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# FOIA MARKER

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**Record Group/Collection:** Donated Historical Materials  
**Collection/Office of Origin:** Frieden, Lex, Collection  
**Series:** Related Materials  
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**OA/ID Number:** 52077  
**Folder ID Number:** 52077-009

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**Folder Title:**  
Demographics of Disability [Videoconference] [1987]

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**Stack:**

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**Shelf:**

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PRESENTER ITINERARY

SCHEDULE OF EVENTS for the videoconference is:

September 15, 1987 (Tuesday)

- o 8:00 A.M. - 12 Noon           Teleprompter Practice  
Casual dress is appropriate.
  
- o 1:00 P.M. to 5:00 P.M. -    Full Rehearsal  
Take a book or magazine as most  
of the rehearsal is used for  
technical and logistical  
arrangements rather than  
presenters practice before the  
cameras.

September 16, 1987 (Wednesday)

- o 11:00 A.M. to 3:30 P.M. -    Videoconference  
Please be at the studio by 9:30  
A.M.

IMPORTANT NAMES, ADDRESSES, PHONE NUMBERS

KEY BRIDGE MARRIOTT 1401 Lee Highway Arlington, VA	703/524-6400
STUDIO, BIZNET U.S. Chamber of Commerce Building 1615 H Street, NW - Third Floor Washington, DC	202/463-5921
EMERGENCY EDUCATION NETWORK National Emergency Training Center N-310 Emmitsburg, MD	301/447-1068

## GROUND TRANSPORTATION

Ground transportation is available by subway, called The METRO, from National Airport to the Key Bridge Marriott Hotel. Take the Blue Line to Rosslyn Station stop, go to the street level, turn left on Fort Myer Drive. The Key Bridge Marriott Hotel is 4 blocks from the Metro stop.

Taxis are also available from all airports.

PLEASE KEEP ALL RECEIPTS TO SUBMIT FOR REIMBURSEMENT

## STAFF

At the studio you will meet many people. Your primary contacts are the following:

Michael Larkin - Producer

Laura McKinley - Associate Producer

Both of these people work for Technical Resources, Inc. (TRI). If you have any questions or problems, please let them know.

MEETING THE EMERGENCY NEEDS OF PEOPLE WHO ARE DISABLED OR ELDERLY

TELEPROMPTER REHEARSAL SCHEDULE

BIZNET Studio  
U.S. Chamber of Commerce Building  
Third Floor Conference Room  
1615 H Street, N.W.  
Washington, D.C.

Tuesday, September 15, 1987

Jean-Remi Champagne 8:30 - 8:45 A.M.

Greg Wilder 8:45 - 9:10

Ron Coleman (Eva Williams) 9:10 - 9:30

Janet Bradford 9:30 - 9:50

Pat Snyder 9:50 - 10:30

Jake Pauls 10:30 - 10:50

David Cunningham 10:50 - 11:15

Edwina Juillet 11:15 - 11:40

✓ Lex Frieden 11:40 - 12 NOON



# Federal Emergency Management Agency

Washington, D.C. 20472

MEMORANDUM FOR: Teleconference Speakers

FROM: Alan Clive  
Teleconference <sup>D.C.</sup> Coordinator

SUBJECT: Words to Watch

Your attention is drawn to the attached guidelines on appropriate language in speaking or writing about persons with disabilities for the FEMA teleconference, "Meeting the Emergency Needs of Persons who are Disabled or Elderly," scheduled for September 16, 1987. Included is a list of phrases now considered out-of-date or negative in connotation, which should not be used during our broadcast-or at all, for that matter.

Many persons with disabilities will be watching this program. There is no point in needlessly offending them by using such phrases as "confined to a wheelchair," "deaf-mute," and the like. We also have an obligation to serve as an example of proper semantics to our audience of nondisabled viewers.

Please keep these suggestions in mind if any revisions are required in your script, and during the interactive portions of the telecast itself. If you have any questions on this matter, you may contact me at (202) 646-3957.

Attachment

SEMANTICS THAT WILL NOT Demean OR OFFEND PEOPLE WHO  
HAPPEN TO HAVE A PHYSICAL DISABILITY

By: George Alderson

Sticks and stones will break my bones, but names will never hurt me. Do you really believe this old rhyme that most everyone has heard? Demeaning words and names can hurt and will never contribute to "Have a nice day."

Language is powerful! It does reflect and helps to shape our perception of people. Many of the words being used in our society about disability are not only incorrect in many instances, but demeaning as well. Some words have been used incorrectly for so many years that many people don't know the difference.

Political, medical and legal terms have affected many words we use about disability. Therefore, our language contains many technical terms which often do not convey our intended social message.

EXAMPLES OF GOOD AND BAD USAGE.....

Since each person is an unique individual in their own right, they should always be portrayed before any wheelchair or other mobility device. Never place the person in second position.

DON'T SAY.....

"Mrs. Green is a crippled teacher and is wheelchair bound. All of her students are normal."

PLEASE SAY INSTEAD.....

"Mrs. Green is a teacher who is disabled and uses a wheelchair. All the students in her class are non-disabled."

DON'T SAY.....

"Ann is an arthritic and her friend, Jane, is a diabetic."

PLEASE SAY INSTEAD.....

"Ann has arthritis and her friend, Jane, has diabetes."

Arthritic and diabetic are conditions. Ann and Jane are not conditions, they are people.

DON'T SAY.....

"John was diagnosed as having rheumatoid arthritis." A person is never diagnosed.

PLEASE SAY INSTEAD.....

"John's condition was diagnosed as rheumatoid arthritis."

OUTDATED AND INCORRECT WORDS.....

There are "hard" words, and there are "soft" words. There are "positive" and there are "negative" words. The following words have strong negative and demeaning connotations. Please avoid them and discourage their use by others.....

.....  
afflicted-say the person has \_\_\_\_\_  
bedridden-say has to remain in bed  
cerebral-palsied-say has cerebral palsy  
confined-to-a-wheelchair-uses a wheelchair  
crazy-no substitute  
crippled-has an orthopedic problem  
blind as a bat-no substitute  
deaf and dumb-no substitute  
defect-say difference in structure at birth  
deformed-no substitute  
feeble minded-no substitute  
deaf mute-no substitute  
gimp-no substitute  
invalid-(literally means not valid)  
Lame-no substitute **ORTHOPEDIC PROBLEM.**  
maimed-no substitute  
paralytic-no substitute  
poor-has nothing to do with a person's wealth  
unfortunate- no substitute  
retard-no substitute  
spastic- no substitute  
stricken-say the person has \_\_\_\_\_  
victim- only in the case of an accident  
wheelchair bound-say uses a wheelchair  
withered-no substitute  
peg-leg-no substitute  
fit- say seizure  
patient- use only when in a hospital or under the care of a physician-otherwise use client or guest  
normal- who can define normal? use only with statistical material, not with people-can imply others are sub-normal or abnormal

SEMANTICS THAT WILL NOT DEMEAN OR OFFEND PEOPLE WHO

HAPPEN TO HAVE A PHYSICAL DISABILITY

Individuals who work in the media exert an exceptionally powerful influence on attitudes toward the 36 million Americans with physical disabilities. When the individuals in this country who happen to be physically disabled are presented by media personnell in a realistic and accurate manner, then negative, attitudinal banniers will gradually begin to disappear.

WHEN REPORTING A STORY ABOUT A PERSON WITH A PHYSICAL DISABILITY.....

Keep in mind that a disabling condition may not necessarily be handicapping. Handicap is often used as a synonym for disability. An example of the origin of "handicap" is "hand-in-cap," as in begging. Usage of "handicap" is beginning to become less acceptable.

WHEN REPORTING A STORY ABOUT A DOG THAT GUIDES A PERSON WHO IS BLIND.....

Please use the generic name "dog guide" if you do not know the registered name of the dog. Words such as, Seeing Eye, Leader Dog, Guide Dog and Pilot Dog are all registered names and refer to one particular dog training school. This is extremely important when wills or bequests are probated in a court of law. Please do not continue this error in your writings. It could possible cause a monotary bequest to go to the wrong place.

DO NOT USE "HANDICAPPER".....

"Handicapper" is one who predicts the winner of a horse race, usually for publication. There is no connection between the "handicapper" and a person who happens to be disabled.

IS THE DISABILITY CRUCIAL TO THE STORY?

If it isn't, then do not refer to it in your story.

KEEP AWAY FROM GROUP LABELING.....

"The handicapped" or "the disabled" puts all 36 million people with disabilities into the same catagony.

"SUFFERING FROM" IS AN EXPRESSION THAT SHOULD NOT BE USED

When a person has pain or suffering, should we remind them of it? They are more aware than we are. Don't add pity.

CONDITIONS ARE NEVER PEOPLE.....

Does an "epileptic", "paraplegic", "quad-plegic" or "cripple" pay his phone bill or shop in the super market, or do people pay their bills, do their shopping, go fishing or watch television?

When the subject of paying bills arises, one cannot help but wonder how the subconscious attitude of prospective employers are affected by the manner in which our establishment chooses to refer to a person who happens to have a disability.

One might possess a rather negative attitudinal bannier without realizing it simply by having been exposed to these manners of reference for years and years. Hiring practices related to availability of work for persons who have disabilities could be, and probably have been, negatively affected by this manner of designation.

There are some people who will have no misgivings about using terms such as "crippled" and other demeaning statements about themselves or others. We happen to believe, however, that a caring person will refrain from using such terms as a matter of respect and courtesy.

By: George Alderson, Author of:  
HANDICAPPED/HANDICAPABLE, Weekly Feature Column  
Syndicated by: Columbia Features, Inc  
36 West 44th Street  
New York, NY 10036 (212) 840-1812  
Available-AP Data Feature-UPI Data News-U.S. Mail



# Federal Emergency Management Agency

Washington, D.C. 20472

**FEB 13 1987**

Mr. Lex Frieden  
Executive Director  
National Council on the Handicapped  
800 Independence Avenue S.W., Room 814  
Washington, D.C. 20591

Dear Mr. Frieden:

The Federal Emergency Management Agency (FEMA) is planning a teleconference on disaster-related needs of disabled and elderly persons, scheduled for presentation in the fall of 1987. This unique television event is part of FEMA's annual schedule of such presentations. Broadcast from studios in Washington, D.C., the teleconference will bring together experts from around the country to speak on the issue, which is a vital concern for emergency managers. The 3-1/2 hour program is available to any of 4,000 sites in the United States equipped to receive the satellite signal of the Emergency Education Network (EENET). Transmission date for the EENET presentation, "Meeting the Emergency Needs of Disabled and Elderly Persons," is September 16, 1987.

To assist us in producing the broadcast, we would appreciate it if you could make a presentation on the demography of the population with disabilities. Especially useful would be data from the 1985 Harris Poll of disabled Americans. Your part in the program will be approximately 10-12 minutes. We would need your presence at the downtown Washington studio on the afternoon or evening of Tuesday, September 15, and briefly on Wednesday, September 16, during the morning of the telecast. We will be in touch with a more exact schedule later.

All presentations must be scripted and all visual aids used must be compatible with television broadcast standards. For more information on these matters, please contact our EENET Office in Emmitsburg, Maryland, at FTS 652-1225.

Additionally, we are seeking help in publicizing the event, and would like to meet with Andrea Fardman of your staff in this regard. We look forward to working with you and thank you in advance for your cooperation.

Sincerely,

Katherine H. Shannon  
Acting Director of Equal Opportunity



# Federal Emergency Management Agency

Washington, D.C. 20472

March 30, 1987

MEMORANDUM FOR: Lex Frieden, Executive Director  
National Council on the Handicapped

FROM: Alan Clive  
Equal Opportunity Division

SUBJECT: Teleconference Update

Thank you for accepting the invitation to participate in the September 16, 1987 teleconference, "Meeting the Emergency Needs of People Who Are Disabled or Elderly," sponsored by the Federal Emergency Management Agency (FEMA).

Your topic is "Demography of People with Disabilities," which is currently scheduled for approximately 8-9 total minutes. You are also invited to participate in one or both of the half-hour interactive segments, during which panelists answer viewer questions phoned in on an 800 number.

