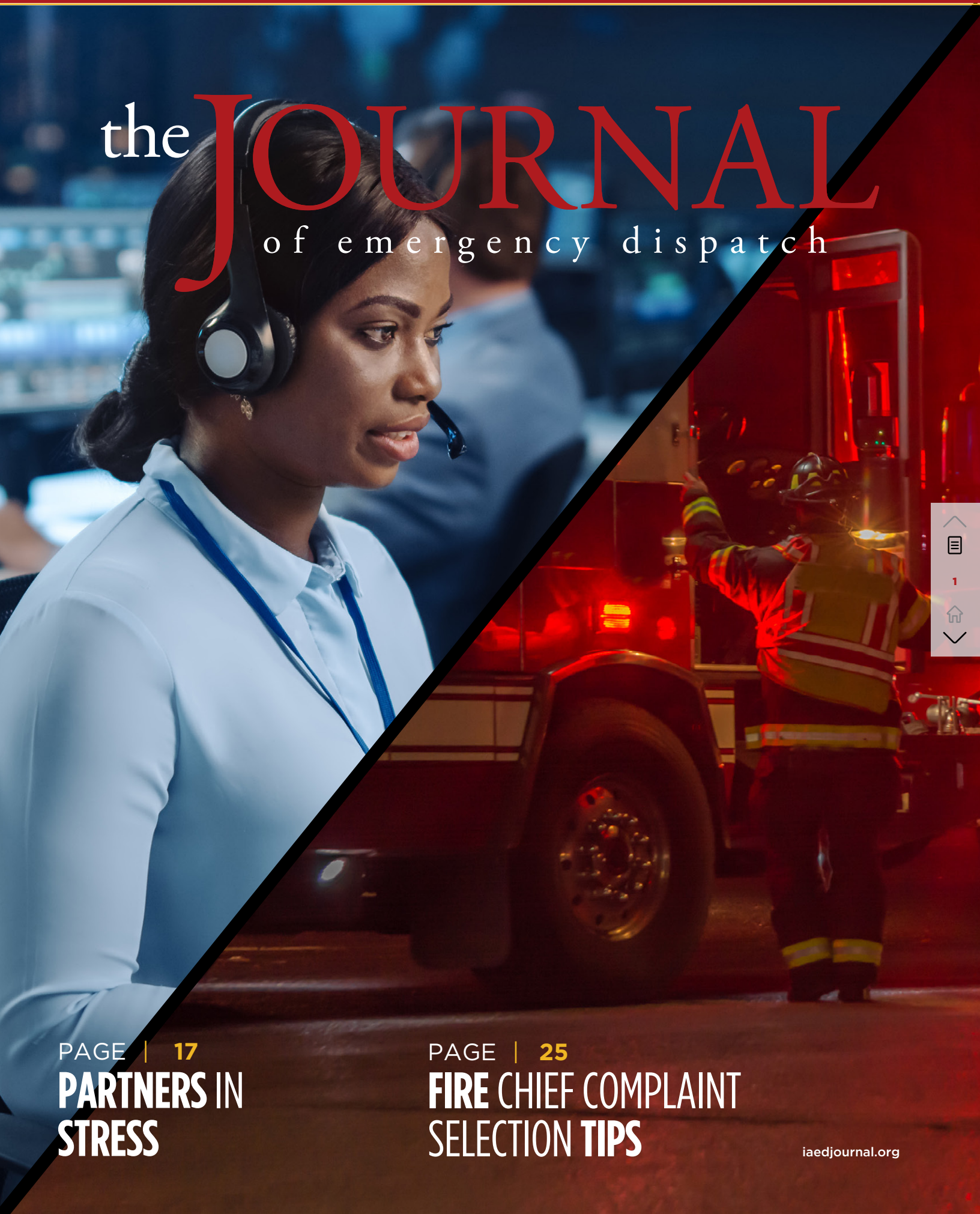

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FEATURE

Follow IAED on social media.

Anna is an IAED Administrative Assistant with eight years of experience. She has a master's degree in Ukrainian Linguistics. In her free time, Anna likes to hike with her dog, Trixie, travel with her spouse, study psychology, grow succulents, and take photos of her friends.

ANNA SHMYNETS

5 | DEAR READER

Dr. Lanier is a retired Naval Officer. André teaches for the U.S. Navy with dual certifications on the Orion P-3C (Submarine hunter) and the Triton MQ-4 (Unmanned) airframes. His primary role is to prepare naval flight officers to efficiently and effectively accomplish their missions and lead their crew. André became involved with the 911 profession when he was selected to present a series of lectures at multiple IAED NAVIGATOR conferences.

ANDRÉ LANIER

8 | GUEST WRITER

Mike is the Improvement Guide for FirstWatch, a company which provides near-real-time monitoring and analysis of data along with performance improvement coaching for EMS agencies. He teaches Improvement Science in the Master's in Healthcare Administration and Interprofessional Leadership at the University of California San Francisco and the Emergency Health Services Management Graduate Program at the University of Maryland, Baltimore County. He's the author of Super-Charge Your Stress Management in the Age of COVID-19.

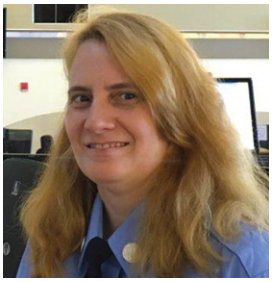
MIKE TAIGMAN

17 | FEATURE

Jonathan, MA, NREMT, is editorial director of EMS World. He can be reached at jon@emsworld.com.

JONATHAN BASSETT

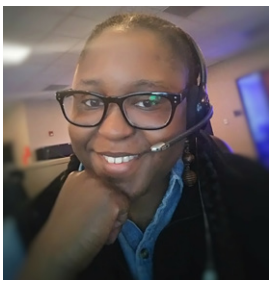
17 | FEATURE



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

7 | SURVIVING THE HEADSET



Samantha is a 911 telecommunicator and police dispatcher who hails from Powder Springs, Georgia (USA). She holds a Bachelor's of Science in Addiction Counseling. She is an experienced professional in the customer service industry, having previously worked in retail and banking, and for over five years now has worked at Cobb County 911. Samantha can be reached at samantha.hawkins@cobbcounty.org.

SAMANTHA HAWKINS

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INTERNATIONAL ACADEMIES OF EMERGENCY DISPATCH

110 South Regent Street, 8th Floor
Salt Lake City, UT 84111 USA
USA/Canada toll-free: 800-960-6236
Intl/Local: 801-359-6916
Fax: 801-359-0996
emergencydispatch.org
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By meeting certain requirements, certified membership is provided for qualified individual applicants. Accredited Center of Excellence status is also available to dispatch agencies that comply with Academy standards.

NEVER HAVE I EVER CALLED 911

Big differences between admin assistants and EMDs

Anna Shmynets

Throughout my life, I've worked as an administrative assistant in many fields: insurance, law, IT, sales, transportation, you name it. I always loved my jobs for never repeating the same day twice. I enjoy helping my colleagues, facing challenges, and solving puzzles. I was told IAED™ is not like any place I worked in before. And they were right. This is not just a company; it is a distinctive place with a remarkable history and a lifesaving approach.

During these two months, I have discovered and learned quantities of new things: the difference between a heart attack and a stroke, the first law of medical empathy, and that the Standard Occupational Classification puts emergency dispatchers in the same category as "Office and Administrative Support Occupations."

Don't get me wrong, I think my job is a vital part of the operations of the company I work at. As the "eyes and ears" of a company, administrative support handles routine chores for a team or even the whole company. However, I was very surprised to know that SOC defines my job to be the same as 911 dispatchers.

Before working at IAED, I did not have a clear image of an EMD's job. I thought that it was a call center job: You take a call, write down the patient's address, and send an ambulance for them. Easy. Sadly, I was so far from the true picture.

First off, emergency dispatchers answer more calls than I can imagine. According to NENA, approximately 240 million calls are made to 911 in our country each year. That means 650,000 calls a day! Can you imagine an office worker taking that many calls? Emergency dispatchers listen to life's worst occasions all day long, and they must be able to respond to any type of call at any second.

One of the advantages of my work as an admin assistant is a nice, classic schedule—I work from 8:30 a.m. to 4:30 p.m. Not too early or too late, right? Well, many of the EMDs work when we are asleep. They stay on the line for us as long as we need them because they care. Even though the EMD is not physically at the emergency location, they still deal with lots of stress. The truth is half of them deal with PTSD regularly, diagnosed or undiagnosed.

I believe there is no such thing as an unimportant profession in this world, but some of them need to get more recognition because they deserve it. Emergency dispatchers are not the same as office support. Period. We need to reclassify them as a protective service occupation, the same as police officers, paramedics, and firefighters. It will allow people with this profession to get more benefits like early retirement, for example. But what is even more important, it will help to represent their true role and gain more respect. ●



A THING NOT LOOKED FOR IS SELDOM FOUND

Asking Not Alert patients to complete the Stroke Diagnostic Tool can be clinically revealing

Jeff Clawson, M.D., Brett Patterson, and Greg Scott

Hi Brett,

Why does the Stroke Diagnostic launch for Not alert stroke patients?

I know there is the "Patient unable to complete request" in each question of the diagnostic, but one can sound a bit silly when they have already told you they are Not alert and you start asking them to do things.

I understand there is a high probability of stroke in the unable to complete option, but wouldn't the high probability maybe relate to the Not alert answer?

It is 0300 in the morning so I hope this made sense??

Thanks,

Mel Johnson
DispatchSmarter Advisor—Australia/ New Zealand, Priority Dispatch Corp.

Hi Mel:

We did not disable the SDxT for patients recorded as Not alert because there is such a wide range of actual acuity in that subset of patients and many are able to complete the diagnostic. Additionally, we now get a positive result if the patient is unable (versus refused), and this can be clinically revealing. We would need some outcome data to estimate the relationship of unable to complete versus the Not alert condition as compared to Stroke Dx. However, because stroke can affect the patient's level of consciousness, I would assume a relationship exists.

I have copied Greg Scott as he may be able to shed some light on the distribution of 28-C-1 patients with regard to SDxT suffixes, although I would not prioritize this as urgent for him at this moment.

Thoughts, Greg?

Brett A. Patterson
Academics & Standards Associate Chair, Medical Council of Standards International Academies of Emergency Dispatch®

Brett & Mel,

To confirm what Brett is saying, we actually published a study on this topic (see below link). It turned out that the among "Not alert" patients, some could complete tasks in the Stroke Diagnostic Tool and some could not. Indeed, the patients who could not complete any of the tasks were at high risk for stroke.

aedrjournal.org/characterization-of-hospital-confirmed-stroke-evidence-for-callers-who-were-unable-to-complete-stroke-test-requests-from-the-emergency-medical-dispatcher

Greg Scott
Associate Director of Protocol Evolution
International Academies of Emergency Dispatch

All,

There are obviously patients too sick to respond at all, and there are plenty of Not alert patients that can make an attempt. The point is that the unable to complete option is catching stroke patients, and this is a good thing.

Brett

All,

I agree with the responses. I would add that doctors don't "feel silly" when they ask things that often reveal pertinent negatives. Frenza's Law is also pertinent here: "A thing not looked for is seldom found." And, finally, "Don't trip over seconds while looking for correctness."

Jeff Clawson, M.D.

EXPERIENCE KNOWS BEST

Longevity is a virtue

Heidi DiGennaro

How many of you work with people who have been there since the dawn of dirt? How many of them do you think need to go, just retire already? Think their brain has checked out ahead of their actual retirement date? How many keep a simultaneous clock counting down until when so-and-so retires so you can plan an after-retirement party to celebrate their leaving? Yeah, we all know or knew people like them.

What about the people with several years, a decade, or more time in? Or have a couple years, some of them hard years, under their belt? What do they all have in common?

Experience. Words frequently repeated to trainees are "it will come with exposure" and "as you gain experience." There is no substitute for experience. Until your butt is in the hot seat with the world crashing spectacularly around you and YOU are expected to know what to do, you won't understand experience and what it can teach you.

Don't misunderstand me; simulations are great to create a foundation for you. Tabletop exercises, asking "what if?," or even reading policies you haven't seen since they were put into effect DO help you. They give you an idea of how things should go, what needs to be done, and keep the panic/anxiety/stress monster at bay. Which allows you to fake it until you make it.

Let's be clear. We don't want you to fake it—we want you to know what to do. But when you don't know, you need a starting point. Find your starting point and that's where experience becomes a factor. Examples: Okay, the last time I had a fight with a ridiculous number of people I called SaveMyButt County next to us and they sent us people. If I have another big fight with weapons, let's call SaveMyButt County again. Or let's say the summer kids camp is turning into a mass casualty from heat exposure. SuperRich County has an MCI trailer and they offered it the last time the camp had a problem, so let's call SuperRich County. If there isn't already a policy or MOU saying to call them, your experience gives you a tool.

Take your frequent callers. When that one person having their daily mental health crisis calls in, experience lets you know what calms or triggers them and where to find their family member's phone number. You may not have had this caller before, but your co-worker—the one about to retire—is on a first-name basis with them and is comfortable asking them after protocols if they drank their favorite cold medication again, the one that alters their mental status.

Experienced co-workers know where businesses used to be so when one of the Old Guard out on the road calls out that there's an emergency at the restaurant that burned down 10 years ago, the co-worker knows exactly where they are. This knowledge helps you when a caller doesn't know where they are other than saying they are in the parking lot of that restaurant that burned down and you have no map. These experienced co-workers will help you through major incidents even while complaining the entire time.

If you have an incident that you think you could have done better, review it. Ask your supervisor to go over it with you and offer suggestions. Ask for an after-action. Learn from what went right, what went wrong, and where you can do better. You are using experience as a teacher.

Final thoughts: As you gain experience, you're going to be the one that the newer people will turn to for help. You'll be their guide, you'll share your experiences, and you'll forget you were ever that scared or nervous when you first started. Remind yourself you are going to be a teacher and ask yourself what kind of teacher you want to be. ●

HOW DO YOU DEFINE LEADERSHIP?

Looking in from the outside

André Lanier

If you were to take a non-scientific qualitative poll in your emergency communications center (ECC) asking the question, "What is the definition of leadership?" you would probably get many different responses. The responses may also differ based upon the position of the individual asked. What difference does leadership make? Leadership will affect commitment, performance, productivity, tenure, and job satisfaction among organizational aspects.

