

# Friday Night [under the] Lights 2014



*Happy Friday.*

I hope all is wonderful in your respective Worlds...

Many of you who have been in EMS & Emergency Services for a while probably remember one of the most challenging Mass Casualty Incidents of early EMS. 33 years ago yesterday, at the Hyatt Regency in Kansas City Missouri, two overhead suspended walkways collapsed onto a dance competition that was being held in the hotel's lobby. The falling structures killed 114 people and injured 216 others. At the time, it was the deadliest structural collapse in U.S. history, not surpassed until the collapse of the south tower of the World Trade Center in 2001.



A good friend and colleague of mine, Jerry Overton [Chair of the International Academies of Emergency Dispatch and the former Authority Director of Kansas City Metropolitan Ambulance Services Trust and the Richmond Ambulance Authority] was on that scene and worked through the night helping to manage the chaos. Many times, I've heard him talk about the unbelievable carnage and the emotional and physical challenges trying to identify and rescue survivors. As horrible as that event was, it became an historically

important experience in management of large scale civilian trauma. EMS as a profession learned a great deal about search and rescue, identification and extrication of survivors, structural stabilization, triage and utilization of resources (such as helicopters and large numbers of volunteer local physicians). What may have seemed intuitively to be extremely useful, ended up being a significant operational challenge (the physicians were not experienced in field operations and had difficulty integrating effectively into field operations; the helicopters could transport only one patient at a time yet required significant LZ resources and created disruptive rotor wash).

Today, we have better defined guidelines for use of aeromedical resources at large scale events and Incident Management principles and practice have been almost universally standardized. The Hyatt structural collapse marked the beginning of educational efforts to better prepare rescuers, principles and practices of Urban Heavy Rescue and an awareness that the unimaginable could happen to any one of us...

Of historical note, Dr. Joseph Waeckerle, a Kansas City emergency physician was the lead physician on scene triaging and managing the injured. He made some of the toughest decisions an emergency physician of the time would ever have to make, including the administration of pain medicine to mortally injured patients who were still conscious and told they were going to die. He also made a critical decision to amputate the leg of a young patient who was rapidly deteriorating and was not able to be extricated from the structural entanglement (the procedure was completed with a chain saw).

None of us wants to think about stuff like this. It's not supposed to happen.

Unfortunately, it does. And if you're reading this, you're part of a team that signed up to be ready to directly provide (or support the provision of) care for these patients.

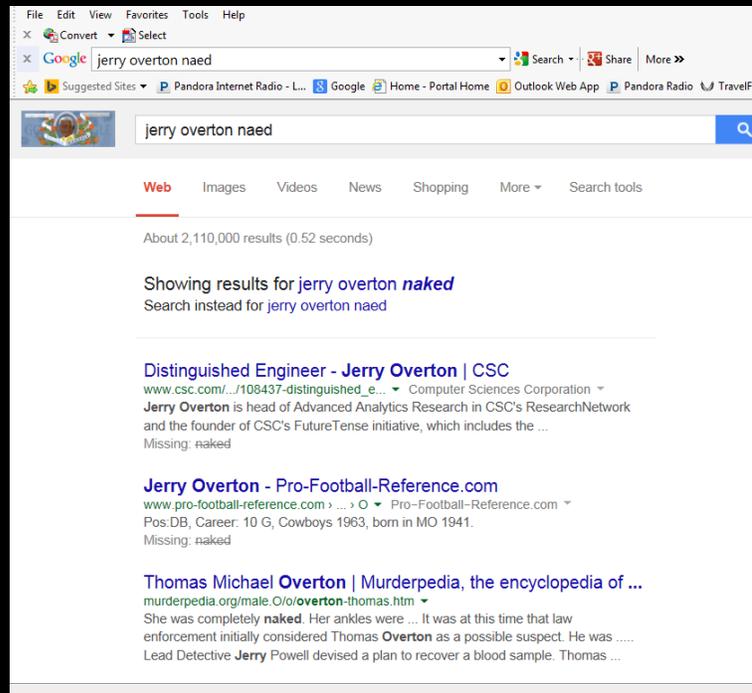
Catastrophe medicine becomes more effective with every event we face. It has to.