As noted in our original letter to you, all presentations must be scripted and use of slides or videotape is strongly encouraged. We must have a draft of your script and a copy of any proposed A/V material no later than Monday, June 15. The EENET staff can provide information on creating television-compatible visuals. You can contact EENET at (301) 447-1068.

Please send your script and visuals to me at FEMA, Room 815, 500 C. Street S.W., Washington, D.C. 20472, (202) 646-3957. At the same time, may I request that you send me short biographical statement (not to exceed one page) that can be used by the teleconference emcee during your introduction.

Since there will be two rehearsals on Tuesday, September 15, we will need your presence at the Washington TV studio throughout that day, as well as on Wednesday, September 16. If you are coming from out of town, it would be well to arrive the evening of September 14. You will receive further information on travel arrangements and hotel accommodations at a later date.

Again, our thanks for your assistance in producing what we expect to be a most successful teleconference.

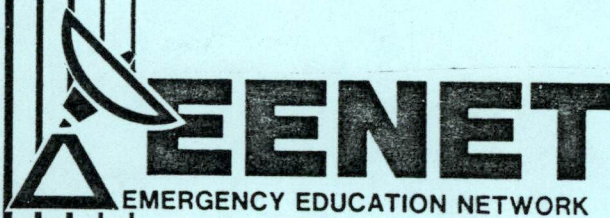
**TRI** TECHNICAL RESOURCES, INC.

3202 Monroe Street  
Rockville, Maryland 20852  
301-231-5250  
Telex 386441

JEANNE E. HARBAUGH @ FENET  
301/447-1068



**GUIDELINES  
FOR VIDEOCONFERENCE  
PRESENTERS AND PANELISTS**



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## PART I

### MAKING YOUR TV APPEARANCE

#### THE TELEVISION STUDIO

When presenters arrive at the television studio, they check in with the TRI Production Manager, or go directly to the greenroom, the waiting room for presenters. There will be a television monitor in the greenroom, so presenters can watch the program while they wait their turn to be on camera.

At the studio, you will meet many people--the sponsor's agents, usually called the Executive Producer (they pay for the program!), the TRI Production Manager and assistants, the TRI Technical Producer and assistants, the Director, technical crew, and studio staff.

The pace at the studio is controlled chaos, but production personnel will help you in any way--feel free to ask them questions. If time permits, someone will give you a quick tour of the facilities--the studio and set, the control room, the makeup area, etc.

Remember, you are in the hands of TV production professionals. They will ensure you are where you need to be at the proper time; they will make sure you look and sound your best at all times.

#### YOUR PRESENTATION

When you are asked to make a presentation for a videoconference, you may be given a topic, a general outline, a detailed outline, or you may be asked to submit what you think should be presented. But always you will be given a general time limit for your presentation.

As your presentation evolves into script, the time constraint is refined. By rehearsal, adjustments are complete and precise timing is determined. Television is a media of constraints; all elements of the program--openings, closings, credits, presentations, and audiovisuals--must remain within imposed time restrictions.

The videoconference sponsor and TRI work closely with you through the script development process--writing, editing, and rewriting process. Preparing oral presentation is much different than the

written word. Practice your presentation out loud in front of your spouse, a mirror, your dog, etc. The more often you listen to yourself speak the words, the more refined your script will become. Short simple sentences and simple vocabulary work best. Break up compound and complex sentences. A good rule is, if you cannot get through the sentence in a comfortable breath, it's too long. If your audience can't understand the points you are making, then the script is not effective. It's difficult to keep a television audience's attention; the professionals know this-- commercials have to get their message across in 30 or 60 seconds.

Practice your presentation with a stopwatch. A teleprompter is used for the videoconference--all of your script will be in front of you on the teleprompter. You will have the opportunity to practice using the teleprompter before rehearsal. (Even the "Great Communicator" uses a teleprompter!) As you practice, imagine you are speaking to a friend or small group. Plant your feet if you are standing, and keep your torso still if you sit during your delivery. Use your hands and head movements to make your points and to avoid a glazed look.

The teleprompter operator follows you as you speak. Slow down and speed up as you feel comfortable. The Floor Manager will see to it that you stay within your time limits.

By rehearsal time (usually the day before broadcast), you will learn to use, trust, and rely on the teleprompter. It, in turn, will help you give a smooth, confident, and professional appearance. Memorization is impossible and ad-libbing is dangerous. The teleprompter will make things easier for you. Practice repeatedly and get comfortable with the teleprompter. If you can, have someone videotape your practice sessions. Check your eye contact, animation, diction, expressions, and pacing. Watch out for distracting mannerisms--squinting, fidgeting, shifting your weight from foot to foot. The camera exaggerates whatever you do. Watch interviews on TV and analyze the qualities of the best and worst guests.

When you are on camera, the Floor Manager will give you cues or signals. Some standard cues, or signals, are:

- o raised fingers indicates the number of minutes remaining in your presentation
- o a hand forming the letter "C" means you have 30 seconds left
- o a raised fist means 15 seconds left
- o a circular motion with a raised hand means you are out of time and you should finish as soon as possible

- o slowly pulling hands apart means slow up your presentation
- o rapid circular movement of both hands at waist level means speed up

### WHAT TO WEAR

Normal business clothes are appropriate for most videoconferences, but be sure to avoid the following:

- o Black, white, or red suits or dresses
- o White shirts or blouses
- o Warm, bulky clothing
- o Noisy accessories such as multiple bracelets
- o Bright, metallic accessories, including bracelets, earrings, necklaces, tie clasps, and lapel pins. Watches can cause flares on the screen. The Floor Manager may collect any flare-producing accessories before the program begins.
- o Pocket change or keys. The Floor Manager may also collect these.

Tones of grey, brown, and blue are best. Pastel colors also work well.

Television tends to make you look slightly heavier than you are. Choose clothing that is trimly cut and well tailored. The studio is usually cool (55-65 degrees) until the lights go on. If you're prone to chills, bring a wrap that can be removed.

If you usually wear glasses, by all means do so during the program. Any problems with glare or reflection can be solved. Please do not wear photogrey or tinted lenses; they become too dark under the lights. It is important that the audience see your eyes.

Men and women will be made up at the studio by a skilled makeup artist. Television lighting tends to wash out your complexion; just the right makeup touches will make you look healthy and relaxed. Avoid having your hair cut the day before the broadcast; lights highlight the trim lines. If you need a trim, have it done two or three days prior to the program.

If there is a meal break, be careful what you eat and how you eat it. A light, low-cholesterol meal is best. This helps fend off after-meal lethargy, as well as the tendency to have a dry mouth while on camera. Also, if food gets on your clothing, there is

little that can be done to remove it before the videoconference resumes.

### ON-CAMERA CONDUCT

The usual videoconference format includes a combination of presentations, panel discussions, and interactive time with participants. A moderator makes introductions, sets up segments, and generally keeps the program moving.

The studio lights are very bright and very hot. Try to relax and stay calm. If you feel nervous before the telecast, stretch or yawn to relax your throat muscles and breathe deeply several times. Being yourself and maintaining a sense of humor is the surest way to succeed as an effective panelist and presenter.

When sitting as a panelist, always assume you are on camera. Maintain your poise--be aware of your facial expressions, hand gestures, and posture. Always try to appear interested and attentive. If you have papers, don't shuffle them. The sound is amplified by the microphone you will be wearing. Don't write unless you're making notes for a significant contribution. Look at other panelists or the moderator when they are speaking. Do not look for the camera; it will find you.

When making your presentation and while listening and responding to phoned-in questions, look directly at the camera. The camera lens is your audience; don't be afraid to address your remarks to it. Most studio cameras have red "tally" lights to indicate which camera is on. Don't be alarmed if occasionally none are lit. Graphics or pretaped material is being shown. If there are no tally lights, your Floor Manager will help you find which camera to address.

Speak in a normal tone of voice. The audio technician will test your normal speaking voice to get the proper level of amplification. If you need to cough or clear your throat, put your hand under your chin to shield the microphone. Avoid hitting or bumping the microphone.

During the broadcast, there are people and equipment moving in the studio. The Floor Manager is the one to pay attention to.

### RESPONDING TO QUESTIONS ON THE AIR

Some pointers:

- o Honor each question with an answer that is direct and to the point. Take a position and support it with specifics.

- o Divide complicated questions into understandable parts and deal with each in order.
- o In general, give short answers--three or four sentences.
- o If faced with a statement rather than a question, just turn it around into a question and answer it briefly.
- o Never respond to a question with another question.
- o If you don't know the answer, don't bluff it! If it is outside your specialty, simply tell the questioner you don't have the answer. Offer an opinion if you like. The moderator will move to someone with the answer.
- o Prepare a couple of questions for your colleagues on the program.
- o If you're asked a hostile question, answer briefly and slip quickly into a statement you want to make. Don't give the questioner an opportunity to argue.
- o Watch out for questions that insist on a yes/no answer. If yes or no won't do, say pleasantly but firmly, "I'm sorry we don't have time for me to give you a proper answer to that."

As a panelist, your job of answering questions is an easy one. The videoconference moderator is responsible for making the program "flow." Rely on the moderator.

Remember, you, and all presenters, have been selected to participate in the videoconference because you are knowledgeable about the topic and are able to talk about it confidently. Relax and treat this presentation as another way of delivering your material and message.

## PART II

### SUPPORTING VISUALS PRODUCTION

The following information will assist in preparing the best possible supporting visuals (e.g., slides, videotapes, card art, etc.) for your videoconference presentations. Using visuals, and lots of them, to illustrate and reinforce key points makes the difference between a dull program and an interesting, eye-catching, memorable production. If you have additional questions, please contact the TRI Production Manager.

#### GRAPHICS

Electronic, computer-generated text (words, letters, numbers) can be designed at the studio to support your presentation. They are used for two reasons: 1) to highlight key points; and, 2) to give the viewer something to look at while you are giving your presentation. No matter how dynamic the speaker, no matter how riveting the subject matter, audiences are bound to grow weary of the same image on the screen for more than four minutes. When the viewer reads highlights of your topic, it also reinforces the learning and results in better retention of the subject matter.

Effective text graphics are brief and simple. Only text (alphanumeric) can be produced. Each such graphic is limited to approximately seven lines of text, 20 characters per line at one time on the screen. Symbols or foreign characters cannot be produced. For best results, only two electronic text graphics, referred to by production people as "Chyrons," should be used per presentation minute.

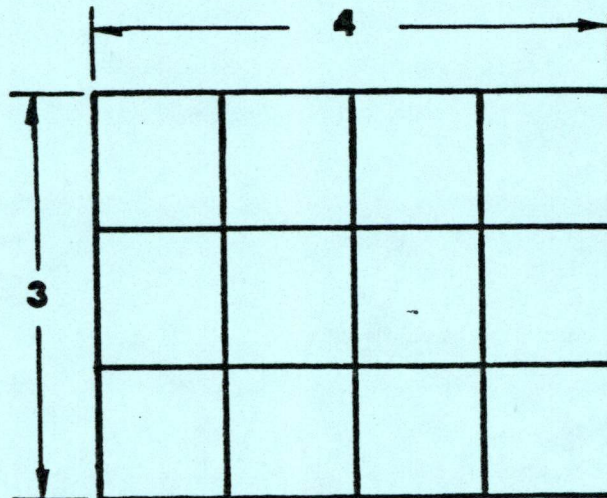
Electronic text is designed and created well before the program. Until your presentation is fully scripted and on the teleprompter, preparing such graphics is extremely difficult; these graphics must be timed and keyed to the presentation. The Director calls up the graphic and leaves it on the screen based on your script. The result is a smooth, well-choreographed presentation that looks polished and professional. With ad-libs, however, such coordination of words and pictures is impossible, and the viewer is left with a "talking head" for the duration of the presentation.

ASPECT RATIO

The ratio proportion of a television screen is three to four (3:4); the TV is horizontally oriented within an area three units high and four units wide. This is known as the "aspect ratio."

Although your eye easily adjusts to other proportions, neither the TV camera nor the TV screen at the local receive sites can. If the camera is pulled back far enough to include an entire graphic that does not conform to aspect ratio, it is very likely that the information on the graphic will become so small that it is unreadable. If the graphic is cropped by the camera to aspect ratio, information on the outside edges is lost. Thirty-five millimeter or 2" x 2" slide transparencies can only be used on television if they are horizontally oriented (even then they are NOT automatically in the correct 3:4 aspect ratio).