Since the beginning of written language, the question of what leadership is has been studied and evaluated. Effective leadership is a key ingredient to the success of all organizations. Leadership is one of the most researched topics and the least understood. Even though defining leadership has been attempted by scholars throughout the ages, a measure of ambiguity still exists. The words "leadership," "leader," and "follower" appeared in ancient Egyptian writing as early as 2300 B.C.E.[1] Writings on these concepts and principles have continued across the millennia through various works by authors such as Confucius, Homer, Plato, Aristotle, Machiavelli, and Shakespeare. Books on leadership styles and beliefs continue to be written. In 2018, over 1,200 books with the word "leadership" in the title were published.

The lack of a common leadership definition is especially perturbing because leadership is accepted as a key ingredient to the success of organizations. The lack of certainty is compounded by phenomena such as cultural diversity which is increasingly exposing leaders to new challenges. For organizations to run effectively, coordination and the ability for some legitimate authority to issue commands must be present. There must be (a) legal authority, (b) traditional beliefs about authority, and (c) charismatic grounds so that the systematic analysis of legitimate authority could be carried out.

Current and previous researchers have continuously applied leadership categories, such as styles, traits, and behaviors, to their research to understand the causes and effects of the categories. As stated by Bass and Bass in 2008, one researcher found 221 scholarly definitions for the term leadership. Conversely, "[t]he definitions most commonly used tend to concentrate on the leader as a person, on the behavior of the leader, on the effects of the leader, and on the interaction process between the leader and the led."[2] The following quote is yet another way to define leadership:[3]

Leadership is an interaction between two or more members of a group that often involves a structuring or restructuring of the situation and perceptions and expectations of the members. Leaders are agents of change—persons whose acts affect other people more than other people's acts affect them. Leadership occurs when one group member modifies the motivation or competencies of others in the group.

Does the leadership within your PSAP match the above definition? Now that we have defined leadership, we also have to look at different categories of leadership. Leadership characteristics can be broken down into two distinct categories. These are different than leadership styles. One leadership category is based on the hierarchy of the organization—designated leadership. Normally these are the personnel (communication center directors, communication training officers, line supervisors) who have years of experience, 911 wisdom, and a greater understanding of the processes required to make the PSAP work.

The second category of leadership is situational leadership. Situations will arise where someone is more experienced with the events that are unfolding and that person becomes the leader. Every telecommunicator's experience and wisdom is different. The experience will be different between telecommunicators, line supervisors, CTOs, and directors. If someone has gone through an event before (such as multi-car accident with injuries or a chemical fire near a neighborhood), they will have the experience and knowledge to step up as the leader until the situation is handled.

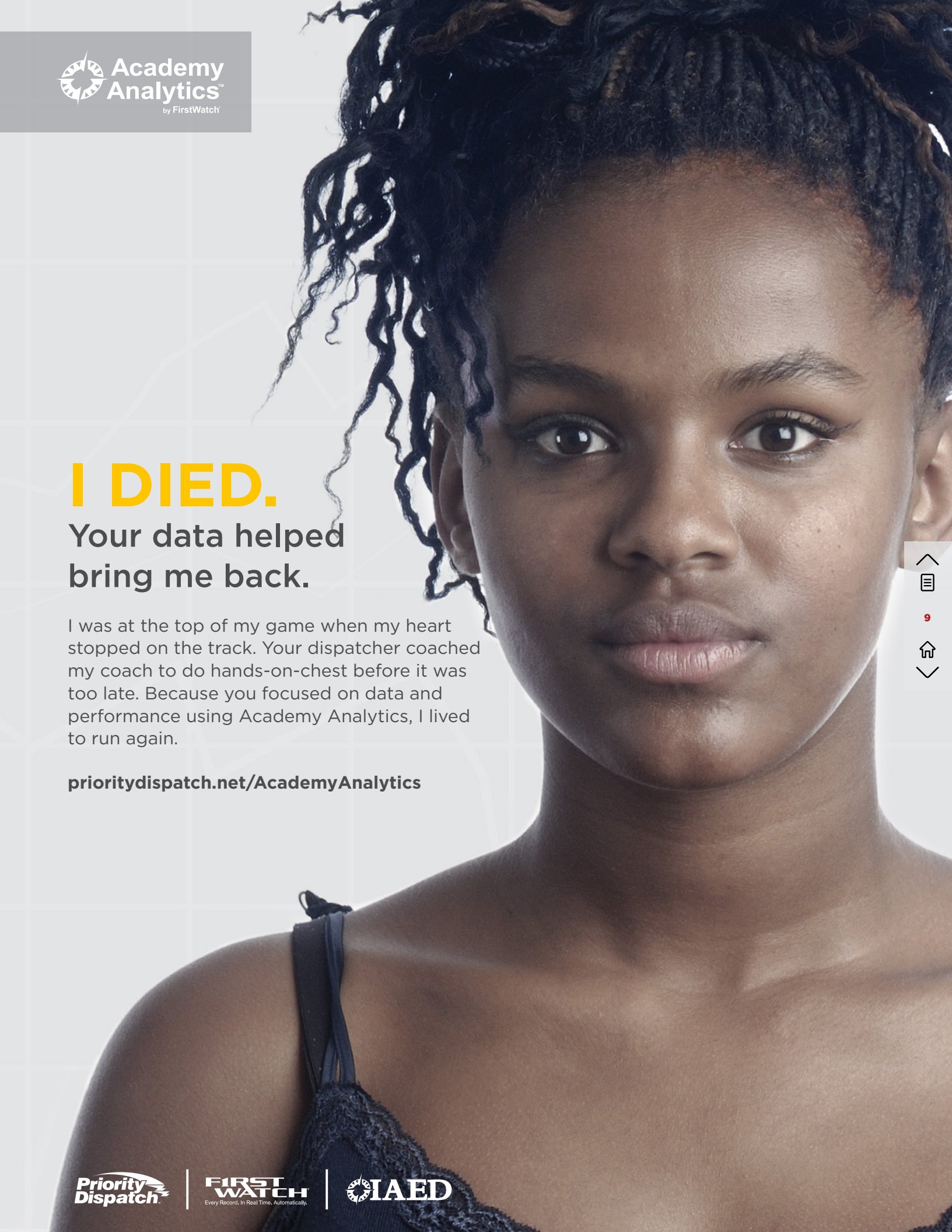
{ Leaders are agents of change.

A good question to ask is whether or not this is able to take place on the "floor" of your ECC. Are we allowing our 911 telecommunicators to be assertive enough to make this happen? One person will never have all of the answers, so let those that can step up to the plate and handle the situation.

Now is a great time to take a look at your training and resources to see if we can find that elusive definition of leadership in your PSAP. Now that a definition of leadership has been discussed, we will next take a look at some leadership styles in the next edition of *The Journal of Emergency Dispatch*.

Sources

1. Bass, B. & Bass, R. (2008). The Bass Handbook of Leadership: Theory research, &managerial applications (4th ed.). New York, NY: Free Press.
2. See Note 1.
3. See Note 1.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WHERE'S THE LOGIC?

No use fooling ProQA

Brett Patterson

Hi Brett:

I have a quick question about ProQA®.

We are using ProQA version 5.1.1.37 and logic 13.3.128. The Stroke Diagnostic Tool version is 5.1.0.46.

When we select "unable to complete the request" in the tool, the score given is 2.

I think it's incorrect because if the patient cannot complete the request, we teach as part of the Medical Priority Dispatch System™ (MPDS®) curriculum that the score is 0.

There are many reasons why the patient cannot complete the request—normally not verbal, Deaf, amputation, too weak, on the floor …

I don't want to teach to my students we need to trick ProQA and enter the answer "refuse to complete the request."

Thanks for your help with this!

Guillaume Pelletier
Directeur clinique et
de l'enseignement
Centre de communication
santé Laurentides
Blainville, Quebec, Canada

Hi Guillaume!

Good to hear from you.

We recently expanded the options to include an "unable" versus "refused" option to capture those patients who tried but could not complete the task as there is evidence these patients are actually having a stroke. This is why the software assigns a score to these patients.

So, we need to teach our EMDs the difference between these options.

Your first examples—normally non-verbal, Deaf, cannot understand, or no arms—should be in the "refused" bucket, along with those callers and patients who are not willing to try the test.

However, if they are willing to try and simply cannot complete the test, i.e., too weak, on the floor, etc., they belong in the "unable" bucket, as they may well be having a stroke.

Brett A. Patterson
Academics & Standards Associate
Chair, Medical Council of Standards
International Academies of
Emergency Dispatch®

Hey Brett,

We had a call for a patient who was bleeding from their trach. The question came up as to which protocol to use: Protocol 21: Hemorrhage/Lacerations for the bleeding or Protocol 6: Breathing Problems since it specifically states in Case Entry to use Protocol 6 for trach-related issues. From what I could gather, the main issue was that the patient was bleeding, but I wanted to make sure that would be the correct choice since Protocol 21 doesn't really discuss trach issues and it wasn't bleeding through tubes. Looking for feedback on protocol selection. Thanks.

Jeff Hutchens
EMS Shift Commander
EMD/EFD/ETC Instructor
Guilford County EMS
Greensboro, North Carolina, USA

Hi Jeff:

Interesting call for sure. I am asked about multiple complaint calls often, but I have not heard this one before. Thanks so

much for including the audio file as this is always most helpful.

This gentleman provides a nearly complete Chief Complaint Description: "She's a dialysis patient. She has a trach and it's bleeding really bad. She's choking, throwing up blood. We need an ambulance to help."

What we don't know at this point, and what might have made a Chief Complaint Protocol Selection clearer, is "exactly what happened." Was this spontaneous or traumatic in nature? I don't have the ProQA sequence but there was a pause at Protocol 21's TRAUMA or MEDICAL Key Question Qualifier, where the EMD apparently selected TRAUMA.

I would first say that selecting Protocol 21 for this case did not prove problematic. Although direct pressure instructions were provided, the EMD did the right thing by not pushing the issue too far, and she attempted to clarify exactly where the bleeding was coming from before she gave these instructions (internal versus external). The towel was described as already being over her tracheostomy, and it was self-administered so the patient was not likely to press hard enough to cause harm. The call was apparently coded as "Abnormal breathing," which generates an appropriate DELTA-Level response on Protocol 21.

However, for educational purposes, I think Protocol 6 is most appropriate in this case for a few reasons. First, as you mention, breathing-related tracheostomy problems are best addressed on Protocol 6 (Case Entry Rule 10), and it was obvious the bleeding was causing this patient breathing problems. Second, there's not much we can do externally for tracheostomy bleeding, so the respiratory issue is really primary and may be addressed by the "special equipment or instructions" prompt of Protocol 6. Finally, when we have two Priority Symptoms offered, the foremost complaint should be considered (why are they calling?), and the blood in the airway takes clinical priority for me and probably the patient too. Blood loss in this case is secondary to choking or aspiration at this point in the patient's continuum.

With that said, this EMD made her decision in the moment, the response was appropriate, no adverse outcome was noted, and we have the benefit of hindsight.

I think our opportunity is educational. Do mind if we print this as an FAQ for *The Journal of Emergency Dispatch*? I think other EMDs will find the scenario interesting and informative. What say you?

Brett

Brett,

Thank you very much. We were all puzzled by this one, and it's not a common call for sure. We wanted to treat it as an educational opportunity for this calltaker and the rest of our staff for future incidents. My gut told me Protocol 6 due to the tracheostomy issues, but I started second-guessing myself. Thank you for that feedback and I will certainly pass along. And yes, feel free to post as you wish!

Thanks,

Jeff

OnStar Advisor Tony sits at the console ready to help.

CHOKING. BABY DELIVERY. DIRECTIONS

OnStar has it covered

Audrey Fraizer

You name it, OnStar has it covered.

Just because the EMDs at OnStar answer emergency calls made from inside a car doesn't mean they haven't been there and done that. Choking. Allergic reaction. Cardiac arrest. Stroke. Baby delivery. Breathing difficulties.

And, of course, managing vehicle crashes, sinking vehicles, vehicles in floodwaters, and single and multiple injuries resulting from the accidents.

"A member can call for any protocol and receive help," said Ruby Hilton, Emergency Quality Assurance Lead, General Motors - OnStar, Charlotte, North Carolina (USA). "We gather the information, coordinate response, and give PAIs, when necessary."

As part of their services, OnStar delivers in-vehicle driver's assistance. OnStar-certified advisors are trained to assist members in ways not altogether uncommon to PSAPs.

They also go the extra mile, so to speak.

They direct tow trucks to the scene of stalled vehicles, provide turn-by-turn traveling directions, offer remote door unlocking assistance, give help during natural disasters without cellphone connection, and all in addition to handling medical emergencies when a driver or passenger hits the red emergency button inside the member's vehicle. They offer 24/7 connectivity to a dedicated TTY advisor.

"It's all here," said Charlene Poranganel, Assistant Manager for Global Emergency Services Outreach at GM Canada. "We go the extra mile to build relationships throughout the community and EMS and educate the public on what we do."

Run parallel to a PSAP

The EMDs are certified through the International Academies of Emergency Dispatch® (IAED™). The 55 EMDs at each of OnStar's two locations—North Carolina and Oshawa, Ontario, Canada—are scheduled to eight-hour rotating shifts in the 24-hour operations. Extensive training is part of the package as well as perfecting the calm and controlled attitude of the professional EMD. OnStar is a long-standing medical ACE with the same credentialing required of any other ACE.

Paul Stiegler, M.D., has been the OnStar medical director for 11 years. His over 35 years in direct hands-on emergency medicine gives him the ideal background for assisting in all things medical from the nonvisual environment perspective. He has navigated OnStar centers through both day-to-day medical emergencies and during disasters. His monthly training routine includes hitting the OnStar button from a parked location near his home in Madison, Wisconsin (USA), and play-acting emergency medical situations.

"They run the script with me, and I critique them," he said.[1]

His biggest piece of advice to drivers: If something goes wrong medically while driving, pull over and call for help. "Don't overthink things and think you're fine driving to the hospital," he said.[2]

Difference is in the delivery

OnStar is like any other PSAP with one difference, said Hilton.

OnStar doesn't dispatch calls. The EMDs coordinate dispatch, contacting the EMS agency closest to the area where the call originated. This gives EMDs the added complexity of interacting with some 6,000 emergency communication centers across the United States and Canada.

So, don't let the absence of dispatch cloud your perspective of OnStar services.

"We are not just a call center," said Poranganel. "The nature of the calls we take put us at the same level of importance of any PSAP."

OnStar's broad reach depends on designing and monitoring a system that continually meets the needs of each individual patient while preserving the capacity of the system as a whole to surge when needed. The system depends on Protocol, technology, features not commonly found in a traditional PSAP, and the skills of a medical director experienced in emergency medicine.

