

# MINUTES

## MEDICAL CONTROL COMMITTEE

Myrtle Beach

February 7, 1992

<u>Members Present</u>	<u>Others Present</u>
Ed DesChamps, M.D.	Simmons Hanes, M.D.
Carol Baker, M.D.	Doug Warren
Bob Malanuk, M.D.	Al Futrell
Jim Raymond, M.D.	Dick Wigle, M.D.
Earl Bryant, M.D.	Bill Mastrioni
Douglas Norcross, M.D.	Marshall Stone
Debra Perina, M.D.	Joe Fanning
John Sorrell, M.D.	Bob Bailey
	Al Smith
	Bill Minikiewicz
	Thomy Windham
	John Zirkle
	Phil Clark

The meeting was opened by Dr. Raymond, Chairman. He called for review and approval of the minutes of both the October 16 and November 15 meetings. The minutes were approved. Dr. Raymond then reviewed the agenda for the day. He said that the agenda was long but that he was going to try to get through all of it.

Dr. Raymond the welcomed visitors. He also introduced Mr. Bob Bailey, the state director of Emergency Medical Services in North Carolina.

Dr. Perina presented the first item on the agenda -- "Do not Resuscitate Orders." She said that these orders were very much needed in South Carolina.

Mr. Minikiewicz of Calhoun County said that he supported any effort to develop a set of DNR protocols for South Carolina.

Mr. Bailey said that the state of North Carolina had developed a protocol for patients who do not wish to be resuscitated. He said that the big issue is control of the document itself. He said that they sought the assistance of the North Carolina Medical Society. Use of this protocol is

voluntary in North Carolina. However to use it requires a letter from the local EMS and the local medical director.

Mr. Bailey said that although the support of the Medical Society was most important to secure implementation it is also most important to educate the public once the protocols are in place. A subcommittee of the Bio-ethics committee of the Medical Society developed the packet of information on DNR orders. The EMS Division then proceeded to let everyone know. Mr. Bailey said that they decided that it could be implemented without a change in the law. It also passed the review of the State Attorney General. Mr. Bailey also pointed out that the DNR orders must be reviewed each year.

Mr. Minikiewicz said that there had been several incidents in the Columbia area recently that caused problems for EMTs -- in that there orders are to do everything that they can to save lives. He said that existing EMS law requires that the EMT is under duty to act.

Dr. Baker said that this does not address the living will. Dr. DesChamps suggested that we need to seek assistance from an Ombudsman from the Governor's Office.

Mr. Futrell said that he would have some legal staff at the next Medical Control Committee meeting. Until then we can only decide what we think is needed and make these suggestions to them for review and reaction.

Dr. Perina suggested that DHEC should be the lead agency to get this enacted.

A motion to act on this was held until the committee could get legal advice and direction.

The next item on the agenda was to review proposed additions to the state approved drug list. Mr Al Smith presented the requests for four drugs for use in the prehospital EMS setting and one drug to be used during interhospital transport. He said that Glucagon was requested by Dr. Simmons Hanes of Calhoun County and Dr. Hightower of the Savannah River Plant. It was requested for use in dosages of .5 - 1. Mg. It was to be administered SubQ and IM. Dr. Hanes said that it was requested for adult use only.

(-----) made the motion that Glucagon be approved for addition to the prehospital drug list (IM or SubQ) in the hypoglycemic patient where IV access cannot be obtained in the adult population over age 12. Dr. Malanuk seconded the motion. It was approved.

Mr. Smith then presented a request for the addition of D-10W for interhospital transport. This request came from Ms. Fran Byrd of the Neonate Unit at Richland Memorial Hospital.

Dr. Perina said that this need is primarily a problem of the neonate patient. Dr. Perina made the motion that the committee approves D-10W as an IV interfacility drug for the neonates only. Dr. DesChamps seconded the motion. The motion passed.

Dr. Sorrell asked if there needed to be an approval by the committee for a small deviation in sugar solution.

Dr. Raymond said that the committee should not consider any verbal requests but that it should formally be presented prior to the formation of the agenda.

Mr. Smith then presented ADENOCARD for P.S.V.T. for the purpose of prehospital transport where the trip would take a long time. Dr. Hanes had also requested approval of this drug.

Dr. DesChamps made a motion to approve Adenocard (adenosine). Dr. Perina seconded the motion. The motion passed.

Mr. Smith then presented the request for Nifedipine to be added to the prehospital drug list.

Dr. Sorrell made the motion that Nifedipine be approved for prehospital use. The motion was seconded by Dr. Norcross.

In discussion it was pointed out that there were some problems with this drug that had been discussed by this committee before. If the drug didn't get immediate patient response in the field its presence might mask the symptoms and delay appropriate therapy. The motion failed.

In response to a request by Dr. Hanes that the committee look into approving some drug for hypertensive emergencies, Dr. Raymond said that the committee will entertain another suggestion if it is offered as a formal request.

Dr. DesChamps then presented the problem of instances where paramedics are being instructed to use drugs in doses other than those that have been approved by the committee. He wanted to know if it was the committee's position to hold to the dosage range previously approved, or do we allow people to "do their thing regardless of sanction".

Dr. Raymond responded that all drugs, in the past, have been approved in a dosage range, and that all persons should abide by these rules.

Dr. Sorrell said that he would like to see paramedics be able to use drugs as listed under written standing orders, but that the Physician could approve the administration of any approved drug in any dosage.

In answer to some discussion the committee was informed that both the physician and the paramedic would be liable if there were any problems resulting from the treatment.

Dr. Raymond said that this item will be held over for the next agenda.

The next agenda item was a request that paramedics that are in a service that doesn't run interhospital transports and consequently don't use interhospital transport drugs should not have to take interfacility drug training. After brief discussion Dr. Raymond referred this request to the

training committee.

Mr. Futrell then presented some requests that he had received regarding the correct handling of situations involving controlled substances. He asked for clarification on whether paramedics could be allowed to transport terminally ill patients on morphine pumps.