For other audiovisual aids, such as a chalkboard, the aspect ratio must also be considered. Writing or drawing done on a blackboard must conform to aspect ratio, or be drawn on a blackboard that conforms to aspect ratio.

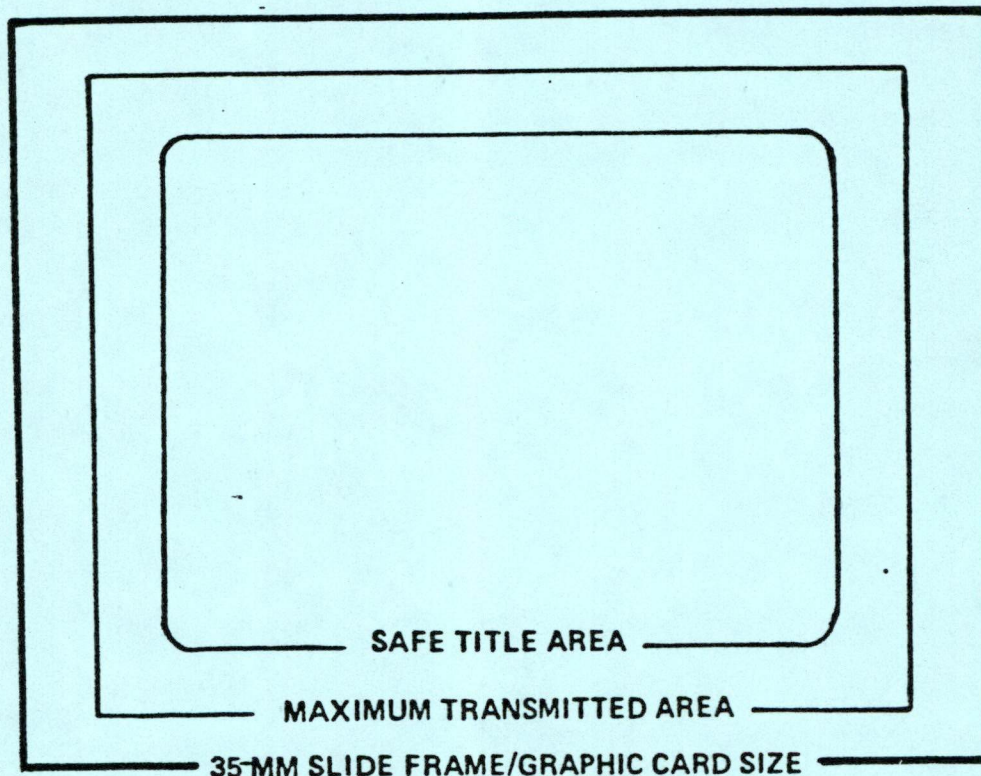


SAFE TITLE AREA

Visuals in aspect ratio may not be entirely visible on the television screen due to a peripheral loss of the picture area caused by various electronic manipulations. Some TV sets may crop off edges of the TV picture. To make sure that all the information on the visual is visible on the screen, the entire visual must be contained in the "safe title area."

About one-third of the outside edge area is lost on each of the four sides of a visual. The area remaining in the center is the safe title area. The visual should be centered in the safe title area, leaving some surrounding margin.

The diagram below depicts the safe title area in relation to the edges of the TV screen. This is the area in which all text information must be contained.



**All material must be contained in the safe title area**

COLORIZATION: GRAPHIC SLIDES & CARD ART

Artwork prepared for a videoconference may be electronically stored prior to going on-the-air. This makes it easier to retrieve and use by control room personnel during the broadcast.

Background Color

Due to the technical characteristics of TV equipment, electronic storage is best if the artwork or slide has a totally black background (low luminance value). Color can be added to the background electronically in the studio in order to match it to the other backgrounds used.

Foreground Color

Foreground images (symbols, shapes, flow charts) should be bright (high luminance value). If only one color is used in the foreground image, then it should be white. Color can be added in the studio as appropriate. If more than one color is used in the foreground images, the colors should have high luminance value, and a good contrast to each other in both black and white and in color (i.e., one color should have a slightly higher luminance value than the other).

Level of Detail

Keep all visuals simple--if there is too much detail, some of it will be totally invisible on the TV screen. Lines should be thicker rather than thinner due to the relatively poor resolution of television. Limit text on the slide, and always observe aspect ratio and safe title area constraints as outlined above. Allow plenty of margin (called "bleed") at the edges of the slides.

COLORIZATION: PHOTOGRAPHIC MATERIAL

The colorization guidelines above are intended principally for graphic material. Any photographic material used will not need an electronically-generated background, nor is it necessary to supply photographic material in negative form--color positives are best for videoconference purposes.



## National Council on the Handicapped

800 Independence Avenue, S.W.  
Suite 814  
Washington, D.C. 20591

202-267-3846 voice  
202-267-3232 TDD

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An Independent  
Federal Agency

June 19, 1987

Alan Clive  
Federal Center Plaza  
500 C Street, SW  
Suite 815, or 818  
Washington, DC

Dear Alan:

Here is the script. I appreciate your assistance and apologize for its lateness. If there are questions, please don't hesitate to call me.

Sincerely,

A handwritten signature in cursive script that reads "LaVerne M. Chase".

LaVerne M. Chase  
Fellow

Enclosure

## DEMOGRAPHICS OF DISABILITY

### FEMA PRESENTATION

#### Who are people with disabilities?

Currently, an estimated 36 million people in the U.S. have some degree of disability. These disabling conditions vary from spinal cord injuries to mental retardation to epilepsy to mental illness to deafness, to name only a few.

Broadly defined, disabilities can be grouped into three categories which are physical disabilities such as cerebral palsy; sensory disabilities such as blindness and deafness; and mental disabilities such as schizophrenia and mental retardation. Many disabilities are hidden and not readily apparent, such as heart disease.

#### How many people with disabilities are there in America?

Although we know generally how many people with disabilities there are in the United States, specific numbers vary considerably depending upon who does the defining and when the statistics were gathered. According to the National Center for Health Statistics there are:

18.4 million people with orthopedic impairments;

17 million persons with hearing impairments;

8.2 million with visual impairments;

2.1 million with speech impairments;

26.8 million with arthritis;

24.3 million with hypertensive disease;

16.4 million with heart disease

1.6 million missing extremities or parts of extremities; and

1.2 million who are partially or completely paralyzed

Other studies found that in terms of mental disabilities, there are approximately 5.7 million mentally retarded persons in the U.S., and between 1.7-2.4 million people with mental illness.

It is estimated that by the year 2000, for every non-disabled person in this country, there will be one disabled person or one person over sixty five.

Where do persons with disabilities live?

People with disabilities live everywhere. People with mental disabilities, who do not also have physical disabilities, do not automatically have special housing needs and therefore can live anywhere, in any community whether it be rural, urban or suburban.

On the other hand, people with physical disabilities in which their mobility is impaired, usually live in places that are architecturally accessible. Accessible housing can be in the form of apartments or single family housing. Furthermore, people who have sensory impairments such as blindness or deafness require adaptations in their homes to accommodate their disabilities. For example, some deaf people may have flashing lights to signify emergencies and some blind people may have special alarms for safety reasons.

In the past, disabled people tended to be residentially and institutionally segregated. Being disabled does not necessarily mean that an individual is dependent upon another person; many disabled persons choose to live alone and function independently. Nowadays, due to changes in the economy, laws, public policy, attitudes, technology, and architectural design standards, people with disabilities are more widely dispersed throughout society.

What does it mean to be disabled?

The first nationwide Harris poll of disabled persons was conducted in 1986. The survey revealed several interesting things about persons with disabilities:

- o Disabled Americans have far less education, as a group, than do non-disabled Americans.

- o Disabled Americans are much poorer than non-disabled Americans.

o Not working is perhaps the truest definition of what it means to be disabled in America. Nearly 2/3 of all disabled people between the ages of 16 and 64 are not working.

o Being disabled means having less social life than non-disabled people and, for a majority of disabled persons, not being able to get around and socialize as much as they would like.

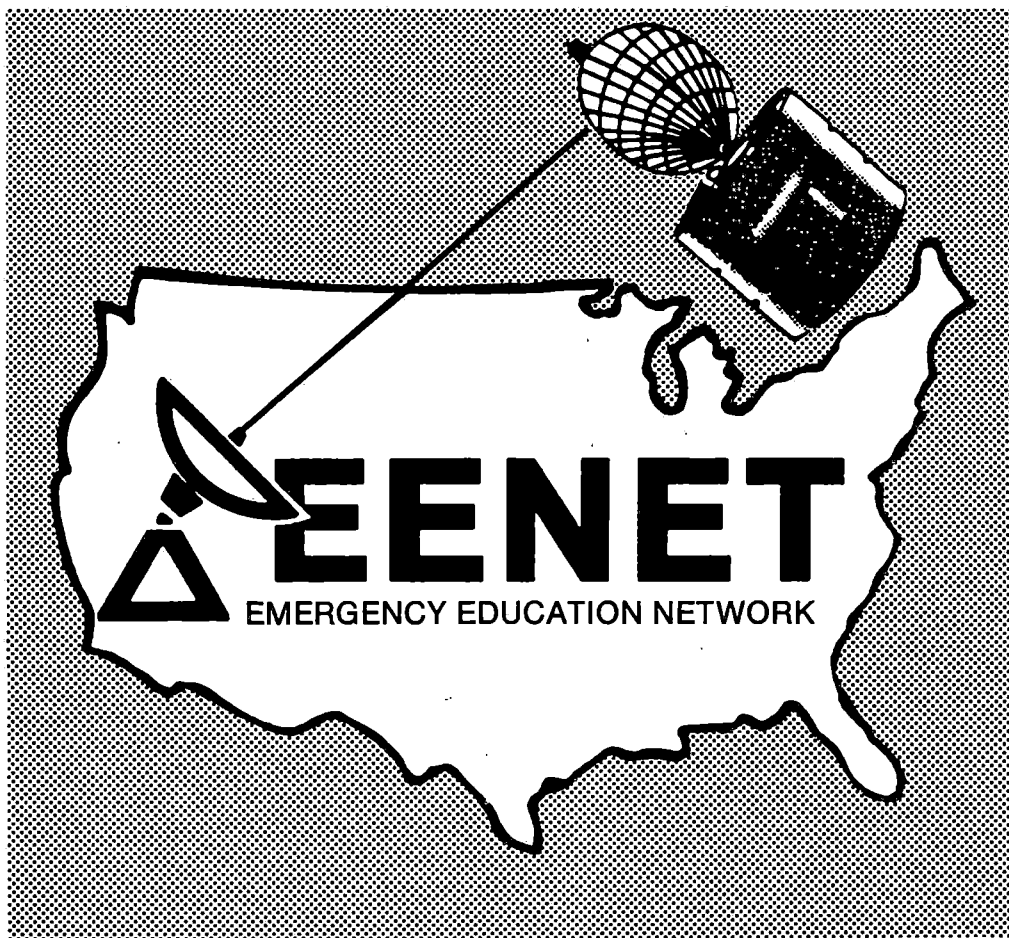
What is the Independent Living Movement?

The Independent Living Movement is a civil rights, advocacy, and self-help movement. Independent living emphasizes the goals of self-sufficient community living and maximum autonomy for disabled persons. The independent living movement has been facilitated by federal and state legislation and funding.

Summary & Pep talk

Statistics involving people with disabilities can be confusing, contradictory, and inaccurate at best. The important things to remember are that people with disabilities are one in every eight people in America and that people with disabilities are people first. You will find them in every situation with which you are dealing -- some may be more obvious than others. As we make sociological and technological progress, and people with disabilities gain more power, there will naturally be more disabled people in the community.

The fact of the matter is that people with disabilities are alive and well. This is not a cliché, it is a fact. We work, we play, and we have families. We also have emergencies just like other people. If you encounter disabled people, ask them if they need assistance and ask how to assist them. Do not assume you know what they need.



