NEW YORK

EMERGENCY MEDICINE: HOW TO SAVE A LIFE

'...You dial 911—and then what? Would you know what to do in the crucial twenty minutes (or so) before the ambulance arrives?...'

THE TRUTH IS, NEW YORK CITY IS NOT a great place to have a heart attack, an emergency that requires split-second responses. It takes an average of sixteen minutes for a city Emergency Medical Services ambulance to respond to "priority one" calls; for other calls, the average response time is twenty minutes.* But if treatment for cardiac arrest (no pulse, no breathing) doesn't begin before four to six minutes have elapsed, most doctors acknowledge, the patient risks death or, perhaps even worse, irreversible brain damage. That leaves John or Jane Public to deal with the crisis.

You dial 911—and then what? Would you know what to do during those first crucial moments when it is, literally, do or let die?

Most of us don't know what to do. We're like the desperately concerned passengers on the BMT Brighton subway line who were trapped out of reach of help when fellow passenger Ah Chong was stricken with a heart attack. No one, evidently, knew how to administer cardiopulmonary resuscitation (CPR); no one could breathe air into his lungs and massage his heart until a doctor arrived. And so he died.

Not that CPR works every time. Jim Alexander, first-aid specialist with the American Red Cross in Greater New York, has helped save five heart-attack victims in his work with the BRAVO Volunteer Ambulance Service of Bay Ridge, Brooklyn. "Only 5 out of 82 tries," he says. "But it's great to know those five are walking around today because you knew what to do.

"One man in his sixties collapsed outside an ice cream parlor. When we got there, a big crowd was standing around, and a police officer was standing over the guy, doing nothing (most cops don't use CPR on a victim, I've found). There were three of us in the crew, and we worked on him on the street for ten to fifteen minutes. The cop thought it was hopeless—he kept yelling, 'Get him out of here!' But we kept working, and he got a pulse. At the hospital, the cop was actually crying when the doctor told him the man had made it."

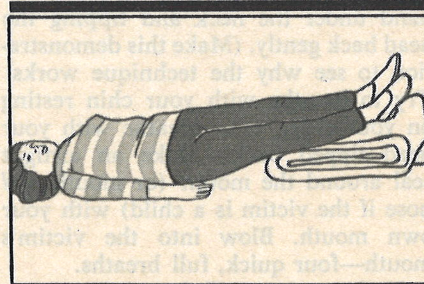
CPR could probably save 100,000 heart-attack victims a year, if more people knew how to give it. Some 19,000 New Yorkers learned how last year, and 42,000 were issued Red Cross first-aid certificates. (The term "first aid" refers to any type of immediate care given to a victim of injury or sudden illness. CPR is a special first-aid technique, a combination of mouth-to-mouth breathing and external heart massage. It is used only when the victim's heart stops working. Many first-aid courses include only a brief demonstration of CPR—and that is not enough to qualify anyone to give CPR in an emergency.) But there are millions of New Yorkers to educate, and the demand for training outstrips the supply of trained instructors. "People are banging down the doors," said one Red Cross official.

First-aid and CPR courses are given by Red Cross instructors at many Red Cross chapters, Y's, and community centers, at large medical centers that have "outreach" programs, and by volunteer ambulance corps. You can call the Red Cross, 787-1000, for advice on locating a class near you.

In the meantime, you don't have to feel totally helpless. There are emergency measures you can take without having had a first-aid course—although most hands-on techniques cannot be learned from reading. Here are the basic guidelines for treating some of the most common and dangerous emergencies while you're waiting for an ambulance. They are listed in order of priority. (Knowing what to do first is basically a matter of common sense: You wouldn't treat a person's burns if breathing had stopped.) You may never have to use this information. Then again, you may save a friend's life.

Indeed, the EMS system is sometimes so overloaded that there are no ambulances to be dispatched. On a typical eight-hour shift in the Bronx, studied by the State Assembly's Committee on Legislative Oversight and Investigation, two callers had to wait an hour before an ambulance could even be started on the way to them; 27 other callers found an ambulance unavailable for shorter periods of time.