The committee, by consensus agreed that morphine pumps should be considered patient administered medication and paramedics could transport such patients. This in no way refers to I-VAC controlled morphine drops.

Mr. Futrell said that the Drug Control people had a problem with standing orders being issued on controlled substances. He said that this means that changes in the protocols will have to be made on the drug list for such drugs.

Mr. Stone presented a recommendation (attached) for the identification (definition) of a trauma patient for the purpose of the Trauma Registry. He said that the difficulty in developing a definition was based on meeting the needs of all hospitals -- to include Levels, I, II, and III.

Dr. Norcross noted that items 1-5 of the proposal were based on the ACS document, but that he was not sure that this is adequate for what we want.

Mr. Futrell said that this is consistent with what the EMS Division wants of the registry.

Dr. Wigle said that he need trauma patients in the registry for determining the real costs and other research needed in the total trauma area.

There was further discussion regarding the need to develop all trauma data for research and also the problems in requiring Level III hospitals to collect data on more trauma patients that is in the minimum requirement from the ACS document. It was suggested that since this is a minimum data set, then those hospitals wishing to collect more data will be allowed to do so. However, some felt that the hospitals with the responsibility of research need the additional data from the other hospitals.

Dr. Raymond decided that this would require more information and discussion than would be possible and that it should be held for the next meeting.

Marshall Stone the distributed a draft set of Regional Triage and By-Pass Protocols. These were on the agenda for consideration, but will be delayed for consideration at the next meeting.

Dr. Baker presented a request for reconsideration of a proposed pilot program for using rectal valium. She said that a concern before was the possibility of rectal perforation and that it was not FDA approved. Dr. Seigler, who originally requested the pilot, asked FDA if a new drug application was needed. Their response was that a new application was not required. Dr. Baker

said that the protocol has been changed to use soft catheters and only one dose.

Dr. Bryant made a motion that the request for a pilot project for rectal valium be approved. Dr. DesChamps seconded the motion and the committee voted for approval.

Dr. Baker said that she would provide the staff all supporting packets of information that will then constitute complete information.

Dr. DesChamps presented the idea of the need for medical control for basic EMTs. He feels that the medical control director of an ambulance service should have authority/control over the activities.

Mr. Futrell stated that the medical control physician has control over the Basic EMT, however he can't restrict him from doing basic procedures. He suggested that that kind of control could be exercised through the service director.

The Committee, by consensus decided that Mr. Futrell could resolve this problem. Mr. Futrell told the committee that he would resolve it and bring it back to the next meeting.

Dr. Sorrel presented the problem of the need for emergency medical dispatch training. He suggested that a uniform method for dispatching EMS emergencies be developed. He suggested that (1) dispatchers should be required to have specific training and (2) that dispatchers be included under medical control.

Mr. Futrell said that there are some working committees that are dealing with the idea of training of dispatchers under the 911 system of emergency access. He said that while we could get training for dispatchers it would be difficult to require them to be under medical control since some dispatchers are under the control of the sheriff or others not in EMS.

Dr. Sorrell said that some policy or guidelines are needed for the state on what are the medical control responsibilities and what involvement medical control should have in dispatch.

Mr. Futrell said that his office will look into the situation of medical control physicians' responsibilities for dispatchers, however, he feels that they should pose little liability for the medical control physician.

Doug Warren shared that there was funding available for dispatcher training with a target date for a training program to begin by July 1, 1993.

Dr. Sorrel then presented a request from a number of ambulance services that nursing homes be required to give the paramedic/EMT patient information before the EMT has to accept the patient. He said that often the EMT is given only the instructions "to just take the patient to a hospital."

The consensus of the committee was that this was frequently a problem and that there was a big need for change.

Mr. Futrell said that this request would be given to the Division of Health Services Regulations with the request that they change the regulations or get a letter out to nursing homes saying that they should provide patient history to the EMS personnel prior to transport.

Dr. Raymond said that the committee would depend on Mr. Futrell to look into the resolution of this.

Dr. Perina then reported on the problem in getting the EMS personnel to leave copies of the run report at the hospital. She said that while a copy should be left to be a part of the patient's file, the need becomes much more obvious in hospitals that are maintaining trauma registers.

Mr. Fanning stated that staff is already undertaking to improve this situation. Compliance personnel will routinely check the run reports of each service and inform them that they are to leave the run reports at the hospital. Services for which we have been made aware of consistent noncompliance are being informed that this will affect their eligibility for state grant-in-aid funds. The Division needs to be informed of any noncompliance if we are to effectively monitor the situation.

Staff was instructed to poll the members and determine the best possible date for a committee meeting in March.

The agenda being completed, Dr. Raymond declared the meeting adjourned

## Medical Control Committee Meeting

### Minutes

March 24, 1992

<b>MEMBERS PRESENT:</b>	<b>OTHERS:</b>
Jim Raymond, M.D.	Elizabeth Levy, J.D.
Richard Bell, M.D.	Mike Stein, M.D.
Bob Malanuk, M.D.	Barbara Koenig, M.D.
Ed DesChamps, M.D.	A.M. Futrell
John Sorrell, M.D.	Marshall Stone
Doug Norcross, M.D.	Joe Fanning
Debra Perina, M.D.	Doug Warren
Carol Baker, M.D.	John Madden
	Thomy Wyndam
	Eric John Powell
	Al Smith

The meeting was opened by Dr. Raymond, Chairman.

He then asked for corrections and approval of the minutes of the last meeting. Dr. DesChamps said that he had a different conclusion from the discussion of medical control for Basic EMT's than that which was reported in the minutes. He said that he preferred to discuss it when Mr. Futrell was there since it was Mr. Futrell's statement that was open for interpretation. This will be resolved in the next meeting. Dr. Sorrel's name was added as the one who made the motion to prove Glucagon as an addition to the prehospital drug list. The third change was that D-10W was approved as an IV interfacility drug **for all patients**, not just neonates as recorded in the minutes. The minutes were then approved with these changes.