**LOCAL RECEIVE SITE COORDINATION GUIDE**

**Meeting The Emergency Needs Of People  
Who Are Disabled Or Elderly**

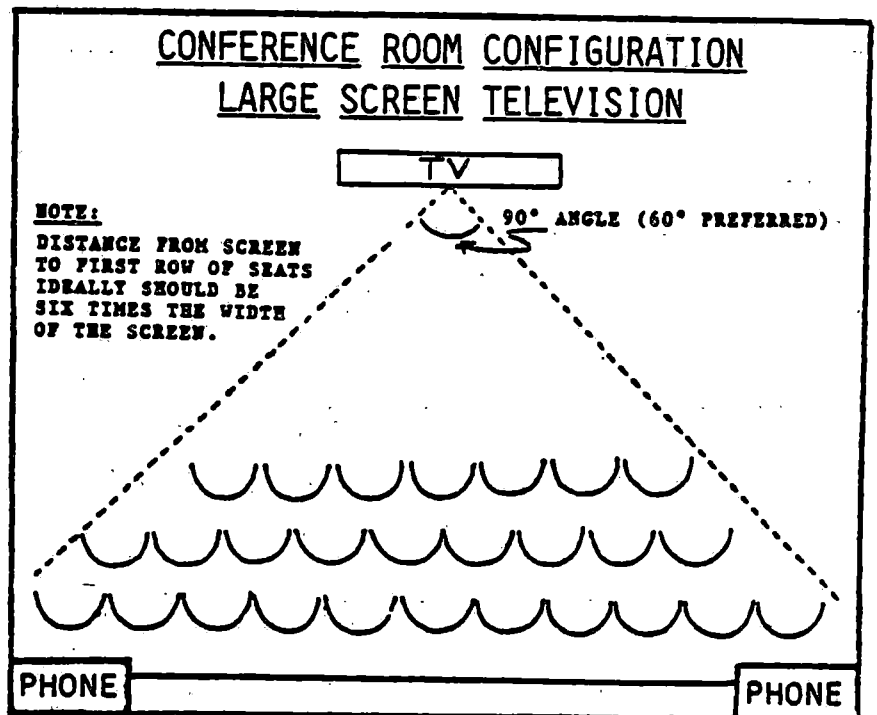
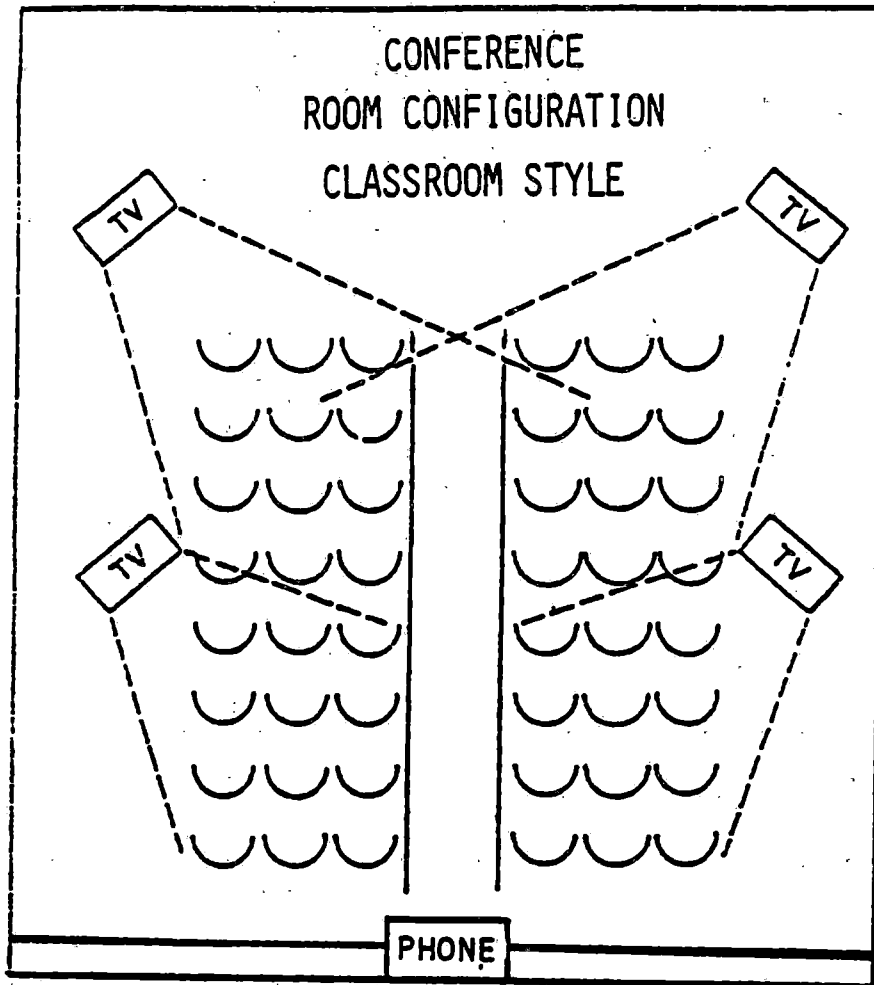
**September 16, 1987**

**Federal Emergency Management Agency  
Videoconference**



# ROOM CONFIGURATIONS FOR TELECONFERENCING

TELEPHONES MUST BE AS FAR FROM THE TV MONITORS AS POSSIBLE



## LOCAL RECEIVE SITE COORDINATION GUIDE

### SETTING UP A LOCAL RECEIVE SITE

Any person or group may set up a Local Receive Site and participate in a FEMA videoconference. This may be accomplished several ways:

- A. Contact your local cable company and ask if they will carry the videoconference for your organization.
- B. Many city/county governments have dedicated internal cable systems which carry programs such as these into offices and other facilities. Contact your local government cable access office for specific information.
- C. Use a local facility which has a TVRO, for example, a college or university, a hospital, a local industry, a hotel/motel.  
  
Arrange for a viewing room [you'll need the date, time, and satellite reception information], video projection system [TV], and a telephone for the interactive [call-in] segments.
- D. Rent a portable TVRO ["dish"] and have it set up at your viewing place.
- E. Set up a TeleVision Receive-Only earth station [i.e., "dish"] at your viewing facility.

### AUDIO INTERACTION - VIEWER PARTICIPATION VIA TELEPHONE

A major feature of videoconferences is the opportunity for viewers to call into the studio and ask questions or make comments of the program presenters. This live interaction sets videoconferences apart from many other types of video programs. Arrange to have a telephone in the viewing room to use during the program [speaker phones may be used]. Please review the "Room Configurations for Videoconferencing" diagram in this Guide to help set up the optimal audio arrangement for your Local Receive Site.

Since the audio portion of the interaction is carried over the satellite, the responses from presenters will only be heard over the speaker on the TV monitor rather than the telephone. Therefore, adjustments to the audio level on the monitor may be required. The use of a telephone with "push-to-talk" capability will help reduce speaker feedback problems.

Procedures for calling into the studio follow. You may want to read these to viewers at your Local Receive Site. Notice that it is suggested that one person [usually the Local Receive Site Coordinator] place all calls; this makes the process run smoother.

#### =====PHONE INTERACTION INSTRUCTIONS=====

Several times today during the videoconference, we will have the opportunity to phone into the TV studio and ask questions or make comments to the panel. The phone we will use is there [point to your phone].

If you have a question or comment, jot it down. Bring your written note with you when you come to the phone. Please keep the questions or comments brief and ask only one question at a time. Two part questions are difficult for the panelists to remember as they form answers. Also, remember there are thousands of viewers who also want to participate.

Our signal to call will come from the Moderator, or, there will be a message at the bottom of the screen which reads, "Phones are open." When this happens, please form a line by the telephone. I will place the call and will hand you the handset. The studio operator will answer, "FEMA Teleconference." Give the studio operator your name, city and state. For example, say, "This is John Doe from Paduka, Kentucky." You will then be put on HOLD--do not hang up.

Your cue to ask your question will come OVER THE TV--YOU WILL NOT RECEIVE AUDIO OVER THE PHONE; YOU MUST LISTEN CLOSELY TO THE TV. The Moderator will call you by name. You will hear yourself, the Moderator, and the panelists over the TV.

State your question or comment clearly. Your voice will come back over the TV slightly delayed, like an echo. As you speak, you may find it helpful to cover your free ear with your hand while you ask your question so that you are not distracted by the echo from the TV. This procedure also helps minimize audio feedback problems.

If your question is asked by someone else, please be seated.

AFTER YOU ASK YOUR QUESTION, STAY ON THE PHONE UNTIL THE MODERATOR MOVES ON TO THE NEXT QUESTIONER.

I will then take the phone from you and hang up. I must redial for each question.

Please make yourselves comfortable. The program will begin in just a moment.

=====

Remember the GOLDEN RULE of participating in a videoconference: WHEN IN DOUBT ABOUT WHAT TO DO, LISTEN TO THE MODERATOR. THE MODERATOR WILL ALWAYS GIVE CLEAR AND PRECISE INSTRUCTIONS OVER THE TV.

Because of the volume of callers, not all calls can be answered. But we will try to answer as many as possible. More calls can be answered if questions are not duplicated. If you get a busy signal, keep trying.

### VIDEOTAPING

Videotaping FEMA's EENET videoconferences is encouraged; written permission is not required to copy or rebroadcast FEMA videoconferences as long as programs are used for educational purposes only. There are no copyrights; FEMA videoconference broadcasts are in the public domain. No charge is made for videotaping rights.

Duplicate videotapes may be made for training and education purposes. It is hoped you will share these programs with others.

If you are recording the program on 3/4" tape, at least five 60-minute tapes will be needed as the program is 270-minutes long. An announcement will be made at the end of each hour in the program so you can change your video-cassette.

If the 1/2" Beta format is used, an L-750 tape recorded at the Beta III setting will be required. The entire videoconference can be recorded on one tape.

If 1/2" VHS format tape is used, two T-120 tapes should be used. Select either LP or ELP setting on the recorder.

### VIDEOTAPE AND TRANSCRIPT PURCHASE

Videotapes and transcripts of these live programs are available for purchase from EENET. An order form is included in this Guide.

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### GLOSSARY OF TERMS

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**DOWNLINK:** the equipment required to receive the audio and video signals from the satellite and relay them to a Local Receive Site.

**INTERACTIVE AUDIO:** live voice communication between Local Receive Sites and the studio.

**LOCAL RECEIVE SITE:** a facility established by any public or private person/group to view a videoconference. Viewers at Local Receive Sites participate by calling into the studio during the broadcast to talk to presenters.

**LOCAL RECEIVE SITE COORDINATOR:** a person who sponsors and/or coordinates a Local Receive Site in order to participate in a videoconference.

**STUDIO:** the facility where the television signal originates [i.e., a full television studio].

**TVRO:** TeleVision Receive-Only earth station. A satellite antenna [i.e., "dish"] used to receive satellite transmissions; may be portable or stationary.

**UPLINK:** the equipment required to relay the video and audio signals from an origination site [studio] to the satellite.



# FEDERAL EMERGENCY MANAGEMENT AGENCY

## VIDEOCONFERENCE SCHEDULE

<u>DATE</u>	<u>TITLE</u>	<u>PROGRAM FORMAT*</u> (SEE BACK)
<u>1986</u>		
September 5	"Liquified Compressed Gas: Prescription for a B.L.E.V.E. - Part I"	A
NO EVENTS DURING <u>OCTOBER</u> AND <u>NOVEMBER</u>		
December 11	"Emergency Exercises--Getting Involved in Community Preparedness"	B
December 17	"Handling the Radiation Accident Victim in the Hospital Emergency Department"	B
<u>1987</u>		
January 21	"The National Flood Insurance Program . . . TODAY"	A
February 25	"Stress Management and Physical Fitness for Firefighters: Taking Care of Number One"	A
March 18	"Liability and Risk Management: Issues for Emergency Managers"	B
April 15	"Liquified Compressed Gas: Prescription for a B.L.E.V.E. - Part II"	A
May 20	"National Emergency Preparedness: Every American's Responsibility"	A
June 17	"The Incident Command System: Professionalism in Managing Emergencies"	A
July 15	"Natural Hazards: Mechanics and Impact"	A
August 19	"Information Management: Avoiding the Disaster"	A
September 16	"Meeting the Emergency Needs of People Who Are Disabled or Elderly"	A

\*See back of this sheet (PROGRAM FORMATS) for more details.