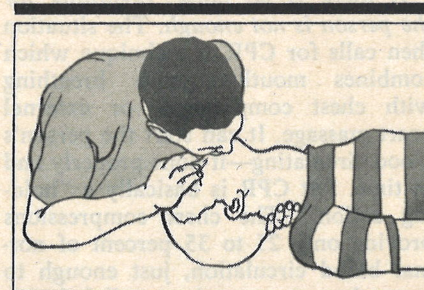
Avoid Rough Handling



NEVER MOVE AN INJURED PERSON UNLESS it is absolutely necessary. The more someone in pain is jostled about, the greater the intensity of pain and the danger of the body's going into shock. And improperly moving someone with neck or back injuries may cause damage to the spinal cord—possibly paralysis.

Put the patient in a position that is both comfortable and appropriate for the injury or illness: A person who is conscious and having trouble breathing should have the head and shoulders elevated; a person who has chest pains may feel better sitting up; a person in shock should lie flat. Elevate a bleeding limb above the level of the heart. Never raise both the head and the feet. Someone who is bleeding from the mouth or vomiting should lie on one side, to prevent choking.

Check for Breathing and Heartbeat



TRY TO WAKE THE PERSON IF HE APPEARS to be unconscious. If he does not respond, gently tilt his head, chin pointing up; put one hand on his forehead and the other under his neck. (*Don't tilt his head back, though, if a neck or back injury is suspected.*)

Look (at the chest to see if it's moving), *listen* (with your ear close to the

Illustrated by Joyce Macdonald.

'...You risk loss of the victim's limb when you apply a tourniquet; use one *only* if nothing else works and the victim may die...'

person's mouth), and *feel* (the breath on your cheek). Check the pulse in the neck, the carotid artery. To find it, place the tips of your index and middle fingers on the person's Adam's apple; gently slide them sideways toward you into the groove of the neck.

If the person is not breathing, try to open the airway (trachea). That is, get more air into the lungs by placing one hand under the neck and tipping the head back gently. (Make this demonstration to see why the technique works: Try to breathe with your chin resting on your chest; then breathe with your head tipped back.) Make an airtight seal around the mouth (or mouth *and* nose if the victim is a child) with your own mouth. Blow into the victim's mouth—four quick, full breaths.

If the person still is not breathing, there may nevertheless be a heartbeat. To start the lungs working, a trained rescuer would automatically give mouth-to-mouth breathing. The procedure has been described above: Tilt the person's head back to open the airway. Pinch the victim's nostrils closed. Make an airtight seal around his mouth with your mouth and blow hard into the lungs—one breath every five seconds. (No, you don't breathe out pure carbon dioxide, as your grade-school teacher may have led you to believe. What you exhale contains enough oxygen to sustain another person.) If the breathing is done properly, the chest will rise, indicating that an adequate amount of air has reached the lungs. Mouth-to-mouth is more difficult than it looks or sounds, since it must be given in proper intervals and with appropriate force; it's best learned under supervision.

If there is no pulse, breathing for the person is not enough. The situation then calls for CPR, a technique which combines mouth-to-mouth breathing with chest compression, or external heart massage. It can start the person's blood circulating—if done properly and in time. But CPR is basically a "holding action." The chest compressions provide only 25 to 35 percent of normal blood circulation, just enough to keep the person going until help arrives. CPR must be learned by *doing,* and then only on a special training mannequin, since you can't "try it out" on another person. Also, it's not enough to learn it once. The Red Cross certifies CPR graduates for one year only, since the average person tends to get out of practice.

Help a Person Who Is Choking

FIRST, ASK THE PERSON TO TRY TO speak. Any sound, even strangled choking noises or hoarse coughing, means the airway is only partially obstructed. Give the person moral support, but don't interfere—for a moment, that is. Coughing is the body's natural defense against choking, and it may do the trick.

