoms so sought after in Dispatch Life Support fit into the process of Chief Complaint selection?

The intent of these Rules is to guide EMDs with regard to their interpretation of a caller’s complaint. In other words, the Rules regarding Chief Complaint Protocol selection are there to help us select a Chief Complaint Protocol after translating a caller’s complaint description into a Chief Complaint. They were never designed to literally take a caller’s words or impression and translate that directly into a Chief Complaint Protocol selection. The human interpretation of a caller’s complaint description is, and always will be, a fundamental EMD process. “Press 1 if you’re choking” is simply not an option.

In other words, the trained EMD must listen carefully and clarify, when necessary, the answer to Case Entry Question 3, then use that information, both clinically and circumstantially, to formulate an accurate Chief Complaint. Once this is done, the EMD can use the Chief Complaint Selection Rules, along with a thorough understanding of the MPDS, to select a Chief Complaint Protocol appropriate for the case. To do this, the EMD must be familiar with the ability of various protocols to deal with that circumstance, both in terms of addressing priority symptoms in Key Questioning and coding, and in DLS Links and instructions.

Let’s get back to some examples. The son of a cancer patient calls to report that he is no longer able to care for his ailing mother. He says her condition is worsening. Her generalized pain is unbearable and not responsive to the powerful medications she is taking. She is lethargic and not responding well to commands. She is very weak and now unable to ambulate with or without assistance.
Given this complaint description, what is the actual Chief Complaint? Is it pain or the inability to ambulate? Is it a decreased level of consciousness, fainting, or near fainting? Or, is he reporting the deteriorating condition of a cancer patient, for which no specific Chief Complaint Protocol is titled? For most of us, Protocol 26: Sick Person (Specific Diagnosis) is a logical, even intuitive, choice. But what about that change in level of consciousness? And what about our Chief Complaint Selection Rule? How does that priority symptom fit in?

The answer is simpler than it appears. Yes, this caller is reporting a Sick Person. Yes, the patient has a change in her level of consciousness. And yes, Protocol 26 addresses this change in level of consciousness through questioning, coding, and instruction. Just like that, we have listened to the complaint description and formulated a Chief Complaint of unconsciousness.

Unconsciousness, as an episodic event, is a clear Chief Complaint, especially when expressed without a specific cause. And in the absence of a specific cause better addressed elsewhere in the protocol, Protocol 31: Unconscious/Fainting (Near) best addresses this complaint under these circumstances.

In summary, the process needed for selecting the most appropriate Chief Complaint Protocol for a given case requires more than recognizing keywords in a complaint description and loosely applying a Protocol Rule. In fact, hurrying through Chief Complaint identification is the mother of incorrect selection. Key to the process is the EMD’s ability to understand why the call is being made, which literally means listening to the complaint description, clarifying when necessary, and determining exactly what happened.

The answer is simpler than it appears. Yes, this caller is reporting a Sick Person. Yes, the patient has a change in her level of consciousness. And yes, Protocol 26 addresses this change in level of consciousness through questioning, coding, and instruction. Just like that, we have listened to the caller’s complaint with appropriate questioning, we have assigned an appropriate Determinant Descriptor (26-D-1 or 26-C-1, depending on the answer to “Is she alert?”), and we will provide appropriate instructions to monitor the patient until arrival.

Now let’s take that same patient in an unconscious state. Yes, she has been ill. But she has now become unconscious, which is likely the reason for the call, and this we can easily clarify. What have we done here? We have listened to the complaint description and formulated a Chief Complaint of unconsciousness.

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In summary, the process needed for selecting the most appropriate Chief Complaint Protocol for a given case requires more than recognizing keywords in a complaint description and loosely applying a Protocol Rule. In fact, hurrying through Chief Complaint identification is the mother of incorrect selection. Key to the process is the EMD’s ability to understand why the call is being made, which literally means listening to the complaint description, clarifying when necessary, and determining exactly what happened. A complete complaint description must always be required to contain enough information to generate an accurate Chief Complaint.

Understand that the actual Chief Complaint may or may not be literally aligned with the complaint description. The art in this process is knowing just how much information is needed to correctly synthesize the description into a usable Chief Complaint. With this information, the trained EMD, equipped with some basic knowledge about what protocols are available and what the capabilities of those protocols are, can then select a Chief Complaint Protocol using the Chief Complaint Selection Rules to make sure the key factors provided are addressed by the protocol selected.

