



Erasmus+ Programme – Strategic Partnership
Project Title: **“One Minute May Save A Life”**
No. project: **2015-1-RO01-KA202-014982**

Part 1

Role Playing Exercises

This exercise is intended to be a very simple but quite precise tool in order to teach trainees possible hypothetical situations that may actually happen at work. The point of this exercise is to allow the trainee to familiarize himself in accordance with the depths of possible crisis he/she needs to handle in order to be an effective dispatcher. The concept here is to make these exercises as realistic as possible and to have trainees to have a feedback after the end of the role playing that they are about to experience. More or less these simulations are what every soldier, fighter pilot, police officer or anyone who is put in a position that needs to react effectively must go through. It would be highly problematic if someone goes to enter into such a position and he/she is unprepared for the task at hand. In fact the more preparatory hours one spends practising how to act in a dive situation the more one is likely to act in a beneficial manner to the person in need who in this case is the caller. Therefore and because no situation is alike the trainee dispatcher must have the opportunity to assess himself under conditions that simulate actual possible cases that he/she will be called to act on. Doubtless no novice dispatcher is equipped to handle critical situations the first moment he enters the post but given the circumstances engulfing critical incidents it is imperative that one gets to be as ready as possible. Below structured role playing will initiate a trainee into the art and complexity of handling an incident.

Method

Assume that there is a class of trainee dispatchers of about 12 persons sitting in a class. In the class there are two instructors one who will call John the senior and the junior who will call Peter. In order to best exhibit and teach learners will participate in a role playing scenario where the instructor will play the caller. In the classroom there is a structure that resembles exactly what is in an actual call center for dispatchers. Thereby the instructor will go in another room and he will call. The phone will be answered by a trainee the junior instructor will select. Even though the students will not be able to see the senior instructor they will be able to listen to him. The class is wired so as to allow both voices to be heard. That way the other students will be able to listen both caller and dispatcher and will be the audience. After each simulation the instructors will give feedback and will in addition allow the students to ask any questions they want. Naturally a variety of simulations will be practiced starting from simple to complex

but not unnecessarily in that order so as not to make that arrangement predictable. The students need to become aware that situations may be either easy or complex but must be able to deal with both.

So in this first simulation John the senior instructor goes to the other room so as to become the caller while Peter the junior instructor asks Tom to come and play the role of the dispatcher.

Scenario 1

Dispatcher – 100 What is your emergency?

Caller – My son's hurt.

Dispatcher – What happened?

Caller – He fell down the stairs. He hit his head. There is blood pouring from his head. I am very afraid. Oh my God.

Dispatcher – Is he conscious?

Caller – Yes thank God. Please hurry.

Dispatcher – Will you need an ambulance?

Caller – Yes. I don't know what to do. I am afraid to carry him in the hospital by myself. I will for sure.

Dispatcher – How old is your son?

Caller – 13

Dispatcher – State your name please.

Caller – My name is Andrew Polson.

Dispatcher – State your address please.

Caller – My address 245 Grier Street in Riverview.

Dispatcher – Please tell us your phone number

Caller – It is 221-4512

Dispatcher – Sir, help is on the way, please stay on the line.

Caller – Please tell them to hurry. I am afraid. My son does not look good.... oh there is so much blood.

Dispatcher – Is he conscious?

Caller – Yes. I think so.

Dispatcher – Can he talk to you?

Caller – Don't know.

Dispatcher – Please see if he can respond.

Caller – Yes

Caller talking to his son. Son replies

Caller – Yes he understands me.

Dispatcher – He is not immobile. He is able to move a bit his fingers?

Caller – Yes but... I can't see him like that.... I am punching myself. Hurry please.

Dispatcher – Help is on the way. They should be arriving any moment. From what I gather is that it appears that there is blood on the forehead of your son because he fell down from the stairs.

Caller – Yes

Dispatcher – I assume you have not seen your son injured in that way before and this is kind of scary.

Caller – No

Dispatcher – I am not there, nor can I know exactly the situation but from what you are saying your son will be okay.

Caller – I hear the sirens of the ambulance. I will need to close the phone and go down to open the door. Thanks for your assistance.

Dispatcher – You are welcome.

Phone call ends.

John the senior instructor returns to classroom. Peter is in the podium and leaves so that John takes the lead role. Tom sat down along with the other classmates. John the senior instructor proceeds to ask the class.

John – I need to mention that this is what veteran dispatchers might deem to be an easy to handle call. I am also of the same opinion. Now the question is why that is so. Since you took the role of the dispatcher Tom, it might be best to ask you.

Tom – Perhaps because there was no crime or suicide.

John – Any other reasons?

Tom – Could be that the boys injury was not that serious.

John – You are the dispatcher. You don't know how serious any injury could be. It may turn to be an internal injury but no one can assess that up until the boy gets to the hospital. What do you think Tom?

Tom – I understand, but from the simulation it appeared that the father was rather scared and he may have exaggerated the situation.

John – True but you do not know this for sure. You can never be there therefore you are only guessing. The question remains why this is a simple call and not a complex one. Any other students wish to offer their opinion?

Among Tom's classmates Steve offered to state his opinion.

John – Yes Steve.

Steve – I think that it is not a complex call because as a dispatcher you only need to get the callers data and address and send for the ambulance. In addition a dispatcher keeps talking to guide the parent.

John – Steve is right. This is a pretty straightforward situation. Even if the injured boy has an altogether different condition, this is not up to us to assess it. That is the job of the doctor much like the ambulance guys have another task to perform so is ours. In this very specific simulation our job is precise and needs to be done in as simple manner as possible. It is possible for you to also notice that the caller who was named Andrew Polson was quite frightened and that the dispatcher tried to contain the situation and to calm down Mr Polson. Even though the Dispatcher can't know anything about how seriously is the medical situation of Mr Polson's son, the Dispatcher knows that there is nothing to be gained by a Mr Polson in panic.

John the instructor proceeds with role playing simulation number 2. He invites another student Sam to be the dispatcher and he sends Peter to become the caller while he stays in the class to monitor reactions of students.

Simulation 2

Dispatcher – 100 What is your emergency?

Caller – I am very scared. There is a thief in my house.

Dispatcher – Is he armed?

Caller – Do not know. I awake from noise. I overheard sounds of steps. I locked my bedroom door and I am now calling you from my mobile phone. I hid in my bedroom bathroom. I am afraid to go out. I am 70 years of age. I live alone.

Dispatcher – What is your name?

Caller – Mike Wallace

Dispatcher – What is your address?

Caller – Greengrove road, Hillsboro

Dispatcher – What is your phone number?

Caller – 70801319

Dispatcher – Okay I am sending the police right now. Stay on the line do not hang up.

Caller – Yes. I hope they won't take long. I am afraid.

Dispatcher – You said you locked the bedroom door and you also locked yourself in the bathroom. So there you have two doors protecting you up until the police arrives which will be very soon.

Caller – Yes but what if he has a gun... what if he shoots his way through.

Dispatcher – I understand your concerns, but most likely he will either runaway by himself or the police will get him. They will be there very soon.

Caller – Yes... you sent them already?

Dispatcher – Yes.... and sir keep in mind that because it is night time the sirens of the police cars will be overheard from afar so if any thief is still in the house, they most likely will try to escape by running. So stay calm... police are on their way.

Caller – Do not hear the sirens yet.

Dispatcher – Sir only one minute passed from the time you called. It might seem a long time but the police will arrive quickly. Do you hear any more noises?

Caller – No... but that's because I am behind thick walls.

Dispatcher – Is the bathroom door thick?

Caller – Yes it is. I think it is solid wood.

Dispatcher – So there is silence.

Caller – Yes.....oh.....

Dispatcher – What is it?

Caller – I hear the police sirens. Oh thank God..... I am so relieved. Hope is for here.....my house.

Dispatcher – It must be... but stay on the line. If you hear sirens sound getting louder that will take away all your doubts. There is no other police car in this vicinity. It is for you.

Caller – I will go out. There is police sound sirens outside the house. Thank you

Dispatcher – You are welcome.

End of phone call

As Peter the junior instructor comes back to class and is joined with John they proceed to ask the class if the trainee Dispatcher Sam has used good technique and sound tactic in dealing with the caller.

John – So what do you think. Has Sam used successfully key words if any and was he precise?

A student named Haven lifts her hand.

John – Yes Haven

Haven – I think he did

John – How?

Haven – Sam asked the nature of emergency and quickly asked later the address of the caller and name. He also identified that the caller was in no immediate danger, that he was safely closed in the bathroom, and that the police were already on their way quite quickly. Sam also

kept Mr Mike Wallace on the phone and was talking to him, directing him to the fact that the police are on their way up until they came. I think it was a successful call.

John – I tend to agree with you. The Dispatcher behaved and acted competently. The caller was directed in a manner that expedites quick action from the dispatcher. At the same time, no errors were noticed from his behalf and in addition the Dispatcher kept the caller on the line in case anything was about to come up or occur. At this point the psychology and behavior of the caller must be controlled so that no panic occurs. It is critical that the caller feels assured and secure and that actions have been taken to address his needs. Once that is achieved, there is the time interval between Dispatcher telling the caller that assistance is on the way and the actual estimated time of arrival of either ambulance, police or firefighters arriving. Within those minutes a lot can happen if the caller loses his sense of security. To the caller a minute at a critical event may look like an eternity, therefore we should keep that in mind. If the initial phase of the conversation between caller and dispatcher goes well, then it becomes way easier for things to go later well. The caller is always uneasy, may feel actual threat to himself, his family, others, so when he/she does call, it is inevitable that his voice and mannerism may be one of panic, fear or exasperation. We need to keep in mind also that even if he/she appears calm in the beginning, in a second is notice he/she may unleash all his emotions on the Dispatcher who must try to control and contain the conversation so as to establish as quickly as possible, name, address, type of incident or critical event and direct the caller to understand that help is on the way. Naturally, we expect that things are never that easy and that many times it is hard to get the information we seek at the speed we seek it so as to identify the need and problem. In fact many difficult calls are made and the Dispatcher needs to be calm and be quick so as to define the needs of the caller. Having said that, it is inevitable that with enough practice one gets way more skilled at this context rather than the beginning and at times even veterans may have hard time coping with complex situations but our job is to help people and this is what we are trained to do. Next we will see and practice on more simulations.

Simulation 3

Fire in the house of a family with two children, John senior instructor is the caller Peta a student trainee dispatcher is the Dispatcher.

Dispatcher – 911 What is your emergency?

Caller – Help my house is on fire. I have two kids.

Dispatcher – Are they inside?

Caller – Yes

Dispatcher – Are you inside?

Caller – Yes, please help

Dispatcher – What is your address Sir?

Caller – Protagoras street near Athens avenue, number 33. Oh my God hurry.

Dispatcher – Sir are your kids with you?

Caller – Yes

Dispatcher – Is your wife there with you?

Caller – Yes, oh my God, I am going to burn

Dispatcher – Sir, is there a way out? Is there a place where you can go out. Keep calm seek a way out. Are you in a block building or a family house?

Caller – A family house.

Dispatcher – Is there an exit door near you?

Caller – There is so much smoke, fire, my children are screaming.

Dispatcher – Is there a way out? Help is already on the way but if there is a way out seek it, take yourself and the children out.

Caller – There is a stairway from a near window.

Dispatcher – Is there a fire there?

Caller – No

Dispatcher – Is the fire away?

Caller – Yes

Dispatcher – Head then over there

Caller – Yes

Dispatcher – Are you there?

Caller – Yes

Dispatcher – Can you and the children go out?

Caller – I think so

Dispatcher – Climb down but do stay on the line unless you can't. If you need to use your hands, keep me online but put it in your pocket up until you climb safely down you and your children.