If the person cannot make any sounds, the airway is totally blocked. No oxygen can reach the lungs. What to do? The American Red Cross teaches a series of back blows and upward thrusts on the diaphragm to aid persons with an obstructed airway, a procedure that is also recommended in the American Medical Association's first-aid guide. However, Dr. Henry Heimlich, who developed the "Heimlich maneuver" of upward thrusts on the diaphragm, strongly opposes the use of back blows: "Even if a back slap were to work in a rare instance," he says, "in many cases back slaps have driven the object tighter into the throat or into the lungs." His maneuver:

Stand behind the person and use both hands to press a closed fist into the abdomen, slightly above the navel and below the rib cage, thumb side against the abdomen. An inward and upward thrust forces a flow of air from the lungs, which expels the object from the airway. Repeat the "Heimlich maneuver" several times if necessary in order to expel the object. If the choking person is seated, you can kneel behind his chair and reach around the back of the chair to perform the maneuver in the same way.

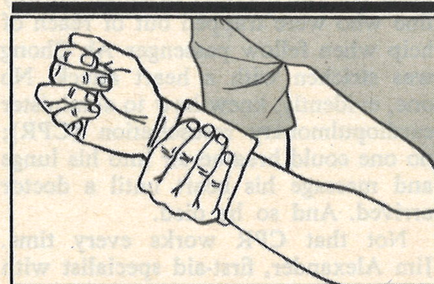
When the airway is totally blocked for more than two or three minutes, the person will pass out. If the unconscious person has fallen to the floor, place him on his back, face upward. Kneel astride his thighs, facing him; place one of your hands on top of the other with the heel of the bottom hand slightly above the navel and below the rib cage, and press inward and upward on the abdomen with a quick thrust; repeat if necessary to dislodge the object. This astride position should be used by a small rescuer who cannot reach around the victim's waist.

A choking person who is alone should place his fist on his abdomen, as described above, grasp the fist with the other hand, and press it into the abdomen. An alternative method: The choking person should lean forward, against the back of a firm chair, the edge of a table, or a sink, and press his body against the hard surface to perform the maneuver.

As a last resort, if the airway is still blocked, insert your index finger along the inside of the cheek and deeply into the throat, to the base of the tongue. Using a hooking action, dislodge the object, taking care not to force it deeper into the airway. Since inserting the finger into the throat may drive the object deeper into the airway, Dr. Heimlich warns that it *is* a last resort.

Once the airway is clear, you must give the unconscious victim mouth-to-mouth breathing until he can breathe for himself.

Control Heavy Bleeding



IF BLOOD IS FLOWING RAPIDLY OUT OF an open wound, there is a danger of shock or death. Bleeding can be deceptive—be sure you find out where the blood is coming from. Then apply *direct pressure* on that spot, preferably with a clean cloth or thick, sterile gauze pad. If nothing else is within reach, use your bare hand.

If possible, elevate the wound (arm, leg, hand, or neck) above the person's heart. This helps slow down the loss of blood. If direct pressure does not stanch the flow, try—*in addition*—indirect pressure on the large arteries in the arm and leg. Arm wound: Grasp the victim's upper arm about halfway between armpit and elbow, thumb on the outside of the arm and fingers on the inside. Using the flat surface of your fingers, press toward your thumb, compressing the brachial artery against

the arm bone. Leg wound: With victim flat on his back, place your hand over the pressure point, which is right in the center of the "crease" where the leg joins the body. Keeping your arm straight, lean forward to apply pressure.

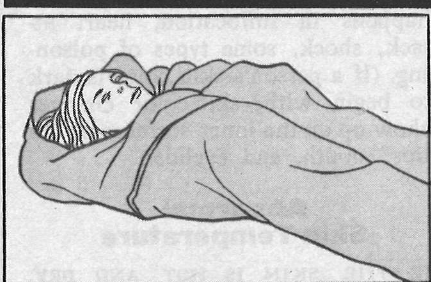
The use of a tourniquet is extremely dangerous—in reality, you risk a limb to save a life—and it should only be applied in the case of life-threatening hemorrhaging. If, as a very last resort, a tourniquet is applied, the rescuer must write down the time it was applied and must be sure the tourniquet is not loosened until the victim reaches the doctor.

Treat for Poisoning

IF THE PERSON IS UNCONSCIOUS, CHECK the pulse and breathing; start mouth-to-mouth resuscitation or CPR if necessary. Try to identify the poison. Call the Poison Control Center for help: **340-4494.**

If the person is conscious, dilute the poison by giving a glass of milk or water. Call Poison Control to find out what to do next. It is far better to let the Poison Control experts tell you how to counteract the poison than to follow the instructions on the label of the poison bottle—these instructions are sometimes not specific enough, and indeed are sometimes incorrect.