**Author’s Note:** EMDs are not the only communication center staff selecting Chief Complaint Protocols. ED-Qs do this every time they make a judgment, in hindsight, about the appropriateness of an EMD’s Chief Complaint selection in a given case. The simple fact is that even ED-Qs sometimes disagree on which protocol is appropriate for a given case. This is inevitable because of the incredible variation of Chief Complaint descriptions that we are all responsible for first interpreting as Chief Complaints and then, based on that judgment, selecting just one of a relatively small number of Chief Complaint Protocols.

In my position with the Academy, I am asked to weigh in on Chief Complaint Protocol selection decisions on a daily basis, and this is often instigated by a disagreement between EMDs, or between ED-Qs, or a combination of both. In fact, this article is a result of many of those discussions. The point is that when even the experts disagree, the need for education and improvement becomes obvious, and that is the intent here. And while this article is sure to generate some debate, my hope is that those ensuing discussions will be productive and will hopefully spawn improvements to the way we approach Chief Complaint Protocol selection, thereby decreasing the variance we work so hard to eliminate in our quality improvement processes.
YOU MUST BE MEDICAL CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Art and Science,” which starts on page 34. Take this quiz for 1.0 CDE unit.

1. A Chief Complaint may be described as:
   a. the diagnosis made by the EMD based on the caller’s description of symptoms.
   b. the reason the caller is seeking help.
   c. the exact problem identified by the caller.
   d. a condition selected from a list and based on the EMD’s impression of the caller.

2. The selection of an appropriate Chief Complaint Protocol helps to meet the primary objectives of the MPDS but DOES NOT include the following consideration:
   a. safety
   b. response allocation
   c. patient care
   d. insurance coverage

3. The second Case Entry Rule is designed to:
   a. identify any safety issues.
   b. establish priorities when multiple complaints are expressed in the caller’s complaint description.
   c. identify specific MOIs addressed by the MPDS.
   d. establish the appropriate PAIs.

4. Case Entry Question 3 is perhaps the most important question in the MPDS because:
   a. it determines whether the caller is qualified to give an accurate description.
   b. an immediate response may be imminent.
   c. recognizing the problem aids in triaging response.
   d. understanding exactly what’s happening, or has happened, at a given scene is essential to determining an accurate Chief Complaint.

5. The Chief Complaint Selection Rules are found:
   a. primarily on the Case Entry Protocol but also on various Chief Complaint Protocols.
   b. only in the Performance Standards.
   c. only in the “Principles of Emergency Medical Dispatch.”
   d. as part of Case Exit to verify that the correct Chief Complaint Protocol was selected.

6. More than one protocol may address a particular priority symptom—we are not always limited to a Chief Complaint Protocol with the same name as the priority symptom.
   a. true
   b. false

7. The “trigger finger” approach to Chief Complaint Protocol selection is the tendency of an EMD to:
   a. hurry through a call to get on to the next one during a busy period.
   b. select a Chief Complaint Protocol based on keywords heard in the complaint description, rather than considering the entire description as a whole.
   c. disconnect a call when a hang-up is suspected.
   d. get their fingers stuck in a bent position due to the repetition of keyboard strokes.

8. Rules regarding Chief Complaint Protocol selection are there to help an EMD select a Chief Complaint Protocol:
   a. before the caller retracts the initial description.
   b. based on the caller’s diagnosis.
   c. after translating a caller’s complaint description into a Chief Complaint.
   d. without considering the entire description as a whole.

9. Key to the process of selecting the correct Chief Complaint Protocol is the EMD’s ability to:
   a. understand why the call is being made.
   b. clarify when necessary.
   c. determine exactly what happened.
   d. all of the above

10. A complete complaint description must always be required to contain enough information to generate an accurate Chief Complaint.
    a. true
    b. false
We’re gonna need a bigger protocol

Becca Barrus

It should have been a routine trip to the laundromat, but instead it ended with a call to 911 for firefighters to rescue a trapped toddler. Was he trapped in a washer or dryer? No, he was stuck inside a claw machine. You know the ones—big glass boxes filled with tempting treasures like toys and stuffed animals that can only be won if you grab them with a mechanical claw. Apparently the three-year-old boy climbed up inside the prize drop flap and couldn’t get back out.