# Federal Emergency Management Agency

National Emergency Training Center  
Emmitsburg, Maryland 21727

## MEETING THE EMERGENCY NEEDS OF PEOPLE WHO ARE DISABLED OR ELDERLY

### VIDEOCONFERENCE INFORMATION SHEET

September 16, 1987

"Meeting the Emergency Needs of People Who are Disabled or Elderly" is the topic for the Federal Emergency Management Agency's September 16th videoconference. This live program, produced by the Emergency Education Network (EENET) in conjunction with FEMA's Office of Personnel and Equal Opportunity, will air Wednesday, September 16, 1987 beginning at 11:00 A.M. and ending at 3:30 P.M. Eastern Daylight Time.

The goal of this program is to outline the disaster-related needs of people who are disabled or elderly and how emergency service personnel can best meet those needs. This program will be of interest to members of major advocacy groups, private sector service organizations, public sector social service agencies, emergency management professionals, the media, and elected and appointed community leaders, as well as people who are disabled or elderly.

This program will be close-captioned for people who are hearing impaired.

This educational program will point out: 1) the need for disaster-relief agencies or organizations to consider the needs of people who are disabled or elderly, and 2) how these agencies and organizations can develop an emergency response system that will meet those needs.

Presenters and panelists will discuss the demographics of disabled or elderly persons; a case study of disabled or elderly people in a disaster (Coalinga earthquake); information dissemination before a disaster strikes to disabled or elderly people; identification and evacuation; sheltering; building safety; and post-disaster problems. Viewers will be able to call into the studio to speak with these experts using a toll-free telephone number.

Originating in Washington, D.C., this EENET videoconference will be transmitted nationwide by satellite, and can be accessed by a C-band antenna or "dish." Satellite information is: SPACENET 1, CHANNEL 1, downlink frequency 3720 MHz (backup Channel 3, downlink frequency 3760 MHz), horizontal polarization, audio frequency 6.2/6.8 MHz, (SPACENET 1 is located over the equator at 120° West).

For further information contact:

Emergency Education Network  
National Emergency Training Center  
Room N-310  
Emmitsburg, Maryland 21727  
Telephone: 301/447-1068

**PLEASE SHARE THIS INFORMATION WITH APPROPRIATE AGENCIES OR GROUPS IN YOUR COMMUNITY.**



# Federal Emergency Management Agency

National Emergency Training Center  
Emmitsburg, Maryland 21727

## MEETING THE EMERGENCY NEEDS OF PEOPLE WHO ARE DISABLED OR ELDERLY

September 16, 1987

### VIDEOCONFERENCE AGENDA

	EASTERN TIME	CENTRAL TIME	MOUNTAIN TIME	PACIFIC TIME
TECHNICAL TEST	10:30	9:30	8:30	7:30
LIVE BROADCAST	11:00	10:00	9:00	8:00
PRERECORDED MATERIALS	1:00	12:00	11:00	10:00
LIVE BROADCAST RESUMES	2:00	1:00	12:00	11:00

=====

#### INTRODUCTION

Julius W. Becton, Jr., Director  
Federal Emergency Management Agency

#### DEMOGRAPHY OF DISABILITY

Lex Frieden, Executive Director  
National Council on the Handicapped

#### DEMOGRAPHY OF ELDERLY PERSONS

David Cunningham, Senior Program Specialist  
American Association of Retired Persons

#### THE COALINGA EARTHQUAKE AND DISABLED PERSONS

Pat Snyder, Disaster Health Services  
The American Red Cross

#### BEFORE DISASTER STRIKES: INFORMATION DISSEMINATION FOR VISUALLY IMPAIRED PERSONS

Alan Clive, Equal Employment Manager  
Office of Personnel and Equal Opportunity  
Federal Emergency Management Agency

#### BEFORE DISASTER STRIKES: INFORMATION FOR MENTALLY HANDICAPPED PERSONS (Videotape)

#### COMMUNICATION: FIRE SAFETY FOR HEARING IMPAIRED PERSONS

Ron Coleman, Fire Chief  
Fullerton, CA Fire Department

COMMUNITY INVOLVEMENT IN TRAINING FIREFIGHTERS IN CANADA

Jean-Remi Champagne  
National Research Council of Canada

EVACUATION: BASIC PHILOSOPHY AND TECHNIQUES

Edwina Juliet, Director  
Quality Assurance and Risk Management  
Martha Jefferson Hospital, Charlottesville, VA

IDENTIFICATION AND EVACUATION: THE HURRICANE ELENA EXPERIENCE

Guy Daines, Director  
Pinellas County, FL Emergency Medical Services

PANEL DISCUSSION WITH NATIONAL AUDIENCE INTERACTION

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1:00-2:00 P.M. BREAK - PRERECORDED MATERIALS FOR LOCAL TAPING

---

SHELTERING DISABLED AND ELDERLY PERSONS

Pat Snyder, Disaster Health Services  
The American Red Cross

MANAGING THE MICRO-EMERGENCY

Kathleen Henning, Emergency Coordinator  
Montgomery County, MD Department of Fire and Rescue Services

POST-DISASTER PROBLEMS OF ELDERLY PERSONS

Greg Wilder, Aging Specialist  
Region VII Administration on Aging

BUILDING SAFETY FOR PERSONS WITH DISABILITIES

Jake Pauls, Fire Protection Consultant  
Hughes Associates, Inc.

EDUCATING THE EMERGENCY SERVICES COMMUNITY: THE CSTI EXPERIENCE

Janet Bradford, Program Manager  
California Specialized Training Institute

PANEL DISCUSSION WITH NATIONAL AUDIENCE INTERACTION

WORKSHOP AND RESOURCE MATERIALS

for

FEDERAL EMERGENCY MANAGEMENT AGENCY

VIDEOCONFERENCE

SEPTEMBER 16, 1987

MEETING THE EMERGENCY NEEDS OF PEOPLE WHO ARE DISABLED OR ELDERLY

Produced by the  
EMERGENCY EDUCATION NETWORK

## WORKSHOP INSTRUCTIONS

To run concurrently with or following the September 16th videoconference, you may want to conduct a workshop with participants at your local receive site. A workshop may be held: 1) prior to the 11:00 A.M. Eastern Daylight Time live broadcast; 2) during the break (1:00 - 2:00 P.M. Eastern Daylight Time); 3) immediately after the program (ends at 3:30 P.M. Eastern Daylight Time); or, 4) at a later date using a videotape of the videoconference.

Below are three suggested topics around which to plan your workshop. Alter these topics or substitute others as appropriate to your goals. The plenary group can concentrate on a single topic or you may want to break into smaller work groups, which can meet separately and report back to the plenary session.

### Topic 1 - Self-Help Tips

You have formed a "disabled-in-disaster" task force in your community. The committee membership includes public safety agencies and persons who are disabled or elderly. You will advise the city's Emergency Services Coordinator on considerations for meeting the disaster-related needs of these population groups.

At your first meeting the task force decided its highest priority should be promoting self-help among your area's people with disabilities. You are now having your second meeting. The Emergency Services Coordinator has just reported that next year's budget will allow for printing and distributing a brochure on self-help. Your task is to develop the information to be included in the brochure. Specifically:

- What plans should be made by persons with disabilities (e.g., home plan, neighborhood plan, workplace plan)?
- What specific considerations will be required for persons who are:  
1) mobility impaired; 2) visually impaired; 3) hearing impaired; and,  
4) mentally impaired?
- How would you propose to distribute the brochure most effectively?
- What other means could be used to ensure that persons who are disabled or elderly have and use this important information?

### Topic 2 - Community Services Organizations

Your group is a subcommittee of the community's Human Services Commission (HSC). You have been appointed by the Mayor to coordinate activities of

volunteer agencies within the city. Commission members represent a sample of the service organizations in the city, such as the American Red Cross, American Cancer Society, Council on Aging, Independent Living Center, etc.

Recently the city's Emergency Services Coordinator made a presentation at an HSC meeting about disaster-related problems of people who are disabled or elderly. The speaker encouraged the HSC to organize the community service/-volunteer sectors for disaster purposes. The Coordinator also solicited input from the HSC about the number and types of persons in your community who are elderly or have a disability.

Your task is to develop a process to respond to these issues. Specifically:

- How can you determine the number and types of persons who are elderly or disabled in your community? What agencies would you contact? How else could you solicit this information?
- What resources can the HSC and the other volunteer/service organizations provide in time of emergency?
- How would you propose to identify and organize resources for a disaster response to the needs of people who are elderly or disabled? With what local government agencies would you have to coordinate? How would you propose to interact with these agencies during the planning, mitigation, emergency, and recovery phases?

### Topic 3 - Public Safety/Governmental Considerations

Your group represents the community's Office of Emergency Services. Although you have close liaison with the city's police and fire departments, your office is independent and reports directly to the mayor or city manager. Recently, a major fire at a board and care home in your city killed four people who were unable to evacuate from the third floor of the old, unsafe structure.

This incident focused media and public attention on the need for emergency planning for persons who are disabled or elderly, whether they reside in institutions or in the general community.

Your task is to ensure that the community prepares effectively so that all citizens are adequately served in emergencies.

Specifically:

- What can be done to provide emergency preparedness information to persons who are visually impaired or mentally impaired?
- What plans will you make to notify persons who are hearing impaired in the event of an emergency?
- What special plans will be required to evacuate people who are disabled or elderly from high-rise buildings? What about an evacuation of an entire portion of the city?

- What steps will be taken to ensure accessible and properly stocked and staffed shelters?
- What agencies should be involved in the foregoing efforts? What are their areas of involvement? How would you coordinate them?
- How will you communicate your planning decisions to the public during the planning, emergency, and recovery phases?
- What other steps should the city take in this area?

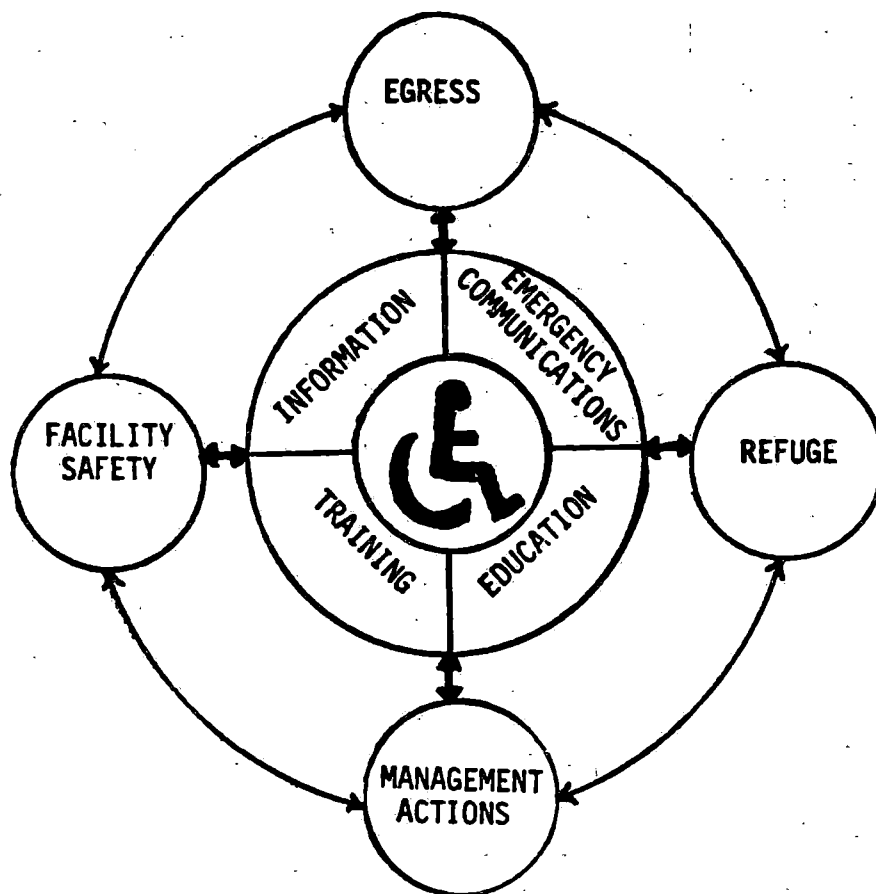
### WHO TO INVITE

Workshop participants should include a cross section of individuals and organizations that have a role in meeting emergency needs of people who are disabled or elderly. Start with consumers who are disabled or elderly or who serve as advocates for them. Contact major advocacy groups in your community. Representatives from service organizations (e.g., American Red Cross, Easter Seal, Heart Association, Council on Aging,) should be included, as well as persons from public sector social service agencies.