Caller – Yes, thank you

Caller stays with the line open.

Caller – I am down safely. I already near the sirens from the fire trucks. Everything is okay thank you.

Dispatcher – Thank you sir.

Simulation ends. John goes back to class, Peta goes also back and joins the rest of the trainees. John takes up his position in the podium.

John – I wish to inquire whether any of you has spotted any mistakes in the role rehearsal that went before. Keep in mind that this situation was more complex than simulation 1 and 2. Silence reigns for a minute then one of the trainees with the name **Stuart** raises his hand.

John – Yes Stuart

Stuart – I think that it went pretty well except maybe the part that Peta should have gotten his address sooner.

John – That is right. As soon as you establish contact with the caller, get name, address, situation, and dispatch right away the necessary department to deal with the situation otherwise the caller may escape you due to his intense emotions and fear that is generated by the situation other than that, I must say that Peta did really good and she tried very well to guide the caller to unlock from what I deem to be a situation that paralyzed him out of fear. Remember people that at those situations in between smoke, fire, confusion, fear for one's loved ones, screams of crying children, one gets easily lost. Therefore, if we direct people, we kick start their own best survival instincts. Though we do need to keep in mind that this scenario that may well happen in reality is not an easy one to deal with, but this is where we need to do our best because a call may indeed save lives.

Simulation 4

This scenario and role rehearsal involves a family at dinner time and a young girl choking from food. Peter, the junior instructor will be the caller and Stuart the Dispatcher.

Dispatcher – What is your emergency?

Caller – I'm in my house with family. My nephew was eating. He is choking on his food. He is bad.

Dispatcher – Is he awake? Conscious or not?

Caller – He is conscious, but he appears not good. His breathing is very difficult.

Dispatcher – Does anyone from the rest of the family know how to perform the Heimlich maneuver?

Caller – Never heard of it. And I think no one here has a clue of anything medical.

Dispatcher – Please stay calm. Give me your address and name.

Caller – Proclus street near Heroes square. Name is Andreas Heracleous

Dispatcher – Thank you sir. Help is already on the way. How's the situation with your nephew?

Caller – Appear weak

Dispatcher – Could you or someone there try to squeeze his abdominal area?

Caller – Yes

Dispatcher – Please do it up until Medics arrive. Please stay on the line up until help arrives.

Simulation ends.

Peter transfers from exercise room to classroom and joins senior instructor John while Stuart takes his place. John speaks out to the class.

John – This exercise as you can see is clearly different from simulation 3. Here we have a young male from the description choking. We also have a family that has no idea or training or how to deal with this said situation. Therefore there is not so much we can do other than to dispatch the medics as soon as possible. Everything here went by the book and fast but you have to keep in mind that we only can do so much. In exercise 3 there were things that could be done but here very little other than to dispatch appropriate services. The Dispatcher told the older adult to press the abdominal area of the nephew. Other than that, we could do no more. This sad fact is also part of the weight a dispatcher needs to carry in his daily routine. You get to hear people in crisis, in critical events, in situations that are not easy. Later when you go home and watch news on Tv you may hear of a family that called you but in the end there was a serious loss or injury. Needless to say or state that events affect us especially when you get to hear the voices of people that later on may face a drama. It is not easy and that is why we always worry if a dispatcher gets a nervous breakdown. Naturally, safe guards are in place on your future job sights but it is a job that is complex and at days very difficult. At times there may be a streak of days that always have difficult cases and at others few things happening. One thing is for sure it

is not a boring job. Having said that, I need you to pay attention to the larger picture, that in the end you may be the link that defines whether a person will survive or not. Always stay focus on that.

Simulation 5

This scenario involves a woman who has a child believed to have been underwater in the bathtub and in an undefined state as to the extent of her situation. Peter the junior instructor will be the dispatcher while **Karen** will impersonate the woman in need.

Dispatcher – What is your emergency?

Caller – Please help. My 6 year old daughter was playing in the bathtub, and I am afraid she might have drowned.

Dispatcher – Is your baby breathing?

Caller – Don't know for sure. Yes..... she is hardly. Don't know please hurry.

Dispatcher – Your name and address?

Caller – Pulias avenue 72 cross Ilithion street

Dispatcher – Madam, help is on the way. Do you know CPR?

Caller – No, I think have seen it on TV

Dispatcher – Then stay calm. The child is breathing you stated.

Caller – Yes..... now I see. Yes she is but not normal

Dispatcher – Help is on the way Madam. Try to keep as relaxed as possible.

Caller – Hurry.... Please tell them to hurry. Don't know what I will do if my daughter doesn't make it.

Dispatcher – Medics should be there quite soon. They are on their way as we speak. Stay calm.

Caller – Yes

Exercise ends. As previously instructor and trainee go back to their places. This time John asks that Peter takes the podium.

Peter – What are your observations. Was everything in order?

One of the students raises hand.

Peter – Yes Peta

Peta – I think it went by the book. It is sad though that we can't do more. The mother did not know CPR and she had to wait there up until help arrives. But no one knows at that time if the child will be okay. One can only know after.

Peter – Yes and indeed this part is agonizing and never easy, but this is again a situation where one does help by sending in help but one is not God to be there and make bad things go away. We always going to be exposed to these situations.

Class did not make any other comments. Exercise ended.

Special chapter on suicide intention

Here the class of trainees will be dealing with perhaps one of the most difficult and complex part in what is to be a dispatcher. Before proceeding to the simulation it might be beneficial to have material informative on that regard.

What are your beliefs about suicide? This matters! Some popular myths about suicide presented by the Crisis Clinic of Seattle, are listed below:

Myth People who talk about suicide don't really do it.

Myth Talking about suicide encourages it. The best thing to do is ignore it.

Myth Only a certain type of person commits suicide.

Myth Suicide is a lower class phenomenon, or suicide only occurs in certain ethnic groups.

Myth Suicide is inherited and runs in certain families.

Myth Suicidal people are mentally ill.

Myth People under a psychiatrist's care rarely commit suicide.

Myth An unsuccessful attempt at suicide is not to be taken seriously.

Myth When the adolescent talks about killing himself, he is just looking for attention.

Myth If you ask about a gun, it may give them an idea!

Assessing risk

STEP ONE

Once you have determined someone may be suicidal, you need to ask directly if he is considering killing himself or if he has thought about suicide. This is critical and can be done successfully by crisis workers. You will not put the idea in someone's mind by asking.

What if the person admits he is considering suicide? Your job is to determine how serious the situation is. Some high risk factors to consider are listed below.

STEP TWO

Ask the person if he has a plan. The more concrete the plan, the higher the risk. If the plan is workable and the person has the method, he is a very high risk.

Increased Risk Factors

- History of suicide attempts. Talk about the last one and this one.
- A person who feels his loved ones would be better off without him or would not miss him.
- A person who has suffered recent losses of any kind.
- Alcohol or drug involvement.
- A person with health problems or who is on medication.
- A person who lives alone.
- A hostile person is a higher risk than one who is passive or has only a few hostile thoughts.
- The longer the person has had suicidal thoughts, the higher the risk.
- A person who is disoriented, disorganized, or confused.
- A person who knows someone who was successful in a suicide attempt.
- A person who seems to feel that nothing, including counseling or therapy or "anything" can help.
- Family members during a divorce.

Responding to Suicide

PLEASE NOTE:

- Take all threats seriously.
- Never leave the person alone on the line.
- Determine patient's current state.

ASK:

1. Have you been thinking about suicide?

2. Do you have a plan?
3. What is your plan?
4. When do you plan to do this?
5. Do you have a gun? Where is it?

How to Gain Trust

- Don't try to talk them out of their feelings. Acknowledge the desire to die and encourage ambivalence. Be honest about your feelings. Be prepared for resistance – be calmly persistent.
- Create a safe environment – ask them to put away weapons or drugs. Don't moralize or judge.
- Take your time – don't interrupt the caller if at all possible.
- Take care of yourself – you may be traumatized, communicate with others about how you feel.

Suicidal Subjects

There are several ways you may become aware of a suicidal incident. Depending on the source and the amount of information gathered, the deposition varies.

FAMILY MEMBER OR FRIEND CALLING

If the information of a threat of suicide is received from a secondary source, you must interrogate to determine the scope and severity of the problem in order to determine what action, if any, you can take:

Where: Where was the subject the last you heard?

Where is the subject going?

Where could the subject be going?

Where does the subject live?

Where is the caller?

When: When did you last hear from the subject?

When did the subject make the threat?

When did the subject leave?

How long ago did the subject take the action?

What: What do you believe the subject is going to do?
 What means does he have to complete the act?
 What happened to bring this on?
 What did the party say to the caller?
 What is the patient's history of suicide attempts?
 What does the caller feel about the severity of the threat?
 What weapons or medications does the party have access to?

Who: Caller information
 Subject information, full description
 Vehicle information

CRISIS CLINIC CALLING

If the crisis has the suicidal subject on the line, that Call Receiver will keep the subject on line and relay the information to you. The crisis clinic will generally not call unless the Call Receiver feels the party has already done something harmful to himself or is a threat to another. The crisis clinic will relay the information to the police or fire department when there is a good address.

The crisis clinic usually is required to call the police or fire department back for a follow up on the relay. Locate your agency's guidelines on this.

SUICIDAL SUBJECT CALLING

Things You Can Do

Manipulate – emphasize the future – breach confidentiality – use others – use the fact they called for help – take all threats seriously – tell them they don't want to die – listen and clarify – lie if necessary – be honest about your feelings – be empathetic – be persistent – tell the person you care – care – talk about other subjects – get a commitment from the person.

Things You Can't Do

Dismiss threats – play down the caller's feelings or pain – leave the caller – whisper to others – tell the person they are being selfish – tell the person they are being coward – engage in

philosophical or moral arguments – sound shocked by anything the person says – judge – dare the caller to go through with it – tell the caller they are only trying to get attention – give up – blame yourself if you are unable to help.

Now John and Peter will demonstrate a simulation of a caller who might be thinking of committing suicide.

Simulation 6

Dispatcher – What is your emergency?

Caller – I am going to commit suicide. I am in a 5 story building standing on the ledge.

Dispatcher – You are standing on a ledge?

Caller – Yes. I will jump

Dispatcher – How may I call you?

Caller – Call me Michael. I will kill myself. There is no sense in living. Had a small company. It's bankrupt 10 employees of mine will not get their paychecks, my house is mortgaged, I owe money everywhere to creditors. What's the point, there is no way I can escape this. The banks will foreclose on my business, they will take my house.... my children 4 of them will have nothing to eat. Can't face this reality. I can't be there to watch this go down. My wife and children have no idea. They don't know what's happening. I am so cut, in so many ways.

Caller stays silent for a second. It gives the opportunity to Dispatcher to utter his words. Remember we don't interrupt.

Dispatcher – You are dimply hurting.

Caller – More than anyone can imagine.

Dispatcher – Is there any other way?

Caller – None I can think of.

Dispatcher – Have you talked to people that specialize in restructuring banks?

Caller – None cares

Dispatcher – And you are where is your work now?

Caller – Yes in the building. I am on the rooftop.

Dispatcher – Michael, if I may. It is always very hard. May I ask you where you are?

Caller – Don't try to persuade me away from this. I will do it.

Dispatcher – What if I could sent someone that you can talk.

Caller – It does not matter. What do you care anyway?

Dispatcher – Caring is what we do here.

Caller – Nobody cares man.

Dispatcher – Maybe some people do. What is your location?

Caller – Why should I tell you so that you will sent the fire department and police?