The Palatine Fire Department (Palatine, Illinois, USA) was called and puzzled over how to get him out. According to one account, they thought about breaking the glass, but decided against it because they didn’t want the boy to get cut by the shards. They ended up taking off the top of the machine and lowering a firefighter far enough into it to pull the boy out. The toddler was upset but not injured, and soon everyone went on their way.

Children have a knack for getting stuck in just about anything—claw machines, banisters, chairs, swing sets. The list goes on and on. It isn’t just kids that get stuck either. Adults have been known to get caught in vending machines, chimneys, threshers, and children’s playground equipment. In some of these cases, the trapped individual is merely inconvenienced; however, in others, the victim is in real danger. So which Fire Priority Dispatch System™ (FPDS®) Protocol would you use to dispatch them?

Stuck on you


As with any other emergency situation, it’s important to consider the primary incident. A person trapped in a car due to a crash will be handled differently than a person trapped in a car due to a malfunctioning trunk hatch. Both are potentially dangerous situations and require a high level of response, but they are each surrounded by differing contexts and can even require different sets of tools for extrication.
Situations where the reason for calling is the primary incident, like the little boy stuck in the claw machine, would be triaged using Protocol 58. In FPDS version 7, the name of Protocol 58 has been changed from “Extrication/Entrapped (Machinery, Vehicle—Non-MVA)” to simply “Extrication/Entrapment.” Gary Galasso, chair of the Fire Council of Standards, explained that the deletion of “(Machinery, Vehicle – Non-MVA)” was to get emergency dispatchers away from thinking that only situations involving some sort of machinery would fall under Protocol 58. The Protocol is made to handle people with their legs trapped in a swing as well as people with their fingers caught in ice cream machines.

A question of injury

A Key Question has been added to Protocol 58 in version 7. Key Question 4 is now “Are there any obvious injuries?” and the subsequent questions have been renumbered accordingly. Should the caller report serious bleeding, X-4 directs you to Control Bleeding instructions, another new and useful feature of this version.

The first three Key Questions—What are they/you trapped in? Are they/you still trapped? What part of the body is trapped?—will drive your Determinant Code selection. The Determinant Codes can be divided up based on the what and when of the emergency. The most time pressing and potentially dangerous situations will naturally result in a higher acuity Determinant Code. What if the caller has managed to wriggle the stuck hand free from a PVC pipe but there are cuts and bruising? 58-A-2 “No longer trapped with injuries.” If the caller’s head is caught in an inactive thresher? 58-D-1 “ENTRAPMENT/TRAPPED (hand, wrist, forearm, foot, lower leg).” Galasso explained the change by saying that few people knew what “peripheral” meant without having to look it up. It’s quicker and more straightforward to have the body parts listed next to the Determinant Code. Another Determinant Code was added to the BRAVO level: 58-B-3 “ENTRAPMENT/TRAPPED (NON-THREATENED),” the definition of which is listed as “An entrapment situation where there is no immediate threat to health or life. The victim is not visibly injured or has very minor injuries. The primary problem is that the victim is unable to self-extricate.”

Assuming it is a more dire situation, caught body parts that warrant a DELTA designation are the head, trunk/torso/chest, upper arm, and upper leg; those that warrant a BRAVO designation are the hand, wrist, forearm, foot, and lower leg; and those that warrant an ALPHA designation are a finger, toe, and hair.

Down but not out

According to Galasso, new Determinant Codes were inserted into Protocol 58 in version 7 to accommodate situations where a person is stuck but has no injuries. It would not apply to situations like a motor vehicle collision, where the passengers are pinned and, more often than not, injured. Rule 3 on Protocol 58 in version 7 says that “For ENTRAPMENTS due to a motor vehicle collision (MVC), use Protocol 77.”

One of the reasons Protocol 58 was revamped was because of folks at Alachua County Sheriff’s Office in Gainesville, Florida (USA). They submitted a Proposal for Change (PFC) because Protocol 58 would either under- or over-triage for most extrication situations they faced.