Dr. Raymond introduced "Do Not Resuscitate" orders (DNR) as the first item on the agenda. A document explaining North Carolina's DNR had been handed out at the previous meeting and was used as the base for discussion.

Elizabeth Levy, DHEC attorney, explained that the South Carolina legislation is not designed to address this situation in the prehospital emergency medical setting. However, she was unsure

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about problems with current written living wills or other written directive providing DNR instructions for the EMT. Ms. Levy suggested that we can develop our own DNR order form and take it to the Attorney General's office for approval.

Dr. Malanuk said that the rule is written for inpatients in the hospital setting. He said that a written directive from the Attorney General's office is needed.

Dr. Raymond requested that EMS staff poll all other states addressing difficult logistical issues regarding DNR. He also requested an executive summary from this information for committee members. Dr. Raymond suggested that staff clarify the difference between DNR and the living will and the durable power of attorney and bring it all back for the next meeting.

Mr. Madden said that Preston Callison, attorney for the Hospital Association, has been working on this issue for hospitals. He said that he would send Ms. Levy whatever information that might be helpful to her.

Dr. Raymond said that this would be placed on the agenda for the next meeting.

Dr. Raymond asked Marshall Stone to present the results of several preference surveys regarding a proper definition for the trauma patient for the purpose of the trauma registry.

Dr. Bell made the motion that the minimum data set as outlined on the survey summary (items A-D attached) be accepted as the definition for trauma. Dr. Malanuk seconded the motion.

- A. All Trauma admissions > 48 hours
- B. All trauma admissions that go directly to the ICU
- C. Trauma that is transferred
- D. Trauma deaths of admitted and treated patients in the E.D

Considerable discussion followed regarding the purpose of the registry, the use of the data at the local and state levels, and the registry components. Dr. Bell said that the register was developed, as requested by DHEC, for the purpose of encouraging the hospitals to start quality assurance programs, and also to get some idea of what the injury problem was in the state of South Carolina. He said that some of the other purposes as planned will not reach fruition for several years and some experience with the register.

Dr. Perina reminded the group that the trauma register has already been developed and that it was not being discussed. The purpose of discussion was to determine which patients would be included in the trauma register, influencing the size of the trauma register in each hospital.

It was also brought out that one of the problems that will impact on how inclusive the register will be is the consequent burden on the Community Trauma Center hospitals and their reluctance to accept this additional load.

It was suggested that the committee add all that go directly to the O.R. The committee felt that all true trauma in this category would be captured in the group who stayed more than 24 hours. It was also suggested that all admissions to the hospital be included, while others suggested that only those who stayed more than 48 hours be included.

Dr. Norcross made a motion that the original motion be amended to include those patients admitted to the hospital for more than 24 hours. Dr. Baker seconded the motion. The amendment passed.

The motion for definition of the trauma patient as made by Dr. Bell and amended by Dr. Norcross passed.

Dr. DesChamps then made a motion that the committee adopt item B under suggested exclusions from the trauma register which states "that those over 65 and that have a single hip fracture that is the result of a fall from a height of not greater than the person's height. Dr. Bell seconded the motion. The motion passed.

Dr. Perina, acting chairman, said that, because of time, the subject of Triage and By-pass protocols will be carried over as the first agenda item for the next meeting.

Marshall Stone then presented additional information provided by two trauma center applicants for consideration for designation. The purpose of committee consideration was to determine if sufficient information was submitted to warrant a site visit, and also who should be sent.

He first presented both the additional items needed for Spartanburg Regional Medical Center and their response by recent letter.

Dr. Bell made a motion that EMS staff make a site visit to this hospital to verify the information and report at the next meeting. Dr. DesChamps seconded the motion. The motion passed.

Mr. Stone then presented both the deficiencies found and the response by Hilton Head Hospital.

Dr. Bell made the motion that EMS staff makes a site visit to Hilton Head Hospital to verify the information and report at the next meeting. Dr. Norcross seconded the motion. The motion passed.

The next agenda item was "Administration of approved prehospital drugs in doses other than what is approved". Some felt that no one should be giving drugs other than approved drugs, approved dosages, and approved routes of administration.

Another felt uncomfortable telling the physician the dosage that he must direct. Others suggested that this was placing too much responsibility on the paramedic.

Dr. Malanuk made a motion that the committee recognize the drug list as acceptable and that any changes be set by the committee. Dr. DesChamps seconded the motion. The motion passed. Dr. Sorrell requested that notice be taken of his dissenting vote, for the record.

Dr. Perina then suggested that since the committee has agreed that there should be no deviation from the drug list something should be done about those who are regularly deviating from the standard. She said that it was prudent to send a letter of clarification from DHEC saying that only the drugs listed in the drug list, in the dosages listed in the drug list, and the routes of administration described in the drug list are allowed for use by the paramedics. Anyone wishing to effect a change in any of the above would petition the committee.

Dr. Perina also set up a subcommittee for the purpose of reviewing the present drug list to assure (1) that the routes of administration were appropriate for each drug; (2) that the dosages for each of the drugs were listed in acceptable ranges to accommodate the differences between various patient weights, ages etc. Doctors Sorrell, Baker and DesChamps were selected to review the list and to report back to the full committee.

Mr. Smith requested clarification on the indications for the newly approved prehospital drug, adenosine. The committee agreed by consensus that adenosine should be indicated for PSVT as well as SVT.

Mr. Doug Warren was asked to report on Emergency Medical Dispatch, training programs implemented to date, and the activities of the committee to develop a training program for dispatchers for fire, law enforcement, and EMS.

There was some discussion regarding the need for medical control of dispatchers and responsibilities and legal problems of medical control in the setting where another agency has control of the dispatcher.

Mr. Warren said that the committee may want to influence the curriculum development. He said also that the committee might wish to write to Rick Johnson, Executive Director of the Criminal Justice Academy, and strongly urge that medical input be obtained in developing the medical portion of 911 dispatch center training.

It was also suggested that while the medical control physician may not want to be closely involved in dispatch controlled by another agency, the management of the local EMS might want to be involved to be sure that they have an adequate capability to handle EMS calls.