Dispatcher – No. We can handle it discreetly. It is very difficult. Your situation might not look so easy, but what if there is another way. What if you didn't look into all your options? Other people called in same situation as you did and there were solutions but did not know of it. What might be your location?

Caller – I don't know if I should tell you.

Dispatcher – I will be discreet.

Caller – No I will kill myself. I will jump

Dispatcher – What if there are other options. I understand your will to die, though what if there was another way.... away out of these many complex problems you face.

Caller – Don't know. I will be the laughing stock of everyone if I don't kill myself.

Dispatcher – It is not easy. What you are saying it might be true but what if there is also other parts that you may miss. Let us look other options or choices. There are always choices, sometimes emotions blind us and we do not see them. Where are you located Michael?

Caller – 83st between Famagusta square and Efxinos kiosk. What are you going to do?

Dispatcher – Give you the option to see things through before you attempt something irreversible.... there are always different ways to go about. It just might be the case that you have not seen things clearly. What if I sent someone to have a conversation with you?

Caller – Don't know. You are not going to trick me?

Dispatcher – What is to prevent you from killing yourself later if I will trick you I will not. I can't even if I wanted. I wish to assist. I don't know all the facts, don't know what it is to be on your position or financial situation. I will not try to patronize you. I only wish to assist.

Caller – Hope you don't lie to me. Don't want the police to come. Just someone to talk to.

Dispatcher – As you state. It will be so Michael. There are people that can help.

Caller – Don't know. I am not sure.

Dispatcher – Why not give it a chance.

Caller – Okay just send one. Only one person.

Dispatcher – Will do. Please stay though with me. Someone will be there soon.

The dispatcher passes the message to all relevant departments while he keeps Michael talking on the line. Simulation ends.

Part 2

MEDICAL CONDITIONS

The following general information about medical conditions supplements your EMD training or supplements your knowledge if you are not an EMD.

SHOCK

In medical terms, the condition defined as shock refers to a lack of tissue perfusion because of insufficient blood flow to vital organs. In general, it can be caused by hypovolemia (loss of circulating blood volume), inadequate cardiac function (inability of the heart to pump properly), or vasodilatation (gross enlargement of the arteries and/or veins). The blood is responsible for transporting oxygen, glucose (sugar), and other essential elements to all cells in the body. A reduction in blood flow robs the cells of these essential elements and in four to six minutes the cells begin to die. In an effort to correct the effects of shock, the body's nervous system releases adrenaline with the following results:

1. Rapid heart rate – Increases the flow of available blood.
2. Pale skin – The body shunts the blood from the extremities to the core to protect the vital organs. Cool, sweaty skin – The result of the blood leaving the skin.
3. Confused, agitated mental state – Due to reduced oxygen and other essential elements in the brain.
4. Dizziness, fainting – A lack of sufficient circulating blood volume to the brain when the patient attempts an upright position.

The extent and severity of these symptoms are in direct proportion to the mechanism of the problem. Age, other chronic problems, and medicines taken by the patient may also alter these symptoms.

Anaphylactic shock presents some special additional problems in addition to those found in the other forms of shock. It is defined as circulatory failure from an allergic reaction that occurs after exposure to a foreign substance (antigen). Causes include: injection or ingestion of a drug, ingestion of food (seafood and shellfish, peanuts are common sources), insect stings and bites, x-ray contrast agents. Reactions can occur within minutes after exposure to these substances. Disturbances to the skin, respiratory system, circulation, soft tissue, and gastrointestinal system may be involved.

SKIN: Raised, red rash; itching, especially of the face, upper chest; hives may spread over large areas of the body; swelling of the face, tongue, throat, eyelids, and lips; cyanosis (purple color) may be visible around the lips.

RESPIRATORY SYSTEM: Wheezing and stridor (musical wheeze with inhalation) with difficulty breathing may develop. Fluids in the bronchi cause a persistent cough. Constriction of the smaller bronchi causes wheezing and swelling in the upper airway creating the stridor. Complaints of tightness in the chest are common.

CIRCULATION: Dizziness, fainting, and unconsciousness may result from a rapid drop in blood pressure and circulating blood volume.

Reactions can be as mild as minor itching with associated rash to death in minutes from respiratory obstruction and vascular collapse. In general, persons who are re-exposed to sources that have caused reactions in the past can expect the problem to become worse with subsequent episodes. Usually, the faster the reaction initially presents itself, the worse the reaction will become.

If the caller is the one suffering from the reaction it is important to remember to keep them calm. The more upset the caller becomes the faster their heart rate increases which causes more oxygen consumption, therefore increasing the work load on the respiratory system.

Septic shock, which is vascular collapse brought about by severe systemic infection, is usually seen in elderly, bedridden, or alcoholic patients. Severe infection from any source, such as ruptured appendix, ruptured bowel, severe pneumonia, infected kidney and urinary tract can rapidly spread to the whole body. Patients in nursing homes and bedridden in their homes are prime candidates. The typical signs of shock will be present and pose a life-threatening emergency.

Note children and elderly patients are similar in that their systems will deteriorate faster than a healthy adult. Shock in the elderly patient has a far greater mortality rate.

HOW TO USE SHOCK INFORMATION

It's important to know 'shock' is not an emotional response. Shock is a physical condition. As an Emergency Medical Dispatcher, knowledge of shock symptoms is your best tool to determine

the severity of the medical emergency. The questions you will ask are designed to determine if the patient is in shock. Whatever the illness or injury, shock is one of the main indicators of a pre-hospital emergency. The questions designed in any EMD system will assess the following:

- Level of consciousness
- Adequacy of breathing

After these two main determinants are noted, the extent and severity of shock is the next most important factor in determining response.

Questions relating to illness may include:

- Age, Sex
- History of illness or event
- Medications
- Onset and conditions now
- Volume depletion

Questions relating to trauma are concerned with mechanism and potential. Again, the potential for shock is in proportion to the type and severity of the injury, the results of the injury, or potential for death. Many times the caller is not with the patient but the 'mechanism' indicates severity. Severe cases include:

- Falls greater than 12'
- Head-on/T-bone accidents
- Medication and alcohol overdoses
- Gunshot/sharp or blunt trauma

You will use the information on how shock works and looks throughout the medical test. Watch for questions in your EMD program that relate to shock for that call type.

ABDOMINAL PAIN

By definition, abdominal pain signifies the presence of an 'acute abdomen' which covers a variety of medical conditions that result in irritation or inflammation of the abdominal lining (peritoneum). In general, abdominal pain may originate from problems with the gastrointestinal, cardiovascular, or genitourinary systems.

The organs in the abdomen are separated into two major categories: hollow and solid. Hollow organs are the esophagus, stomach, gall bladder, bile ducts, small intestine, large intestine (which includes the rectum), appendix, urethras, urinary bladder, fallopian tubes, uterus, vagina, and inferior vena cava. Solid organs are the liver, spleen, pancreas, ovaries and kidneys.

Disorders of the abdomen fall into five main categories, and both the hollow and solid organs will produce similar symptoms.

INFLAMMATION The reaction of tissue to injury. Usually it has a history of slow onset over hours or days. Pain is usually steady. Often there is a history of fever or chills. This condition can be life threatening.

HEMORRHAGE May occur acutely or chronically, usually with steady pain. Usually no fever is present. Pain can radiate to one or both shoulders if the diaphragm is irritated. Signs and symptoms of shock may be present.

PERFORATION A hole in a hollow organ. Steady pain of sudden onset is felt. It is always a serious problem. Fever develops several hours after perforation.

OBSTRUCTION Blockage in a hollow organ. Pain is usually crampy as the organ attempts to work against the obstructed area. It is moderately rapid in onset without fever. Nausea and vomiting are common.

ISCHEMIA Complete or temporary lack of blood, and therefore oxygen, to an organ. Steady pain occurs that is sudden in onset, unchanging, and often severe.

In addition to pain, bleeding can occur in either the upper or the lower portions of the gastrointestinal (GI) tract. It may occur suddenly, at a rapid rate, or slowly over a prolonged period.

Vomiting of blood can be frightening as well as life threatening. The signs and symptoms of hypovolemia (shock) will be present when the source of the bleeding is a significant problem. Signs, such as 'coffee ground emesis,' are an indication the source of the bleeding is in the stomach and the rate of the bleeding is slow enough for the gastric acids to change its appearance. Vomiting of frank red blood typically indicates a dangerous source of hemorrhage, such as esophageal varices, a tear in the esophagus, or a perforated ulcer.

Blood-coated, black, and tarry stools usually are indicators of GI hemorrhage that may be serious. Small amounts of bright red blood from the rectum are due to hemorrhoids, and when the blood mixes with the water in the bowl, the volume of blood loss appears more significant than it is. Dark blood is a sign of old blood that is being rejected (as it is not to be where it is). Bright red blood is a sign of new bleeding. Depending on the amount of blood the darker blood is more life threatening.

The signs and symptoms of hypovolemia (shock) are the common indicators of the seriousness of problems related to abdominal pain. An exception can be upper abdominal fullness or steady ache. In males ages 35 and older and females age 40 and older, this discomfort may indicate a heart attack (MI). Often the patient attempts to treat this problem with home products that

control indigestion without success. They may also become pale, sweaty, and lightheaded like the hypovolemic patient.

Sharp or stabbing upper abdominal pain that radiates through to the back may indicate an aneurysm in the abdominal aorta. Patients are usually age 60 and older (classic presentation is a 70-year-old male) and may present initially as a fainting (syncopal) episode due to a rapid drop in blood pressure. The aorta develops a bulge secondary to a weak area in the wall of the vessel. The bulge may develop slowly over a period of months or rapidly in a matter of minutes. Should the weak area rupture, it becomes a life-threatening emergency due to severe hypovolemic shock. If the caller states that there is a pulsating mass in the abdominal area, relay that information immediately to the responding units, and never allow the caller to touch the mass.

HOW TO USE ABDOMINAL PAIN INFORMATION

The severity of abdominal pain usually is not the determinate for an ALS response. The true concerns are:

- Location and description of the pain – cardiac or true abdominal
- Bleeding external – color and amount are severity indicators
- Bleeding internal – indicated by shock symptoms
- Loss of consciousness – indicating possible shock or bleeding
- Age or sex – directly relate to possibilities
- History – either medical, pregnancy, or trauma

Your job is not to diagnose the problem, but to assess the patient over the phone by indicators. You obtain these indicators by asking direct questions or listening to information on how the patient acts, feels and looks. An example of questions that assist the Call Receiver with assessing abdominal pain severity:

Male:

Age and medical history

Location and description of the pain

Does the pain change

Unable to sit up without passing out (shock)

Other signs or symptoms: shortness of breath, dizziness, nausea

Female:

All of the above and:

Possibility of pregnancy

Vaginal bleeding, unusually heavy or clots

BURNS

Burns are divided into four categories and are classified by severity based on their characteristics as defined by the damage they inflict on the patient's skin and underlying tissue/bone. They are further classified into four categories related to severity. They are then separated into three classifications – Major, Moderate, and Minor – which establish their triage priorities.

Burns to the face and/or inhalation of super – heated air and/or smoke are always considered Major due to possible injury to the upper respiratory tract from soft tissue swelling. Patients may not display obvious signs of injury other than singed nostril hairs or sore throat and/or stridor.

Due to their delicate skin and small vascular system, infants and toddlers may be more seriously burned than they appear. A thorough understanding of the mechanism (source) of the burn is vital.

BURN CATEGORIES (TYPES OF BURNS)

Thermal: Burns from contact with flame, hot gases, or hot objects

Electrical: Burns from an electrical charge passing through tissue and bone.

Chemical: Burns caused by caustic substances that have made direct contact with the skin.