If a child’s head becomes caught in between a banister’s balusters, in FPDS v6.1 it would be coded as a 58-D-1 “ENTRAPMENT (except PERIPHERAL, finger, or toe)” because the head is not a peripheral body part. PERIPHERAL was defined in the Additional Information section as the foot, the forearm, the hand, the lower leg, and the wrist.

“A DELTA response for us meant that we’d send six units to the scene,” said Allen Siorek, former Fire Chief for Gainesville Fire Department, which Alachua County dispatches for. “We didn’t need six units; in a lot of cases, we really only needed a screwdriver.”

Jennifer Altenburger, the Alachua EFD who put together the PFC, echoed Siorek’s sentiment when she wrote, “Of our last seven or eight inaccessible incidents, only two needed anything more than a screwdriver, a pair of scissors, and a tube of Vaseline.” They certainly didn’t need a multi-unit response.

New Determinant Codes were inserted into Protocol 58.

Now, with 58-B-3 “ENTRAPMENT/TRAPPED (NON-THREATENED),” the part of the body that’s stuck is important, but not as important as whether or not the stuck person is in danger. An arm caught up to the armpit in an active meat slicer would warrant a 58-D-1. An arm caught up to the armpit in a Pringles can would warrant a 58-B-3.

Uptown trunk

In the United States, any vehicle made after 2002 is required by law to
have a trunk release option inside the trunk itself. The National Highway Traffic Safety Administration (NHTSA) made the decree after data showed that at least 1,250 people had become trapped in car trunks in the past 20 years, and 11 children had died in 1998 as a result of becoming trapped in trunks.²

FPDS version 7 has also added a DLS Link specifically for situations in which a person has become trapped in a vehicle trunk (D-4). Vehicle trunk incidents were handled on Protocol 58 before the update, alerting first responders to the fact that someone was stuck in a trunk and telling second-party callers to “maintain verbal contact with the trapped people and assure them that help is on the way.” Now, on top of that, there is a set of instructions to walk first- and second-party callers through opening a vehicle trunk, whether through pulling the trunk release handle or folding the back seat down. While it is helpful to let them know that first responders are on the way, it’s even more helpful to be able to give trapped persons active instructions that can get them out of the claustrophobic situation as quickly as possible.

If for some reason the trunk release doesn’t work and the trapped person cannot push the back seats down in a bid for freedom, the last ditch effort on D-4 is having the trapped person locate the tire iron (under trunk carpet) or other tool and try to pry the latch open. If that doesn’t work, they will have to wait for the first responders to arrive and break them out using specialized tools.

A person trapped in a vehicle trunk may or may not be in mortal danger, but it’s better to err on the side of caution and get them out as quickly as possible. Axiom 2 reminds the EFD that “Carbon monoxide buildup for a person entrapped in the trunk of a car may reach toxic levels.”

Situations in which a person has been kidnapped and trapped in a trunk ought to be handled with the Police Priority Dispatch System™ (PPDS). As always, the more information you can give the firefighters before they arrive on scene, the better.

The main question Galasso wants you to have in mind as you approach a situation calling for the use of Protocol 58 is, “Is there a chance of impending or further injury?” If so, act accordingly by picking the correct Determinant Code and reading the appropriate PDIs and PAIs.

Sources
YOU MUST BE FIRE CERTIFIED TO TAKE THIS QUIZ

Answers to this quiz are found in the article “Apparent Trap,” which starts on page 40. Take this quiz for 1.0 CDE unit.

1. _____ is defined as “A situation involving prevention of escape in which there is an increased threat of injury, illness, or death to a person.”
   a. boxed in
   b. ENTRAPMENT
   c. inveiglement
   d. pinned

2. In FPDS version 7, which of the following protocols does NOT mention a victim being entrapped?
   a. Protocol 57: Explosion
   b. Protocol 67: Outside Fire
   c. Protocol 71: Vehicle Fire
   d. Protocol 83: Weather/Disaster Situations

3. In FPDS version 7, the name of Protocol 58 has been changed from “Extrication/Entrapped (Machinery, Vehicle – Non-MVA)” to simply “Extrication/Entrapment.”
   a. true
   b. false

4. A new Key Question was added to Protocol 58: Extrication/Entrapment. What is the question?
   a. “Can you describe the extent of the damage?”
   b. “Is this a suicide attempt?”
   c. “How long have they/you been trapped?”
   d. “Are there any obvious injuries?”