Connecting to their members

OnStar's Injury Severity Prediction, introduced in 2010, helps predict the severity of crash victims' injuries and communicates the information to first responders for use in determining pre-hospital treatment. The feature's algorithm analyzes such factors as force and direction of impact. OnStar Advisors relay the severity rating to 911 centers, which may choose to adjust the level and priority of response dispatched to a crash scene.

OnStar's specialty drive teams are scheduled during peak times—early morning rush hour, evening rush hour, and mid-day (for lunch)—and adhering to time zones across North America.

OnStar Advisor Andrea is ready to help the next caller.

At the start of the pandemic, EMDs worked remotely in home offices from early March to June 2020 when, at that point, the OnStar emergency team convinced local authorities to qualify advisors as essential service workers. At the centers, everyone wears a mask and sits at the six-foot socially distanced screened consoles.

OnStar's integration of the Academy's Protocol and its implementation was not automatic. Slight modifications, approved by the Academy's Council of Medical Standards, were necessary to better accommodate the caller's environment. For example, an instruction to pull over the vehicle in a critical situation is unique to OnStar. In case the driver or passenger should question an EMD's qualifications, they are told upfront about the EMD's certification and emergency qualifications.

Some things never change

The one overarching appeal of emergency communications is consistent no matter an EMD's staging point. Hilton started at OnStar 10 years ago, moving to quality assurance after three years as an advisor. She enjoys the variability—not knowing what the next call will bring and the situational awareness it takes to understand what is happening to the caller.

But most of all?

"The real reward is making a difference in someone's life," she said.

Poranganel, who has been with OnStar for 13 years, shares the same passion.

"It's the people," she said. "In an emergency, an OnStar Advisor is always ready to help."

Last year, OnStar emergency advisors handled about 150,000 calls in the U.S. and Canada and responded to more than 6,000 vehicle crashes every month. OnStar has about five million subscribers. ●

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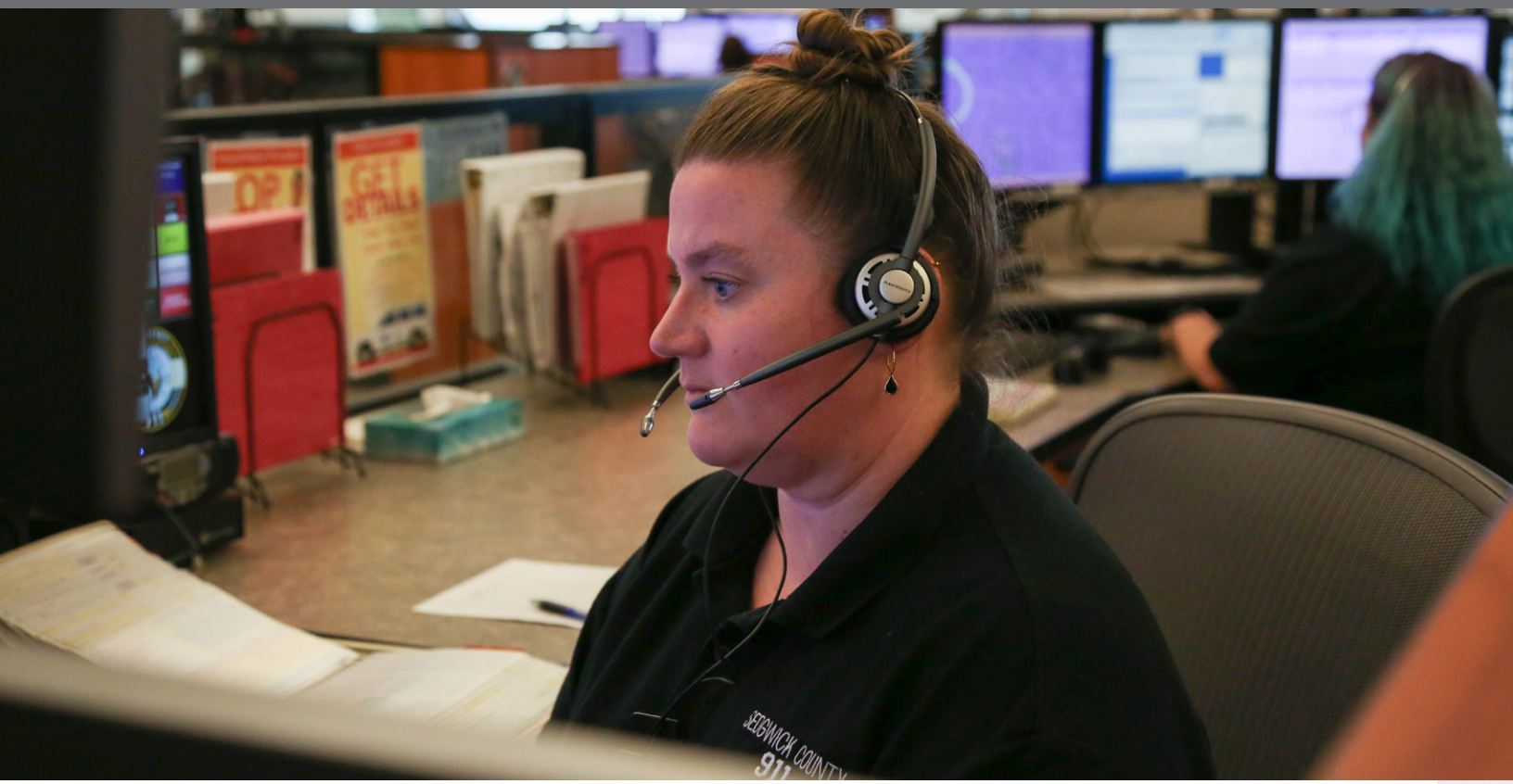


Breanna Tracy, QI Specialist

DON'T YOU CRY NO MORE

Kansas comm. center prioritizes mental health of dispatchers

Becca Barrus

Luke Blankenship got into 911 "mostly by accident." The Support Services Major for Sedgwick County Department of Emergency Communications (Wichita, Kansas, USA) started as a calltaker in 2012 soon after he graduated high school and stuck around because he thought the job was cool.

"If a job's cool, sometimes that's enough for a 20-year-old," Blankenship said with a laugh.

More than that, though, it made him feel like he was part of something bigger. And later when he became a dispatcher, Blankenship got to work with first responders directly and became aware that the decisions he made at the console always had a direct impact.

"The things I was doing mattered," he said.

The work of Blankenship and his colleagues at Sedgwick County impact the roughly half million people who live in the service area, including Wichita, which is the largest city in Kansas. The center is located right in downtown Wichita in the government district, near the courthouses and jail. Since it was built in 2007, the dispatch agency has shared it with the emergency management department—emergency management is on the first floor and dispatching is on the second. It's also only two blocks away from the Arkansas River and not too far from Kimlan Sandwiches, the place Blankenship likes to stop to grab a banh mi after a shift. You can't beat really fresh bread and the crunch of pickled vegetables for a couple of bucks after an eight-hour shift.

Sedgwick County dispatches for 30 individual medical, law enforcement, and career and volunteer fire agencies. On any given day, the number of calltakers, emergency dispatchers, and supervisors on the floor is 18, and they have two "power shifts" where calltakers come in during peak call times to help with the call volume.

One of the things the dispatchers appreciate about working at Sedgwick County is that everyone in leadership roles has been promoted internally. That means that those who are in charge of making decisions are aware of the challenges and stresses the calltakers and dispatchers face because they used to work the consoles themselves (and still can, in a pinch).

It's because the leadership understands the stresses of the job that a trained, in-house peer support team was made a priority for the employees. The team provides support for calltakers and dispatchers who are distressed after a critical incident or the day-to-day cumulative stress. All around the center there are canvases on the walls that were painted by dispatch staff in a kind of art therapy that gives a colorful representation of who they are as a team and as individuals. Because no two dispatchers are exactly the same,

the leadership team follows a servant leadership style that focuses on the person as a whole rather than just as a "warm body" at a console.

Each employee is also granted one mental health day a year where they can call in, no questions asked, and receive a day off using either paid or unpaid leave. "The mental health day is something we fought for for a while and we finally made it happen in the last two years," Blankenship said.

The best stress aid, though, is the Quiet Room. Inside the Sedgwick County facility, there's a private room where employees can go when they're feeling overwhelmed to close the door and decompress. There's no television and no distractions—just an oasis of serenity in an otherwise hectic environment.

And speaking of the environment, being smack dab in the heart of America's Tornado Alley, Sedgwick County is used to handling calls related to tornadoes and other storms. In fact, the 911 supervisor on duty at any time is in charge of activating the area's tornado sirens. The supervisor monitors the storm warnings, making sure they hit the button at the right time. The dispatch center works closely with the emergency management team on the floor below them in those instances. Whenever a storm is on the horizon, the center prepares for a huge influx of calls. According to Blankenship, there are a surprising amount of calls reporting that houses have been set on fire by lightning strikes.

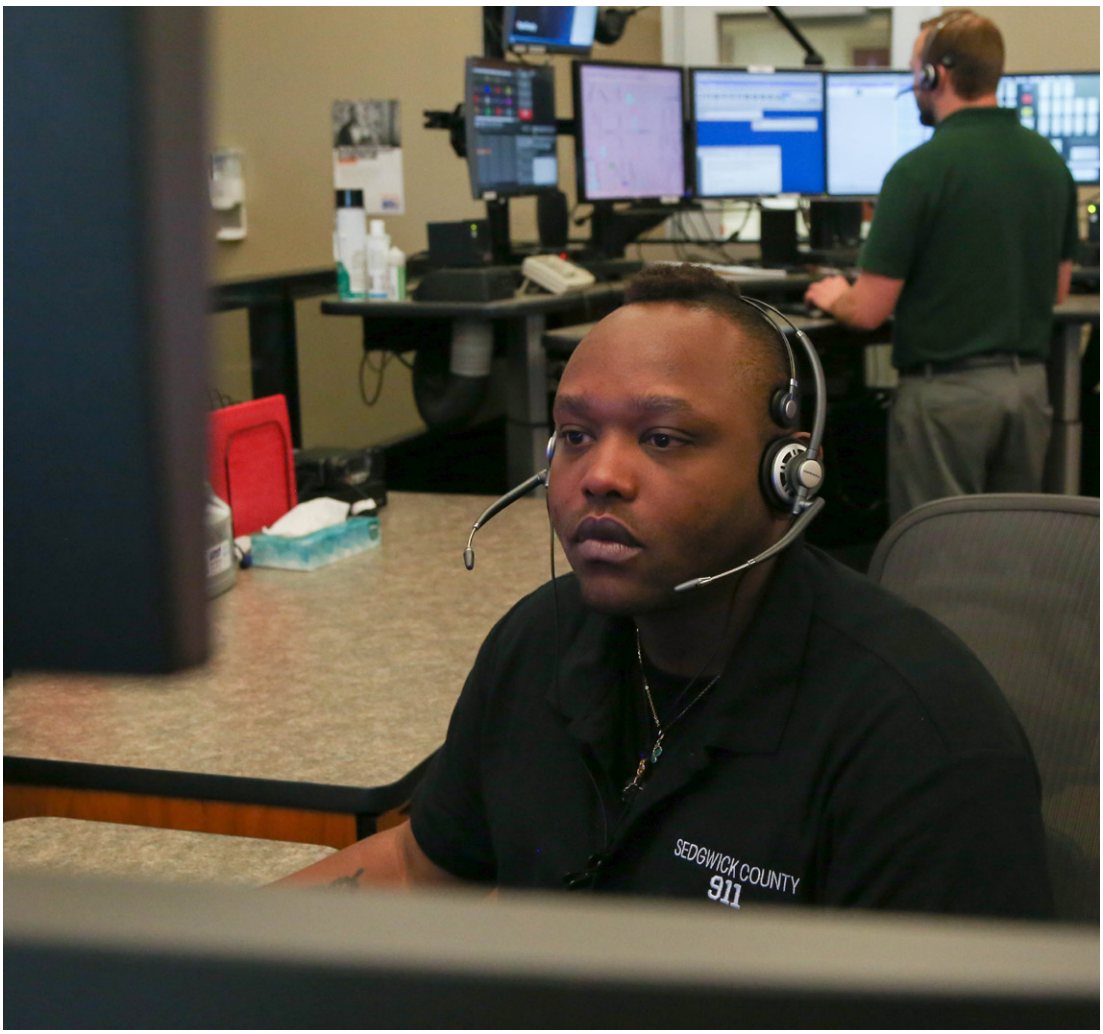
As is the instinct in most dispatchers, the Sedgwick County dispatchers are eager to help, especially during a natural disaster. The center has a protocol, though, that dispatchers should call in first and ask if they're needed rather than driving straight there to help. They understand the importance of having enough people on the floor to handle the influx of calls and also having a second shift ready to go to relieve the first one.

When it isn't tornado season, nearly 80% of calls fielded by Sedgwick County are law enforcement ones—anything from reckless drivers to bank robberies to shootings. Because it covers the biggest metropolitan area in the region, it attracts more people which generates more day-to-day police responses, like disturbances between individuals and vehicle accidents.