---

*Before I continue on though, I want to share a disturbing moment I just experienced while fact checking on the specifics of the Hyatt collapse.*

I wanted to make sure I got Jerry's title perfectly correct before I typed it so I turned to my trusty partner of fact – Google.

When I typed in "Jerry Overton naed (national academies of emergency dispatch)", Google redirected me (as it does) to the more common, frequently searched terms as noted below...



Jerry – If your title isn't exactly right it's because I chose to not look any further... And I didn't know you had a brother Thomas but it looks like he had some interesting times himself...

## More lessons learned – and a call to change...

Just like none of us would have imagined two walkways would collapse in a hotel, we don't like to think about the possibility of a large scale event involving explosives.

After all, blast injuries are usually confined to the battlefield. They have been the devastating result of war. They've not historically been a civilian threat in the US.

*Until now.*

Unfortunately, in the past 5 years, the US has seen an increasing number of civilian explosions and the large scale impact of these events on patients, EMS systems, healthcare and public safety agencies. As a result (just like the Hyatt collapse), we know more about how to manage these events and how to coordinate our efforts and maximize the potential to have a positive impact on as many victims as we can.

One of the most dramatic lessons we've learned is the control of hemorrhage.

The last issue of Prehospital Emergency Care published an exceptionally good article on management of external hemorrhage that addresses this evolving threat (a new "mechanism of injury"). Lynn White [AMR Director of Resuscitation and Accountable Care] was a co-author of the paper (if anyone can name an organ system, illness or injury that Lynn hasn't published a paper on, will you please let me know?).

### SPECIAL CONTRIBUTION

#### AN EVIDENCE-BASED PREHOSPITAL GUIDELINE FOR EXTERNAL HEMORRHAGE CONTROL: AMERICAN COLLEGE OF SURGEONS COMMITTEE ON TRAUMA

Eileen M. Bulger, MD, FACS, David Snyder, PhD, Karen Schoelles, MD, FACP, Cathy Gotschall, ScD, Drew Dawson, BA, Eddy Lang, MD, CM CCFP (EM) CSPQ, Nels D. Sanddal, PhD, NREMT, Frank K. Butler, MD, FFAO, FUHM, Mary Fallat, MD, FACS, Peter Taillac, MD, Lynn White, MS, CCRP, Jeffrey P. Salomone, MD, FACS, NREMT-P, William Seifarth, MS, NREMT-P, Michael J. Betzner, MD, FRCPC, Jay Johannigman, MD, FACS, Norman McSwain, Jr., MD, FACS, NREMT-P

Received January 21, 2014 from the University of Washington, Seattle, Washington (EB), ECRI Institute of Health Technology Assessment, Washington DC (DS, KS), Office of Emergency Medical Services National Highway Traffic Safety Administration, Washington DC (CG, DD), University of Calgary, Alberta, Canada (EL, MJB), American College of Surgeons, Chicago, IL (NDS), Committee on Tactical Combat Casualty Care, Joint Trauma System (FKB), University of Louisville, Louisville, Kentucky (MP), University of Utah, Salt Lake City, Utah (PT), American Medical Response, Inc. (LW), Maricopa Medical Center, Phoenix, Arizona (JPS), Department of Homeland Security, Office of Health Affairs (WS), University of Cincinnati, Cincinnati, Ohio (JJ), and Tulane School of Medicine, New Orleans, Louisiana (NM). Revision received February 12, 2014; accepted for publication February 13, 2014.

The systematic review of the evidence used for the development of these guidelines was conducted by ECRI Institute with funding provided by the National Highway Traffic Safety Administration, DTNH22-11-C-00223.

This publication was developed in part with funding from the National Highway Traffic Safety Administration (NHTSA) of the U.S. Department of Transportation (DOT). The opinions, findings and conclusions expressed in this publication are those of the authors and not necessarily those of NHTSA or DOT. The United States Government assumes no liability for its content or use thereof. If trade or manufacturer's names or products are mentioned, it is because they are considered essential to the object of the publication and should not be construed as an endorsement. The United States Government does not endorse products or manufacturers.

The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or as reflecting the views of the Department of the Army or the Department of Defense.