Prevent Shock



SHOCK CAN BE MORE DEADLY TO AN ACcident victim than injuries. As a rescuer, you cannot treat shock; you can only prevent it by keeping the victim calm and comfortable. It's important to maintain a normal body temperature, so shade the person from hot sun or cover with blankets, although only enough to keep him from getting a chill.

If you begin to see signs of shock—

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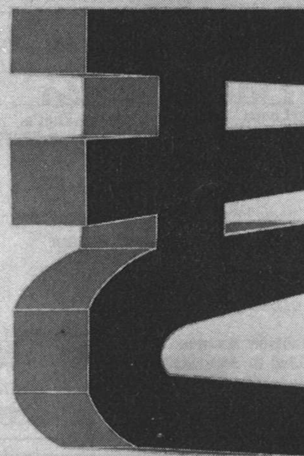

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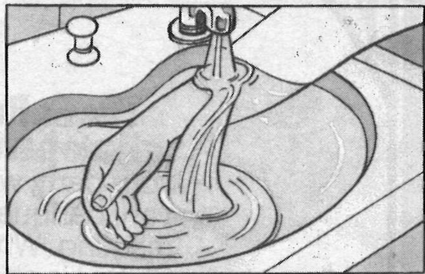
the skin gets clammy, muscles go limp, eyes become vacant, and eyelids are droopy—keep the patient lying flat.

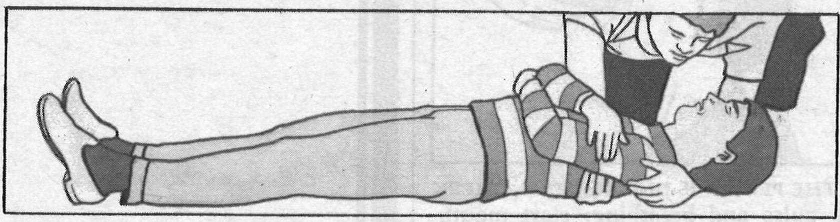
Treat Burns



A SIMPLE COOKING PRINCIPLE OFFERS A graphic clue to burn care: When you take a roast out of the oven, it continues to cook for several minutes, because it's still hot. So it is with burns. You have to cool them off. First-degree burns (*signals:* redness, swelling, pain) and second-degree burns (*signals:* red or mottled appearance, development of blisters, wet appearance of skin surface, greater depth than first-degree burns) should be submerged for about twenty minutes in cold (*not* ice) water. To keep the air away from a first- or second-degree burn, apply freshly laundered cloths wrung out in ice water; blot dry; apply dry, sterile gauze or a clean cloth. Do *not* break blisters.

For third-degree burns (*signals:* white or charred appearance, loss of

Trouble Signs



INDIGESTION OR HEART ATTACK? Would you know the difference? Here are some common symptoms and what they might mean. Don't try to be your own doctor—but do call for help.

Gasping

DEEP GASPS COULD BE A SIGN OF heart failure or mean that the airway is blocked. If bright, frothy blood comes out each time the person exhales, suspect lung damage.

Chest Pains

INTENSE PRESSURE OR TIGHTNESS OF the chest persisting for five minutes or more, then radiating out to the shoulder or arm, neck, or jaw may be an early warning of a heart attack. Often there is also sweating, nausea or vomiting, or shortness of breath.

Dilated or Contracted Pupils

IF BLUE EYES LOOK BLACK, THE PUPIL is *dilated*—it doesn't react to light. It may be a sign of cardiac arrest, some type of respiratory emergency, a drug overdose, or the late stages of shock. Certain drugs, such as morphine, and some types of poisons cause the reverse effect—the pupils contract to *pinpoint* size.

Rapid Pulse

MOST NORMAL ADULT PULSES FALL within a range of 50 to 100 beats a minute. Children's pulses are slightly more rapid. A rapid pulse may signal shock, fright, or hypertension.