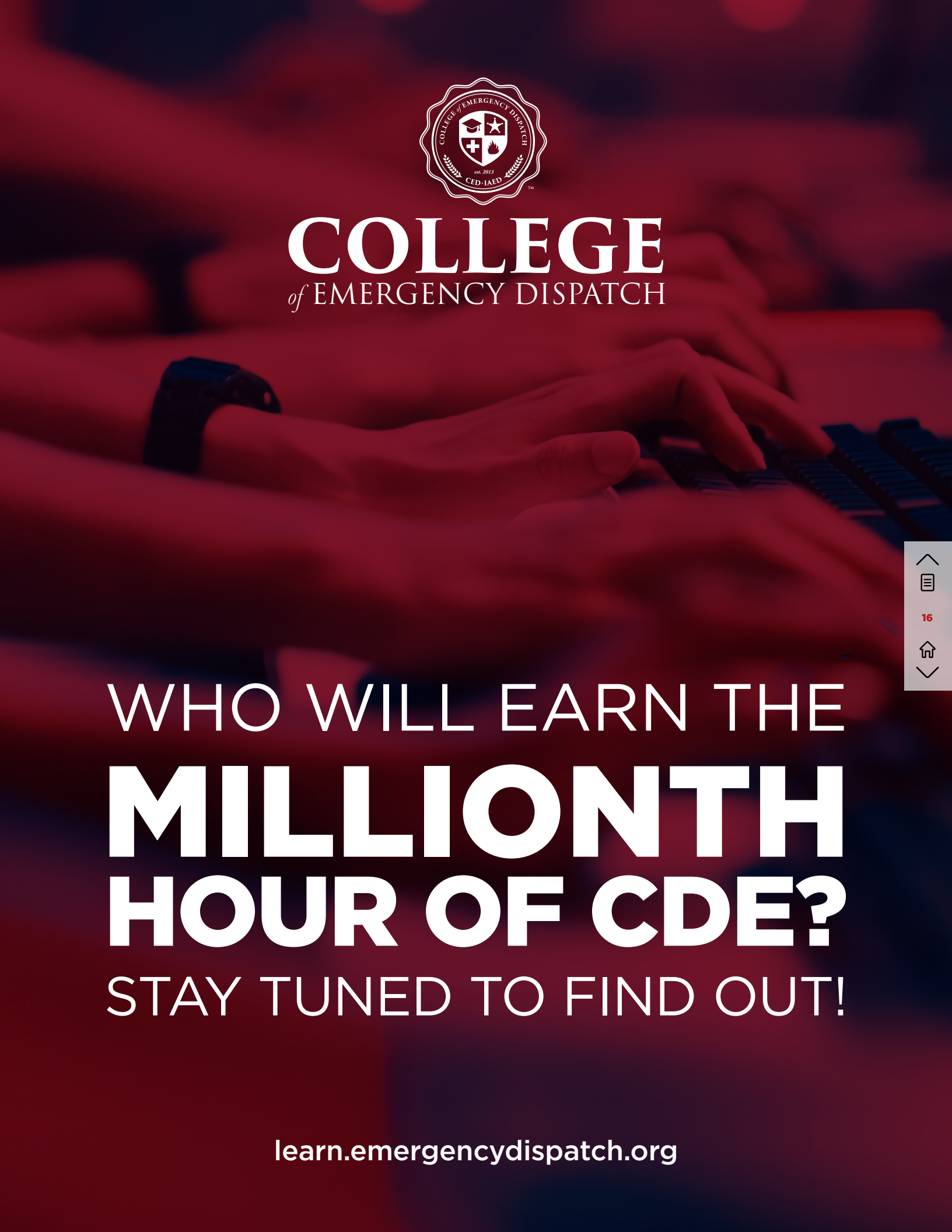
Emergency dispatchers in the agency are cross-trained in all disciplines, which is much needed as it's the primary PSAP for the most populated counties in the state and they take a substantial number of EMS and fire calls as well. Training for dispatchers is divided into phases, learning each discipline at a time, and on any given day they might be serving in a number of roles.

Sedgwick County has been a consolidated PSAP since 1977, long before it moved to its current building. The comm. center floor had a conveyor belt system to take notecards from calltakers to the dispatchers Because they didn't have GPS or computer-generated maps, there was a giant map of the county on the wall printed on sheet metal. Thin lines of tape marked jurisdiction boundaries and notes were written directly on it.

The conveyor belt is gone now, although the map hangs in the current agency, reminding the dispatchers where they've come from and who they're covering. The calltakers and dispatchers of Sedgwick County are the first first responders for their community and they're ready to go. ●



Dominic Saisi, Dispatcher II (front) and Luke Blankenship, Support Services Major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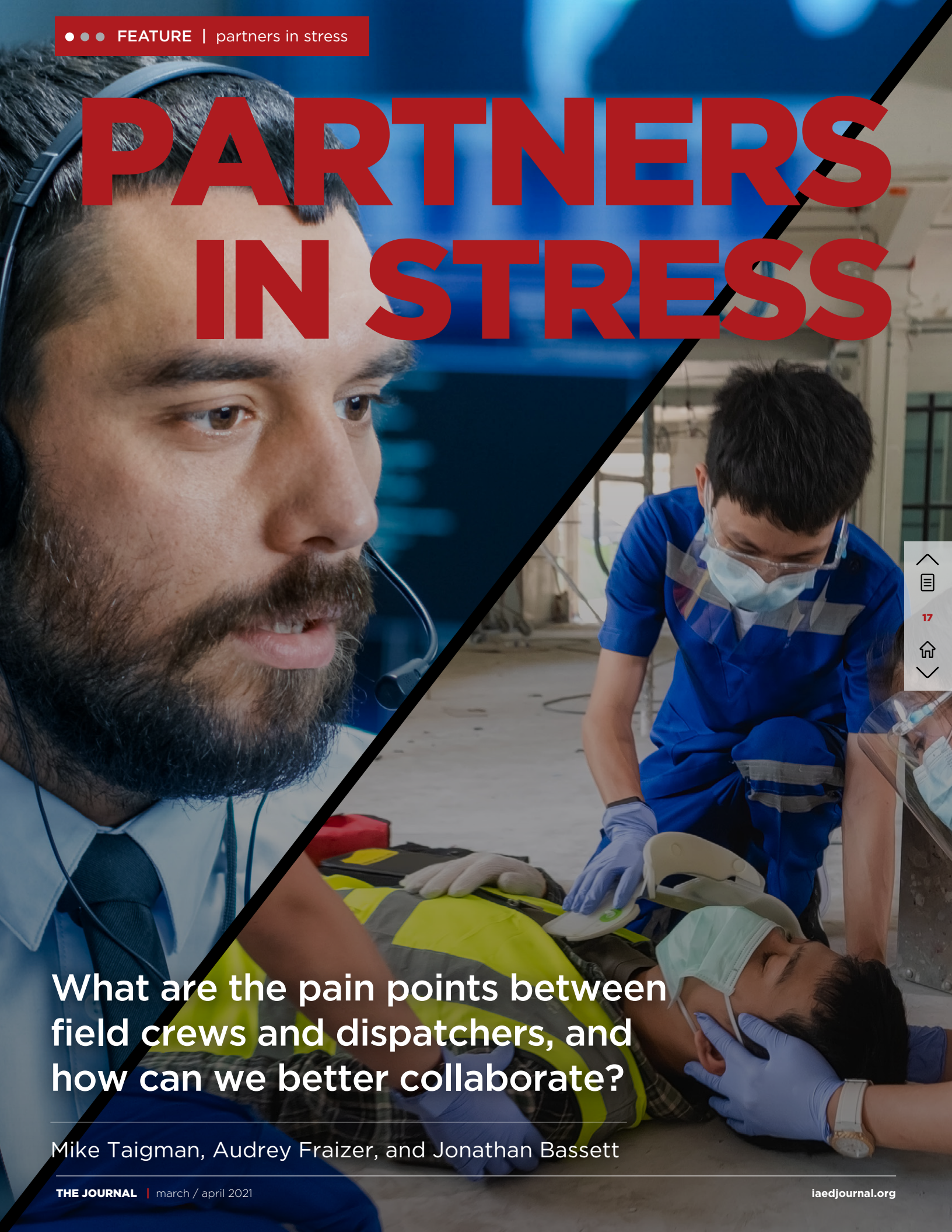


What are the pain points between field crews and dispatchers, and how can we better collaborate?

Mike Taigman, Audrey Fraizer, and Jonathan Bassett

Some systems are built to inspire conflict. Democrats and Republicans. Boston Red Sox and New York Yankees. 911 dispatchers and field crews.

Almost everyone who has worked in emergency services for longer than the pandemic has heard a bit of snippy, sarcastic radio traffic or in-person communication. A conversation circa 1980 between an emergency dispatcher and a paramedic in the Midwest highlights the issue.

Paramedic: (Slamming a cold Big Mac with one bite taken on the desk) Well I hope you had a hot lunch.

Dispatcher: Well yes, I did. Thank you very much.

Of course, you can't see the facial expressions or hear the tone of voice. If you could, it would inspire you to pull your children behind you for protection.

Our three organizations—FirstWatch, the International Academies of Emergency Dispatch®, and EMS World—set out to learn about the current state of dispatch and field crew relations. We started by inviting respondents to answer a survey asking emergency dispatchers about the kinds of things field crews do that cause them stress and vice versa. We asked field crews what emergency dispatchers could do to decrease their stress and vice versa. We also asked both groups what they could do to improve the relationship. We interviewed some of the respondents to get an in-depth perspective. Seventy-three emergency dispatchers and 156 EMTs/paramedics participated. The results are enlightening.

Views from the dispatch center

Comments from emergency dispatchers about their EMS counterparts couldn't exactly be described as "glowing approval." Quite the contrary. An overwhelming majority—84.9%—clearly indicated that the relationships between dispatchers and responders travel a bumpy road with lots of potholes. They are partners in stress.

Emergency dispatchers don't complement the EMS chain of command—at least that's their view from inside the communication center. An attitude of dispatch happening outside the EMS circle, rather than alongside, culminates with "some officers and firefighters seem[ing] to think it is OK to belittle and be smart-alecky, thinking it's cute or [that it] garners them points with other officers," according to one survey respondent.

Or, in a more negative perception of the dispatch profession from the outside looking in, "[Field crews] are condescending and treat us like we're stupid."

A failure to understand—or even try to understand—the process followed inside a center is a prevailing roadblock in creating solid relationships, according to the survey. "Partners in the field want to question everything from dispatch. They don't understand how it works." The lack of two-way communication and underappreciation of dispatch confounds the situation. Field crew perception that "dispatch is out to get them" adds to the "confusion, inconsistency, and disruptions in service."

Stress spinning off from the frustration, impatience, and "snarky" behavior, however, does not diminish the shared belief in the importance of their work. The survey made that much clear. Respect, acknowledgement, appreciation, collaboration, and realizing "our job duties are very different but equally valuable" go a long way in patching up grievances and paving a smoother road to successful working relationships. "We are a team." "We complement one another." "Be patient." "Remember dispatch [consists of] their coworkers. We don't send them to calls to be jerks; we are doing our job and asking they do theirs."

The lack of comradery—while not universal—is rooted in change, or so it seems. Consolidation. Expectations. Moving at a quick pace without the "wriggle room" to understand what the other is doing.

Suzanne Fitzgerald, EMD, Learning and Development (head trainer), South Western Ambulance Service (NHS Foundation Trust (SWASFT), Bristol, U.K., started her EMD career 19 years ago in a county dispatch center. The crew would go on a call, give dispatch feedback, and greet each other by name in the hallway. Over the years, the small county centers merged into larger and larger centers to the point where SWASFT now provides services for a fifth of England (six counties and the Isles of Scilly), employs over 4,000 staff members, and manages 96 ambulance stations, three clinical control rooms, six air ambulance bases, and two hazardous response teams.

Fitzgerald attributes a green fracture [crack] in working relationships to growth and size, and it's not the fault of people doing the jobs. She compares it to growing up in a small town that morphs into a metropolis.

"It's not so much a friction between people but a loss of connection," she said. "As time goes on, and things get bigger, people stop knowing each other so well."

Rather than abandoning connections, Fitzgerald suggested using technology to bridge the gap between communications and field crews. For example, an online

photographic yearbook—like the ones U.S. schools produce for their students—could tag names to faces. The names and faces would appear on the dispatch and ambulance screens on every call and subsequent assignment.

"I could walk by someone in the hub and give a hello if I knew we've communicated over the radio," she said. "I would know the face. Simple as that."

The connection extends inside SWASFT's two communication hubs, she said. While COVID restrictions have interrupted the development of closer ties between veteran and new dispatchers, she looks forward to conversations about the part of dispatch that isn't taught or subject to certification.

"EMDs are professionals. We are experts in helping others," she said. "It's important that we develop trust. Trust in our callers. Trust in our responders. Trust in each other. These are the types of conversations we need to have."

{ EMDs are experts in helping others.

Melissa Sawyer, EMD, Senior Communication Specialist, Northwell Health, New Jersey (USA), learned firsthand about trust in EMS following an auto accident that nearly claimed her life. In 2004, Sawyer, who was then 17-years-old, was ejected from her car and declared clinically dead when the ambulance crew arrived. She credits the EMT for both saving her life and guiding her choice in a career. After one year in recovery, she signed up for EMT training.

"I heard my calling and answered it," she said. "I knew this is what I had to do."

Five years on the road with a private ambulance company and Sawyer applied for a dispatch position at Northwell Health. Inside operations was new to her, though she quickly settled into the concept of helping before the EMT shows up. She specializes as a flight follower and radio operator.

From experience on both sides of the emergency response and dispatch dynamic, Sawyer understands the components of creating good working relationships. The EMT perspective lends to providing crews the details of the situation they're walking into. The emergency dispatcher perspective sharpens her situational awareness—what she can sense about an incident or individual without being directly told.

Sawyer's team's shared situational awareness takes into consideration the needs of response. She leaves space to discuss their concerns. Fatigue. COVID. Behavioral situations they might encounter.

"I know what it's like not to know what's going on," she said. "I also know the stress of not physically being there to help. The PAIs are huge when it comes to helping the patient before EMTs arrive and letting them know more about the patient's condition."

The stress levels attributed to COVID for dispatch and response add to the importance of trust, she said.

"People are dying while on the phone over and over again," she said. "Nothing prepared us for this. We're doing our best, knowing what we do betters the chances of our patients."

Mike Fallow, EMD, Emergency Communications Officer (ECO), Alberta Health Service, Alberta, Canada, also worked the street before going into emergency dispatch. He is a volunteer firefighter for the Peace River Fire Department, Alberta, Canada, going on 17 years. The combined experience, he said, contributes to his acknowledging the two-way partnership.

"It's a matter of trusting that the other knows their job," Fallow said. "EMS reacts to what they see. Dispatchers react to what we hear or ask. We have the protocol to guide us. It would be impossible to help people without all of this working together."

While patience, trust, and mutual respect go a long way in improving on already good working relationships, actions also contribute to the harmony.

Several dispatchers recommended inviting crews to stop in the communication center to put a face with the voice. Ride-alongs in the ambulance, crews spending an hour in dispatch, training and education, and allowing time to ask questions and voice concerns while not in the heat of the moment were also cited as potential game-changers. Others suggested speaking at a normal rate and repeating information slowly and calmly, without letting emotions or an exasperated sigh get in the way.

Then there's the matter of addressing the problem: communication. Rather than ignore a troublesome situation, go to the source. "Ask them what their issues with dispatch are and work on fixing/addressing those issues," noted one respondent. An oversight or taking the other for granted tarnishes relationships. For example, to decrease stress on crews, "Check to see if there is something they need from dispatch they aren't getting, then work to make sure they have what they need."

Collaboration, however, is the clincher. No one is alone and no one works in isolation. Commonality comes through doing the best for the patient and, in doing so, valuing each other's expertise. "Realize we are all on the same team," according to one survey reply. "We complement each other. Respect should be the default."