Nuclear: Burns secondary to exposure to nuclear radiation.

CLASSIFICATION BY SEVERITY (CHARACTERISTICS OR DEGREE OF DAMAGE)

Superficial: Mild, superficial, requiring little or no medical attention. Affects only the epidermis (outer layer of the skin). Sunburn and mild scald are examples. (First Degree)

Partial Thickness: Blisters with damage to dermis (second layer of the skin) only. Will heal without scarring with reasonable care over a period of days or weeks. (Second Degree)

Full Thickness: Full thickness of skin through the dermis. Presents with black charring or may be dry and white or like leather. Destroys the nerves, so may be painless. If more than small area, will require skin graft to prevent scarring and/or disability. (Third Degree)

Fourth degree: Through muscle and/or bone. Damage not always obvious, as electrocution is often the source. With electrocution, often the only signs of damage are entrance and exit wounds.

BURN CLASSIFICATIONS

Major

1. Second degree burns involving more than 25 percent of adult's body surface or more than 20 percent of child's body surface.
2. Third degree burns involving 10 percent or more of body surface.
3. Third degree burns involving hands, face, eyes, ears, feet, and genitals.
4. All inhalation injuries.
5. Electrical burns.
6. Burns complicated by fractures and other trauma.
7. Burns in poor risk patients; i.e., infants, elderly with severe chronic illness.

Moderate

1. Second degree burns involving between 15 and 25 percent of adult's body surface or 10 to 20 percent of child's body surface.
2. Third degrees burns of 2 to 20 percent of body surface not involving eyes, face, hands, and feet.

Minor

1. Lesser burns not covered by Major and Moderate classes.

HELPFUL INSTRUCTIONS FROM FIREFIGHTERS

- Douse and remove smoldering clothes from patient.
- Wash chemicals off patient with copious amounts of water.
- Brush solid substances (i.e., lime) off patient.
- Treat other injuries as any other injured patient.
- Treat shock the same as any injured patient.
- Cover burns with dry dressings or sheets (sterile if possible). Minor burns can be covered with a cool towel.
- Do not apply ointments, sprays or creams to burns (unless minor).
- Keep patient warm.
- Do not apply ice to burns.

HOW TO USE BURN INFORMATION

Moderate or minor burns do not require an ALS response. In your questions to the caller, you must be able to quickly assess the extent and area of the burn. Asking the caller what percent of the body is burned probably will not be effective. However if you are asked to get this information and a Rule of Nine Chart is not available it can be quickly determined by the patient's palm. Each palm size burn is approximately one percent of the body. The EMD is concerned with:

- Adequacy of respiratory system – burns or inhalation
- Potential for shock
- Potential for further injury to the patient – extremities involved, chemicals, explosion, electrocution
- Cause – Is there danger now? Fire out?

CARDIOVASCULAR CHEST PAIN

This section deals with chest pain as it relates to the heart and vascular system.

HEART ATTACK (MYOCARDIAL INFARCTION)

An acute myocardial infarction (MI) occurs when there is a sudden blockage (known as a thrombus or blood clot) of a coronary artery, which supplies blood to the heart muscle (myocardium). The clot is formed secondary to narrowing of one or more of the coronary arteries due to arteriosclerosis. This condition is known as coronary artery disease (CAD) and occurs when the arteries develop cholesterol deposits, scarring, or calcium deposits which gradually build up over a period of years. This disease may begin at an early age and may strike persons in their 30s and 40s. The acute stage is most common in persons in their 50s and older.

An MI is an acute medical emergency because the MI patient is at risk from three very serious complications: sudden cardiac arrest, cardiogenic shock, and pulmonary edema. The MI patient is also prone to develop lethal cardiac arrhythmias, which occur most frequently in the first hour. These arrhythmias often cause cardiac arrest without warning.

MI pain is usually a very intense, continuous pain that is located under the sternum. It may radiate down the left arm or to both arms, the jaw, neck, back, and sometimes may be centered in the stomach. The pain is often described as crushing, squeezing, heavy, tight, stabbing, or aching.

The pain may have started while the patient was sleeping, at rest, or sitting quietly. Nitroglycerin, rest, or antacids will not relieve the pain.

The patient often appears pale and sweaty (diaphoretic), is anxious, and complains of SOB, nausea (with or without vomiting), weakness, dizziness, and palpitations. Often the SOB (dyspnea) is the result of left heart failure, which causes pulmonary edema to form in the lungs.

A small percentage of patients may experience a “silent MI.” These patients will not complain of chest pain, but instead will describe a fullness in the stomach area and often comment that if they could just belch, the problem would go away. Their only other complaint may be sudden SOB, lightheadedness, or generalized weakness.

ANGINA PECTORIS

Angina is a symptom of coronary artery disease and is caused by a reduced blood supply to the heart muscle. The pain occurs when the need of the myocardium for oxygen temporarily exceeds the available supply of oxygenated blood. Thus, the pain is triggered by physical exertion, emotional stress, and extreme temperatures and is relieved by rest, nitroglycerin, or a change in the environment. The pain usually lasts for 10 to 15 minutes as the artery is only narrowed, not completely blocked, as with an MI.

CONGESTIVE HEART FAILURE (CHF)

Congestive heart failure (CHF) occurs when one or both of the ventricles in the heart lose pumping efficiency. The right ventricle is responsible for accepting blood from the venous side of the vascular system and when it fails, the blood backs up in the venous system causing fluid to accumulate in the soft tissue of the extremities and abdominal organs. Failure of the left ventricle causes fluid to accumulate in the lungs (pulmonary edema).

The most common cause of CHF is an MI. As most MIs affect the left ventricle, pulmonary edema becomes a frequent side effect of serious MI's and is often severe enough to be life threatening. Other causes of CHF include cardiac rhythm disturbances; high blood pressure; fluid overload from various sources, such as excess salt in the diet; or heart valve disease.

Other acute causes of chest pain, as it relates to cardiovascular problems would present with MI-type symptoms. These would include pericarditis, hypertension, and thoracic aneurysm.

HOW TO USE CHEST PAIN INFORMATION

The patient will have signs and symptoms; the information provided here is not to assist you in assigning a cause to the patient, but to give you knowledge that the differing symptoms and signs are indicators. Recognizing the indicators over the phone can be accomplished first by understanding what they mean and knowing what questions to ask. It is important that the Call Receiver understand that cardiac problems can rapidly progress to death. The EMD must be trained and efficient with Dispatcher – assisted CPR. The rationalization that CPR cannot be given over the phone by a one-person agency is faulty. It has been done; lives have been saved. It may not always be possible, but that is not a reason to disallow the system.

- Recognize the symptoms of cardiac problems
- Dispatch ALS
- Stay on line for changing conditions

- Pass on all information to responding units

DIABETES

One of the main sources of energy in the body is glucose (sugar). Without it, the body's furnace will not function properly. Diabetes mellitus is an inherited disease affecting the production and/or utilization of the hormone insulin from the pancreas. Without insulin, the body's sugar will not break down to a usable form and will cause either hypoglycemia (too little sugar in the blood stream) or hyperglycemia (too much sugar in the blood stream).

Diabetes is controllable through diet, oral medications that stimulate insulin utilization or production, or by using insulin injections. Diabetics using insulin need to balance the amount of insulin used with proper food intake. Their lifestyle can also affect the control of insulin with the body's demand for glucose. The diabetic must be able to make adjustments in both as the need arises.

HYPOGLYCEMIA (INSULIN SHOCK)

In hypoglycemia, the glucose is used up by the body cells faster than it appears in the blood stream. This condition can be the result of too much insulin or too little food.

The onset of hypoglycemia is usually very rapid, although it may be slow if the patient is taking long-acting insulin. If conscious, the patient may relate a history of taking regular amounts of insulin, but exercising strenuously, dealing with high stress, or not eating. Common symptoms are headache, dizziness, confusion, weakness, and hunger. It is vital to understanding the diabetic's problem to know whether they have eaten today and also taken their insulin or medication.

Conscious patients may also display behavioral problems, such as: disorientation, lack of coordination, confusion, irritability, or hostility.

If the patient is unconscious, the history may be difficult to obtain. Usually the only information that is reliable is whether the onset of symptoms was rapid (over minutes) or gradual (over hours or days).

Signs of low blood sugar include drooling; pale, cool, moist skin; full, rapid pulse; normal blood pressure and respiration; and seizures in the late stages.

HYPERGLYCEMIA (DIABETIC COMA)

High blood glucose accumulates in the body because it is not being utilized. This condition occurs when the amount of insulin in the body is not adequate or is not adequately used by the body. When the body cells are not able to utilize glucose for energy, fat is broken down, and the waste products of ketones (such as acetone) and acids are produced. For that reason, this condition is also called ketoacidosis. It may occur when a diabetic patient fails to take insulin or

other diabetic medications, or when the body is challenged by some unusual stress, such as infection.

The body produces extra urine in an attempt to eliminate the extra sugar circulating in the blood. This fluid loss, combined with the acidosis, causes coma. The dehydration can also cause hypovolemia and hypotension. In an attempt to correct the acidosis, hyperventilation occurs.

The onset of hyperglycemia is generally gradual, over 12 to 48 hours. The chief complaint will often be abdominal pain, with nausea and vomiting. The patient may also complain of intense thirst, increased urination, a recent infection, or fever.

If the patient is unconscious, the history may be difficult to obtain. Signs of high blood sugar include warm, dry skin; rapid, deep respiration; rapid, weak pulse; possibly lowered blood pressure with postural hypotension; and possibly a sweet fruity breath odor which smells like fingernail polish remover, or alcohol.

HOW TO USE DIABETES INFORMATION

From the above, the student can extract many signs and symptoms of a diabetic who is ill. If the patient is a known diabetic and having signs and symptoms that indicate a reaction, an ALS response will generally be initiated. If the signs and symptoms sound like a diabetic reaction on a patient who is not known to be a diabetic, the ALS or BLS response will be determined on the severity of the symptoms:

- Level of consciousness
- Adequacy of breathing
- Condition now
- History, onset, insulin or other diabetes medication taken, food eaten

ELECTROCUTION

Electric shock has the potential for two separate effects on the human body. One can be seriously burned as a result of the electricity traveling through bones and muscles. The second is the effect electricity has on the electrical conduction responsible for controlling heart beats.

The body produces significant amount of resistance to the passage of electricity. This resistance produces heat and results in burns to the tissue through which the electricity is travelling. The bones of the body are natural conductors for electricity causing the charge to travel under the surface of the skin. For this reason the only visible signs of electrocution may be an entrance wound in one part of the body surface and an exit wound in some other location. Usually the

entrance wound is located at the electrical source and the exit wound at the part of the body nearest an external ground that is a better conductor than the body.

For this reason, the patient may appear to have minor burns on the skin surface, but the destruction to the tissue under the skin may be extensive. Therefore, electrocutions should always be considered life threatening until proven otherwise by qualified medical personnel.

The heart is stimulated to beat, thereby producing a pumping action, by periodic electrical impulses. The addition of significant electrical impulses from an outside source can alter the normal periodic heart rhythm and result in an uncoordinated beating called fibrillation. The effect on the ventricles of the heart is the complete loss of circulating blood due to cardiac arrest.

Common sense says that the higher the voltage/amperage of the electrical source the more potentially serious the injuries; but age, chronic illnesses, etc., may also determine the severity of the problem. Simple 110-volt house current can be deadly, depending on the combination of factors involved.

HOW TO USE ELECTROCUTION INFORMATION

In addition to determining the condition of the patient, the Call Receiver should ask the circumstances of the electrocution. Responding units need to know if they will encounter live electrical lines or other dangers. EMDs should also recognize the potential for injuries that are not visible to the caller.