Dr. Norcross made a motion that a letter be drafted that strongly urges medical involvement in the development of curriculum for dispatch of medical related emergencies. Dr. DesChamps seconded the motion. The motion passed.

Dr. Perina delayed a report on "problems of paramedics getting information on nursing home patients" until the next meeting.

Mr. John Zirkle was recognized to speak to the "Approval of transport of patients with self administered drugs." He requested clarification of a motion in the last meeting concerning morphine pumps. Some misunderstanding had developed about self administered pumps verses pre-programmed automatic pumps. The Medical Control Committee affirmed that relative to home bound patient transfers, the patient's medication pump was considered a patient administered medication so long as it was self contained, administered through a venous line and the paramedic didn't have to do anything to it. In these circumstances a paramedic may transport such patients without the assistance of a registered nurse.

Further, the committee asked that the Training Committee address the issue of maintenance of central lines for paramedics since this is a route for some home bound and transfer medication.

Dr. DesChamps requested that the next agenda include determining the responsibilities of state EMS and the Medical Control Committee as to compliance with OSHA regulations by local ambulance services. He felt that DHEC and the committee had a responsibility to ensure that all licensed ambulance services comply with OSHA standards.

After polling those present, Dr. Perina named May 12, 1992 as the date of the next committee meeting

# MEDICAL CONTROL COMMITTEE

## MINUTES

May 12, 1992

<u>MEMBERS PRESENT:</u>	<u>OTHERS:</u>
Jim Raymond, M.D.	Cheryl Bullard, J.D.
Carol Baker, M.D.	Mike Stein, M.D.
Bob Malanuk, M.D.	Dick Wigle, M.D.
Ed DesChamps, M.D.	A.M. Futrell
Debra Perina, M.D.	Marshall Stone
Doug Norcross, M.D.	Joe Fanning
	Doug Warren
	John Madden
	Freddie Andrews
	Debbie Hession
	Al Smith
	Butch Carter
	John Zirkle

The meeting was called to order by Dr. Jim Raymond, Chairman. He then asked for approval of the minutes of the last meeting. The minutes distributed at the meeting had one change from those mailed out. These corrected minutes include the formation of a subcommittee for the purpose of reviewing the present drug list to assure (1) that the routes of administration were appropriate for each drug; (2) that the dosages for each of the drugs were listed in acceptable ranges to accommodate the differences between various patient weights, ages etc. Doctors Sorrell, Baker and DesChamps were selected to review the list and to report back to the full committee.

Dr. DesChamps requested that the minutes also be corrected to reflect the committee's approval of Basic and Intermediate EMT's to transport patients with self administered medication pumps. The Committee approved the minutes as amended.

The first item on the agenda was discussion of the issue of "Do Not Resuscitate Orders". Cheryl Bullard from the Legal Department of DHEC was recognized to present her analysis of what would result when implementing such orders under present South Carolina law. This analysis was distributed to the committee members for discussion. Ms. Bullard's analysis includes;

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requirements for declaration of a desire for natural death; ambiguities in the S.C. law; and her recommendations. She said that she had inadvertently omitted §44-77-50 which states that the intention that the definition be honored by family and friends and any health facility. She said that these ambiguities which she found did not necessarily reflect all. Ms. Bullard said that if we decide to seek an Attorney General's opinion regarding "Do not resuscitate" and the current law, we should make sure all the ambiguities which she stated are addressed. She said that she found that forming a multi-disciplinary task force has provided the greatest amount of success with the least amount of resistance. She also recommended that the task force develop proposed legislation for the next session. She distributed copies of the Florida legislation for the committee to review, noting that some of it has already been implemented while a part will be implemented in October of 92.

Ms. Bullard was commended for her study and suggestions.

Dr. Raymond requested that Mr. Futrell have his staff develop a list of key people who should be on a multidisciplinary committee, as described. The staff will also request the attorney General's opinion. The committee can then begin setting up a multidisciplinary task force regarding developing "Do Not Resuscitate Orders".

The next topic presented was development of "Triage and treatment protocols on a regional basis". Mr. Marshall Stone distributed a staff proposal which could be used as a guideline for developing regional plans. He explained that it was composed of two parts, methodology and what should be included in a regional plan. The methodology included suggestions for formation and composition of a committee and the process by which the plan would be developed. This process sets up a method by which the regional hospital and the state office of EMS could work with community trauma centers to determine their roles and also to include the non-trauma hospitals in the development of regional plans.

Dr. Norcross stated that he had reservations regarding discussion with Community Trauma Centers in developing guidelines on who they should take and who they shouldn't take. He felt that this would come across as dictatorial. He suggested that protocols be developed throughout the region for prehospital treatment and bypass, with the assistance of local medical control physicians. The bottom line is to develop a set of protocols as to where the local EMS will take the patient.

Dr. Stein said that of all that we have done so far, the development of protocols to assure that the patient will be transported to the appropriate hospital is by far the most important thing to make the trauma system work. He felt that the recommendations for a trauma system must have some teeth to make them work.

Dr. Norcross said that these plans must be modified to meet the needs of the specific local areas.

Dr. Malanuk said that he was concerned about the development of a trauma systems plan for the state when there were large geographic holes not covered by a trauma center. Discussion included the plans to go back to those non-participating hospitals beginning July 1, 1992, and after the hospitals awaiting designation have been designated.

It was suggested that the description of the state trauma system showing where the participating trauma centers are located, the areas covered by trauma centers and the areas not covered should be made available in order to allow the public to be informed regarding their access to the system.

The committee agreed that the development of the system, with protocols, and implemented in the areas covered by trauma centers was the most important step to be made at this time.

Dr. Perina said that in looking at the map showing coverage of trauma centers it is apparent that some areas will not be included in such coverage in the future. With this knowledge she suggested that a state wide air transport plan should be developed to assure that all areas be covered. She also felt such a plan was necessary to implement a state trauma system.