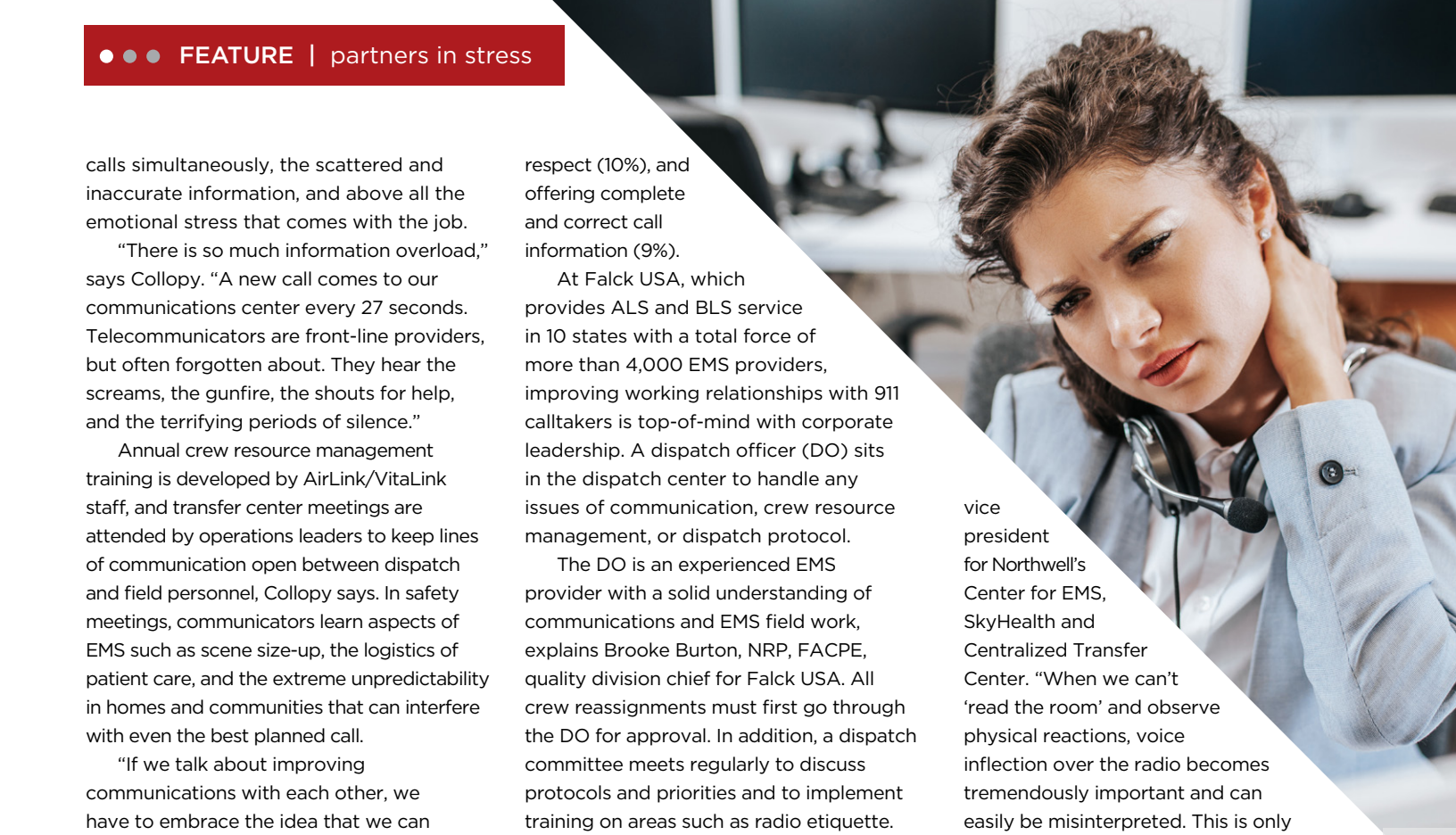
Views from the ambulance

An overwhelming 90% of EMS respondents to the poll conducted by *EMS World* and *The Journal of Emergency Dispatch* answered "yes" to whether emergency dispatchers they work with sometimes cause stress. Not surprising, given the nature of the work.

"Anyone who denies that there is tension between communicators and EMS field providers is naïve or not being honest," says Kevin Collopy, BA, FP-C, CCEMT-P, NRP, CMTE, clinical outcomes manager at AirLink/VitaLink Critical Care Transport at New Hanover Regional Medical Center in Wilmington, North Carolina (USA). "Despite everyone's best efforts, there is always going to be that gap between the reality and the ideal, from both perspectives."

Common friction points cited in the survey responses include attitude and professionalism (37% of responses), improper or inaccurate dispatching (30%), lack of understanding of EMS work (12%), and poor communication (11%).

New EMS hires at AirLink/VitaLink spend an entire day side-by-side with the service's telecommunicators to get a look inside the shift of a dispatcher, says Collopy—the unpredictability, the need to multitask and handle multiple



calls simultaneously, the scattered and inaccurate information, and above all the emotional stress that comes with the job.

"There is so much information overload," says Collopy. "A new call comes to our communications center every 27 seconds. Telecommunicators are front-line providers, but often forgotten about. They hear the screams, the gunfire, the shouts for help, and the terrifying periods of silence."

Annual crew resource management training is developed by AirLink/VitaLink staff, and transfer center meetings are attended by operations leaders to keep lines of communication open between dispatch and field personnel, Collopy says. In safety meetings, communicators learn aspects of EMS such as scene size-up, the logistics of patient care, and the extreme unpredictability in homes and communities that can interfere with even the best planned call.

"If we talk about improving communications with each other, we have to embrace the idea that we can always make the working relationship more effective," says Collopy. "Nobody should take these discussions personally. We have to respect both paradigms. Quality management should improve the entire call."

According to our survey, 1 in 5 respondents felt that understanding EMS work more fully would lead to decreased stress. This was followed by reducing crew favoritism and improving staging practices (17%), providing clear and concise communication (15%), better attitude and respect (10%), and offering complete and correct call information (9%).

At Falck USA, which provides ALS and BLS service in 10 states with a total force of more than 4,000 EMS providers, improving working relationships with 911 calltakers is top-of-mind with corporate leadership. A dispatch officer (DO) sits in the dispatch center to handle any issues of communication, crew resource management, or dispatch protocol.

The DO is an experienced EMS provider with a solid understanding of communications and EMS field work, explains Brooke Burton, NRP, FACPE, quality division chief for Falck USA. All crew reassignments must first go through the DO for approval. In addition, a dispatch committee meets regularly to discuss protocols and priorities and to implement training on areas such as radio etiquette.

"So much comes down to communication styles," says Burton, adding that emerging technology such as automated key replies ("525 has arrived on scene," etc.) go a long way to ease stressful exchanges while facilitating free flow of critical data. Furthermore, a section of EMT and paramedic curricula should be devoted to EMD training and the nuances of radio communication, Burton says.

No matter how large the service and how sophisticated its communication systems, much of the difficulties between EMS personnel and telecommunicators arise from basic human interactions.

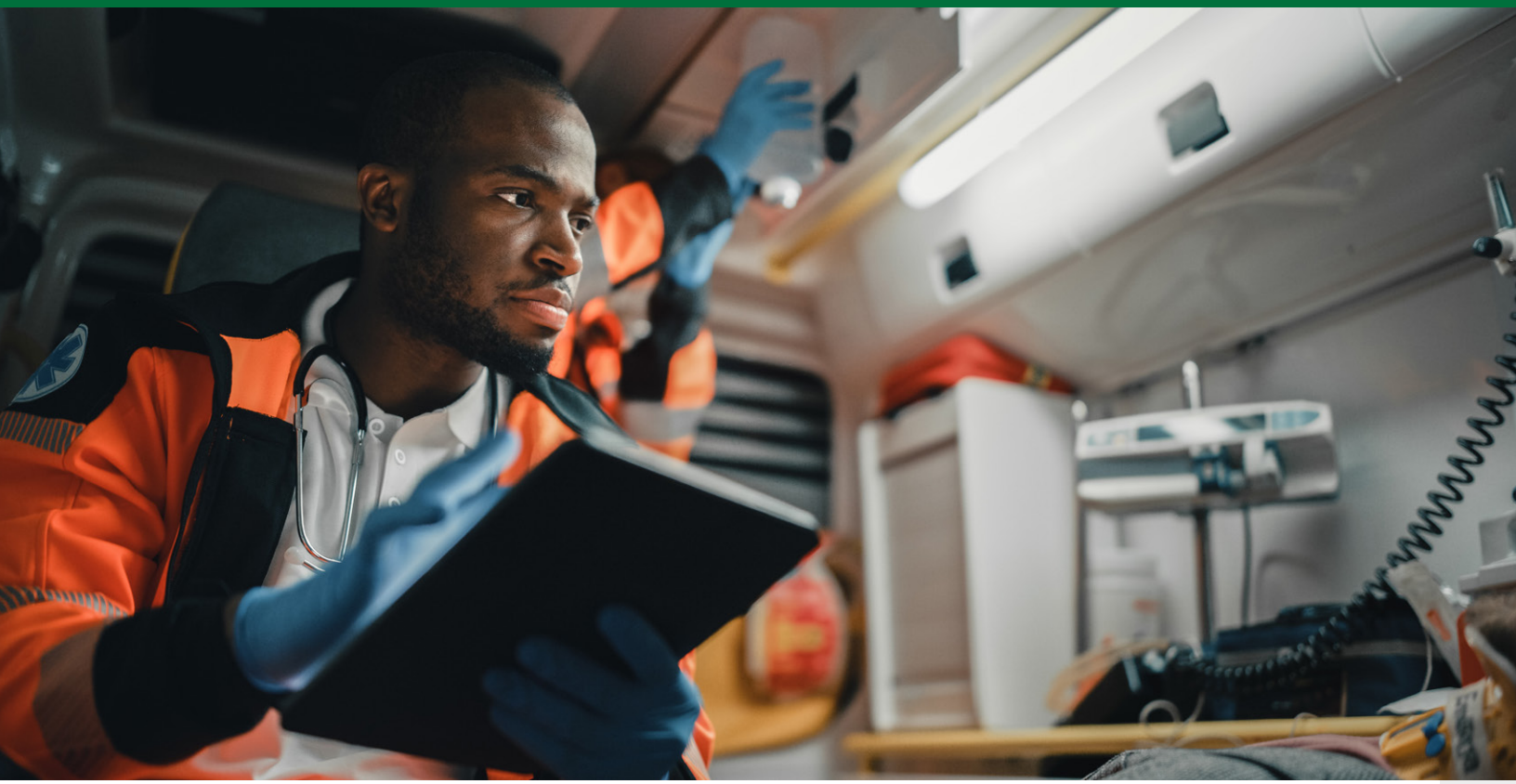
Northwell Health Center for EMS is the largest hospital-based ambulance service in the New York Metropolitan area. Northwell's EMTs and paramedics provide care to more than 120,000 patients annually throughout the five boroughs and Long Island. Their communication center and EMS crews delivered critical lifesaving treatment and transport services at the U.S. epicenter of the COVID outbreak in 2020.

"Human communication is challenged when we're only communicating with one of our senses," says Jonathan Washko, MBA, FACPE, NRP, AEMD, assistant vice president for Northwell's Center for EMS, SkyHealth and Centralized Transfer Center. "When we can't 'read the room' and observe physical reactions, voice inflection over the radio becomes tremendously important and can easily be misinterpreted. This is only heightened during times of extreme duress."

With an advanced emergency medical dispatch certification and as a member of his system's Medical Dispatch Review Committee, Washko meets monthly to address issues related to the medical triage system and improving the working relationship between communicators and EMS personnel. This gives field providers and other stakeholders feedback into the system and how to mitigate operational issues that arise. "The mission is loop closure," says Washko.

New EMTs and paramedics spend time in Northwell's communications center as part of their initial orientation, Washko explains, adding that Northwell dispatchers are compensated on the same level as paramedics and are valued members of the organization. Training on emotional intelligence is a requirement for transfer center staff. Supervisors monitor the radios in real time and there is a zero-tolerance policy for infractions, Washko says. Field providers and communications staff are encouraged to pursue leadership positions on the "other" side.

"We do want a degree of inherent healthy tension in that exchange," Washko says of the dispatch-field crew interchange. "That comes with the job and heightens performance. But there is a limit to it. It's all about building relationships and breaking down those barriers." ●



SPOILER ALERT

Study shows that wording matters

Becca Barrus

Precision and detail are of the utmost importance in the emergency medical field where vital time constraints can cause even seasoned professionals to make errors and miss key information that can make all the difference to a patient in an emergency. That's why it's important that emergency medical dispatchers (EMDs) ask the key questions (KQs) in the Medical Priority Dispatch System™ (MPDS®) exactly as scripted. The KQs have been formulated, researched, and tested by experts to save the patient crucial time and increase their chances for better outcomes by using precise wording to get the point across to the caller as quickly as possible. KQs like "How old is s/he?" and "Is s/he changing color?" prompt the precise answers from the callers required for the EMD to accurately assess the patient and the scene, provide proper Dispatch Life Support, and relay key information to EMS responders.

But how can we be sure the protocol wording prompts the caller for the necessary information? For example, when you ask a caller if the patient is "completely alert," is there often hesitation? "Alert" may have a different meaning in medical settings than it does to laypeople, and it's crucial to get the answer quickly and accurately.

One of the very first articles published in the *Annals of Emergency Dispatch and Response* (AEDR) journal was written by Dr. Jeff Clawson in 2013 about "the Holy Grails of EMD."[1] Being able to determine alertness over the phone was (and still is) the number one item on this list of issues that need to be continually addressed and improved in emergency medical dispatch.

"The level of consciousness or alertness is one of the most important things you can determine as an EMD," said Greg Scott, Associate Director, Protocol Evolution, International Academies of Emergency Dispatch® (IAED)™. "If someone's not completely alert, that's a red flag that they are a pretty sick patient. They could go downhill fast."

The tricky thing about language—especially English—is that some words have different meanings depending on when and where you use it. When you ask if the patient is completely alert, you are trying to nail down the medical definition of alertness. In clinical settings, someone who is completely alert is considered as acting in a usual way and maintains a functional mental status. In other words, he or she is aware of what's happening and can respond in a normal manner.

In the field, paramedics and emergency medical technicians (EMTs) use three or four questions to determine if a patient is alert. In the dispatch center, where you want to find out what's happening as quickly as possible so you can dispatch help, you're trying to determine the alertness in just one question. It's a tricky business, one that, like Dr. Clawson said, needs constant updating and revisiting.

