

## Experience Can Lead A Dispatcher Astray

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## INTRODUCTION

Utah Valley Dispatch Special Service District is located in Spanish Fork, Utah, and provides centralized dispatch services for police, fire, and Emergency Medical Service (EMS) agencies in Utah and Juab counties. All 45 dispatchers working in the center are certified in CPR, Emergency Fire Dispatch (EFD), and Emergency Medical Dispatch (EMD). These dispatchers are trained to give lifesaving instructions to callers during emergency medical situations.

At the time of the call, the EMD was on her fourth week of training and taking 911 emergencies as well as non-emergency calls on her own with little instruction. Her training included structured interrogation of callers to obtain critical information quickly, as well as EMD certification. This was her first CPR call.

The call began with the first MPDS protocol question: "911, what is the address of the emergency?"

"My boyfriend is not breathing," the caller replied. "He's cold and everything!"

The language used here—'not breathing' and 'cold'—poses challenges for EMDs because they are descriptors that could indicate an obvious death. In my experience reviewing medical calls, these obvious death descriptors complicate the critical decision of whether to provide CPR. Additionally, they can lead an EMD to engage in dispatcher diagnosis and discontinue providing CPR instructions. In this case, the EMD could have interpreted the two above descriptors as a clear sign of an obvious death, which would necessitate the selection of the Cardiac or Respiratory Arrest/Death protocol. However, the dispatcher, given her physical removal from the scene, could not know at that point that the patient was in fact deceased.

## MANAGEMENT AND OUTCOME:

After reporting those obvious death descriptors, the caller pleaded, "Oh hurry! I don't know what to do! I don't know what to do!" The EMD explained that help was being sent and started giving instructions. Additional patient information was provided when the caller stated that "he's discolored." The EMD found the immediate tone of the caller to be in need of assistance and issued CPR instructions even when the caller gave more descriptors that could indicate a death: "He peed the bed" and "he's on the bed, and he's black."

The EMD reiterated that the patient needed to be on the floor in a gentle, yet firm tone. The caller then complied. CPR was performed on the patient until EMS arrived and supplied more patient care, which included all possible attempts to revive the patient. While continuing CPR, EMS transported the patient to the hospital with lights-and-siren. The doctor in the ER called the death, but not until all life-saving measures were taken.

When I met with the EMD later, I asked how she felt about the call. She replied that she handled a lot of medical calls, and what made this call go so well was that the caller was cooperative. Also, she felt a steadying influence knowing that her trainer was nearby. After the call, she received immediate praise from the floor supervisor and wasn't left with the traumatic feeling she often feels when dealing with uncooperative callers.

## DISCUSSION:

The EMD acted correctly by following the protocol and continuing to give CPR instructions—despite the tragic result. A common saying in EMS circles is appropriate here: "We can't save the lives of every patient. However, we can help everyone." Sometimes the best one can do is administer potentially life-saving instructions, or keep a calm and

professional demeanor, during a particularly challenging situation. Even though this case lacks a happy ending, the EMD can be proud that the patient received an appropriate amount of prehospital care.

Additionally, this call highlights a key challenge of being an emergency dispatcher: properly interpreting a caller's verbal report. Ultimately, the EMD makes choices, such as protocol selection, or which PAIs to provide, based upon an evolving description given by the caller. In a non-visual environment, it can be a challenge to decide whether the caller's statements about the patient fit decomposition or some other condition. This idea is echoed in the Emergency Medical Dispatch Course Manual, which states that "information normally obtained visually may be taken for granted, causing assumptions to replace facts." An illustrative example is when a caller declares the patient is not breathing; in this scenario, "it is easy to assume that the patient is also unconscious." Related to this notion of forming unwarranted assumptions, the presence of obvious death descriptors might cause an EMD to assume a death has occurred, even when there isn't enough evidence to reach that conclusion.

Fortunately, the EMD in this call—most likely because of her inexperience—did not seem to consider any other choice but to adhere to the protocol and the evidence. Clearly, experience and intuition can play a role in decision-making, but that does not mean an emergency dispatcher should disregard the protocol. For if the protocol is ignored, the dispatcher risks acting on assumptions that are ultimately harmful to the patient. More to the point, the danger here is that harboring these assumptions might stop a dispatcher from providing life-saving instructions. Counterintuitively, experience can sometimes lead a dispatcher astray from the core task. Let's remember: it's our job to deliver training to the caller so they can deliver care to the patient.

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## REFERENCES:

Patterson B, ed. *Emergency Medical Dispatch Course Manual*. 25th ed. Salt Lake City: The International Academies of Emergency Dispatch; 2015: Section 4.3.