For the viewpoint of emergency management professionals, you need representation from the local police and fire departments and from your community's emergency management agency. Print and electronic media play a vital role during emergencies and should not be ignored. Get managers from area television stations. Finally, the elected and appointed leadership of your community should be invited. These leaders--the mayor, city councilors, the city manager--make budgetary and staffing decisions that determine the ultimate effectiveness of emergency services for people who are disabled or elderly.

### VIDEOCONFERENCE EVALUATION

A self-mailing Evaluation Form is attached at the back of this Guide. Duplicate and distribute this form (front and back) for each participant at your receive site. Ask each participant to take a few minutes to fill in the Evaluation Form. Fold, staple, and return this Evaluation Form.



# Developing an emergency preparedness plan for the physically disabled

by Lisa B. Carver

**E**ach day safety professionals face many problems. These problems range from the simple everyday tasks, such as routine paperwork, to difficult and even unusual problems such as maintaining a safe working environment in a petrochemical plant. The passage of the Architectural Barriers Act of 1968, the Rehabilitation Act of 1973, and the Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978, opened doors to the physically disabled enabling them to possess jobs in areas which were not open to them in the past. Also, due to the present idea of mainstreaming, the physically disabled are merged back into everyday life and the work force.

These developments have introduced the problem of providing a safe working environment for physically disabled employees. These employees could have disabilities ranging from impaired speech

and hearing, to blindness, or being confined to a wheelchair. Many of these disabilities can prevent the employees from being alerted in an emergency situation or can prevent them from escaping during an emergency, thus, endangering their lives. This article will explain the basic concepts to be considered when establishing an emergency preparedness plan for the physically disabled in an industrial or business setting.

First, the company's philosophy on providing life-safety for the physically disabled should be determined. These philosophies will vary from organization to organization depending upon such variables as size, location, number of physically disabled employees and safety objectives. In addition to these variables certain viewpoints warrant consideration before a philosophy can be determined. These viewpoints include:<sup>1</sup>

1. Nondiscrimination in safety mea-

asures (identical safety). Safety measures should be the same for both physically disabled and able-bodied individuals.

2. Equivalent safety. The physically disabled should be as safe from life-threatening conditions as the able-bodied, although there may be different strategies for providing safety for the physically disabled.
3. No detriment to the freedom of the general public. Life safety measures for the physically disabled should not increase life safety threats to the able-bodied. Instead, measures for physically disabled individuals should be designed to increase the general public safety.
4. Highest risk/least ability criterion. Safety measures might be designed to provide adequate protection for individuals with the least capability for self-protection.

5. Right to ask. Physically handicapped individuals should be as free to accept risk as their able-bodied counterparts. Denying the physically disabled access to facilities open to the general public is unacceptable as a safety measure.
6. Right to information. Physically disabled individuals should have access to the information necessary to determine their level of risk, in light of their specific disabilities, in different building types.

Once the company has decided upon a philosophy, an emergency preparedness plan can be formulated. In the center of Figure 1<sup>2</sup> is the international symbol of the handicapped. Generally, the symbol is white on a blue background. Encircling the symbol are eight areas which need consideration when formulating an emergency preparedness plan for the physically disabled employee. The eight areas are:

1. Egress
2. Refuge
3. Management actions
4. Facility safety
5. Emergency communications
6. Education
7. Training
8. Information.

Before separately addressing each of the eight areas listed above, general information needs to be gathered about possible emergencies and types of disabilities that might be found among the company's employees. To learn more about a specific disability, the safety professional can contact the plant's medical department or any association for the physically disabled. Many private and government organizations are available to aid the safety professional in achieving the company's goal of providing a safe working environment for physically disabled employees. Several of these organizations are the Alabama Institute for the Deaf and Blind, Mainstream, Inc., Paralyzed Veterans of America, and the President's Committee on Employment of the Handicapped.

After general information has been gathered, considerations concerning the eight areas in Figure 1 can begin. Since the areas are interrelated, the starting point for the emergency preparedness plan can be arbitrarily selected. For example, it is possible to begin with egress. There are many factors to consider when providing adequate egress for the physically disabled. Some of these factors include:

1. Is the door width wide enough to allow passage of a wheelchair?
2. Are there certain configurations and sizes of corridors that can create exit problems for the physically disabled?
3. Do doors contain opening hardware which would interfere or make it more difficult for the physically disabled to operate it?

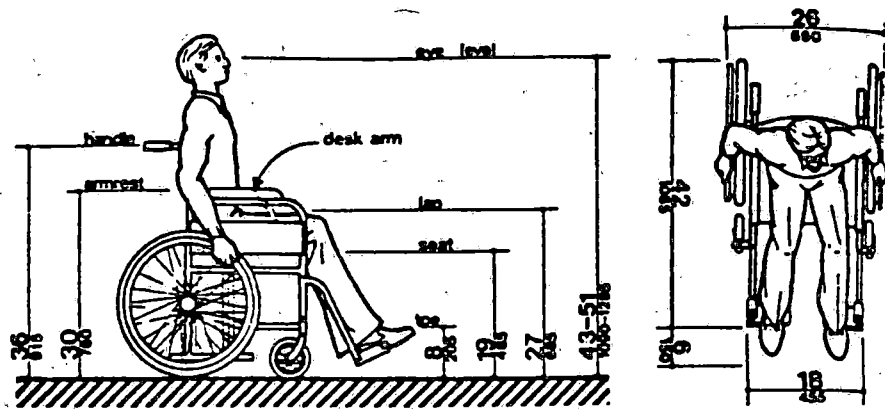
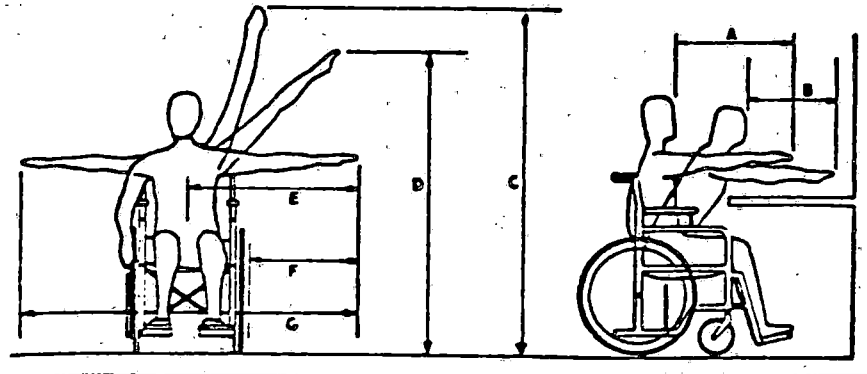


Figure 2a



Wheelchair Reach  
 A 20-24" Avg 22"  
 B 20.5-32.2" Avg 30.3"  
 C 54-78" Avg 60"  
 D 48" Diagonal Reach  
 E Avg 33.5" Center Reach With  
 F Avg 18.75" Side Reach  
 G 54-74.5" Avg 54.5"

Figure 2b

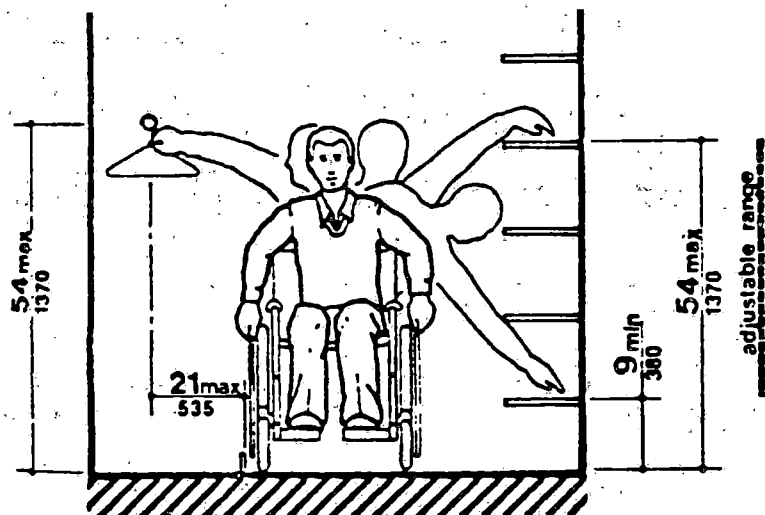


Figure 2c

These are only some of the questions which must be answered when discussing egress components.

According to the *Accident Prevention Manual for Industrial Operations—Administration and Programs*, the following guidelines should be kept in mind when answering questions concerning egress.

#### Wheelchair checklist

"The space requirements of the average wheelchair are as follows: Most wheelchairs are 36 inches high, 26 inches wide, and 42 inches long. (See Figure

2a.) They require at least 60 x 60 inches to make a 180 or 360 degree turn. However, 60 x 78 inches is preferred to make a smoother U-turn.

"People who use wheelchairs are usually able to stretch their arms 48 inches on the diagonal and extend their arms 64½ inches straight out. The average reach directly upward is 60 inches. (See Figure 2a.) The usual maximum downward reach from the chair is 10 inches. (See Figure 2b.) Shorter distances may be needed, however, to accomplish certain tasks. (See Figure 2c.)"

Since the width requirements for an average wheelchair is 26 inches, all entry and interior doors should be 32 inches wide. Perhaps this width requirement is one reason for the changing of the minimum door size from 28 inches to 32 inches in *NFPA 101, The Life Safety Code*. Preferred opening hardware on doors is a vertical grab handle, however, if a knob is used it should be 36 inches from the floor. Interior doors should open with a single effort and have thresholds nearly level with the floor.<sup>4</sup>

In the past, there were no codes or standards applying to egress requirements for buildings that house or may house the physically disabled. However, there are some standards which do have specific provisions for the physically disabled. The ANSI Accessibility Standard addresses fire safety for the physically disabled, but only in its warning system provisions. These provisions primarily address the problems of individuals confined to wheelchairs.<sup>5</sup> Also, during 1980, the NFPA was considering a proposal that applied directly to new buildings which are accessible to the physically disabled for inclusion in *NFPA 101*. This proposal contained provisions for floor compartmentalization and size, fire resistive ratings, and duct protection, plus five exceptions. This proposal was not accepted by the NFPA membership and thus did not become part of the *Life Safety Code*.

Much data have been collected on how the able-bodied individual responds in an emergency situation; however, there is a significant lack of data on how the physically disabled individual responds in an emergency situation. For example, during a fire emergency, the able-bodied employee tends to use the exit most frequently used during daily routine travel. Although this same behavior can usually be expected from a disabled employee, there is no data to support this assumption. A second example could involve a visually impaired individual. Suppose that there is a fire or natural disaster such as an earthquake. How would this person evacuate the building when normally he/she relies upon familiar sounds for direction in leaving the building? In such an emergency there would exist only confusion and unfamiliar sounds. Such a question is difficult to answer because no one is sure how that person would respond.

Perhaps this lack of data is one reason why there are so few codes and standards that apply to the unique problems of egress for the physically disabled. Therefore, much of the burden for providing adequate egress components falls upon the safety professional's shoulders. Consequently, when entering information about egress into the emergency preparedness plan, the safety professional must consider the facility's pertinent and significant problems as applied to egress. One way of learning about these prob-

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*... responsibility for determining the safety of the facility to the physically disabled falls on the safety professional.*

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lems would be to talk with the disabled employees and ask what difficulties they have encountered.

Continuing clockwise around the outer circle in Figure 1, the safety professional next encounters the topic of refuge. Refuge indicates the provision of a safe place for employees to stay pending evacuation if they are unable to leave the building for one reason or another. First of all, the area of refuge should be of fire-resistive construction. It should have adequate ventilation and smoke control. Second, the size of the area should be adequate. One means of determining adequate size is as follows:<sup>6</sup>

1. 10% of population to be served at 15 square feet/person.
2. 90% of population to be served at 6 square feet/person.