Completely alert versus responding normally

The MPDS is used in over 2,500 dispatch centers in 56 countries and has been translated into 25 languages. However, phrases or words being translated directly from North American English (the source language) don't always have the same cultural or linguistic meaning in the target language. An example of meaning getting lost in translation from source to target language is Brazilian Portuguese, the primary language used at O Serviço de Atendimento Móvel de Urgência—or SAMU 192—in São Paolo, Brazil. They reported to the Academy that the current wording of the KQ "Is s/he completely alert?" ("Ele/a está completamente alerta?") was causing confusion for the callers. SAMU 192, which is an IAED Accredited Center of Excellence (ACE), suggested that it be reworded to "Is s/he responding normally?" ("Ele/a está respondendo normalmente?"), with "completely alert" as a KQ clarifier. The IAED did a study in 2019 and found that with the changed wording, there was a huge shift in understanding from the callers.[2]

"It was like flipping on a light switch," said Dr. Chris Olola, Director, IAED Biomedical Informatics and Research. "They understood the KQ almost immediately."

"Since we saw such compelling results from the SAMU study, we wanted to see what would happen if we replicated the study in North American English," added Scott.

Methods

To test whether or not caller response would be improved by a wording change in North American English, the research department conducted a study with four emergency medical dispatch centers in the United States in 2020.[3] Each agency was an IAED Accredited Center of Excellence, which is important to ensure consistent use of the protocol and reduce variation from EMD deviations and non-compliance. For half of the calls involving "not alert" patients (pre-intervention study phase), the calltakers stuck with the current KQ and clarifier: "Is s/he completely alert (responding appropriately)?" For the other half (post-intervention study phase), calltakers asked the test question and clarifier "Is s/he responding normally (completely alert)?" instead. One of the purposes of the study was to measure the caller's ability to affirmatively answer "yes" or "no" to the KQ the first time it was asked. Another purpose was to measure how often uncertain responses were given ("I'm not sure" or "I can't tell") and/or how often the EMD used the KQ clarifiers.

The result? When asked the test or experimental KQ, not only was there a decrease in the use of the clarifier—meaning that the KQ was answered definitively the first time it was asked—there was also a decrease in caller uncertainty when compared to being asked the current KQ.

Wording matters

What makes the difference between the current KQ and the test KQ? After all, it gets the same idea across: it's just worded differently. Different words have different associations. Think back to the last time you were dressed "appropriately." It might change based on whether you were at work, at the pool, or at a fancy party, right? In some cases, being dressed appropriately might not mean that you were as comfortably as you would be in your regular clothes. Now think about a time you dressed "normally." What's normal for you might not be exactly what's normal for your co-worker, however perhaps you and your co-worker both view normal as meaning "acceptable" within a range of possible outfits. "Appropriate" and "normal" seem to have similar definitions, but they can be functionally different.

It's the same idea with the caller. If you ask them if the patient is responding "normally," they have a good idea of what their grandfather is normally like. If he cusses them out regularly, it's probably normal for him to cuss out the caller after a stroke, although it wouldn't necessarily be appropriate for him to do it. Even if they don't know the patient (for example, if they're calling for someone who collapsed in a movie theater), they still have a general idea of what "normal" behavior looks like.

Snapshots in time

Have you ever coded a patient as "not completely alert" only to have the paramedics arrive on scene to find that the patient is "completely alert"? Maybe you beat yourself up about it, thinking that you must have coded it wrong or the caller didn't give you all of the pertinent information. Actually, you may have been entirely correct.

Situations where you're asking about the patient's alertness, particularly in cases of syncope, seizure, diabetic event, or a stroke, are usually time sensitive. Things can change very quickly. The paramedics aren't seeing the patient at the same moment in time you, the EMD, captured on the phone. You've most likely talked with or about them very soon after the emergency event, and after your assessment, the paramedics can take eight, ten, or more minutes to get to the patient's side, and in that time the patient may have improved, stayed same, or gotten worse.

"Your findings are important," Scott said. "In cases where the findings of the EMD and the paramedic are different, the paramedic shouldn't think that the EMD got it all wrong. They should believe and trust the EMD's decision at the time. The paramedic should be asking, 'Has something changed? Was some pertinent information not relayed to the EMD? Should I be investigating this further?'"

So, now that you've read about the importance of wording and how the test KQ performed better than the current KQ, does that mean you should start using it immediately? Not yet! It still has to be approved by the Medical Council of Standards and officially put into the Protocol. You should still use the KQ as scripted until further notice. ●

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STAY ALERT

Out of the **13.2 million** MPDS® calls recorded by the IAED™ Data Center, there were **916,810** cases recorded of Not Conscious/Not Alert at Case Entry.

26.16%
were triaged using **Protocol 9:**
Cardiac or Respiratory Arrest/Death

14.10%
were triaged using **Protocol 12:**
Convulsions/Seizures

6.28%
were triaged using **Protocol 23:**
Overdose/Poisoning (Ingestion)

6.11%
were triaged using **Protocol 32:**
Unknown Problem (Person Down)

BE NIMBLE, BE QUICK

But don't rush the FPDS Chief Complaint Selection

Audrey Fraizer

The Fire Priority Dispatch System™ (FPDS®) reached a milestone in 2021, and not just because it celebrated 21 years in dispatch center action since the Academy introduced Version 1 in 2000.

FPDS Version 7.1.99 (released two days prior to ringing in the New Year 2021) included the addition of the EIDS Tool to allow agencies to conduct COVID-19 surveillance during fire-rescue calls during the height of the pandemic. Additionally, several suffixes were disqualified and subsequently eliminated because they were either unachievable in software or resulted in codes that would never be used; they would result in a code that would always be superseded by one of higher acuity. This was primarily done with Protocol 59: Fuel Spill/Fuel Odor and Protocol 71: Vehicle Fire.

This type of code/suffix scrutiny within the protocol paves the way for additional similar revisions anticipated in the upcoming release of Version 8.0.

"Like Dr. Clawson has described the work on the Medical Protocol," said Gary Galasso, Academy Council of Fire Standards Chair, "We're never done." Galasso is referring to Jeff Clawson, M.D., originator of the Priority Dispatch Systems™ used in communication centers around the world, and his dedication to the medical, fire, and police protocols.

The essentials

There are four essential objectives of fire emergency call processing that are considered fundamental and mandatory components of every emergency call:

1. the collection of incident information
2. the collection of scene safety information
3. the identification of a correct response
4. the assessment of the need for Dispatch Life Support Instructions

Chief Complaint selection characterizes the diversity among the protocol systems.

Despite all three disciplines of protocols belonging to the same family and following the same basic call processing procedures, there are notable differences. Each protocol system grows from recognizing what is happening in the respective fields, what is expected to happen, and how they apply in the centers.

"If we don't carefully consider how the protocol functions in the dispatch center as well as operationally for the Fire Service, we are completely wasting our time," said Mike Thompson, IAED™, Academy Fire Curriculum Council Chair. "We are always actively seeking what is changing in the industry and how to reflect the changes in the Protocol."

Each system has individualized approaches to arriving at the Chief Complaint.

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. The IAED Performance Standards,

however, allow the dispatcher to temporarily interrupt the protocol script at any time to add an acceptable calming or caller/scene management statement. A dispatcher may also ask clarifying questions to accurately identify the Chief Complaint when the caller's description of the incident is unclear.

The universal Case Entry Question in all three disciplines is "*Okay, tell me exactly what happened.*" It is designed to solicit a complete *complaint description* from the caller that can then be interpreted by the trained emergency dispatcher to determine an accurate *Chief Complaint* and, ultimately, select an appropriate *Chief Complaint Protocol*.

Selection priorities

Each of the 33 FPDS Chief Complaint Protocols handles specific types of events, allowing the calltaker to ask relevant questions and to provide appropriate safety instructions. Caller interrogation using the FPDS is based on three fire-rescue incident priorities: life safety, incident stabilization, and property conservation. Questions dealing with potential life safety issues (whether for callers, bystanders, or responders) are asked first, and subsequent questions elicit information that influences the selection of an appropriate type and level of response: structure types, size of fire, potential for spreading, near brush/grass, and so on.[1]

Version 7.0 also included six new protocols, which place the emergency dispatcher in a role as a rescuer:

- Protocol 78: Backcountry Rescue
- Protocol 79: Lost Person
- Protocol 80: Outside Tank Fire
- Protocol 81: Sinking Vehicle/Vehicle in Floodwater
- Protocol 82: Vegetation/Wildland/ Brush/Grass Fire
- Protocol 83: Weather/Disaster Situations

These six new protocols were added to help the emergency dispatcher send a more informed response earlier in the questioning sequence. Catastrophic event data showed that emergency resources were quickly depleted in some scenarios, delaying first responder arrivals or even making response impossible. Acting on additional compiled call data, the IAED decided that FPDS v7.0 needed to move away from the prevailing position to "shelter in place until the firefighters arrive" and provide immediate instruction in instances where death or serious injury may be imminent. This prompted the creation of a number of new Pre-Arrival Instruction sequences to address those "danger close" situations.

Know the circumstances

The Fire Chief Complaint Protocols are precise in their language and application. Though two protocols may seem similar, they address different situations that require collecting specific information. For example, Protocol 58: Extrication/Entrapment is not the same as Protocol 54: Confined Space/Structure Collapse. As Rule 2 on Protocol 58 explains, "All calls involving ENTRAPMENTS are considered extrication situations until responding units arrive and assess the circumstances," (such as a person trapped inside a vehicle or a child who has stuck his head between two railing posts). However, confined spaces are defined on Protocol 54 as having the size and shape to allow a person to bodily enter, having restricted openings that make it difficult to enter or leave, and yet are not designed for continuous human occupancy. They're found in industrial settings, commercial facilities, hospitals, universities, and even on farms.[2]

Choosing the correct protocol takes constant training, particularly focusing on low frequency but high-risk situations, as described in the previous example.

"Unless you keep refreshing and practicing, you're not going to know which to go to," Galasso said.

Protocol is a science and a matter of staying ahead of the rapidly evolving worlds of fire service and emergency communications.

"Things are constantly changing out there, and FPDS has to respond to those changes and anticipate what's ahead," Thompson said. "We will always strive to stay on top of and ahead of emerging trends in the industry."

Future versions of the FPDS will incorporate multi-disciplinary question/ instruction functionality and combine the principles inherent in the three disciplines, Thompson said. This will include medical assistance in fire situations based on commonality and research, although the PAIs will remain the same across disciplines.

"New things come up, and we're out there looking every single day," Thompson said. "We want people to know that the FPDS is the cutting edge."

Distribution

An increase in the use of data to drive decision-making in the fire service has encouraged fire dispatch centers to adopt dispatch practices that include a standardized process for gathering key information and assigning a specific FPDS code (Determinant Descriptor).

The IAED's Data Center has collected fire call data from participating agencies for the past five years (5/19/2016–4/11/2021). Overall, of the 972,390 fire calls handled, the top five protocols were Protocol 52: Alarms (433,359, 44.57%), Protocol 53: Service Call (101,253, 10.41%); Protocol 69: Structure Fire (86,120, 8.86%), Protocol 77: Traffic Collision/Transportation Incident (79,286, 8.15%), and Protocol 67: Outside Fire (75,794, 7.79%).[3]

Detailed knowledge of the distribution of call and event types can assist fire services with planning and operational decision making, including call response need, crew resource allocation, and even the purchase of new equipment and apparatus (for example, finding a HAZMAT situation in an outside fire calls for a specific class of extinguishing agent depending on the class of hazard reported). In the communication center, knowledge of call type distribution provides the opportunity to track trends and patterns over time and to compare the call distributions of similar agencies. Knowing which call types are common and which are rare can drive more effective training that focuses on ensuring calltaker proficiency with common calls and preventing loss of familiarity with call types that are rare but potentially serious if mishandled.[4] ●

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YELLOW CAB PROTOCOL

Research and evidence-based practice key to figuring out emergency services' response

Greg Scott

"150 years of Tradition, Unimpeded by Progress." Those were the now infamous words posted on the wall of the fictitious Chicago fire station in the 1991 movie "Backdraft." They have been repeated and debated for many years among both fire service critics and advocates, all trying to determine if current fire department practices are providing the best public safety value, and if not, how can they be improved with newer, more widely proven methods of operation? Yet we should be debating this issue more broadly, among all the emergency services, including police, EMS, and yes—emergency dispatch.

In 1995, Michael Callaham, M.D., published an editorial in Emergency Medical News that had a message equally harsh in its judgment of the EMS world as the "Backdraft" slogan was for fire departments. Dr. Callaham challenged the pre-hospital emergency services profession to justify its practices using a simple, alternative, hypothetical model for EMS he termed the "Yellow Cab Protocol."

The Yellow Cab Protocol is essentially what its name implies: All 911 medical calls receive a Yellow Cab response in place of an ambulance, fire engine, or any other well-equipped vehicle with a well-trained crew on it. The vital question for all of us is: Would the patient outcome be any worse (or better) using the Yellow Cab Protocol?

Ironically, nearly thirty years later this question is still difficult for us to answer. Aside from the relatively few workable arrests and severe trauma calls we handle, we still don't have a good means of measuring the risks and costs of emergency medical dispatch and response—and comparing them to the benefits of pre-hospital care provided to our patients. In short, we need to do a much better job of justifying what we do. How? Callaham gave us the answer decades ago, but too few listened—he called it Research!

The good news for us in the emergency dispatch profession is that the International Academies of Emergency Dispatch® (IAED™) has been working hard to change this situation. Evidence-based medical dispatch protocols are the catalyst to improving the entire EMS profession. Slowly but surely the IAED has used its resources to make outcome-based research a reality.

Much has changed since the mid-1990s. Mobile phones, and now smartphones, have replaced landlines as the primary means of remote voice communication. Texting has replaced most paging services, and we have an explosion of new portable and wearable devices to give us more information about a potential medical emergency than ever before. And perhaps even the Yellow Cab Protocol can now be called the "Uber Protocol." However, amid all the new technology, we must not lose sight of our biggest challenge—proving our worth to our patients and our communities. And we shouldn't slow down until the day we can say, unequivocally, that after years of research and evidence-based practice, the Yellow Cab Protocol is the only tradition unimpeded by progress. ●

EDITORIAL

Managed Care and Pre-Hospital EMS: Wake-Up Call or Taps?

BY MICHAEL CALLAHAM, MD

Prehospital emergency medical care has become a tradition on the American scene, a major industry that is woven into the structure of emergency medicine. It is exciting, dramatic, and has generated lots of satisfying re-enactments on television. Consumers mistakenly assume it is based on science and clinical knowledge in the same way that much of in-hospital and physician outpatient care is. The truth is that it's largely based on intuition and tradition, and our knowledge base has changed little over the past few decades, despite the pleas of some researchers and clinicians.