5. The X-4 DLS Link on Protocol 58 directs you to which new instructions?
   a. Amputation
   b. Burn Care
   c. Control Bleeding
   d. Person Trapped in Vehicle Trunk

6. Determinant Code 58-B-1 has changed from “ENTRAPMENT (PERIPHERAL only)” in FPDS v6.1 to what in version 7?
   a. ENTRAPMENT/TRAPPED (MINOR)
   b. ENTRAPMENT/TRAPPED (hand, wrist, forearm, foot, lower leg)
   c. ENTRAPMENT (finger or toe)
   d. ENTRAPMENT (NON-THREATENED)

7. A caller says that her daughter’s finger has gotten stuck in a hole in a park bench. What severity designation would that warrant?
   a. DELTA
   b. CHARLIE
   c. BRAVO
   d. ALPHA

8. Rule 3 on Protocol 58 in version 7 says that “Carbon monoxide buildup for a person entrapped in the trunk of a car may reach toxic levels.”
   a. true
   b. false

9. How many children died in the United States in 1998 after becoming trapped inside vehicle trunks?
   a. 11
   b. 26
   c. 43
   d. 77

10. Which DLS Link on Protocol 58 will take you to instructions for a victim trapped in a vehicle trunk?
    a. B-3
    b. D-1
    c. D-2
    d. D-4
CAMPING TRIP CURTAILED
Twister mows through remote Manitoba

Audrey Fraizer

Ilill Catagas was on the road after work, driving to meet her husband and children at their RV parked in their favorite campground near Lake Manitoba, Canada.

She recalls nothing out of the ordinary about the drive. Heavy clouds forewarned a storm, but that was typical for the time of year. She knew the route well, having traveled this way often to spend long weekends among fellow camping enthusiasts, people they’d known for years.

Like most trips to the lake, Catagas anticipated a relaxing family-oriented getaway while on break from her job at Medical Transportation Coordination Centre (MTCC), Manitoba, Canada. She started with the agency in 2006 and is the center’s administrative assistant.

Never did she realize that something was following her the evening of Aug. 3, 2018. Not until she reached the campground did she turn around to see the menace twisting behind her.

“I never suspected what was going to happen next,” Catagas said.

Darks clouds were rotating. Rain pelted the ground. Winds were picking up. Catagas saw a down spout coming out from the funnel cloud. The sky went from day to night. Sheltering was imperative. She alerted her family. From inside the RV, they had not known the extent of the incoming bad weather.

In seconds—but who’s counting—a caravan of 40 campers in assorted vehicles were tearing down the road to the closest home in this rural section of south-central Manitoba. The homeowner, also one of the campers, ushered everyone into the basement. The adults put mattresses over the children before hunkering down against a wall away from the small barely aboveground windows. The funnel cloud had touched ground. They were now in the path of a tornado.

“We just prayed,” Catagas said.

The sound outside was like a million freight trains barreling toward the home, Catagas recalls. The frame of the house crackled. The foundation shook. At this point, Catagas draws a blank. Her ears ached from the increasing pressure. She simply wanted this to end. She was terrified for the people in the room, particularly the children protected by a thin layer of mattress.

A man at a window relayed the tornado’s proximity.

“He said the tornado was in the yard,” she said.

Then it stopped. The storm had passed. The adults decided it was safe to go outside.

The aftermath shocked them. The house was intact, but the yard was leveled, as if razed to the ground by a bulldozer. Trees were uprooted and, in some places, only a hole in the earth remained. The outbuildings were gone and so was the home of an elderly couple next door.

“We went over to make sure they were okay,” Catagas said. “They survived.”

The sky was tinged pea green, and rain continued to fall. They caravanned to the campground. There was little left of the place they had evacuated earlier that evening. RVs were demolished and some had been picked up and dumped into the lake. Debris hung from the few remaining trees and carpeted the ground. They went door to door of the remaining RVs to check on everyone’s safety. They asked each other “Where do we go from here?”

EMD Ava Grexton, dispatch manager on shift at MTCC, was supervising the communication center when the first call came in at 9:02 p.m.