- Patient conscious?
- Patient breathing normally?
- CPR in progress?
- Any visible injuries or complaints?
- What was the source and is it off?

DROWNING AND NEAR DROWNING

Drowning is death in or under the water. Near drowning is submersion under water that does not result in death.

Drowning occurs in a predictable series of events. Initially, large amounts of water are often swallowed. Small amounts of water in the upper airway and the voice box cause coughing and laryngospasm, closing off the trachea (windpipe). If the victim is rescued at this point, there will be no water in the lungs. Laryngospasm makes further attempts at breathing useless, whether the victim is under water or at the surface (it also makes rescue attempts at this stage difficult). Lack of breathing results in hypoxia and unconsciousness. Eventually, anoxia cause muscular relaxation and the laryngospasm will cease, allowing water to fill the lungs.

Even though the body reacts differently to fresh water than to salt water, the end result is the same. What does make a difference in treatment rationale is a history of near drowning in cold water. Victims have fully recovered after 40 minutes of complete submersion in cold water. Cold-water near drowning causes hypothermia (lower than normal body temperature). The medical community does not consider these patients dead until they are warm and dead.

Bystanders are often not completely reliable sources for estimating the time of submersion, although that estimate should be solicited if possible. Family or friends may relate other aspects of the incident, such as a dive into shallow water, alcohol or drug intoxication, or important past medical history.

All near – drownings, regardless of the time of submersion, should be seen by a physician. Delayed side effects, such as pulmonary edema, can develop some time after the actual incident and can be life threatening.

When receiving a call for an emergency response to a drowning, you should attempt to get information on the circumstances. You will take into consideration the surroundings – a river where diving occurred, a pool with a lifeguard, a bathtub and a baby.

- Is the patient in or out of the water?
- Is the patient conscious?
- Is the patient breathing normally?
- Is CPR in progress?
- Any other injuries? (if applicable)

If the patient was submerged, it is essential that a response is initiated and the person is transported to medical care, even if the patient appears to have no medical problems.

NEUROLOGIC DISORDERS

Neurologic disorders, excluding those related to trauma, most commonly include the following categories: stroke (CVA), cerebral aneurysm, and seizures secondary to cerebral insults. Other cerebral insults, such as cancerous tumors and exotic diseases, will be defined by past diagnoses and should be dispatched based on their affect on the major body functions; i.e., unconsciousness, respiratory function, etc.

STROKE (CVA) BRAIN ATTACK

A cerebrovascular accident (CVA) is the result of a lack of blood flow to a portion of the brain. The part of the brain that is damaged will determine the victim's signs and symptoms. Damage to the brain from a CVA can be extensive enough to cause death, but typically the victim

demonstrates a gradual return to normal or may be left with a reduced, but improved, function of the affected area.

Three distinctly different mechanisms can cause a CVA:

1. A clot may form in a cerebral artery causing a blockage of blood flow. This clot (thrombus) is the result of damage to the wall of the artery and is usually from atherosclerotic vascular disease.
2. A wandering blood clot (embolus) lodges in a cerebral artery, blocking blood flow. Usual sources are heart valve disease, cardiac arrhythmia (atrial fibrillation), sickle cell disease, or rarely, birth control pills.
3. Haemorrhage into brain tissue from rupture of a cerebral aneurysm, usually associated with high blood pressure (hypertension).

A thrombus is the most common source of CVA and is the result of chronic atherosclerosis disease of the arteries. This disease usually takes years to develop and therefore elderly men and women are usually the victims.

Rupture of a cerebral artery may occur in the young or the old. In the elderly, it is normally associated with hypertension (high blood pressure). The young typically have a congenital weakness and the rupture of a cerebral aneurysm is often fatal.

In general, each of the three mechanisms provides a different clinical picture. The victim of a thrombus may have a mild headache, with slowly evolving symptoms of one-sided weakness, a past history of atherosclerosis, and may have had one or more transient ischemic attacks (TIA) – ‘little strokes’ – in the recent past. An embolus is usually of sudden onset, with moderate headache, one-sided weakness, and history of heart disease or chronic atrial fibrillation. Arterial rupture is sudden in onset, produces severe headache, loss of consciousness, seizure. Victims often have a history of hypertension.

It is important for the EMD to realize that a Stroke (brain attack) is just as life threatening as a heart attack. Pre-arrival instructions may not be available to change the condition of the patient (such as CPR) reassurance for the patient and the caller can alleviate more stress, which could increase their hypertension.

CEREBRAL ANEURYSM

Much of this subject was covered in the section on CVAs, but it is important to stress that this is also a disease of the young. Sudden onset of severe headache with altered levels of consciousness, visual disturbances, with or without related seizures, should be considered a serious threat.

Seizure

Febrile seizures are the result of fever in infants and children (up to eight years old). Usually temperatures which exceed 103 degrees Fahrenheit are the source, but it is sometimes related to how rapidly the fever rises. Typically, the seizure will last about as long as other grand mal episodes, but may continue for a number of minutes. Like the adults, status seizures may result and can have the same effect on children. Normally, the seizure assists in reducing the fever and the patient needs to be seen by a physician to treat the source of the fever. Infants and children do not always present with obvious tonic-clonic movement. All the witness may see is a slight twitching of an extremity and/or unusual eye movement. The patient will not respond to stimulus.

In addition to the convulsions, the adult grand mal will include dilated and unreactive pupils, loss of bladder control, temporary purple color around lips/face which returns rapidly to normal when the seizure stops, and blood around the mouth from biting the lips or tongue.

HOW TO USE NEUROLOGIC INFORMATION

In assessing the ALS needs of a neurologic emergency, the EMD must concentrate on critical symptoms.

Level of Consciousness

The seizure patient will NOT be described as conscious or breathing normally as they are not able to respond either during or after the seizure in the postictal stage. In this stage, the patient will be in a state of semi-consciousness, which is normal for seizure activity. Jerking, rigid, gasping, eyes rolled back, stiff are all descriptors used for the person in seizure. Generally, seizures are not an ALS response unless the patient is currently having a seizure or had three or more seizures within a few minutes of each other.

Breathing

Seizure patients are not breathing normally during the seizure. The question “breathing normally” should be used for a postictal seizure, when you are concerned about respiratory distress or arrest due to the seizure activity. Many times babies in seizure come in as “baby not breathing”.

The EMD may receive the call as a known seizure or stroke, or may have to assess the symptoms and signs listed above and determine the severity. Every person has a seizure threshold; therefore, the causes for seizure are many.

Seizure Questions

- History of seizure. First time today?
- Pregnancy, head injury, brain tumor history?
- If epileptic, is this seizure different?

- Febrile seizure, age, seizure history.

OTHER NEUROLOGIC EMERGENCIES

Suspected CVA History of CVA or heart problems? Respiratory difficulty?

Head Pain Sudden onset? Duration? History of migraine?

Related symptoms?

ENVIRONMENTAL EMERGENCIES

HEAT AND COLD

Disorders as a result of exposure to heat include fainting (heat syncope), heat cramps, heat exhaustion, and the most severe form, heat stroke. In all cases, the patient should be removed from the heat source to a cool environment. Fainting, preceded by generalized weakness, dizziness, rapid pulses, hypotension, and muscle cramps are symptoms common to these disorders.

Heat Syncope

This condition is usually the result of a victim who has been standing in a warm environment for a prolonged period. The victim's venous system enlarges causing their blood to pool. The venous pooling reduces the blood flow to the brain and the victim faints. The victim is unconscious for a brief period until the blood flow increases to the brain from the victim lying in a horizontal position. Providing the syncope does not aggravate other chronic conditions that the victim might have, the victim will return to normal without assistance. Secondary problems as a result of the victim sustaining injury from the fall must also be a consideration.

Heat Cramps

As the title implies, the victim's chief complaint will be muscle cramps. These cramps may range from a tingling to severe contractions and are usually located in the extremities and/or abdomen. The typical victim is an individual who is exercising and has replaced sweat loss with water only and as a result becomes salt-depleted. This condition is usually revived with a cool environment and oral replacement of water and electrolytes.

Heat Exhaustion

Heat exhaustion occurs when the victim cannot lose heat rapidly enough (through evaporation of sweat and dilation of the vessels in the skin surface) to compensate for the rapid heat gain. Typically, the victim is involved in strenuous exercise, but this condition may occur in the elderly or inactive. Victims complain of weakness, dizziness, and nausea. Common signs are cold, clammy, pale skin with a weak, rapid pulse. The victim will not be able to remain upright due to hypotension. The victim should be placed in a supine position with elevated extremities. This condition requires fluid, electrolyte replacement and hospitalization.

Heat Stroke

Heat stroke is the second leading cause of death in athletes. The body's temperature mechanism is unable to keep up with the heat generated by strenuous exercise (especially under humid conditions which reduce the amount of heat lost by evaporation from sweating). Rapid dehydration from excessively high temperature also affects the elderly, obese, and those patients taking medicines which cause a loss of body fluids. Other chronic diseases produce classic heat stroke even without exercise. The problem may be gradual in onset, but the victim can collapse suddenly and become comatose rapidly.

The primary sign of victims of heat stroke is skin that is hot and dry to the touch. Victims with exertional heat stroke may have moist skin with full pulses and a normal blood pressure. Classic heat stroke patients demonstrate typical signs of shock without the moist skin. Delirium, seizures, or coma may be present. This is a life-threatening emergency.

Heat Stroke is often discovered in elderly patients who live in an apartment with no cooling systems. Their bodies can no longer control their temperature, and thus lose the ability to sweat. Patients present very hot to the touch, dry and flush skin. These patients need ALS support.

Hypothermia

Hypothermia, or generalized body cooling, occurs when the temperature of the core of the body (the internal organs of the trunk) is below 95 degrees Fahrenheit and is divided into three main categories.

Acute hypothermia Occurs when a victim has been immersed in cold water and becomes very quickly cooled, Thin persons, especially children, are at risk for rapid heat loss from cold water immersion. Immersion hypothermia can occur in water as warm as 70 degrees Fahrenheit

Sub-acute hypothermia Occurs when a person is exposed to a cold environment, usually outdoors, without adequate insulation, shelter or food. Hikers and hunters can die in outside temperatures of 50 degrees Fahrenheit, especially if unexpected wind and rain develop.

Chronic hypothermia Occurs when elderly victims, or persons with chronic diseases, are exposed to cold over an extended period, usually in-doors in poorly heated homes. Alcoholics also can develop hypothermia because of decreased sensitivity to the cold, as well as vasodilatation induced by alcohol.

Typically, generalized body cooling progresses in five stages:

1. Shivering, which is an attempt by the body to generate heat
2. Lethargy, sleepiness, indifference to their plight.
3. Unconsciousness with a glassy stare, slow pulse, and respiratory rates.
4. Freezing of the extremities.
5. Death.

Hypothermia can be a life-threatening emergency and the patient requires special care to see that they are treated and rewarmed properly.

HOW TO USE ENVIRONMENTAL INFORMATION

Understanding the ALS response on environmental emergencies, the EMD can question to determine the severity of the patient's condition.

- Level of consciousness
- Adequacy of breathing
- Other injury
- History of the event
- How long in the heat or cold
- May use pre-arrival instructions

RESPIRATORY DISTRESS

The actual definition of respiratory distress is very straight forward. It is the cessation of normal breathing or the reduction of breathing capability to the point that the oxygen intake is not sufficient to satisfy the needs of the body. The problem is the average lay person either does not recognize that slow, agonal, respirations are not adequate to maintain life; or they exaggerate the actual condition of a person who is in minor distress and is just excited or looking for sympathy. As a result of this confusion, the prudent course is to understand acute respiratory problems and their critical symptoms in order to make the best judgement possible under any given circumstances.