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

Address correspondence to Eileen M. Bulger, MD, Professor of Surgery, Chief of Trauma, Box 359796, Harborview Medical Center, 325 9th Avenue, Seattle, WA 98104, USA. E-mail: ebulger@uw.edu  
doi: 10.3109/10903127.2014.896962

163

Bulger, et.al. PREHOSPITAL EMERGENCY CARE 2014;18:163-173

In the paper, a panel of experts identified all available literature, reviewed pertinent literature and developed, by consensus, specific Evidence-Based Guidelines for the use of tourniquets in the prehospital management of external hemorrhage.

The key recommendations are:

**Recommendation 1:** Recommend the use of tourniquets in the prehospital setting for the control of significant extremity hemorrhage if direct pressure is ineffective or impractical.

**Recommendation 2:** Suggest using commercially produced windlass, pneumatic, or ratcheting devices that have been demonstrated to occlude arterial flow.

**Recommendation 3:** Suggest against the use of narrow, elastic, or bungee-type devices.

**Recommendation 4:** Suggest that improvised tourniquets be applied only if no commercial device is available.

**Recommendation 5:** Suggest against releasing a tourniquet that has been properly applied in the prehospital setting until the patient has reached definitive care.

I would highly recommend reading the article. It's well done and provides very practical guidance in management of external hemorrhage. While I wish we didn't have to worry about this in civilian settings, the next best option is to be as well prepared as we can. It's clear that the simple application of tourniquets when indicated can have a dramatic impact on morbidity & mortality.

And - Lynn White is an excellent resource for questions or consultation (I guess she's the Horse's Mouth on this??).

## Even MORE scoop on management of blast injuries...



The CDC just released a free app available on iTunes that's a nice reference for emergency responders. It's available in the iTunes store.

The app covers:

- Essential information for understanding explosions
- Information about the clinical management of blast injuries
- Special populations treatment considerations (e.g., women who are pregnant, children)
- Emergency management solutions
- Personal safety information
- On-the-scene emergency response guidance

## And one more just to emphasize how important this is... A free Webinar:

**August 5<sup>th</sup> – 2:00p ET - Tourniquets and Hemostatic Dressings: The New Evidence-based Guideline**  
National experts in emergency medicine and trauma care will join the Office of EMS to discuss the lessons learned from Iraq and Afghanistan and how prehospital tourniquet application is saving the lives of fighters overseas. The panel will address the guideline development process using external hemorrhage control as a model and will discuss suggestions for guideline implementation.

Sign up at [https://redflash.clickwebinar.com/EMSFOCUS\\_AUG5\\_EBG/register](https://redflash.clickwebinar.com/EMSFOCUS_AUG5_EBG/register)

## What's your name?

OK. Here's the people part of tonight (touchy-feely warning).

Many years ago, I listened to a pediatric cardiac arrest call with pre-arrival instructions provided by one of my Dispatch Colleagues at the Richmond Ambulance Authority. As you can imagine, it was an extremely emotional call – the grandmother had just discovered a pulseless, apneic child and was frantically trying to help her grandson while on the line with 911.

The Communications Medic did a masterful and commanding job of walking the grandmother through every step – in between crying and screaming, the grandmother provided rescue breathing and compressions as instructed by Mark.

It was painful to listen to. You could hear and feel the grandmother's angst and despair.

The call seemed to take forever (I know, not a description we like to use in EMS, but it DID feel that way).

About 2 minutes before the First Responders arrived, you could hear the child quietly cough, then choke, then cry.

It was the kind of tape Rescue 911 episodes were made of.

The grandmother, out of breath, was almost more concerned and was scared she didn't do the right thing. I listened to Mark calmly walk her through an additional assessment while he reassured her that the Fire Department and EMS were almost there.

As it became clear that the child was now breathing, there was a dramatic sense of relief from both grandma and Mark.

At the end of the tape, as you hear sirens increasingly louder in the background, the grandmother is profusely thanking the dispatcher. "Oh my God – You saved my grandson's life"!

And then she asks...

*"Son, what is your name"?*

He says "Mark".

They had only 30 seconds more of a conversation and the Medics were at the door.

It's a powerful recording.

But what strikes you the most when you listen to it is when she asks "what is your name?"

In today's world, when strangers ask for your name it's usually not for good reasons.

*"What's your name and who is your supervisor? How, exactly do you spell your last name Mr. useless-in-the-customer-service-department-guy"?*

But here's the irony. Human beings love hearing their name.