“We all buckled down to assist,” Grexton said. “Twenty minutes later, EMS was on scene at the campground. Everyone was accounted for.”

The tornado, later categorized an EF4 (Enhanced Fujita Scale with winds speeds between 207–260 mph), caused the death of one man who was inside his home when it hit. Three patients were transported.

Catagas said campers have since worked to reclaim the area.

“We’re family now,” she said. “We’re working together to make good out of the bad.”

A tornado was brewing in Manitoba, Canada, on Aug. 3, 2018.
FOR CRYING OUT LOUD
The best moments can be the most unexpected

Audrey Fraizer

EMD-Q® Tammy Black might be considered lucky having delivered five babies over the phone on five separate occasions.

“Yes, it’s thrilling,” said Black, Lead System Status Controller, Medical Transportation Coordination Centre (MTCC), Manitoba, Canada. “People generally don’t call for help at the best moments of their life, so it’s a good moment when the call is about helping to deliver a baby.”

But it’s not always so easy. MTCC went live with the Medical Priority Dispatch System™ (MPDS®) in September 2006—at the same time MTCC opened—and Black answered MTCC’s first imminent arrival call in February 2007. Black readily recalls how she felt at the time. “It was nerve-wracking,” she said. Mom delivered the baby in the bathtub and dad, who diligently followed the PAIs over the phone, stayed on the highest level of alert.

“He kept apologizing to his wife for the pain, and she kept telling him not to worry,” she said. “But he listened to the instructions, and everything went very well.”

The call was also a teaching moment for the two paramedics standing behind Black during the call. Showing others in EMS how dispatch works is a major benefit (right up there with helping people and coordinating resources), Black said, along with working as part of MTCC’s “phenomenal” team.

In other words, the dedication and enthusiasm Black has for emergency dispatching resonates through her voice. She truly likes the ability to do whatever she can do for both callers and responders, and that goes for a recent baby call when she convinced the driver to pull over rather than continue to the hospital.

“He thought he could make it to the hospital and just wanted us to call the hospital to make sure they were ready for them,” she said. “He didn’t know the baby was crowning. He did pull over, and within minutes of stopping the baby was born.”

Black’s background in health care and special needs education contributes to her natural leaning toward emergency dispatch, and like all MTCC system status controllers she is a trained paramedic. She’s been around MTCC since day one, same as Clinical Manager Michelle Piwniuk. Everything was new at the command and control center serving rural and Northern Manitoba. Protocols. Training. Certification. They were bringing on Regional Health Authority stakeholders one by one.

Although they practiced extensively before going live, they trained on scenarios and not actual calls. Emphasis was placed on using protocols exactly how they were written and getting clear answers from the caller before proceeding with the next question or instruction.

Black is grateful for the protocol’s precision, but she has also discovered the complex layers of emergency dispatch that puts her in a position to assist those new to the profession. After all, she remembers the feelings of anxiety and overwhelming responsibility.

“Yes, it’s scary when you answer the phone and don’t know what will happen when you do answer,” she said. “It’s okay to be scared. It’s okay to ask for help. There’s always someone here. You’re never alone.”

The 10-seat communication center dispatches air and ground resources for 94 EMS stations operating in 650,000 square kilometers (about 403,892 square miles). The population is roughly 1.2 million. In 2017–2018, they dispatched 150,000 incidents.

Baby delivery is a frequent call, relatively speaking. During the 12 years of operation, they have delivered 43 babies over the phone (which means the baby is fully delivered when EMS arrives on scene); 2017 was particularly busy, Piwniuk said.

“We had an uptick,” she said. “Nine babies.”

Black can’t imagine a day when any call becomes routine or mundane, no matter the number of baby delivery calls she answers. A caller saying “Thank you” at the end of the call is just about all it takes to satisfy her. “That’s what keeps me going,” she said. “It’s a wonderful thing to pull all the resources together to help someone. I am very proud of what we do.”

MTCC is an IAED™ Accredited Center of Excellence.
Fire insurers depended on guaranteed safe bets

Audrey Fraizer

Five signatures to a Sanborn Fire Insurance Map of Salt Lake City, Utah (USA), was all it took. Seven years prior to statehood, the nearly mile-high city in the territory west of the Rockies was declared a great place for any fire insurance company to do business.