The first requirement stated above is for the accommodation of the physically disabled, and the second is for the accommodation of able-bodied individuals. Third, the area should be equipped with alarms and two-way communication so as to determine the condition and needs of the occupants during an emergency. The above specifications are recommendations and not requirements.

The third stop on the outer circle is management actions. This area is one of the most important areas to be discussed because the attitudes and actions taken by management greatly affect the outcome of the emergency preparedness plan. If management is unwilling to provide funding and support for training, proper egress, proper alarms, etc., then the effectiveness of the plan may be severely limited. Management and the safety office should work together in deciding what actions need to be taken, how much they will cost and whether or not the action is beneficial to the company as well as the employees concerned.

Some incentives for management include recognition from local government and civic organizations, as well as award programs at higher levels where they carry more weight, such as the Governor's Conference, President's Committees, and "All American Cities," plus insurance premium reductions.<sup>7</sup> The safety professionals must have management on their side when developing an emergency preparedness plan.

The last stop on the outer circle of Figure 1 is facility safety. The goal of the safety professional is to make the facility as safe as possible for every employee. This goal can be difficult (but not impossible) to achieve when the safety of a physically disabled employee is involved.

With good operating procedures and an active safety program, equivalent safety without discrimination can be established for the physically disabled. It is difficult to apply specific recommendations to facility safety since the functions and processes vary among facilities, therefore, the responsibility for determining the safety of the facility to the physically disabled falls on the safety professional.

Before placing a physically disabled employee into a specific job within the facility, a job appraisal should be conducted. The factors to be considered in job appraisal are physical requirements, working conditions, health hazards, and accident hazards. By matching the capabilities of the worker with the requirements of the job, the probability of the worker being injured is lowered. Therefore, overall facility safety is supported.

The inner circle of Figure 1 might be entered at the point of emergency communications. Emergency communications apply to communications within the facility and communications outside the facility. Within the facility there must be a good, reliable system of communicating to employees before, during, and after an emergency. Before the emergency occurs, such communications could be posters describing what actions are to be taken during an actual emergency, drills, education, and training. Communications during an emergency could involve alarms and voice communications over a public address system. However, these do have shortcomings. For example, how can a deaf employee respond to an alarm that uses sound to notify the occupants?

Fortunately, today there is a method of overcoming this problem: strobe light alarms. When the alarm is activated, a strobe light flashes, thus, catching the deaf employee's attention and alerting him to the emergency situation. This same principle is widely used in homes occupied by deaf individuals to alert them when someone is at the door or if the phone is ringing.

Of course, it is necessary that in the work environment the employee be properly trained and educated about the alarm systems in the facility. Also, routine principles which apply to ordinary alarm systems (such as proper maintenance and testing) should be applied to special alarm systems. Even though the facility may be equipped with special alarms, not every occupant of the building will be notified. This fact is true for both the able-bodied and the physically disabled. It is the goal of an alarm system to reach the majority of the occupants.

Emergency communications outside the facility involve preplanning lines of communication with city, state, and federal agencies. If the facility relies upon the local fire department to assist them during an emergency, then the fire department should be properly informed on plant

Type of Handicap Fire Safety Message	WHAT YOU CAN DO — Preparation for and in a Fire Emergency		
	MOVEMENT	HEARING	VISUAL
HOME FIRE ● Escape ● Call FD	<p>*Practice and time alternate escape options.</p> <p>*Establish an emergency contact system via telephone, friends, signals, etc. This is crucial if you live alone</p> <p>Be aware of fire safety in location of bedrooms</p> <p>Survey House for at least two escape routes depending on type of fire emergency and length of warning time.</p> <p>*Notify FD of your location and specific disabilities. Red Dot and I Sticker Programs (problem: security).</p> <p>Keep a small tank of O<sub>2</sub> in bedroom, or other escape breathing device (problem: overconfidence).</p> <p>Have available some device (a battery operated flashing light in bedroom window, for example) to signal your location. This device could be automatically activated in the event of fire.</p>	<p>Remove obstacles to egress. Be aware of certain things becoming obstacles in the event of fire (rugs, etc.).</p> <p>Install ramps and doors which can be opened easily.</p> <p>Survey house for escape routes.</p> <p>*Notify FD. Register</p> <p>Escape fire situation first, then contact FD from neighbor's house</p>	<p>*Practice escape routes. Practice them walking and crawling.</p> <p>Replace windows with sliding sliding glass doors</p> <p>Survey house for at least 2 escape routes</p> <p>*Notify FD. Register</p>

FD = Fire Department  
 \* = of great importance  
 \*\* Points below are applicable to paraplegics.  
 It is assumed that quadruplegics will live with others who know and practice emergency fire evacuation.

Figure 3

processes, about any personnel who may need assistance during an emergency, and about the locations of refuge areas which need to be evacuated. The preplanning of these communications are essential to the emergency preparedness plan.

Proceeding clockwise around the inner circle of Figure 1, the ideas of education and training are encountered. Since education and training are very closely related and often go hand-in-hand, they will be discussed together rather than separately. Of course, education and training are just as important to the able-bodied as to the physically disabled. However, the education and training of the physically disabled may require the use of different teaching methods. Naturally, the blind cannot be instructed through the use of written materials, unless the materials are in Braille and the employee can read Braille, and the deaf cannot be instructed by voice, unless it is translated into sign language, assuming that the employee has an understanding of sign language.

Because of these different disabilities, it may be more time consuming to train and educate the physically disabled. The reason it may be time consuming is that, if the facility has had no previous experience in this area, it will be necessary for them to acquire information about materials and programs for the instruction of the physically disabled. Currently there are several programs of instruction available from municipal fire departments.

Although these programs generally apply to residential fire safety for the physically disabled, the same principles could apply to an industrial setting and the information contained in these programs can be helpful in acquainting the safety professional with the problems that are encountered by the physically disabled. There are educational materials about fire safety which have been translated into Braille for the visually-impaired.

Other materials include "Wheeling to Fire Safety: Fire Emergency Procedures for Paralyzed and Other Handicapped People," a brochure produced by the Eastern Paralyzed Veterans Association, and "Fire Safety for You: A Guide for Handicapped People," released by the National Fire Protection Association.<sup>8</sup>

Once again, the information in these publications may not apply directly to a business or industrial setting, but can be very helpful in deciding which educational and training needs of the physically disabled should be addressed. When developing an educational and training program in a facility the following questions should be asked:<sup>9</sup>

1. In what way would the content of fire safety materials for the physically disabled differ from the content developed for able-bodied individuals? Can material developed for the able-bodied simply be adapted for the physically disabled?
2. How is fire safety education to be conveyed? What form (film, record, brochure) do the materials take?

3. To whom should fire safety education for the physically disabled be conveyed? Adults? Children? Demonstrations? Classes?
4. What organizations, agencies or persons would support the development and dissemination of fire safety education materials for the physically disabled? Who could provide technical assistance? What department would provide funding? How could the material be distributed to the user?
5. Do fire safety issues need to be identified for the physically disabled in their homes?
6. Who needs to be knowledgeable about fire safety for the physically disabled other than the physically disabled?

After the above questions have been answered and an educational program established, presentation (training) of the program can begin. To aid the safety professional in deciding what fire safety messages should be conveyed, he can construct a chart showing the fire safety message and the type of disability involved. Figure 3 depicts an example of this sort of chart.<sup>10</sup> Although Figure 3 shows procedures for the physically disabled to follow at home during a fire emergency, this same method of determining procedures for an industrial setting can be utilized. Once training has begun, any drills, such as evacuation drills, that are conducted should fully involve the physically disabled. Even drills

that are conducted routinely for the benefit of the entire facility should involve the physically disabled. This involvement is very important and is often overlooked.

The last stop on the inner circle is information. Besides having to gather information about each component in Figure 1 separately, information must be passed on to the employees of the facility including the physically disabled employees. The sixth philosophy of life safety for the physically disabled is the right to information about their level of risk in their environment. This right to information should be granted to the disabled; thus, allowing them to decide whether or not to undertake the risk.

Many physically disabled individuals can and are working in industry today. They are self-supporting individuals and often have excellent attendance records and labor turnover records. Also, they often equal or surpass able-bodied workers in production and safety when properly placed and trained. Although certain problems concerning life-safety for the physically disabled are encountered, they can be overcome. This article has attempted to explain these problems and how to overcome them as they apply to emergency preparedness planning.

The areas discussed were egress, refuge, management actions, facility safety, emergency communications, education and training, and information. Due to expanding technology and engineering,

more physically disabled individuals can be equipped to function independently in the work force. However, more data concerning these individuals and disabilities as related to fire and life safety in the workplace need to be collected. This lack of data has been a major problem in the past and is one reason why more codes and standards for fire-life safety of the physically disabled have not been developed. It should be the personal goal of safety professionals to learn more about this problem and aid in the development of adequate codes and standards for fire-life safety of the physically disabled. ❧

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## "BREAKING THE SILENCE"

### "Communicating with the Deaf Patient"

by Todd Stanford, Emergency/October 1986

Dispatched to a nearby residence on an "illness" call, you arrive and find the patient clutching her left arm. She is very diaphoretic and pale. You introduce yourself and ask her what the problem is. She doesn't respond. The patient's brother explains that she is deaf, so you repeat your query, much louder this time. "She is deaf," her brother exclaims. "She can't hear at all!"

Her brother explains that she was playing with his children, when she suddenly started rubbing her arm. You also learn from him that the 50-year-old patient has been deaf since childhood and has a history of hypertension, for which she takes daily medication. He offers to interpret for you. Though it will take slightly longer than usual, you will be able to get an accurate history. Through the patient's brother, you can explain to her what you're doing during the exam and determine your course of action.

You arrive at a one-vehicle accident and find the driver still in the driver's seat. The police are interviewing one of the car's passengers. You get into the passenger side of the car, tell the patient not to move and explain that you have to check him over. As you begin to apply a cervical collar to the patient he turns his head to look at you. "I said, don't move." You don't have much patience with drunk drivers, and you figure this one must be drunk to be this uncooperative with the people trying to help him. He vigorously points to his ear and makes some incomprehensible sounds. You now realize something is seriously wrong. The car is not that banged up, the patient still has his seat belt on and his shoulder restraint in place. There is no indication that he struck his head on anything, yet he appears to be aphasic and suffering a hearing loss. You start thinking the obvious: CVA, head trauma that you missed on initial assessment, or maybe a disease process unfamiliar to you. Maybe the patient is deaf.

The approximate population of the United States in 1985 was 237,954,000 people. There were 334,000 totally deaf people in the U.S. in 1985, according to the Office of Demographic Studies of Gallaudet College in Washington, D.C., a college which specializes in teaching the hearing impaired. From this we see that about .14 percent of the population is totally deaf. This would indicate that 1.4 patients out of every 1,000 we encounter is deaf. In reality, this figure may be different, but statistically it is accurate. Since deafness knows no geographic, cultural or social limitations, it stands to reason that, at some point in our careers, we will encounter a patient who is deaf.

Some common causes of deafness are birth defects, genetic anomalies, chronic exposure to excessively loud noise, sustained use of certain medications, head/ear trauma and, of course, aging. Those persons who are born with this disability, or acquire it very early in life, are frequently functionally aphasic (speech absent or impaired).

Most people learn to speak by mimicking those around them; by associating a series of sounds with a person or object, and later with various concepts such as hunger. If a person is unable to hear a sound, he or she cannot mimic it, therefore, such a person will appear aphasic. These people can be taught to verbalize their needs and desires, but in a stressful situation, attempts to speak may sound incomprehensible.

The conscious deaf person will try to make you aware, as soon as possible, that he or she is deaf; perhaps by handing you a pre-printed card that informs you of this fact. This card may even have the American Sign Language (ASL) alphabet printed on the back. Deaf patients may point to their ears and shake their heads "no." They may reach for your pen and note pad. However they choose to do it, they will make you aware of their handicap.

Exercise common sense with deaf patients. Shouting will not enable them to hear you. They want to be helped or you wouldn't be there, so don't assume they are trying to be difficult. Remember, it's as frustrating for them as it is for you, if not more so. Keep communication simple. The more complex you get, the greater the chance of a misunderstanding. Offer the patient pen and paper. Most handicapped patients have attended school and can write. Ask if the patient takes medicine. This will frequently (even in the case of a non-handicapped patient) supply a good history. Refrain from using medical terminology. To the majority of patients, center of chest means something, sub-sternal does not. Print your notes. Some handwriting can be difficult to read under the best of circumstances. Do not use symbols that may be unfamiliar to the patient. A c doesn't mean "with" to all that many people.