In response to a question regarding the appropriate transfer by the hospital, Mr. Futrell said that risk management dictated to the little hospitals that they should transfer high risk patients out to a trauma center.

Dr. Norcross said that he would prefer working with the agencies in each county individually in developing the protocols for that area. He then made a motion that the regional trauma center surgeon, the regional directors and the regional medical directors begin the process of developing triage and by pass protocols/guidelines for each emergency care system in the region with "this" as one proposed mechanism to do it.

The motion made by Dr. Norcross, seconded by Dr. DesChamps, was carried by the committee.

Dr. Raymond said that the hospitals must be included in the planning process, especially those hospitals desiring to participate.

Mr. Futrell said that a plan should include what that hospital feels they can't handle. Plans are especially needed for protocols from the regional hospitals to the field EMS and the local hospitals who aren't trauma centers.

Dr. Stein said that in some areas of his region he must use the non-trauma hospitals because some areas are too far (outside the one-hour) to transport patients to the closest trauma center. He said that he would prefer to workout the protocols with the local EMS and then go to the hospitals for help.

Mr. Futrell offered to give staff support to each of the Regional Trauma Centers in developing the plans.

Committee members requested a copy of the map which Marshal presented, depicting the areas covered by hospitals planning to participate in the system.

Dr. Raymond requested that each region make a progress report at each committee meeting. Each regional trauma center can identify the resources and problems and report this at the next meeting to include a plan and or process as to how it will be approached.

Next Mr. Stone presented the requests of the hospitals for designation. He reported on the findings of the site team for Spartanburg Regional Medical Center. The highlighted problems were: separate trauma service, specific microsurgery call, and physician directed rehabilitation. Each of these were discussed.

Dr. Perina made the motion that Spartanburg be designated as a Level I Trauma Center with the following concerns that will be addressed at the time of their redesignation:

1. The trauma service role should be clearly defined, and the trauma directors role should be clearly defined. It should be clearly delineated that the director has responsibility for all trauma.
2. A call list for microsurgery should be in place.
3. Periodic monitoring of C.T. response should be done to assure compliance with protocol.
4. A signed agreement for rehabilitation should be in place.

Dr. Norcross seconded the motion. The motion passed.

Mr. Stone then presented the results of the staff follow-up site team visit at Hilton Head Hospital. Hilton Head had responded to all the deficiencies noted in the last letter, and corrections were made as requested. The new administrator has a very positive attitude toward participation as a trauma center. Trauma responsibilities have also been reorganized to support the trauma center function.

Dr. Perina made the motion that Hilton Head Hospital be designated as a Level III Trauma Center. Dr. Malanuk seconded the motion. The motion passed.

Mr. Stone then presented the follow-up information provided by those hospitals that were designated at the last meeting but with reservations. The first of these was Beaufort Memorial Hospital. They had responded to all the concerns expressed in the letter of designation with changes that corrected their deficiencies.

Dr. Norcross made the motion, seconded by Dr. DesChamps that Beaufort's designation status be moved from Category II (with reservations) to Category I (complete designation). The motion passed.

Baptist Hospital's designation was then considered. They had responded to all the concerns expressed in the letter of designation with changes that corrected their deficiencies. Concerns regarding surgical call were clarified.

Dr. DesChamps made the motion, seconded by Dr. Baker that Baptist Hospital's designation status be moved from Category II (with reservations) to Category I (complete designation). The motion passed.

St. Francis Xavier Hospital's designation was then considered. They had responded to all the concerns expressed in the letter of designation with changes that corrected their deficiencies.

Dr. Perina made the motion, seconded by Dr. DesChamps that St. Francis Hospital's designation status be moved from Category II (with reservations) to Category I (complete designation). The motion failed.

Dr. Baker made the motion, seconded by Dr. Norcross that St. Francis Hospital's designation status be moved from Category II (with reservations) to Category I (complete designation) with the provision that there be a written back up call schedule that we are comfortable with. The motion passed.

Staff was requested to send St. Francis a copy of Baptists schedule.

Georgetown Hospital's designation was then considered. They had responded to all the concerns expressed in the letter of designation with changes that corrected their deficiencies.

Dr. DesChamps made the motion, seconded by Dr. Perina that Georgetown Hospital's designation status be moved from Category II (with reservations) to Category I (complete designation). The motion passed.

Grand Strand Hospital's designation was considered next. There was some discussion regarding their definition of protocols for trauma call to include the descriptions of the roles of the team members.

Dr. Baker made the motion that changes in status for Grand Strand not be made until we get clarification. Dr. DesChamps seconded the motion. The motion carried. Staff should make sure that Grand Strand is invited to be at the next meeting to answer questions.

Trident Hospital's designation was then considered. They had responded to all the concerns expressed in the letter of designation with changes that corrected their deficiencies.

Dr. Norcross made the motion, seconded by Dr. DesChamps that Trident Hospital's designation

status be moved from Category II (with reservations) to Category I (complete designation). The motion passed.

The next agenda item was a request by Anderson Memorial Hospital that a site team be sent to verify their response and their capabilities as a Level II (Area Trauma Center). Staff requested that a physician be included on this visit. The committee accepted the information presented for Anderson.

Dr. Malanuk made a motion, seconded by Dr. Baker that a site team to include a physician be sent to verify the information in their latest document. The motion passed.

Mr. Fanning presented a request from Allen Bennett Hospital that a site team be sent to verify its capability as a level III trauma center. Staff had made a technical visit to this hospital and found a number of changes such as surgical call, anesthesiologists, etc. A copy of the information included with their request will be sent to all committee members for their review prior to consideration of Allen Bennett at the next meeting.

Mrs. Debbie Hession presented some items from the training committee. The Committee reviewed the issue of interfacility drug training as requested by the Medical Control Committee. The Training Committee felt that all paramedics should receive interfacility drug training and not just the paramedics who will be doing interfacility transport.