The year was 1889, and only during the past six years had the city paid firefighters to come a runnin’ at the sign of fire, rather than relying on volunteers (paid 25 cents an hour per call until demand for 50 cents an hour resulted in going to a less expensive paid force). Although private businesses and homes had the option of carrying fire insurance, a Sanborn map signed and stamped by a national insurance board increased buyer options.

The massive fire predating a paid department was devastating, nearly incinerating an entire block of downtown Salt Lake City. On a summer day, when most of the volunteers were picnicking at the Great Salt Lake, a huge fireball exploded south of The Church of Jesus Christ of Latter-day Saints’ Salt Lake Temple. A 93-pound keg of gun powder had literally met its match at a wagon depot owned by Hiram Bradley Clawson Jr. Fire department volunteers undoubtedly saw the explosion, but the distance was far too great for timely response.

Local news reported a shock so violent “that nearly every window and glass door in Main Street, a block down on either side, was completely destroyed, the sidewalks being literally carpeted in glass.”¹ Clawson’s machinery and animal hide and wool business was a total loss, along with several other mercantile establishments (a church council house, a bakery, an art bazaar, and a furniture store). Incredibly, no one was seriously injured; about a dozen people were bruised or cut from the force of the explosion and flying glass, and one man suffered a broken arm.²

Although the fire was the largest yet in Utah territorial history, Salt Lake City was also following national trends. The modern department with salaried personnel and standardized equipment became part of municipal administration only late in the 19th century (at the beckoning of fire insurance companies). Sanborn Fire Insurance Maps were created to assess fire insurance liability within state and territorial urban areas.

Sanborn surveyors meticulously documented these areas—building by building and block by block, in communities large and small. The detailed maps designated streets, property boundaries, structural types (down to storage sheds), building use, and they were color-keyed to identify construction (brick, stone, adobe, or a mixture of materials). Since their primary purpose was to assess risk, the maps also showed the location of water mains, hydrants, piping, wells, cisterns, and field storage tanks.

By 1889, the urban Salt Lake City boasted two reservoirs fed water by gravity pressure through nearly 26 miles of pipes connected to 200 fire hydrants.

The 35,000 people living in Salt Lake City were clustered within a square-mile radius extending north, south, east, and west from The Church of Jesus Christ of Latter-day Saints’ temple and tabernacle. The series of Sanborn Fire Insurance Maps issued for the city in 1889 identifies the use of each building in a quadrant, such as church, school, shop, or residence. The business district, one block south of Temple Square and on either side of Commercial Street, was a domino game of dry good stores, apothecaries, saloons, banks,
warehouses, a small Chinese community (stores, laundries, apartments, and restaurants), grocers, law offices, liverys, and machine shops. Prostitution was legal, and structures designated by “FB” (female boarding) were generally considered houses of “easy and paid persuasion.”

The current site of headquarters for the International Academies of Emergency Dispatch (IAED) was occupied by two buildings—a saloon and combination barber and jewelry shop.

The city extended its boundaries in 1889 through the advent of electric street cars to replace the often unreliable mule-pulled street cars. The city’s fire department was outfitted with two Silsby steam fire engines, a two-horse hose cart, two hand hose carts, and one hook and ladder truck (old but fully equipped) and all were regularly called out to extinguish fires. A second engine house was planned, along with the placement of multiple public alarm boxes.

Incidentally, an official inquiry failed to pinpoint the exact cause of the summer blast, and some were of the opinion it was the work of an incendiary. Eventually, it was the powder Clawson stored in a fireproof wagon that city fathers held responsible. Extensive personal losses (only a stock of wool survived the flames) precluded recovering any damages from him. Clawson estimated his loss at $30,000 with insurance covering about two-thirds. Total loss for the city was more than $100,000.

On a positive note, a fire department was born out of the ashes of near disaster.

The last Sanborn map was published in 1977, but the old maps remain popular for historical purposes, particularly the genesis of urban planning. For more about Sanborn Fire Insurance Maps, check out a digital collection at loc.gov/collections/sanborn-maps available through the Library of Congress.

Sources
3. See note 2.
4. See note 1.
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