Normal breathing functions in two phases. The inhalation (inspiration) phase is an active process causing the chest to expand, which in turn expands the lungs and the diaphragm, at the base of the lungs, flattens out causing the bottoms of the lungs to expand. This series of movements cause a reduction of the internal pressure in the chest and results in air traveling

into the lungs. The second phase is basically passive. The chest and diaphragm return to their normal size which causes exhalation of the waste gases brought to the lungs by the blood. Any disease or mechanical condition which alters this function either creates a lack of inspired oxygen or a retention of waste gases. Either of these conditions can cause a serious effect to the body and may result in severe impairment or death.

ASTHMA

Asthma is a disease manifested by bronchial constriction and/or excessive mucus production. The patient often has a history of similar attacks in the past and is usually on an inhaler or bronchodilator pill to be used when they sense an oncoming attack. Episodes are brought on by an outside sources, such as pollen, smoke, dust, stress, exercise, pollutants, and other allergens. The bronchi will increase in diameter with inhalation, but they collapse during exhalation. This condition causes pronounced wheezing and an extended, forced expiratory phase. These patients may have been battling the problem for many hours or even days. They usually call for assistance when their medicine can no longer control their symptoms, or they just become exhausted. Typically, these patients are known to be asthmatic. Because they have a good understanding of their problems, their call for help implies a medical emergency.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic Obstructive Pulmonary Disease (COPD) is divided into two categories: chronic bronchitis and emphysema. Both of these diseases involve progressively destructive changes in the lungs. Like asthma, patients will give a long-standing history of the disease.

Chronic bronchitis is defined as a productive cough for three months of the year for at least two consecutive years. In chronic bronchitis, the lungs produce an excess of mucus and have difficulty expelling mucus from the bronchioles. The carbon dioxide (CO₂) retained in the lungs creates pulmonary hypertension, which can lead to right heart failure.

Emphysema is characterized by decreased elasticity of the lung tissue, resulting in distention of the alveoli which become filled with trapped CO₂. Severe scarring of the lung tissue may also be a result of this disease.

Like the asthma patient, air pollution, stress, or any additional insult to the lungs may push this patient into severe respiratory distress. They will also be able to give a history of this problem. Again, because the patient understands the disease, the call for help must be appreciated as a serious emergency.

PULMONARY EDEMA

Pulmonary edema is an accumulation of fluid in the lungs. The most common cause of this problem is left ventricular heart failure. The most common source of damage to the left ventricle is a myocardial infarction (MI). When a portion of the muscle of the ventricle is

damage, it also reduces its ability to pump the blood out of the heart as fast as normal. The blood backs up into the lungs and the blood loses fluid through the alveoli. This fluid interferes with the normal exchange of oxygen and carbon dioxide causing acute shortness of breath.

Other less common causes of pulmonary edema include conditions which damage the alveoli directly: smoke inhalation or other toxic inhalation, near drowning, aspiration, pneumonia, or infection.

Usually, pulmonary edema takes hours to develop, but may come on rapidly as a result of an MI. Typically, the patient suffers the problem at night when lying down because the heart is unable to process the return of blood from their lower extremities quickly enough. Patients are often forced to sleep in a semi-reclining position in order to reduce the volume of blood return to the heart. Because the patients may wait until they are in serious distress and/or the problem may be secondary to an MI, they should be considered a medical emergency.

OTHER CAUSES

In addition to these most common, serious medical emergencies, a constant vigilance must be maintained for the patient who has received any form of insult to the respiratory system:

- All patients who are said to be unconscious must be protected from the most common airway problem: obstruction of their airway by a relaxed tongue.
- An understanding of the patient's surroundings may prove vital; e.g., the child found unconscious while playing around small toys or the adult who collapses while eating, especially if alcohol is involved. Think air obstruction. The persons at the scene may never think of this.
- Any trauma to the throat or chest (front or back). Soft tissue swelling in the throat may not be obvious to bystanders. Any trauma to the chest with increased SOB should be considered a punctured lung (pneumothorax).
- Vomitus or any liquid left in the mouth of an unconscious patient may block the air passage. It is important to remind bystanders of this while they are awaiting professional help.
- Severe shock may create an inadequate supply of oxygen secondary to a serious lack of blood flow to the vital organs. Placing the patient's legs higher than the patient's head may direct the available blood to these organs.

Historically, the proper management of airways and oxygenation are the most neglected aspect of patient care, especially by the general public. It is therefore vital to take an aggressive posture in this most vital of areas.

HOW THE RESPIRATORY INFORMATION

Breathing is essential to life. If the cause for the respiratory difficulty cannot be alleviated and the patient worsens, the patient may be in danger of death. Most respiratory distress problems cannot be corrected in the field with the exception of choking or other airway blockage than can be removed.

ALL respiratory problems are ALS responses. Shortness of breath in which the patient is able to speak in full sentences or count to 10 without difficulty are not considered ALS emergencies. (Why is this patient really calling?) In some cases, the EMD must be alert to any condition where there is potential for a worsening condition. All patients in respiratory distress should be monitored until the aid crew arrives.

Whether the caller appears to be hyperventilating is not the EMD'S decision. The caller is having a respiratory emergency which needs ALS response. Again err in favor of the patient – the on-scene First Responders or EMT'S can always cancel the Paramedics.

OBSTETRICAL EMERGENCIES

Delivery prior to arrival at a hospital may occur despite the most careful plans. Problems can arise and may cause an unplanned, out-of-hospital birth. Unless the birth is already planned for home delivery, the goal of everyone involved should be to deliver the baby in a hospital if at all possible. As gratifying as assisting a mother to deliver can be, it should be understood there can be serious problems that are better handled in the hospital delivery room.

To obtain a more accurate picture of what stage of labor the mother is experiencing, ask the following questions:

1. "Is this the first baby?" First pregnancies usually have a much longer period of labor.
2. "How advanced is the labor?" Ask how frequent are her contractions. Contractions that are less than two minutes apart are a sign that delivery is imminent.
3. "Has the water broken?" Rupture of the amniotic sac is not necessarily a sign of imminent delivery, but it does indicate that the woman is in the final stage of labor.
4. "Is there a sensation of rectal fullness?" If the mother feels as though she has to move her bowels, this is another sign of imminent delivery. This sensation results from the fetal head pressing against the rectum through the vagina.
5. "Is there a sign of crowning?" Crowning is the bulging out of the presenting part (usually the fetal head) at the vaginal opening.

Pregnancies are divided into three three-month segments called trimesters. When discussing problems related to pregnancy and deliver it is important to establish how far into the pregnancy the patient has progressed as this information can be used to help ascertain specific types of emergencies.

FIRST TRIMESTER

Ectopic Pregnancy

An ectopic pregnancy occurs when the fertilized egg implants outside the uterus, for example, in the fallopian tube. Early in the first trimester it can rupture causing internal bleeding. Severe shock can be the result. The patient will complain of acute lower abdominal pain of sudden onset. Determine if the patient has missed a period and could be pregnant. The patient may or may not include complain of vaginal bleeding or spotting and may also have signs of shock. Women that have had their tubes “tied” are still at risk of ectopic pregnancy. This is a serious emergency.

Abortion

The medical term “abortion” refers to the termination of pregnancy in the first 20 weeks. The abortion may be spontaneous or induced. Miscarriage is the non-medical term for spontaneous abortion. Normally, abortions are not medical emergencies unless they are incomplete and some portion of the placenta is retained; uterine bleeding can then be profuse. In addition, self-induced or criminal abortion can result in perforation of the uterus causing a massive hemorrhage.

SECOND TRIMESTER

Toxemia of Pregnancy (Eclampsia)

Toxaemia occurs when the pregnant woman’s body produces poisons in the blood for reasons that are still unknown. It is most common in the first pregnancy and often appears at about the 24th week. The advanced stage eclampsia is often marked by seizures than can be fatal to both the mother and the fetus.

Obesity, rapid weight gain, and swelling of the face, hands, and feet are characteristic of the early stages of toxemia. As the disease becomes more severe, the patient will complain of headache, visual disturbances, pain in the upper abdomen. The patient will also develop high blood pressure.

THIRD TRIMESTER

Abruptio Placentas

Abruptio is the premature separation of the placenta from the wall of the uterus. There is usually a sharp, tearing pain followed by vaginal bleeding or spotting (although the bleeding may be hidden in the uterus) and the signs/symptoms of shock will progress rapidly. Abdominal trauma to pregnant women can produce this problem also.

Placenta Previa

This condition occurs when the placenta is abnormally located over the opening of the uterus where it enters the birth canal (cervix). When the cervix dilates early in the delivery, the blood vessels in the placenta tear and bleed. Although this is painless bleeding, it can be the most severe bleeding related to pregnancy.

Whenever vaginal bleeding is present, the number of sanitary napkins which are soaked and the rate at which they are filled can be an accurate indication of the actual volume of blood lost in a given period of time.

HOW TO USE OB INFORMATION

Most EMD systems have birth instructions in place. It is a natural process to give birth and has been done since the beginning of time, sometimes assisted, sometimes not. Assisting the caller to get through a new experience with calmness and common sense instruction, and the ability to recognize an obstetrical emergency, should be the EMD's goal.

PEDIATRIC EMERGENCIES

This section deals with the specific emergencies that occur primarily in childhood. Many of the emergencies that affect children are the same as those that occur with adults, but it is vital to remember that children are not miniature adults and require special consideration when dealing with their problems.

Recent studies have shown that infants and small children are especially sensitive to insults that affect their respiratory system in any manner. The primary focus during treatment of the young is the maintenance and control of their respiratory status. During childhood emergencies, everyone concerned with the welfare of the child should be made to understand the importance of maintaining the child's breathing and ventilation. Clues to the pediatric patient with respiratory distress are: respiratory rates over 40 per minute; very slow or very rapid heart rates; skin color that is purple, blue, or gray; and labored breathing that causes the skin to sink between the ribs during inhalation (intercostal retractions); lethargy; or unconsciousness.

A pediatric medical usually involves the respiratory system. Unless congenital problems exist, heart attacks are not to be concerned with. If CPR is needed the mortality rate increases and the change of survival is much less than in an adult.

CROUP

Croup is a viral infection that often follows a cold or other upper respiratory illness. The common age for this disease is 6 months to 3 years. Often the patient will develop a deep, raspy voice in the evening before bedtime. Acute attacks usually occur at night and are the result of swelling of the soft tissue around the larynx (the voice box) which can restrict the flow of air to the lungs causing respiratory distress.

The three primary signs of croup are a high – pitched stridor (wheezing) sound on inspiration; a dry, barking cough; and hoarseness. A low grade fever may be present. Signs of respiratory distress may include flaring of the nostrils and intercostal retractions. Signs of decreased oxygen may include restlessness, agitation, and a very rapid heart rate.

Parents can provide cool, humidified air if available (often cool night air is a good source) while waiting for assistance. Be aware that this problem can be a serious medical emergency.

EPIGLOTTISES

Epiglottitis is a bacterial infection seen in all ages, but most commonly in children 2 to 7 years old. There is often a recent history of upper respiratory illness. Epiglottitis is always considered a life-threatening emergency because the inflamed, swollen epiglottis (the flap of tissue that covers the larynx when food or fluids are ingested) can cause total obstruction of the airway.

The symptoms are of acute onset and the patient may indicate signs of pain during swallowing. The patient is visibly frightened and prefers to sit very still in an upright posture with their chin thrust forward. Drooling is often evident because the patient will not swallow. Stridor will also be present. Other signs may include a high fever, cough, or hoarseness. This patient requires gentle handling and parents must avoid looking in his mouth.