Ms. Hession pointed out that the Training Committee was recommending that:

1. This training be provided in each initial and refresher advanced EMT course.
2. That DHEC would continue to publish the interfacility drug sheets used as a guideline for training.
3. Training could be done by EMS regions or local providers.
4. Documentation of such training must be maintained in the employee's file.
5. Standardized interfacility drug testing will be discontinued but will be added to the state exam.
6. Reciprocities and National Registry paramedics coming into the state must have the training documented to their file before they manage an interfacility drug transport and no later than 120 days after employment.

Discussion was then presented regarding the value of the present in course test for interfacility drugs. Documentation is required to be completed by each sending physician explaining the drug and what it is being used for. Dr. Baker made a motion that we no longer require a separate test for interfacility drugs, but that we let everyone know that interfacility drugs are included in the recertification process. Dr. DesChamps seconded the motion. The motion passed.

The training committee asked for clarification as to whether Basic and Intermediates should be included in the central line maintenance during interhospital transport. Dr. Perina said that the

Medical Control Committee should address the stated need for non-paramedics to monitor central lines. Any one performing this function would have to receive in-service education for the purpose.

Mr. Zirkle said that Basic EMT's are already capable of IV monitoring and that it would be simple enough to teach anyone to monitor central lines for exsanguination or air embolus.

Dr. DesChamps made the motion to ask the training committee to incorporate in the Basic and Intermediate training programs a section on monitoring central lines for exsanguination and air embolism, and that we allow them to transfer and maintain these sorts of patients once the lines are in place. Dr. Baker seconded the motion. The motion carried.

Ms. Hession reported that it was discussed in the training committee that clarification was needed to determine if Basic and Intermediate EMT's can transfer patients on ventilators.

Dr. Perina said that she felt that more information was needed to prepare the committee to discuss this situation. It should be placed on the agenda of the next meeting.

It was requested that Mr. Herbert be asked to provide additional information.

Dr. DesChamps brought up the subject of the control that a medical control physician has over a Basic EMT. After some discussion regarding the authority of the medical control in these situations, it was suggested that complaints be made formality to the state.

Mr. Futrell said that he will get his staff to draft some procedures regarding the formal authority and responsibility of the medical control physician for the Basic EMT. This information will be presented at the next meeting.

There being no further business Dr. Perina declared the meeting adjourned.

## MINUTES

### MEDICAL CONTROL COMMITTEE

June 9, 1992

<u>MEMBERS PRESENT:</u>	<u>OTHERS:</u>
Jim Raymond, M.D.	Stephen L. Daniel, M.D.
Carol Baker, M.D.	Mike Stein, M.D.
Ed DesChamps, M.D.	Dick Wigle, M.D.
Debra Perina, M.D.	A.M. Futrell
	Joe Fanning
	Thomy Windham
	Terry Gilreath
	Debbie Hession
	Al Smith
	Butch Carter
	John Zirkle
	Mary Andrews
	Magen Silcox
	Sharon Clayton

The meeting was called to order by Jim Raymond, M.D., Chairman.

The minutes of May 12, 1992 was approved by the committee with the following changes; Dr. Raymond pointed out that a motion made in the last meeting regarding developing regional trauma plans left inadvertently left out the regional trauma surgeon. The motion should read that the regional trauma center surgeon, the regional directors and the regional medical directors begin the process of developing triage and by pass protocols/guidelines for each emergency care system in the region with "this" as one proposed mechanism to do it.

Dr. DesChamps requested that the minutes also be corrected to reflect the committee's approval of Basic and Intermediate EMT's to transport patients with self administered medication pumps. The Committee approved the minutes with these two amendments.

#### TRAUMA CENTER DESIGNATION

Mr. Fanning recognized Terry Gilreath and Mary Andrews from Allen Bennett Hospital. He

**Medical Control Committee Minutes**

**09 June 1992**

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said that He and Mr. Stone had made a site visit to this hospital, had summarized their findings, and recommended that the committee consider designation based on the report. He presented the findings in each area in which the hospital had been previously found deficient.

After some discussion Dr. Raymond determined that there were not sufficient members of the committee present to make a quorum and consequently to make a decision. The Chairman asked the committee to consider postponing the discussion until the next meeting. A consensus was made to hold discussion on trauma center designation until the next meeting. The review of the designation request of Allen Bennett hospital, and final designation of Roper and Lexington Hospitals was then postponed until the next meeting.

Mr. John Zirkle was then asked to present information regarding a recent request for additional drugs for a hospital based air transport unit using nurses to administer the drugs.

Dr. DesChamps asked about the State Law that addresses an R.N. on the back of the unit and drugs he/she uses.

Mr. Futrell mentioned that a close look must be taken at the Regulation. He then said that Regular Ground units have to abide by the drug list. Units that are called Special Purpose units, usually used for neonatal or cardiac, are staffed by Nurses and not paramedics, the nurses have to be qualified as special purpose EMT's to get past the Regulatory Rule that the ambulance must have an EMT on the back of it.

The issues include the fact that DHEC has control over patient care in the prehospital setting. Also the fact that it is not written in the law for nursing that nurses can possess or administer drugs.

Mr. Zirkle explained that certain hospital based units such as special purpose units (neonates) and hospital based units that used nurses in conjunction with paramedic crew members (i.e. LifeReach, Roper, MEDU) to provide a higher level of care during transport, carried drugs and fluids for nurse use that were not always on the state approved drug list. Dr. Ward of LifeReach had submitted a letter requesting that a number of drugs be added to the state drug list. As a result, a discussion ensued concerning the Medical Control Committee's role in approving drugs for use by a nurse working under physician order on such units.

Dr. Stein said that when he was in Tennessee an R.N. had a "drug box" which she was assigned. The nurse used her "tools" or equipment out of her box, she had nothing to do with what the EMT's were doing.

Ed DesChamps then said that may be we could have a special box for the nurse to use on the ambulance.

Mr. Futrell asked what gives the nurse the authority to administer the drugs.

Ed DesChamps said a physician's order gives the nurse the authority.

Dr. Stein then mentioned again that in Tennessee the nurse left with "the box" and she left with orders as to what should and should not be done en route.