Ask family members or bystanders if they can interpret the patient's speech for you. Don't underestimate a family member's ability to communicate for the patient--some of the best interpreters are children with normal hearing who have a deaf family member. Interpreters can translate verbal expressions into visual signs and vice versa, but they do not translate letter for letter. Many cities have crisis hotlines or other emergency numbers of agencies where an interpreter can be reached for assistance. If such a number exists in your area, call and talk to an interpreter to establish procedures and learn the interpreter's limits and capabilities, preferably prior to an actual emergency.

Look the patient directly in the face. Many deaf patients can "read lips" to some degree. This ability, and reading facial expressions, can aid the patient in understanding you. Needless to say, unruly facial hair that hides your lips is detrimental to these attempts. Even when utilizing the skills of an interpreter, it helps if you talk directly to the patient, rather than to the interpreter. If lights at the scene are shining in someone's face, let it be your own face instead of the patient's. With lights glaring in his or her eyes, a patient will have a difficult time seeing anything, let alone the details of your face in the shadows. This is of great importance at the scene of an outdoor accident when lights from the ambulance compete with the lights of the police vehicles for the "most glaring" award. If you are in a location of poor or inadequate lighting, have someone shine a light on your face, from the side, as you communicate with the patient.

Sign language uses hand and finger positions and movement to convey a question or idea to a deaf patient. The signs described in this article are those used in the American Sign Language, an actual language used by the majority of deaf people on the North American continent. This language has its own rules of

grammar and varies slightly in different geographical areas, as do spoken languages. Just like spoken languages, ASL can only be mastered through practice. It is not the attempt of this writer to educate the reader in ASL, but rather to present several easily remembered signs that will aid in communicating with a deaf patient should the need arise. The directions for these signs are written for a right-handed "sender." If you are left handed, simply substitute "left" where "right" appears and "right" where "left" appears. Unless otherwise noted, hold your hands in front of you, at about chest height. As you sign a word or phrase, also say it to the patient.

### Some Basic Signs

Much of sign language is common sense. Pointing your right index finger at your chest indicates I or me. Similarly, pointing at the other person indicates you; at someone else present, he or she.

To express the concept of medical technician, form a fist with your right hand and insert your right thumb between your index and middle fingers (letter "T" in ASL). Using the tips of the middle, fourth and little fingers, tap the inside of the left wrist twice. This translates into a "technician" palpating a radial pulse.

The word help is formed by placing the left fist in the upturned right palm, at waist level. Raise them together to chin height. The right hand is "helping" the left go from the waist to the chin.

Where is signed by making a fist with the right hand, with the index finger extended. Raise the pointing hand to shoulder level, palm out, and wag your index finger back and forth several times. You are asking here or there?

To indicate pain, form a fist with both hands, index fingers extended. Move both hands toward each other several times with palms toward your chest. The index fingers do not touch, but merely point to each other.

To sign medicine, fully extend the fingers of the right hand, straight out in front of you. Bend the middle finger downward about 90 degrees. Rub the tip of the right middle finger into the left, upturned palm. This mimics grinding something, as in preparing a powdered medicine.

To form the word understand, hold your right fist at the right side of your forehead, palm toward the face, and extend the index finger fully. This symbolizes a light turning on in the head (a "bright idea").

To indicate do not, cross open hands, palms down, in front of the body at waist level. Then move them outward to your sides, maintaining the same hand-to-body alignment. This symbolizes pushing something disagreeable to the side.

Yes is formed by holding the right fist at shoulder level, palm facing forward, and repeatedly bending it at the wrist. This is as though you were making a hand puppet nod its head. The word no is expressed by forming the letter n followed quickly by the letter o. Form a fist with your right hand, palm facing left, and extend your middle and index fingers together in an upward position. Extend your thumb at a right angle to your middle and index fingers (the letter "n"), and then rapidly bring the fingers and thumb together (the letter "o"), as though you are closing a hand puppet's open mouth.

Using and understanding a combination of these signs, you can elicit a fair amount of information from deaf patients, and also express some basic ideas to them. By performing the signs slowly, you will alert the patients to the fact that you are not fluent in their native language. Obviously, the signs described here are only a few of the thousands in use. They are not difficult to do or remember. By combining them with appropriate gestures you should, in most circumstances, be able to communicate sufficiently to provide the same level of care to the deaf patient as you do to the hearing.

The deaf patient is, from an EMS point of view, no different anatomically or physiologically from the hearing patient. While it may present a bit of a challenge to determine deaf patients' symptoms, their vital signs are no different from those of patients with perfect hearing. Your assessment should be as thorough as the situation allows. Show the same courtesy to the deaf patient as you do the hearing patient. Attempt to explain procedures to the patient prior to performing them. While this may be difficult, it should certainly not be impossible to anyone who is certified to provide patient care. It is more productive to consider the deaf patient in the same light as a non-English speaking patient, rather than as handicapped. The deaf have their own language, ASL or a similar manual language and the same illnesses, injuries, pain, emotions, concerns and self-respect as the non-deaf patient. They deserve to be shown the same courtesy and given the same quality of care as any other patient.

### The Non-English Speaking Patient

There are areas of the United States where English is a second language to many residents. In some of these areas, English is not spoken at all. Those of us who are responsible for providing emergency medical care in such areas have learned enough of the potential patients' language to work effectively. A problem arises, however, when we are confronted with the non-English speaking patient whose native language is totally foreign to us. Patients of this type can be encountered anywhere, not just in large cities or around seaports or international airports. The question is, how do we communicate effectively with these patients?

Since the deaf patient is basically a non-English speaking patient, we can utilize some of the same principles with the non-English speaking patient as with the deaf.

- o Interpreter--As with the deaf patient, determine whether or not an interpreter is present. Often children will be bilingual even though the parents are not.
- o Common Language--Attempt to find a common language. Even though a patient does not speak English, he or she may have a second language. If you speak a second language, ask patients if they speak it also.
- o Use English--If you can't find an interpreter or common language, use English. Speak slowly and clearly in a normal tone and volume. Words in the English language often sound similar to words in other languages. This is especially true of medical and anatomical terms. If used in conjunction with appropriate gestures, sufficient communication may be established.

- o Signs--Here we are not referring to ASL per se, but rather to the use of pointing and gesturing to communicate an idea. Patients may not understand "IV" or "intravenous," but they will probably get the idea if you show it to them and mimic inserting it in them.
- o Common Sense--Exercise common sense with these patients, too. The fact that they don't speak English is no indication they're morons. Here again, as with deaf patients, shouting will not help them to understand English.

## "VIRGINIA BEACH PRODUCES SAFETY INFORMATION IN BRAILLE"

by

Janet Clements, Virginia Beach Department of Emergency Services

Noted for its innovative programs for the visually impaired, the Virginia Beach Subregional Library for the Blind has transcribed several emergency brochures into braille. Included among the brochures now available are "Safety Tips for Hurricanes," a FEMA/NOAA publication, and a more site-specific hurricane brochure developed by the Virginia Beach Office of Emergency Services. They are available in braille and on tape for anyone in the Tidewater/Eastern Shore area of the state.

Lee Eskey, Virginia Beach emergency services coordinator, said the library contacted him about their program and asked if he had any information that would be helpful for the visually handicapped. "I immediately thought of our hurricane brochures," he said, "because when a hurricane is imminent, residents of the area, including the visually handicapped, need to know what to do and where to seek shelter."

The idea for providing emergency information for the blind originated with Marilyn Mortensen, special services coordinator for the Bayside Public Library in Virginia Beach. The Bayside Library also serves as the Subregional Library for the Blind and Physically Handicapped.

"In the past few years, there has been a growing emphasis on equal accessibility for the handicapped," she explains. "In our program for the visually impaired, we are trying to increase accessibility to city information. We have been transcribing council meetings, hurricane awareness information, voter registration and consumer information into braille."

Ms. Mortensen pointed out that many blind individuals live alone and have to be self-reliant. In an emergency situation such as a hurricane, they need to know where the shelters are and what to do in case a hurricane is threatening the area.

The hurricane brochure has had such a positive impact that Ms. Mortensen plans to transcribe other emergency information into braille and onto tape.

## "MAN CITES 911' FLAW IN WIFE'S DEATH "

by

Gina Lubrano, Staff Writer

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When Mary Bell Shufeldt had problems breathing last month, her deaf husband knew exactly what to do.

He called 911. Again and again. And no one came until it was too late.

Now, Jay Shufeldt, grieving and alone, wants to know why the system failed him. Police are investigating what went wrong.

"I really loved her," Shufeldt said of his wife who also was deaf. "Now that she's gone, I'm not sure what to do. If 911 had answered the first time, it's quite possible she might have lived."

Shufeldt told of his feelings for this wife of 38 years in sign language. His words were translated by attorney Gregg Relyea during an interview in Relyea's downtown office.

Although the death certificate deduces the cause of death as chronic . . . pulmonary disease, Relyea believes the 72-year-old woman's illness "was not very far along." She had seen a doctor two days before who told her she was in good health, and she had not had an attack in two years, he said. "There is a possibility she could have been saved that night if 911 had responded sooner," he said.

Shufeldt placed his first call about 6:30 p.m. Paramedics arrived at his Hillcrest home about two hours later.

Shufeldt, a retired newspaper composing room worker, said each time he called 911 the night of July 17, he hit the space bar on his TDD machine, a telecommunication device for the deaf. Had the system worked properly, the operator would have known a deaf person was on the line and would have responded by transferring the call to a dispatcher who would have activated the department's TDD machine.

"Yes, there were calls that were made by the Shufeldts on the 911 line and they are on the printer," said police Lt. Curt Munro. "If they are on the printer, it means they were answered . . ."

The question is what happened after the 911 operator answered the call and whether they were transferred to the TDD machine. Munro said he knows exactly what happened, but cannot discuss it because of possible litigation.

Shufeldt said he had confidence in the 911 number because he had called it two weeks earlier to report a stolen car and had received an immediate response. The telephone book instructs people to call 911 in an emergency and even a city directory for the deaf instructs them to call 911.

On July 17, he had expected the same quick response he had received when his car was stolen, but although he made call after call, no one came.

It was only after his daughter arrived from Orange County and called 911 herself and spoke to someone that emergency help arrived. However, Shufeldt said he cannot say for certain whether emergency help came in response to her call or his earlier calls.

Munro explained that a seven-digit emergency number for the deaf is also listed on page A-2 of the telephone book. Even though 911 also may be used by the deaf, the seven-digit number is a direct line to the TDD machine, he said. The Police Department has only one such machine.

"When that line rings, the operator picks up the phone and puts it to the TDD machine," Munro said.

But when a deaf person calls the 911 number, the call has to be transferred to the seven-digit number that is hooked up to the TDD machine before the call can be completed.

The need to transfer slows down the emergency dispatching, Munro admitted.

"I anticipate we're going to take the bugs out of the system. Just exactly how we're going to do it with the 233 (the seven-digit number) and the 911, I don't know. We're evaluating. The problem is that we have only one TDD device."

Relyea believes the problem is a critical one and questions whether Police Department 911 dispatchers are properly trained on what to do when a TDD call is received.

To demonstrate that the system does not work, he made three calls to 911 using the telecommunications device. A dispatcher from the Police Department was his witness.

"They hung up on us three times in a row." Those calls, he said "could have represented three emergencies in a row. It's astonishing that they had a situation with the Shufeldts and have done nothing about it."

Relyea said "the deaf community deserves an explanation--why there was a breakdown in the system. The deaf community should be assured by the police that this type of problem will not happen in the future.

"This situation with Mrs. Shufeldt coupled with our testing of 911 placed in question the reliability of 911 as an emergency phone call service for all--deaf or normal."

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- Person who is elderly
- Advocate for disabled/elderly
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The workshop/resource materials were:  Very useful  Useful  Not very useful

1. The most useful presentations were: \_\_\_\_\_

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3. Did you hold a workshop before, during or after the videoconference?  Yes  No

4. What issues did your workshop discuss? \_\_\_\_\_

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