Our name is our identity (duh). It is the phonetic identification of who we are. When we hear our name, it immediately captures our attention (even things that sound like our name – Yell “Bedrock” near me and I’ll turn, I promise).

Names are personal. Sir & Ma’am are impersonal – could be anyone. But our name is specific to us. It’s who we are.

When grandma asked for the dispatcher’s name, it’s because she wanted to know exactly who he was – it was so important, she needed to know. And when someone asks you your name, they are taking the time to notice.

And if they take that time to notice, that means they care.

And they care about what you did in a much more personal and powerful way.

Think about this. If a stranger does something nice or something impressive and you say “hey, thanks!” – It’s always appreciated. But if you first ask, “what’s your name?” and then use it to say thanks, you’ve made a much more powerful, personal statement.

Which feels more sincere?

“Thank you sir. Have a nice day.”

*Or...*

“What’s your name? Ed – Thanks, Ed. Have a nice day”

Try it. I *promise* you will make people feel good about themselves and think about what they did to earn your interest. It’s particularly powerful for folks that don’t often get recognized.

When you see someone do something really well, or notice something that catches your attention, take 5 seconds, stop, ask their name and tell them thanks. Or nice job. Or that you noticed how well they did something. It’s also so impactful because these people are total strangers. They don’t expect it.

People like to hear their name and they like to be recognized for things they do well.

But here’s the other thing that happens. Pick a day and do it as often as you can.

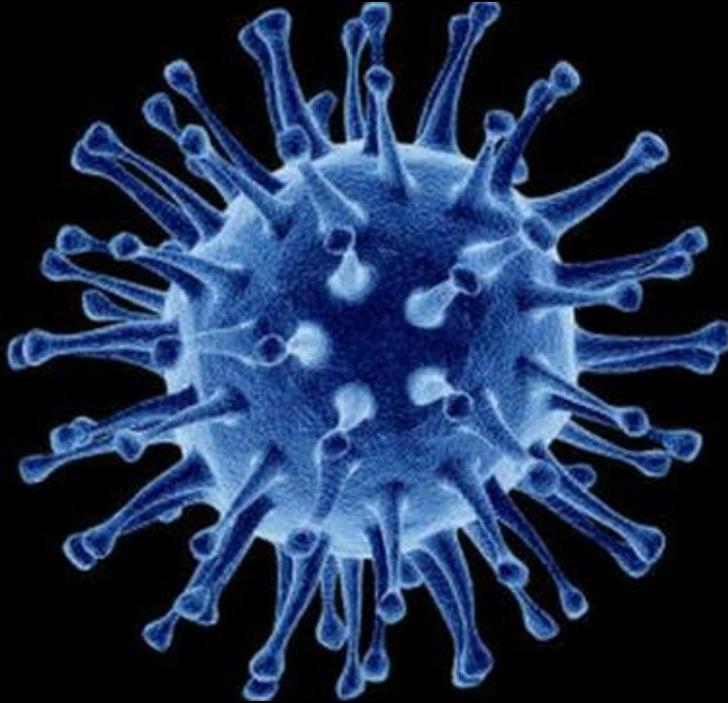
By the end of the day, you’ll feel really good about yourself. It’s contagious.

...and for those of you that think this is too touchy-feely...



*Take that...*

## What's really cool on the outside but awful on your insides?



More to come on this little gem. We'll give it our best shot in the coming weeks...

### Epilogue...

Every once in a while, I get a "gift" Epilogue from real life...

Several weeks ago, I was on a Southwest Flight into Oklahoma City. It was a fairly turbulent approach and the landing was a bit rough and "heavy on the reverse thrusters and braking".

When the plane slowed, the Flight Attendant came on the overhead PA, welcomed us to Oklahoma City and said:

"Ladies and gentleman, our apologies for the rough landing.

The skilled men and women of Southwest Airlines are prepared to safely bring you to your destination regardless of the circumstances.

In the case of this landing, we'd like you to know that it was not the Pilot's fault...

It was not the First Officer's fault...

It was not the Tower's fault...

*It was the asphalt".*

---

That's it from my world. *Happy Friday*. As always, thanks for what you do and how you do it...

And, what was your name again??

*Ed*

---

**Edward M. Racht, MD**

Chief Medical Officer

AMR / Evolution Health

[ed.racht@evhc.net](mailto:ed.racht@evhc.net)