We can count on the fingers of two hands the number of interventions that are of proven effectiveness in out-of-hospital care. In a carefully chosen subset of cardiac arrest patients, early defibrillation saves lives in some cities, in some cities it does not. In most areas the overall survival rate from out-of-hospital cardiac arrest remains dismally low. Nothing else in the ACLS armamentarium has been shown in any scientific fashion to benefit patients in the emergency setting.

A few studies of patients in respiratory distress have shown that bronchodilators en route reduce wheezing faster than if you wait until ED arrival, but no longer term benefit has been demonstrated. For 95 percent or more of our prehospital patients, not even a shred of evidence exists that prehospital care benefits them in any way nor has anyone even studied these cases. Interventions that were exciting and satisfying and anecdotally effective in the minds of thousands of health care personnel, such as MAST garments, high-dose epinephrine, and various CPR adjuncts, have eventually fallen prey to the randomized clinical trial (so long postponed), which proved them of no benefit.

Dr. Callaham is a professor of medicine and the chief of the division of emergency medicine at the University of California, San Francisco.

Prehospital care is largely based on intuition and tradition

In marked contrast to most of modem medicine, there have been virtually no significant proven improvements in treatment in prehospital care. The optimal survival rate of cardiac arrest patients has not increased for two decades. As recently pointed out by Eisenberg[1], there has been no significant technological improvement in external defibrillators since they first appeared on ambulances. In most of modern medicine new therapies have been relentlessly introduced, improved, and proven in randomized clinical trials, and therapy is radically different (and better) than it was a few decades ago. In prehospital care, progress has been defined chiefly by studies that demonstrated that common interventions were useless.

EMS has grown into something never envisioned in the early days of Pantridge, Cobb, and other pioneers who designed systems specifically for early care of patients with infarction (i.e., a very acutely sick population who were likely to benefit from treatment). Most patients transported by ambulance now don't need hospital admission, many don't even need emergency treatment, and fewer still have really acute problems that need treatment within minutes. EMS isn't emergency care any more; it is mostly convenience care.

This has been true for a long time, and for a long time it didn't matter. Patients were happy because they got dramatic and (usually) prompt emergency response; lots of things were done to them, the value of which they of course were unable to judge. The cost was very high—particularly in view of the uncertain benefit—but because it was mostly paid for by insurance or else heavily (and invisibly) subsidized by taxpayers, it excited little comment. Emergency departments were happy because the system brought them lots of patients (some of them paying), the arrival of ambulances with lights and sirens added greatly to the drama and mystique of the ED, and emergency physicians got to "run" the system without (in most localities) actually putting much work into it or taking much responsibility. Local provider agencies were either indifferent or liked the justification of their existence. In any event, the bill was footed by taxpayers or insurers. Various political interests—physicians, but mostly medics, unions, fire departments, and the like—became increasingly invested in the status quo and stable employment. The federal research establishment didn't care because it didn't think much of importance happened in prehospital care anyhow, and therefore they didn't waste any significant research funds on it. No one kept much in the way of data or statistics; those who did very seldom reported it, and no one did large outcome studies of the 95 percent of patients who were neither major trauma or cardiac arrest.

But all this is going to change as managed care takes over the American

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health care scene. Already we hear the rumblings: the denial of ambulance bills, the directions to managed care and HMO members not to use 911 services. No doubt these trends will be opposed by efforts like the proposed Cardin legislation in Congress. trying to restrict the ability of managed care organizations to limit EMS utilization. But nonetheless managed care is going to affect out-of-hospital care, and it must. The chief reason is cost, which is no longer reasonable. In my region, the bill for ambulance transportation and interventions of unproven medical benefit is often the same or greater than the bill for ED treatment by a board certified emergency physician and staff of nurses. And for this price the patient doesn't even get a diagnosis. Nor does anything remotely approaching the quality control and oversight ensured by hospitals and JCAHO occur in prehospital care. The delivered product is unstandardized, unsupervised, and unproven.

Taxpayer subsidies are drying up. Managed care increasingly wants a consumer approach to medicine, and it doesn't want to pay for things that don't work. Outcome studies are being done throughout the rest of medicine; databases of the complication and success rates of hospitals and individual physicians and medical groups are being compiled and used to direct patients to the most cost-effective provider. Can this approach be far behind in EMS? And when objective data start being collected and reported in EMS, does anyone think the results will be enough to impress those who hold the purse strings?

If most of EMS is now convenience care—a fancy, dramatic, free taxi ride—it's too bad we can't do the definitive study: the Yellow Cab randomized clinical trial. In this trial, a city would be randomized by precinct to receive all EMS care either via the traditional model or the Yellow Cab protocol. The Yellow Cab protocol would mean that when you called 911, a Yellow Cab would be immediately dispatched to your location with a very short response time (three or four minutes), free and no questions asked. It would carry no equipment (although modifications might be made to the rear seat to aid prone transport and cleaning) except perhaps a small and very cheap automatic defibrillator, and the driver would receive little or no special training, except perhaps EMT training. No time would be spent on assessment, radio calls, or filling out forms. No medicines would be administered. The patient would be promptly loaded in the back and transported immediately to the nearest appropriate level hospital. There might be a very few branches in the algorithm—immediate defibrillation for cardiac arrest, stabilization of the cervical spine, maybe some simple airway support, transport to the trauma center for obvious gunshots or stabbings—but the whole emphasis would be on simplicity and speed. The system would be cheap, arrive fast, and get you to the hospital fast. The current system of multiple levels of evaluation, assessment, diagnostic impressions, and treatment would be eliminated.

No doubt the reader reacts with horror or laughter. No doubt you think about the occasional case where a medic made an obscure diagnosis or performed a heroic intervention and genuinely saved a patient's life. I've seen such cases too, and those providers should be applauded. But how many of them are there? We have known for years that the vast majority of our EMS patients will do fine no matter what we do or don't do to them. And we prefer to forget about the downside; the times when on-scene delays (average in our town is 30 minutes) led to deterioration only minutes from the hospital. And the times when medics make the wrong diagnosis or administer the wrong treatment or attempt a cowboy intubation that hastens, not helps, respiratory distress, or the patient suffers a complication from a potent drug he didn't really need (but which was exciting and dramatic to administer). Do the saves out number the "clean kills?" We don't know. Most systems don't know. They don't even try to find out. The U.S./European model of prehospital EMS—expensive, elaborate attempts to bring the hospital to the patient, with intricate algorithms and certifications and remote supervision trying to make up for the absence of the level of expertise, direct oversight, and back-up available in the hospital—has never been validated. Or even studied. It has been pointed out by others how difficult it is to resist the technological imperative, that is, use more complex devices and treatments because we have them.

That's why we need the Yellow Cab trial. A few patients will fail to get treatments that could have saved them, but others will not get treatments that would have killed them. And others won't be misdiagnosed and have treatment delayed with worsened results. I suspect that the outcomes of the Yellow Cab trial, not just the survival rates, but the complications, the number of hospital days, the days of disability, would be the same or better than traditional American prehospital care. And it would cost a fraction as much. A horrible idea? We're already learning to live with limits and to think about issues of cost-effectiveness and priorities in health care. Why should we spend a fortune on expensive and ineffective ambulance transportation when children go unvaccinated and huge numbers of adults don't have even primary outpatient care? What would happen if we took all the health care dollars spent on this high-tech EMS model (many of them well disguised and deeply buried in departmental

budgets) and applied them to modes of preventive care that have been studied and that are cost effective? Can we be confident that the overall health of the population wouldn't be much more dramatically improved?

Who will do this study? There is just about as much scientific evidence in support of prehospital EMS as there is for homeopathic medicine, maybe now that the NIH is supporting funding of careful studies of alternative medicine, it will do the same for EMS. But I suspect not. And somehow I also suspect that ethical and logistical problems will prevent the completion of the Yellow Cab trial. (I can imagine the testimony at the Congressional Wyden hearings on consent about this one.)

How then will managed care (and American society) make its decisions about EMS dollars? Will there be genuine leadership and needed funding from the federal research establishment? Will organized emergency medicine step forward with a clarion call for a serious assessment and reform? Will citizens and local agencies demand that data be collected and publicized and tough decisions made on the basis of facts? Will the decisions to cut EMS expenditures be made objectively and scientifically? Or will managed care business managers simply chop and cut and limit expenditures wherever they can, as best as they can, in whatever areas seem most vulnerable, most likely to present the biggest financial return, and which are most relevant to the interests of their particular (narrow) patient population?

Of course, there is another possible scenario. Perhaps EMS won't get its wake-up call. Perhaps as has happened so often before political interests will prevail, and nothing much will change at all. HMOs will be afraid to lose patients or provoke regulation with severe limitations on prehospital care so they will direct their energies elsewhere. They will take the dollars instead from hospitals and physicians, with the eventual result that the ambulance may be state-of-the-art but the receiving hospital will be marginal or closed. Business will go on as usual. More and more Americans won't have health insurance to pay for any EMS care, even the kind that might work. As available revenues shrink, more and more local EMS budgets will be cut in whatever area has the least votes and the least effective political organization. The federal research establishment will continue to provide almost no leadership and little funding. Physicians will continue to claim their system has medical direction when the medical director works 40 hours a month or less and no physician ever sees a patient on the street. Local agencies that can't even cite a cardiac arrest survival rate will continue to brag about their life-saving skills and their superiority to other regions. (As with the children of Lake Wobegon, all American EMS units are about average).

EMS providers would probably think, in this last scenario, that they had dodged the bullet. But for patients and the long-term health of prehospital care, this would be the worst outcome of all. ■

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Dr. Callaham has been a full-time emergency physician for 21 years, has been EMS Medical Director of a large urban county, has directed three paramedic training programs, has served on a virtually infinite list of EMS committees, has conducted EMS research, and says he regards paramedics with respect, admiration, and friendship, and notes that there is a difference between personal anecdote and objective scientific evidence.

More recently Dr. Callaham is:

Current Editor in Chief, Annals of Emergency Medicine

Founding Chair, Department of Emergency Medicine, UCSF

Past President of World Association of Medical Editors

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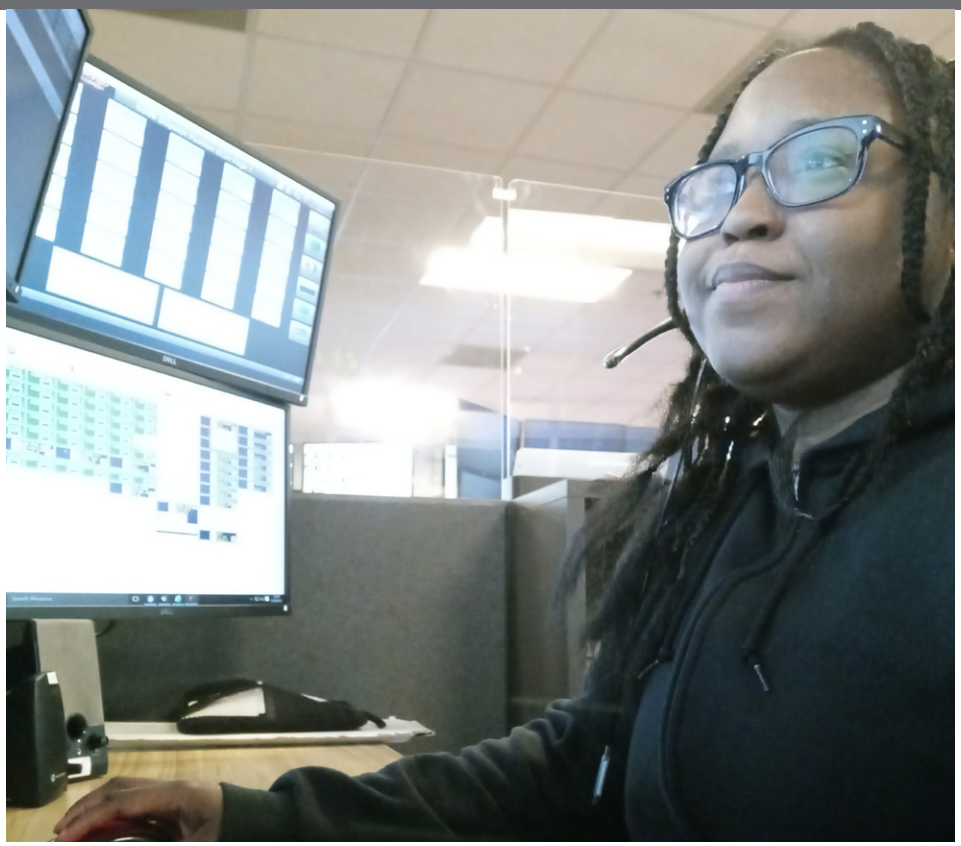


Samantha Hawkins

BEYOND THE COMFORT ZONE

Some calls demand more

Samantha Hawkins

Every 911 operator has that call that will demand more of them than usual … this was mine.

I was the second 911 operator she had spoken with that morning. Only six minutes into our phone conversation on that 911 line, I had determined that she very likely had paranoid schizophrenia with a totally unhealthy splash of "watched one too many fictional espionage dramas." She was a chaotic ball of nervous energy going on incessantly about the electronic bugs in her apartment (and in her brain), the neighbors to the immediate left of her building that were harassing her by staring into her windows at night, and all the reasons why she didn't trust law enforcement to begin with. I tried to sound gentle and reassuring even as I recognized what I was dealing with. In her mind, she was the innocent victim in this situation: just an ordinary citizen trying to go about her day in peace. She was in the middle of doing some household cleaning and was just trying to have a perfectly normal Monday afternoon.

In stark reality, she was the neighborhood "disorderly" who had warranted several calls into our center that day because of reports of her "yelling" and having a "pretty intense and heated" conversation with herself in her apartment. Her address showed previous calls of similar complaints made by her bewildered and terribly alarmed fellow tenants. We had dispatched a couple of uniformed officers to respond to this call and they were currently standing outside her door knocking. The first time she called 911 to tell the operator that she didn't feel like opening up her door before she cursed into the phone and hung up on them. This time when she dialed the emergency line, she happened to reach me.

"Hello, Cobb County 9-1-1, what's the address of your emerge—"

"Why are y'all still outside my door?!" she screamed into my right ear, jolting me upright in my chair.