Unnatural Skin Color

A REDDISH COLOR CAN INDICATE high blood pressure, carbon monoxide poisoning, or heatstroke. *Ashen-gray* skin may mean the person is having a heart attack; if it's grayish-white and glossy, suspect frostbite. A *bluish* color means the body is not getting enough oxygen. This happens in suffocation, heart attack, shock, some types of poisoning. (If a person's skin color is dark to begin with, skin-color changes show up on the inner surfaces of the lips, mouth, and eyelids.)

Abnormal Skin Temperature

IF THE SKIN IS HOT AND DRY, the person probably has a high fever or heatstroke. If it's *cool and clammy,* the body may be going into shock. Skin that is *cool and moist* indicates that the body is losing heat. *Cold and dry* skin is a sign of overexposure to cold—look for problems if the skin turns white. **—M.B.**

all layers of the skin), do not immerse the skin in water, and do not try to remove bits of charred clothing from the skin. If possible, elevate the burned areas. Cover the affected part with a sterile dressing or a freshly ironed or laundered sheet.

For any sort of burn, do not apply any ointments or home remedies.

For burns of the eye, treatment must begin immediately. *Acid* burns need to be flooded with water for five minutes; *alkali* burns need to be flooded for fifteen minutes. In both cases, the water should be poured from the inner corner of the eye outward. Be careful not to wash the chemical into the other eye.

Dealing With Convulsions

CONVULSIONS CAN BE CAUSED BY A HEAD injury, brain disease, an extremely high fever (especially in children), or chronic conditions such as epilepsy. They are frightening to watch because you feel so helpless. Actually, there's not much you can do except let the convulsion pass. It lasts only a few minutes and is characterized by rigidity of body muscles, spastic jerking movements, frothing at the mouth, and, in some cases, loss of bladder or bowel control. Move furniture out of reach and place a rolled handkerchief —not a blunt object—between the victim's teeth *if the mouth is open.* Do not restrain the person, but do check to see that breathing is normal. In some cases, mouth-to-mouth breathing may be necessary.

The Next-Best Thing

IF YOU CAN'T TAKE A COURSE IN FIRST aid, at least buy a book. But don't wait until something happens to thumb through it for help. Read the book when you buy it—and reread it every now and then just to keep the information fresh.

A Sigh of Relief: The First Aid Handbook for Childhood Emergencies (produced by Martin I. Green, Bantam Books, $7.95). Step-by-step illustrations and simple instructions for every childhood injury.

Standard First Aid & Personal Safety (prepared by the American Red Cross, Doubleday, $2.50). One of many Red Cross publications, this book covers all emergencies and closely parallels the information taught in most first-aid classes. This and other, more specific titles are available from the American Red Cross in Greater New York, 150 Amsterdam Avenue (corner of 66th Street), Room 302, Purchasing and Sales. ■

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Books / Peter Forbath, Evan Connell

BEYOND THE HORIZON

'. . . Thesiger's fascinating book records his years as a man with a "strange compulsion to wander in the deserts of the east". . .'

Lovers on the Nile, *by Richard Hall. Random House, $10.95.*
The Last Nomad, *by Wilfred Thesiger. Dutton, $24.95.*

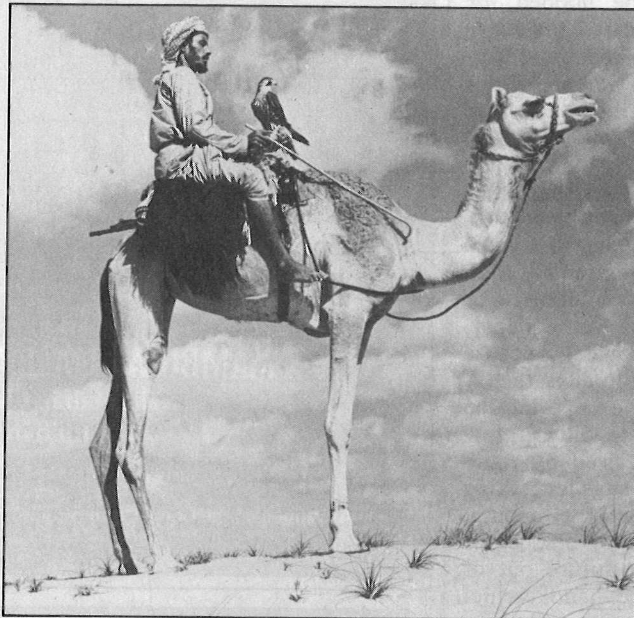
RICHARD HALL, A VETERAN BRITISH reporter on contemporary Africa, displays a delightfully prurient curiosity whenever he turns his journalistic skills to the Africa of the Victorian Age. In his excellent biography of Henry Stanley, he unearthed the hitherto unknown story of Lady Alice Pike, that explorer's one true and ultimately tragic love. Now, in his excursion into the life of Samuel Baker, who discovered the White Nile's secondary source in Lake Albert, Hall cracks an even more sensational secret of that seemingly straitlaced age.