DEHYDRATION AND HYPOVOLEMIA

Volume depletion in infants and children may result from dehydration due to fever, vomiting, diarrhea, or blood loss from a trauma. Relatively small amounts of fluid loss can be catastrophic since there is proportionately less fluid reserve in children than in adults. Signs of blood loss may be obvious, but signs of dehydration may be subtle. Signs may include lethargy, dry lips, decreased skin turgor (skin tends to stay “tented” when pinched), rapid heart rate, and in infants, a depressed fontanel (the soft spot on the top of their head).

HOW TO USE PEDIATRIC INFORMATION

When the caller has a pediatric emergency, it is the EMD’s responsibility to complete the following:

- Assess the child’s present condition
- Recognize ALS needs
- Gather information on child’s or illness’ history
- Monitor the patient for possible changing conditions and needed pre-arrival instructions.

SUMMARY

EMD is an important advancement in emergency medicine. The EMD now provides life saving assistance to those needing medical help. Eventually we hope all emergency medical communications agencies will use pre-arrival instructions for their callers. Like most changes in our society this too can be slow to happen. Mostly the blocks are people who are not aware, uninformed or stuck in their perceptions. We have no hesitancy saying that the EMD saves lives and that EMD should be the standard of care for this profession.

Part 3

DEALING WITH VIOLENT PEOPLE

Intervening in a violent situation involves considerable tact and professionalism. You may be the first contact in a hostage situation or other life-threatening incident. You may have to speak to a violent person who has committed a violent crime or who is considering or capable of violence. Of course we are not 'counseling' anyone, only trying to gain trust and a connection for the purpose of controlling the scene, the caller and possibly protecting life and property. The following guidelines will assist you in your contact.

- Let the person vent what is bothering him. Use good listening skills and empathy. Encourage him to be honest. Accept the caller's feelings. "I can understand how you can feel that way, but I want to help you find another way to solve this problem."
- Try to help the person maintain an element of hope, but don't offer false reassurances. Don't guarantee the police won't take him into custody when they arrive, but keep reminding him there are plenty of people who want to help him work through the problem.
- Remain calm yourself. The person is out of control, and if he senses you are also out of control, he may panic.
- Do not let anything the caller says shock you. Do not let the caller threaten you. Relay any threats to the responding units. **Take all threats seriously.**
- Take your time. Speak slowly. Act quickly.
- Work on making the caller believe you are interested only in helping him, not hurting him. Be sincere and intent. Speak as if the two of you are a team involved in solving a problem.

- Do not allow interruptions in your conversation. One person must speak to the suspect – only one. You must never put the person on hold, whisper, or cover the microphone. Write notes to your partner while you communicate with the suspect.
- Avoid arguments, being judgmental, or analysing the person.
- Assess the severity by asking straightforward questions. “Do you have a gun?” “Where is the gun?”
- Use “I” statements when necessary:
 - “I am worried about the gun, could you put the gun away.”
 - “I want you to go outside and talk to the Officer, and I want you to let the Officer know you are not armed by putting your hands on top of your head.”

ELDERLY & CHILD ABUSE

Elderly and child abuse happens with startling frequency in a surprising number of homes throughout this country. It leaves behind psychological and physical damage. Child abuse is one of the most difficult of all crises for emergency services workers to deal with. Any time you deal with children in crisis, it is emotionally draining for the caregiver. It is almost impossible not to feel intense anger and disgust toward anyone who would harm the helpless for their own needs.

Just how large is the problem? The National Center on Child Abuse and Neglect has put forward some estimates:

- More than one million children are reported victims each year.
- The center estimates that for each child who is reported, two are not, resulting in an estimated two million children who are unreported victims. Some estimate that these figures may be closer to four million.
- One child every four hours, an average of six a day, or 2,000 a year, die as a result of injuries due to abuse.

Signs of Physical Abuse

THERE ARE MANY PHYSICAL CLUES:

- Bruises on the abdomen back, buttocks.
- Bruises that resemble a discernible shape.
- Bruises in varying stages of healing.
- Burns, welts, or bite marks.

- Swelling of the abdomen, vomiting.
- Bald patches, head bumps.
- Rope burns or scratches.

THERE ARE EMOTIONAL CLUES:

- Withdrawn and passive.
- Demanding, aggressive, destructive.
- Too obedient and willing to please.
- Too affectionate to strangers.
- Smaller children cry persistently.
- Dress inappropriately.
- Injuries do not match description of event.

SIGNS OF SEXUAL ABUSE:

- Torn, stained, or bloody underclothing.
- Injuries to the genital area.
- Itching or discomfort in the genital area.
- Blood in urine or stools.
- Difficulty in walking or sitting.
- Complaints of vague medical problems.
- Sexual behavior.
- Fantasy or baby like behavior.
- Irrational fears.

See Police Communications Unit regarding the laws requiring the reporting of child or elder abuse.

RESPONSIBILITY OF REPORTING CHILD ABUSE

The Child Abuse Prevention and Treatment Act and the more recent Elderly Abuse Law make it a requirement for those who suspect abuse or neglect to report it to the authorities. Those provisions include the following:

1. Individuals are bound to report known or suspect cases of child abuse or neglect. Those who work

with children are especially charged with the responsibility.

2. Law enforcement agencies, the courts, and human service agencies are bound to cooperate in the protection of victims of child abuse and neglect. This means you, no matter how vague or unbelievable the report is – ACT ON IT!

3. Those who report child abuse and neglect or suspected child abuse and neglect are given immunity from prosecution under the law.
4. All child abuse or child neglect records are guaranteed to be kept confidential.
5. Under the law, guarantees are made that once a report is received, an investigation will be made promptly and appropriate steps will be taken to protect the child and any other child impacted by the situation.

HOSTAGE NEGOTIATIONS

Most law enforcement agencies have hostage negotiations training and hostage negotiations teams or specialists. Should the Telecommunicator be trained in hostage negotiations? The chances that an emergency communicator would become involved in a communications with the hostage taker is good. Many seasoned 9-1-1 operators have come face to face with this situation. It is not always desirable or possible to hand over the communications to the special teams. Being prepared for such an event includes understanding hostage situations. Although the Call Taker or Dispatcher may never become involved in direct communications, she certainly will be involved in the incident, understanding of the information available is helpful.

Telecommunicator Role

Many 9-1-1 professionals have found themselves talking to a suicidal or homicidal person. In this unit you will learn what brings people to this state and the differing symptoms, signals, and behavior associated with it. This knowledge is great for life – and on the console. What about some help on the console! You find yourself face to face – so to speak – with the homicidal or suicidal person who is also threatening another person, a hostage. The following information describes or categorizes the traits of hostage takers and some ideas on how best to handle them.

Person In Crisis Hostage Takers

Here we will deal with people who are not normally looking for trouble. This time in their lives is either emotionally, psychologically, or mentally out of control and they are dangerous. These people may have been treated for a psychological condition and are possibly on medication, not taking their medication, or ceased treatment. There may be a history of violence, possibly drugs and alcohol are involved. This person may be an abuser; abusers must maintain control. The hostages are usually known to this kind of hostage-taker and in the subject's mind there is a valid reason for this action. Many hostage situations – and the kind the Dispatcher is most likely to come in contact with – are the result of domestic disputes. Remember, in this person's mind, nothing else is working, he cannot cope, he is out of control, and ending it all looks pretty good, considering the alternatives.

The outward condition of this person can be varied. You may encounter confusion, irrational thoughts, anger, frustration, panic. Loud, agitated or slow, depressed speech, or emotional exhaustion may be present. You will have to assess the person's state of mind by what they say and how they say it. This information is vital to the police and medical units standing by. Pass information on regarding speech patterns, physical condition (rapid breathing, stupor), exact wording of any threats, background noises, changes in anything.

If you are speaking to the subject, it may be that hostage negotiators are not available, you have established rapport, or the person refuses to talk to anyone else. It is essential that you give this person all of your attention. If you can avoid operating the radio or any background noise, it is advisable. Any communication on the subject to be passed along can be done in writing. You may have an advisor plugged in and listening, or you may have to handle it alone.

Always remember the hostage's safety. You are dealing with a person who is homicidal and possibly suicidal. The guidelines for speaking to a suicidal person may have to be expanded to include the other lives that are at risk. Also, you have some unknowns – hostages' actions and behaviors now complicate the situation.

If the person is on the phone and the act has not been committed, we can figure there is some ambivalence, a demand that needs to be met, or some other reason the suspect has not completed the threat. We know too well that it is this same act of desperation and crisis that many times ends in tragedy, with no chance to intervene. Intervention is the key word here – to come between, to separate. Your goal is to separate the wish to die or kill from the hope to stay alive and find another way. You are the voice of reason to a person who is unreasonable, the voice of hope to the hopeless, the source of help to the helpless.

Establish Rapport

It is important that the hostage taker develop a trusting relationship with you. They must feel you care. Using first names is important. You should ask their name and give them yours. If you do not feel comfortable giving them your proper name, you may use another if you can be sincere and respond to the name as you would your own. Use the person's name often.

Empathy in Listening

Empathy is accepting the other person's feelings as okay for them, even if they're not the same as yours. To listen effectively you must show unconditional, uncritical acceptance of feelings. The anger or frustration that led to a person being homicidal exists, the homicide is acting out those feelings. To deny someone's feelings as not okay, not valid, and will sever trust and communications faster than hanging up on them. Do not be shocked by a person's desire to act out feelings. Tell them the feelings are okay, but the way he is choosing to express those feelings is not the only choice. Remember, this person has come to this out of choice from a real or imaginary need or simply not seeing any other options.

You will have to be persistent in convincing the person things can change, everything changes, it is possible things could get better.

The second way to cut off communications is to try to minimize a person's feelings or thoughts. "It isn't so bad." "It could be worse." "You are not looking at things realistically." These are all belittling statements. We typically try to make it all better. What we are really saying is, "You are wrong about how you feel, you need to feel the way I would feel." You have now told the person you do not accept or understand them. Tell them it is awful, it must have felt terrible, they must be frightened. This type of acceptance is magical in its affect to disarm the person of hostility.

Determining Severity

These factors are to be considered when involved in a potentially lethal incident:

- Weapons available or used? Type?
- Able to remove the hostage(s)?
- Extent of injuries
- Alcohol or drugs involved
- Mental illness, history of suicide
- Exhibiting hostility or paranoia
- Criminal history
- Relation of suspect to hostage – family, victim?
- Poor concentration, confused, disoriented
- Illogical thoughts, irrational behavior
- Refusal to talk
- Killed before
- Harmed a hostage already
- Concrete plan and time limits
- Expresses self-hatred, hatred for others
- Terminal medical problems or chronic illness

Any and all information must be passed on to the units at the scene. Generally, directions will come from the negotiator. The suspect may have demands. Look to your supervisory personnel or hostage negotiation expert to assist you while trying to assess the scene.

Mentally Disturbed Person

Some of the mental conditions that may cause a person to become violent are:

Psychosis

Paranoia

Mania

Brain disease

Dementia

Hysteria

Manic depression

Schizophrenia

These people are not rational, reasonable, or cooperative. They may be hallucinating, hearing orders, feeling they have a mission, and/or having delusions of persecution. This does not mean you can trick or lie to them. They are alert to any sign of treachery. Just when you feel you have made progress, they may go off the deep end again. This is extremely frustrating.

When dealing with the mentally ill person, never break contact. Persist in your insistence they remain in contact with you. You are the source of help; and even a mentally ill person can understand that. It is difficult to list items that will help with the deranged hostage taker. Showing you care, being persistent, not giving the person choices, and believing what they say are all good guidelines.