Mr. Futrell said that we would have to work on this issue a little bit.

It was agreed that:

1. Clarification of a nurse's authority to function in the hospital based ambulance under physician's order would be sought from the state Board of Nursing.
2. A mechanism must be in place assuring that there was indeed a written order or protocol for each drug carried on these units.
3. The request by Dr. Ward for addition of these drugs to the state drug list was probably not appropriate. It should be viewed as a LifeReach specific request since the state drug list is used to define approved formulary for advanced EMT use.
4. Action on this issue should be deferred until the next meeting when clarification from the nursing board would be presented.

Dr. Stein asked that the following questions be considered for discussion:

- 1) First, could the medical control committee be rearranged in order that the Level 1 Trauma Physicians be allowed to become voting members of the committee?
- 2) He asked if the committee thought it appropriate that 2 of the 4 Level I trauma centers be allowed to be voting members of the committee. Or if they might consider it appropriate to have trauma surgeons from level 1, 2, and 3 hospitals as voting members of the committee.
- 3) He also asked if there was a set of by-laws or something determining the make-up of the committee.

Mr. Futrell said that the committee is composed of the physicians on the EMS Advisory Council and the four regional medical directors. He said that there is a set of guidelines under which the council and committees function. He agreed to provide them for review for discussion of this matter at the next meeting.

The committee by consensus agreed to discuss the constituency of the Medical Control Committee at the next meeting.

Mr. Fanning then reviewed the actions of the Medical Control Committee from the meeting in November 1991 through May 1992. The Actions (attached) show both the decisions made by the committee and the actions taken to follow up on these decisions.

Items of special interest were highlighted for discussion. "DNR" progress includes a list of

organizations suggested for representation on a multidisciplinary committee (attached), and a letter requesting the state Attorney General's opinion (awaiting signature by the chairman of the EMS Advisory Council).

Staff is still working with The Division of Health Licensing within DHEC to determine specific authority for EMS personnel to expect medical information on patients from nursing homes before they are transported. Specific instructions are in the regulations on residential care facilities.

A letter has been sent to all providers explaining that they are to use only those drugs approved by DHEC and in the dosages and routes of administration approved by DHEC. A letter approving a pilot project for use of rectal valium in the field will be mailed this week after it receives final approval by the advisory council.

Dr. Raymond requested that a summary action report be placed at the end of each set of minutes.

The committee agreed that the next meeting should be held on Tuesday, July 14, 1992. Dr. Raymond asked that staff make additional efforts to insure a quorum.

There being no further discussion the meeting was adjourned.

# Minutes

## Medical Control Committee

September 8, 1992

<b>Members present:</b>	<b>Others present:</b>
Jim Raymond, M.D.	Mike Stein, M.D.
Doug Norcross, M.D.	Karl Byrne, M.D.
John Sorrell, M.D.	Debbie Hession
Bob Malanuk, M.D.	Thomy Windham
Carol Baker, M.D.	
Ed DesChamps, M.D.	
Debra Perina, M.D.	
Jim Turner, M.D.	
Richard Bell, M.D.	

<b>Hospital representatives present:</b>	
<u>Conway:</u>	Phil Clayton
	Brian Kellerher, M.D.
<u>Loris:</u>	Frank Watts
	Steven Harvey, M.D.
	Jane Marlowe, R.N.
<u>Allen Bennett:</u>	Mike Massey
<u>East Cooper:</u>	Kevin Kennan, M.D.
	Kathy Sellers, R.N.
	Sandy Raih, R.N.
<u>Anderson:</u>	William Buice, M.D.
	Camille Walker, R.N.
	Kathy Bolander, R.N.
<u>Aiken:</u>	John Tomarchio, M.D.
	Bo Machado, M.D.
<u>Grand Strand:</u>	Collette Faralley.
<u>Roper:</u>	Wanda Brockmeyer, R.N.
	Joy Huntington, R.N.
<u>Lexington:</u>	Megan Silcox, R.N.
	Susan Clayton, R.N.

Dr. Raymond opened the meeting and called for approval of the minutes of the last meeting. The minutes were approved.

He then directed the committee's attention to the main agenda item - that of reviewing the remaining proposals for designation as trauma centers.

Anderson Memorial Hospital was the first hospital to be reviewed. Their proposal was to be designated as an Area Trauma Center (Level II). There was discussion regarding their capabilities in ICU coverage of trauma, anesthesia coverage, and continued training in trauma.

Dr. Norcross made the motion that Anderson Memorial Hospital be designated as a Level II trauma center (Area). This designation is to be as a category II designation until certain items are cleared up, to include monitoring of the response time of the trauma team through ongoing Quality Assurance. And that they be urged to give attention to trauma education. The motion was seconded by Dr. DesChamps. The motion carried.

The remainder of the hospital proposals was for Community Trauma Center (Level III) designation.

Loris Community Hospital was the first of these to be reviewed. The concerns given attention in this review were anesthesiologists' coverage and training of the emergency department physicians for trauma care. The emergency physicians are now trained in trauma care, and anesthesiology coverage is provided at all times through provision of a locum tenens arrangement.

Dr. DesChamps made the motion that Loris Community Hospital be given full designation as a Community Trauma Center (Level III). The motion was seconded by Dr. Sorrell. The motion passed. Dr. Perina abstained.

East Cooper Community Hospital was the next proposal for review. There was some discussion concerning their commitment to taking all trauma patients in their area under a trauma plan. Representatives of the hospital assured the committee that the hospital was committed to providing care for all trauma patients in their area.

Dr. Perina made that motion that East Cooper Community Hospital be given full designation as a Community (Level III) Trauma Center. The motion was seconded by Dr. Sorrell. The motion passed. Dr. Norcross abstained.

Allen Bennett Memorial Hospital's proposal was the next to be reviewed. It was pointed out that surgeons taking call were on call only for their hospital, eliminating the problem of shared call.

Dr. Norcross made a motion, seconded by Dr. DesChamps, that Allen Bennett Memorial Hospital be given full designation as a Community (Level III) Trauma Center. The motion passed. Dr. Baker abstained.

