

Simulation in Training

The backbone of all prehospital care is training. In addition to teaching didactic material and practical skills, training should include simulation to provide practice in realistic situations and to place that training in proper perspective. Frank Dawson explores ways to use simulation to provide realistic practice.

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Are your simulations for real? Do they demonstrate the results of the mechanism of injury? Do they reflect what you are teaching or have taught? Are the minor details missing that give credibility? Do they allow for alternative treatment? Does the simulated patient understand the immediate and progressive effects of the injury? Do they teach a point?

The use of situation role playing in the training of EMT students should be on a progressive basis. As you go from dispatch information to the topics of evaluation and treatment — ABCs, hemorrhage, shock, fractures, soft tissue injury — each can be added as the class progresses. The interaction of one condition upon another can be demonstrated by making the injuries or medical complications as realistic as possible.

During the exercise you should evaluate leadership; completeness of IPS; correct treatment; communication to the patient, bystanders, other emergency personnel; and what the radio report should be. Watch for correct equipment handling and patient transport. Watch for sequential errors, i.e., checking fractures

before assessing airway or bypassing a patient because he appears dead. After the exercise, immediate feedback of both positive and negative findings is imperative. Feedback reinforces learning and allows the instructor to correct errors immediately. It is often helpful to have an outside observer discuss what was noticed, because instructors often assume things were done because they presented them and, therefore, fail to observe the omission.

There are three schools of thought in choosing simulated patients. The first is using persons who have experienced the event to be shown. This gives the student feedback not only concerning injury or illness, but also the emotional aspects. The second uses students. This increases the student's knowledge of signs and symptoms, and helps to identify what the rescuer did correctly from what was omitted or done improperly. The third choice are actors who do excellent simulations and, when used more than once, provide excel-

lent feedback for the student. Where money and time permits, videotape can be used to provide visual feedback for the student and class. Using videotape is also an excellent way for the instructor to identify what parts of the course require further emphasis.

Instruction to the simulated patient should be precise, indicating positioning and sequence of symptomatology. It should include type of response, i.e., alert, semicomatose or comatose. It is essential that the reaction to improper treatment be responded to, such as movement of the patient's head and neck by the rescuers prior to evaluation or before they determine what may have happened, causing signs of paralysis according to type of injury. Movement of broken bones also should elicit pain as should rough handling. In addition, the patient should react when rescuers discuss the problem within hearing distance, demonstrating anguish, apprehension or hostility.

When rescuers fail to introduce themselves and/or ask the model's name, the nonverbal signs of being uncooperative can be instituted, i.e., being noncommunicative, one syllable answers or withdrawing by body movements, especially when a rescuer wants to touch the model. Has the model been told where the rescuer is putting personal objects like glasses? Has the treatment procedure been adequately demonstrated and practiced beforehand? Are objects unnecessary to the scene removed? Does the safety of the res-

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