Criminal

Criminals may take hostages in the act of committing a crime. This person may be antisocial or a sociopath. His behavior is calculated, manipulative, self-motivated, and dangerous. There is an absence of guilt or remorse, except as it relates to himself. This selfishness may assist you in your dealings with him.

These people are likely to know what to expect from the police and cannot be lied to about what will happen. Negotiations should be reality oriented, helping the criminal see the situation he is in. Convince him to trade his physical safety in return for the release of the hostages. The negotiators will give the criminal options which you will pass along. You may remain the contact for the criminal or the team may take over if the person is stable enough to reason.

Corrections Hostages

Hostage takers who take guards at prisons or jails wish to use people for bargaining. Negotiators try to respond very quickly before the group becomes cohesive and develops a leader. These people have demands and needs. The command unit will certainly direct you if you are the only contact with this type of hostage taker.

Political Terrorists

The motive here is war, publicity, trades, or unciting unrest. Terrorists are usually very well organized and are already a very close group, willing to die for a cause. The risk of killing is extremely high. This is the least likely hostage taker you will come in contact with. If you do,

they will probably demand to talk to the command person (hopefully). Any communication with this person will be strictly business, and relayed information from command.

The Hostages

A group of 9-1-1 graveyard operators volunteered for a mock hostage situation with their police department. Two women and one man agreed to simulate bank tellers taken to an abandoned house after the bank robbers were cornered inside the bank. Police Officers acting as bad guys were the suspects. The SWAT team assembled outside the house and negotiations continued for hours. The suspects were not cooperative and the police were attempting to save the prisoners. The scene was played out to the end. Unfortunately, the male “hostage” was killed in the process. The critique of the events revealed the following surprising conclusions:

- Everyone began to believe their role and act accordingly. There was no horseplay or giggles.
- There was a lot of talking going on by the suspects, none by the hostages. The hostages were not allowed to communicate and were told only what the suspects wanted them to hear.
- The hostages who remained alive had hostility for the police. The police were blamed for the shooting of a fellow hostage (but then, maybe they were cranky from graveyard shift).
- The dead hostage had some of the same feelings. He was relying on the police to save him; they did not.

After the critique, it was clear what had happened and everyone discussed the psychological aspects of being a hostage called the Stockholm syndrome.

Stockholm Syndrome

“Syndrome” is a medical word meaning a set of symptoms. “Stockholm” refers to the city in Sweden. An event in this city in which several female captives were held hostage in a bank caused great revelation into the distorted perceptions of victims. This notable occurrence produced a theory that hostages develop a bond with their captors, even to the point of protecting them.

DOMESTIC VIOLENCE

Many injuries and deaths to law enforcement personnel result from traffic accidents and domestic violence. The Telecommunicators responsibility in domestic violence calls is great – your understanding about the severity of this call type, your ability to control and assess the situation, and your ability to use safety techniques for responders and victims, all add up to a great deal of expertise.

Finding information on domestic violence is not difficult – the most prevalent form of violence in America. As many as 16 million Americans are assaulted by a member of their own family yearly. Nearly half of all marriages are marked by violence between the spouses at one time or another. The most difficult part of understanding domestic violence is asking why do people abuse others in their own family?

Victims of domestic violence may be a child, wife, husband, or parents. Siblings often act violently against one another as well as people who live together in any type of relationship (not necessarily married). Domestic Violence is defined as behaviors among household members (current or past) that threaten to cause, or do cause, serious physical harm.

Why Victims Stay

The reasons men abuse women and women abuse men are both complex and simple. The need to control others and a history of alcohol and drug usage may trigger such abuse, but why does a victim stay with an abusive relationship when it keeps happening and even escalating to the point of possible death? Since the majority of abusive relationships statistics point to women receiving 80% of the victimization in relationships, we will refer to our victims as primarily (but not exclusively) women.

- She feels there is no way out. Her low self-esteem is constantly reinforced so she believes she cannot make it in the outside world. When in contact with this woman, try to help her believe she has more strengths and assets than she believes.
- She is afraid that she is crazy and believes she is the cause of the abuse or will not be able to cope on the outside due to her “illness”.
- She fears retribution. She knows what to expect if she stays, he may kill her if she leaves.
- She has been alienated. She generally has no money or ability to get money, and has been kept from friends and family.
- She feels guilty. It is her fault that her family is not right and leaving would make it worse.

- She is ashamed. She will have to come up with reasons and will not be believed. Besides it is her fault and she doesn't want others to find out.
- He feels like less of a man if he admits his wife hits him. He feels it's his fault.

Clues to Battering

- Multiple injuries
- The abuser will explain the victim's injuries
- Obvious disruption and anger
- Evidence of a struggle in home
- Partner has no sympathy for injuries
- Victim acts guilty
- Inconsistent, illogical reasons for injuries

Battered Husbands

The problem of battered husbands is largely still unexplored. Most husbands will not admit they have been battered because the stigma attached to a male who would let a woman beat him is worse than the beating itself. A woman's attacks will usually do less harm and result in much less serious injury than a man's and therefore is not reported or recognized as readily. With the new domestic abuse laws, men are becoming aware of their rights and the calls for intervention have increased.

The reasons for not leaving may well be the same as the woman's – guilt, fear of ridicule, and low self esteem. Many men feel it is unacceptable to strike a woman even in self-defense and will tolerate much abuse before striking back or seeking outside help.

Battering Wives

The first reaction upon hearing about the topic of battered men, for many people, is that of incredulity. Battered husbands are a topic for jokes (such as the cartoon image of a woman chasing her husband with a rolling-pin). One researcher noted that wives were the perpetrators in 73% of the depictions of domestic violence in newspaper comics, setting us up to downplay violent women as acceptable. But another reason is that because women were seen as weaker and more helpless than men due to sex roles, and men on the other hand were seen as more sturdy and self-reliant, the study of abused husbands seemed relatively unimportant.

While it is true that men typically are the more powerful of the two, have more economic opportunity, control and physical nature – the fact remains that there are violent women who are abusive. Why does she batter and why doesn't he leave? Possibly the dynamics are different and the same. Controlling people will use whatever means necessary to control

because they fear 'losing' control. People who love them often don't want to leave and face many obstacles to leaving. Possibly those obstacles may be different for women than men, however the fact remains that the family dynamics are dangerous.

Same Sex Battering

Relationships are relationships and when a controlling person feels they are losing control of a person and they believe violence to be a possible solution – they will batter. That holds true of any relationship, including gay relationships or mother and daughters, father and son or any intimate relationship regardless of the gender of the people involved.

A Battering Relationship?

Yes, you may be a battered person if:

- You are frightened of your partner's temper.
- You are often compliant because you are afraid to hurt your partner's feelings or are afraid of your partner's anger.
- You have the urge to "rescue" your partner when your partner is troubled.
- You find yourself apologizing to yourself or to others for your partner's behavior when you are treated badly.
- You have been hit, kicked, shoved, or had things thrown at you by your partner when he or she was jealous or angry.
- You make decisions about activities and friends according to what your partner wants or how your partner will react.
- You drink heavily or use drugs.
- You have been abused as a child or seen other family abused.

Yes, you may be a batter if:

- You are very jealous
- You sulk silently when upset
- You have an explosive temper.
- You criticize and put down your partner constantly.
- You have difficulty expressing your feelings
- You drink heavily or use drugs
- You believe it is the male role to be in charge, or you have contempt for women.
- You are protective of your partner to the point of being controlling
- You control your partner's behavior, money, and decisions.

- You have broken things, thrown things at your partner, hit, shoved, or kicked your partner when angry.
- You were physically or emotionally abused by a parent.
- You have a father who abuses (or abused) his wife or the opposite.

Fact or Myth?

TRUE OR FALSE

1. Few women are battered.

False. Battering is still seriously underreported. Statistics in studies of domestic violence show that from 28 percent to 50 percent of women in this country suffer violence in their relationships as adults. For a list of women, children and connected female and male parents who lost their lives to domestic violence go to www.remembermyname.com. The list is staggering.

2. Battered victims are masochistic.

False. “Good wives” are taught to change their behavior to avoid beatings – be less aggressive, less provocative, less frigid. The burden of guilt falls on the victim. It is a myth that women receive some pleasure; often seen as akin to sexual pleasure, when she is beaten by the man she loves. Studies indicate that no woman reports any pleasure in the beating, though many wonder about being masochistic because of the prevalence of this myth. Battered men often do not want to fight back or leave but do not enjoy the violent interaction.

3. Battered victims are crazy.

False. This also places blame on the victim and is related to masochism above. Survival behavior is often mislabelled as “crazy” and overt symptoms such as depression, paranoia, and schizophrenia are treated instead of the actual cause – the battering.

4. Middle class women do not get battered as often or as violently as poor women.

False. Middle class women may have more options than poor women and therefore may use social service agencies less often. They might be more concerned about embarrassment and possible harm to their husbands’ or their own careers. The husband’s status can cast doubt on her credibility. Publicity on battering is bringing many middle and upper class battered women out of hiding.

5. Minority women are battered more often.

False. Information indicates the same amount of battering of all women, but minority women may have fewer resources.

6. Religious beliefs will prevent battering.

False. Some women's beliefs help them endure the violence, and this may be their only contact outside the home. For many though, it becomes a source of conflict with their husbands. Some women seeking help from religious leaders are instructed to pray for resolution and wait for the husband to find God; others find someone who understands and helps them break free of the situation.

7. Battered women are uneducated and have few job skills.

False. Women having education ranging from 5th grade to doctoral and professional degrees were studied and it was found that their self-esteem was dependent on their ability to be good wives and housewives. Even highly educated women did not integrate self-esteem with successful careers.

8. Batterers are violent in all their relationships.

False. In one study only 20 percent were violent with other people.

9. Batterers are unsuccessful and lack resources to cope with the world.

False. There are many, many affluent batterers. One study in England showed police, physicians, and military personnel have the highest incidence of battering.

10. Drinking causes battering behavior.

False. Over half of victims indicate a relationship between alcohol and battering. They also indicate they are beaten whether he has been drinking or not.

11. Batterers are psychopathic personalities.

False. The only trait batterers have in common with diagnosed psychopaths is the ability to use charm as a manipulative technique. Unlike the psychopath, the batterer can feel shame and guilt for actions.

12. Police can protect the battered person.

False. This depends on the victim calling the police and their ability and willingness to respond. One study indicates that in 80 percent of all homicides, there had been from one to five previous police interventions.

13. The batterer is not a loving partner.

False. Batterers are often described as fun loving when they are not being coercive.

14. A wife batterer also beats children.

True. Some studies indicate one-third batter or sexually molest their children.

15. Once battered, always battered.

False. Victims who receive beneficial intervention seldom remarry another batterer.

16. Once a batterer, always a batterer.

There is a lack of data in this area. Learning theory indicates batterers can relearn behavior to replace aggression with assertion, coercion with negotiation.

17. Long standing battering relationships can change for the better.

False. At best, assaults are reduced in frequency and severity. Under most conditions violence escalates to homicidal or suicidal levels.

18. Battered people deserve to get beaten.

False. This is putting responsibility with the victim instead of with the batterer. It assumes that the batterer is unable to control his actions, which is not the case. No one deserves to be beaten.

19. Battered victims can always leave home.

False. This again puts the burden on the victim and assumes options not possibly obvious to the victim.

20. Batterers will cease their violence “when we get married.”

False. In many cases suspicion, jealousy, and possessiveness increase after marriage, along with the level of violence.

21. Children need their parent even if violent.

False. Data on the number of children harmed directly and indirectly by the violence in their homes proves this false.