That was the beginning of what ended up being a 30-something-minute phone call. After refusing to answer the officers at her door for what felt like forever, and her refuting all my best, most sound suggestions that she at least crack the front door open to hear what they have to say to her, she finally caved. I sighed with some relief as I listened to her allow them into her home and start a dialogue up with them. She rehashed much of what I had typed in CAD on the call: that she was being illegally eavesdropped on by some unknown, unseen group of figures that had it out for her and that her neighbors were all in cahoots conspiring to get her kicked out of the apartment complex. Meanwhile, she held the phone to her ear and occasionally checked to make sure I was still on the other end. Somehow in her mind I had become more of an ally to her than anyone in that room.

I stayed on, offering a word of comfort or understanding every so often like "I understand why you would be upset, ma'am," and "I am so sorry that happened to you." I didn't quite realize it at the time (because I was thinking I was only doing my job by providing a voice of calm and reason to this troubled young woman), but I was building a rapport with her through my words and tone of voice. At times it was hard for me to find the right thing to say. She obviously needed help and I couldn't help but hope that I wasn't acting as a distraction as the officers talked to her and attempted to convince her to let them transport her to the hospital (no doubt for a mental evaluation). I heard the voice of the female cop on scene as she expressed to my caller her concern for her welfare and how she felt that going to the hospital would be the best thing for her. My caller kept countering with claims that no one understood what she was going through and that the police weren't able to help her either. I tried to coax her into listening silently for just a few seconds to the officers but she continued to speak over them.

In the six years I've spent as an emergency telecommunicator, I have dealt with dozens of mentally ill callers

ranging from the manic to the severely depressed to those with serious psychological problems. I've even spoken a few times to a caller with dissociative identity disorder. I will always credit the months of classroom training and observation of more experienced 911 dispatchers on the floor for guiding me in how to navigate the world of dispatch. The standardized curriculum fine-tuned my customer service skills and greatly enhanced my ability to communicate effectively with others. However, nothing in my training or in any of the protocols I had studied and memorized had fully prepared me for this call. Dealing with 911 callers with mental health problems can require more from an operator than what's in our job description.

I have learned that it is pointless and irresponsible to argue back and forth with a caller over what they perceive to be happening around them. For example, trying to convince someone with paranoid schizophrenia that no one has tapped their phones or is watching or following them is a pretty futile task. It is simply not effective to spend time trying to dispel the demons in their head or debunking their conspiracy theories. Rather than telling them what is or isn't there, you should instead help them to see fact from fiction by asking key, pointed questions. Try to stick to the here and now. When they begin to ramble or run on about something that isn't actually relevant to the call, asking key questions can sometimes help them to stay on course. But other times the only thing you can really do is just listen and be patient with them.

By the time my caller had launched into a tirade over the bugs in her head that someone put there while she was sleeping, I came up with an idea. She was talking a mile a longwinded minute and I could hardly get a word in, but eventually I found an opening.

"Ma'am! Ma'am! I think I know how we can help you. You're right, the police can't understand what you're going through. They can't see the bugs. But you know how you can prove to everyone that the bugs are there? A doctor. Yes, a doctor can take X-rays and an MRI."

She paused just long enough to take a ragged breath in. I could tell from the brief silence that a lightbulb had come on in her head.

"That's what you think? A doctor can see inside my brain, right?"

"Oh yes. If I had bugs in my head that no one saw, I would go to the first doctor I could and tell him to take a good look inside. I'm sure he could give you something to help with that."

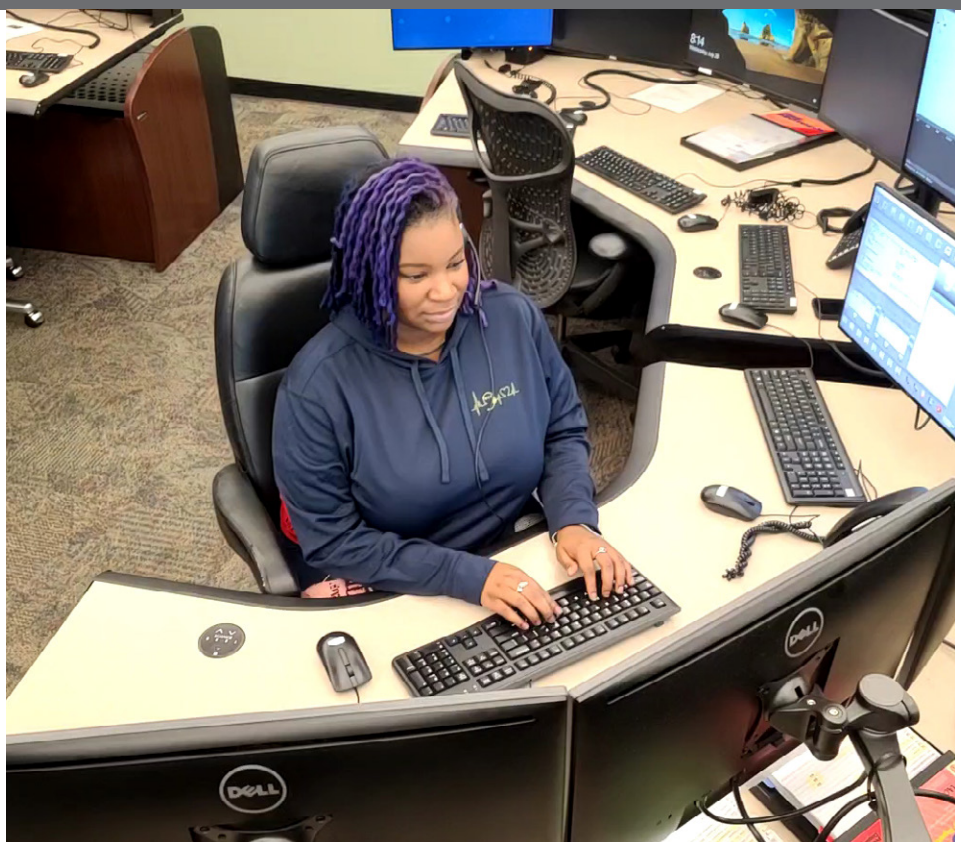
"Yeah! Yeah, that's true!" she exclaimed.

I heard her mutter something to the officers about needing a heavy coat because it was chilly outside. She apparently marched outside to the back of the police car of her own free will, rambling nonsensically about how she still didn't trust them but she would trust the doctor. I was sure that I was done with this call and I readied myself to finally bid her farewell. Before I could get the words out, though, she suddenly asked me to stay on the line with her until she arrived at the hospital. I was partially dumbfounded. I had never stayed on the line with someone riding in the back seat of a squad car.

"They'll take care of you now," I assured her. "The officers are taking you straight to the hospital."

"Maybe … I just want to make sure. I want you to stay on with me to make sure that's where we're going."

At this point I relayed to the dispatcher working that call on the radio that I would be remaining on the phone with the caller at her request until she got to the hospital. The dispatcher nodded and tossed me a supportive thumbs up. The whole car ride there the woman spoke to me in a frantic and excited tone. I was feeling a bit worn out from the call but was self-conscious about not coming off annoyed with her. When the officers pulled up in front of the local hospital, she spat out at rapid-fire speed that she was there and then abruptly disconnected. Not a goodbye. Not a thanks. Nothing but a dial tone. A few minutes afterwards I was beckoned over by the dispatcher who shared a message she had received from one of the officers that responded. They wanted me to know that my staying on the phone and talking to the caller had made a very difficult situation a lot more manageable. That was all I needed to hear to know that I had done my job. ●



EMD Chanelle Hickson

SHOT IN THE DARK

EMD guessed right in choosing profession

Audrey Fraizer

The woman's voice in the background is frantic. "He will choke and die," she sobs. A wheezing noise is interrupted by a series of thumps. The caller states their baby is "having trouble breathing." The thumping grows louder.

Case Entry Key Question, "Okay, tell me exactly what happened," cuts to the core. The baby is choking. He is gagging, struggling. Per instructions, EMD Chanelle Hickson does not ask about the thumping noise but simply tells the caller not to slap him [the baby] on the back. The caller relays the message to the person offline. The thumping ceases. The caller states the baby is heavily congested, possibly choking on mucus. Hickson does what she always does. She follows the protocol.

"The next thing I know the baby stops choking," she said.

The voice in the background coos to the baby, with the sound of a shaking baby rattle adding to the welcome turn of events.

Choking. Fear. Trouble breathing. Cry of relief. Hickson has managed the emotional spectrum of callers during her 2 1/2 years with Alachua County Combined Communications Center (CCC), Gainesville, Florida (USA). And she enjoys every minute of it, knowing she found a way to help people that works for her. You can almost say she's a natural in the profession. She's never scored less than a 90% on the weekly Alachua County CCC Academy exam, said Training Supervisor Tocarria Minafield.

At the same time, she always jumps in to assist others with understanding new material. "Yes, she is a quick study," Minafield said.

Hickson grew up in a law enforcement family. Her mother and father retired from a Florida police department. They tried convincing their daughter to follow in their footsteps. She majored in criminal justice in college but did not want to go down the policing road. Her mother suggested emergency dispatch.

"I took a shot in the dark," Hickson said.

She guessed well—so well, in fact, that Supervisor Alexys Graham, who secures overtime, doesn't have to ask Hickson twice about working extra hours above the three on/three off 12-hour shifts.

"I work all the overtime I can," Hickson said. "It means I get to go in more often."

Hickson's parents taught her about staying calm from their experience on the streets. She does not deny the emotional impact of tough calls. Three stand out. The first was a cardiac arrest and two involved hanging (an adult in one and a child in the other). Like always, she relied on the protocol and PAIs. Script and instructions guided her through similar situations in past 911 calls. These incidents, however, stay with her.

"They felt different," she said. "It's hard for me to explain why. I really tried hard to help them."

Hickson does not dwell on the negative side of emergency dispatch—the irate callers, the crisis, or the outcomes impossible for anyone to change. She realizes the anger callers express is directed at the uncertainty, not at her.

"They're in crisis," she said. "If I can't get through to them, I let them know I need them to help me so that I can help them."

She leaves every call knowing she tried her best, and if the day is particularly tough, she looks to the bright side of her own life.

"I am blessed with a lot of good," she said. "I have family. Both my parents are here. I am in good health. I have very good puppies. I am very appreciative of what I do have."

And, yes, that includes finding a profession that keeps her hand in helping people. "I enjoy coming into work," she said. "I truly do."

In 2020, Alachua County CCC answered 323,165 emergency and non-emergency calls from citizens. Of these calls, 263,113 resulted in a request for service with 189,028 of them specifically for law enforcement services.

CCC 911 telecommunicators are certified by the state of Florida and are Academy-certified EMDs and EFDs. They are also trained in Emergency Mental Health Dispatch (EMHD) and receive Crisis Intervention Training (CIT) to more effectively process requests for service that involve persons in mental health crises. ●

How To: 911 hosts EMD Sami Pohl (left) and EMD/EMD-Q Erica Snyder

GETTING THE HANG OF 911

Podcast shines the light on emergency communications

Audrey Fraizer

Some things never change or, at least, a basic understanding of a given concept does not always make it to subsequent generations.

Take 911, 999, 112, or any three-digit emergency number.

A lot of people think it's an informational number, expecting answers regarding local services, food delivery, and traffic updates. Some calls are pranks and others, there's no telling why the emergency line was the point of contact. While the absurdity of the call may sound funny to the casual observer, they can interfere with what actually needs to be one. For example, a woman in Deltona, Florida, called 911 four times to complain about a nail technician. Even with a police deputy sitting next to her, she still called 911 to complain that her nails were too short.[1] A Texas woman called 911 upset that she did not receive the $1.62-worth of extra shrimp in fried rice that she paid for.[2]

You would think that over the decades—since the first ever 911 call in the United States happened on February 16, 1968, in Haleyville, Alabama (USA) and the world's oldest emergency phone number 999 was introduced in the U.K. on June 30, 1937—a majority would have the hang of it. A majority would understand the basic concept about the proper use and understand not to call for reasons like directory assistance, paying for a traffic ticket, or lodging a complaint against a food establishment or manicurist.

That's not the case, which explains the long life of 911 mascot Red E. Fox (the "E" stands for emergency), the more recently inspired "Cell Phone Sally," created by the Commission on State Emergency Communications in Texas (USA), and podcasts that include Dispatch in Depth and How To: 911.

Dispatch in Depth, moderated by IAED™ Social Media Coordinator Rebecca Barrus, provides insights into issues, research, and people in the profession. A recent episode highlighted a program that endeavors to dispel 911 misconceptions and enlighten the not always so sure when to call or why to call 911. The show, How To: 911, debuted in April 2020. The same principles the hosts present can apply worldwide.

"We know 911 exists, but for most, that's about it," said Sami Pohl, EMD, City of Loveland Emergency Communications, Colorado (USA).

Pohl was relatively new to the profession and realized, despite her increasing understanding of 911, she was—and always would be—a student of emergency communications.

"Ever since my first day, I've been learning," she said, and, if she anticipated an extended learning curve, what about the majority who might never call 911 or call 911 during a major life crisis?

"I wanted to give people a better idea of what we do," she said. Let them know what to expect when and if the time comes.

She reached out to Loveland City Emergency Communications Chief Training Officer Erica Snyder, EMD/EMD-Q. Considering her 14 years in the profession, Snyder agreed. A preliminary list of topics focused on 911 FAQs, education, and etiquette evolved into a platform showcasing the public safety chain of response and outside experts contributing to dispatcher well-being, such as Jim Marshall and Ryan Dedmon. They interview police officers, paramedics, fire fighters, dispatchers, and as Snyder said, "The whole universe" as connected to emergency response.

"We really strive to make sure that through teaching we aren't encouraging the a 'they should know better' thought process when it comes to everyday callers," Pohl said. "And as annoying as it is [such as an inappropriate reason to call 911], we can't fix a problem if we don't try to understand it first."

And since not all communication centers are one size fits all, they compare differences found among agencies, including management, disciplines dispatched, protocol, and the multitude of other factors separating service delivery.

"We cover a lot of territory," Pohl said, with plenty of ground left for future podcasts.

Discussions vary in length and new podcasts are posted every two weeks through **Apple Podcasts**, **YouTube**, and on Facebook at Loveland Emergency Communications Center. You can also contact Pohl and Snyder at **HowTo911@cityofloveland.org** and Instagram **@HowTo911Podcast.**

Sources

1. Hopper J, Netter S. "The Most Hilarious Calls of 911 and Beyond." ABC News. 2010; Dec. 29. abcnews.go.com/US/silliest-911-calls-bad-manicures-pot-laced-cookies/story?id=12502731&singlePage=true (accessed May 18, 2021).
2. See note 1.

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