It was always known that Baker made his stupendous journey up the Nile in the company of a gorgeous young Hungarian woman. But it was always understood that this woman, Florence, was his wife. Not so, Hall reveals. Not only wasn't Florence married to Baker during their years in Africa—scandal enough for Victorian England—but she was, quite literally, his slave. He had bought her at an auction in the Turkish Balkans.

Baker happened on the slave market while on a hunting trip down the Danube. He was in his late thirties, eager to make a name for himself but still frustrated in that ambition. Only a few months before, his attempt to join Livingstone's expedition to the Zambezi had been rebuffed, and he had gone off to the Balkans to get over his disappointment.

Hall hasn't been able to document exactly how Florence came to be for sale. The details of her sordid origins were, obviously, suppressed after Baker became famous enough to defy convention and marry her, and she took a celebrated place in Victorian society as the first white woman to have penetrated the heart of Africa. But her grim childhood was not all that unusual. The Ottoman Empire, where slavery was widely practiced, extended well into Eastern Europe in the mid-nineteenth century, and as Hall notes, "there was a *cachet* for wealthy Turks in having white girls in their harems."

Peter Forbath is the author of The River Congo. *He is at work on a novel about Henry Stanley. Evan Connell is the author of* Mr. Bridge, Mrs. Bridge, *and* The Connoisseur, *among other novels.*



Sport of kings: *A falconer of Sheikh Zayid of Oman, 1948.*

Baker's astonishing decision to buy the slave girl can be understood only as an act of mad passion. And by rights it should have ruined him. That it didn't—that it can be said in fact to have led directly to the fame that had for so long eluded him—is testimony to the young girl's remarkable qualities. "Florence could have been, at first, only the servant to his repressed instincts," Hall writes. "However, events would soon prove her more self-assertive than that."

Unable to return home with her, yet too wildly enamored to part from her, Baker had little choice but to take her far from censorious civilization. And so began their amazing travels, first through Eastern Europe and Turkey, then Egypt, the Sudan, Ethiopia, and finally into darkest Central Africa and the fountains of the Nile. The discovery of Lake Albert won for Baker a knighthood and a place alongside Stanley, Livingstone, Burton, and Speke in the pantheon of African explorers. But, best of all, it won for him the social clout to allow him to legitimize his scandalous liaison with the erstwhile harem girl, "the devoted companion of my pilgrimage," as he would forever lovingly describe her, "to whom I owed success and life."

It is a commonplace to say that the extraordinary travels of Sam and Florence Baker are unimaginable in a day when luxury liners cruise the Antarctic seas and tourists swarm across the Serengeti Plain in zebra-striped minibuses. And yet, for all that, there are men and women who still can find true wildernesses on this earth in which to experience marvelous adventures. Wilfred Thesiger is certainly one of them.

Born in 1910, the eldest son of the British minister in what was then still Abyssinia, Thesiger spent nearly 50 years roaming in the most spectacularly remote places of Africa, Central Asia, and the Middle East, from the swamps of the Upper Nile and the marshes of Iraq through the mountains of Karakoram and the Hindu Kush to the deserts of Arabia. His book, generously illustrated with his own stunning photographs, is a fascinating summing-up of those years—as an explorer, a soldier, a colonial official, and finally simply as a man with a "strange compulsion . . . to wander in the deserts of the east, living year after year among alien people, with no thought of material reward."

Of all the exotic places he's been and alien peoples he's known, Thesiger loved best, in the romantic British tradition of Burton, Doughty, Philby, and Lawrence, the Arabian desert and the