Conway Hospital was then reviewed for designation. Discussion followed regarding the changes this hospital had made to become designated. The hospital has the organization and the support of the physician and administrative staff to become a trauma center.

Dr. Bell made a motion to approve giving full designation for Conway Hospital as a Community Trauma Center (Level III). Dr. DesChamps seconded the motion. The motion passed.

Aiken Regional Medical Center was the final proposal for review. The biggest problem that the original site team found was the absence of a trauma registry. A trauma registry is now set up with personnel from both the emergency department and medical records. Discussion followed regarding trauma alert, referral and problems in transfer.

Dr. Sorrell made the motion that Aiken Regional Medical Center be given full designation as a Community Trauma Center (Level III). Dr. Baker seconded the motion. The motion passed. Dr. Perina abstained.

The next group of hospitals for review was those who had received approval (Category II approval) with some reservations, but with the understanding that certain deficiencies would be corrected before these reservations could be removed.

Lexington Medical Center had resolved their problem of having adequate trauma surgical backup. Dr. Perina made the motion that Lexington Medical Center be given recognition of full designation as a Level III Trauma Center without reservations. Dr. Baker seconded the motion. The motion was approved. Doctors DesChamps and Bell abstained.

Roper Hospital also had resolved their problem of providing adequate trauma surgical backup.

Dr. Bell made the motion that Roper Hospital be given full designation without reservations as a Level III Trauma Center. Dr. Perina seconded the motion. The motion carried. Dr. Norcross abstained. It was pointed out that this designation was only for the primary site of the Roper Hospital and not for satellite operations. The committee agreed by consensus.

Grand Strand General Hospital was the last to be reviewed that had conditions attached to their designation. Grand Strand has provided appropriate trauma team protocols.

Dr. Baker made the motion that Grand Strand General Hospital be given full designation without reservations as a Level III Trauma Center. Dr. Norcross seconded the motion. The motion carried.

Dr. Stein shared with the committee that the trauma surgeon at Spartanburg Medical Center was leaving soon. This caused a discussion as to what action that the Committee/DHEC should take regarding such a substantive change in the resources of a designated trauma center. It was decided that since Dr. Weigle had not yet left that action would not be appropriate until the hospital had notified DHEC of the situation. It was decided, however, that the Division of EMS should write the

hospital a letter informing them of their responsibility to maintain all resources as presented to the Department at the time of designation. The committee was told that Dr. Weigle will be leaving as of January 1, 1993.

The next agenda item was the formation of a committee for "DNR". This committee is to be formed for the purpose of developing procedures, criteria and legislation, if necessary, to allow the development of acceptable protocols for DNR/DO NOT RESUSCITATE. Such protocols will relieve/resolve situations in the prehospital setting where family and physicians have agreed that measures to resuscitate an already terminal patient should not be applied. Since the responsibility of the prehospital EMS system is to use all measures to sustain life and transport to the hospital for appropriate care, such protocols would relieve the EMTs and their local services of an apparent conflict in instruction.

Dr. Perina made a motion that the committee accept the group of 12 organizational representatives as the recommended composition for the "DNR" committee. Dr. Baker seconded the motion. The motion passed.

The composition of the "DNR" committee as agreed upon is:

- |   |                        |
|---|------------------------|
| 1. American College of Emergency Physicians | 2. DHEC                |
| 3. S.C. Health Care Assn. (Nursing Homes)   | 4. S.C. Hospice        |
| 5. S.C. Medical Association                 | 6. EMS Directors Assoc |
| 7. S.C. Hospital Association                | 8. S.C. Bar Assoc      |
| 9. S.C. EMS Advisory Council                | 10. Home Health Assoc  |
| 11. AARP (or the Commission on Aging?)      | 12. S.C. Nurses Assoc  |

The committee by consensus agreed that the direction/purpose of this committee would be to develop a mechanism that allows and supports DNR protocols specifically for the prehospital EMS setting. Staff was asked to develop the purpose and the direction of the committee and to have a representative of the EMS Advisory Council to chair the committee. Staff is also to develop an informational base and provide other support as needed.

The question arose regarding a timetable and criteria for redesignation of the three level I trauma centers which were last redesignated several years ago. This objective had been delayed until the other designations could be completed. Dr. Raymond said that this would be placed on the agenda for the next meeting.

The committee was also requested to develop a Trauma Committee. The request was based on discussions held in the last committee meeting, the long range planning committee discussions, and the criteria stated in the model trauma plan developed for implementation under the national trauma legislation. The committee discussed a number of different ways to meet the intent of the model trauma plan, but did not come to closure as to the best mechanism for establishing a trauma

committee.

Dr. Bell informed the committee that there is a proposal in Congress to shift 3.9 billion in undesignated defense funds to certain health and education programs, to include a set-aside funding which could be directed in part to support the trauma center grant program. He urged committee members to call their senators and urge them to support this legislation with a shift of monies toward trauma center grant programs.

Mr. Futrell was asked to report on the legal opinion for nurses carrying drugs on the ambulance beyond those drugs authorized for hospital use. He stated that he had met with the legal officer and had communicated with the Board of Nursing. The Nursing Practice Act has been amended to allow nurses a wider range of functions. The legal opinion was that nurses participating as a part of an ambulance crew, under physician direction, and with specific ambulance protocols can have a formulary different from the formulary for a paramedic as long as it is written up.

The nurse must have written protocols and written physician orders allowing the expansion of the existing drug list. These procedures can apply to the helicopter services, neonatal services and cardiac care units. It will also carry through to the standard ambulance, if they have written orders for the patient to receive that drug.

Under other business the following were mentioned for follow-up on future agendas:

- A report regarding review of the drug list;
- A Review of pilot programs for possible recognition as standard programs;

The Committee agreed to meet again on Tuesday, November 10, 1992.

There being no further business the meeting was adjourned.

## Medical Control Committee

### Minutes

October 10, 1992

Members present:	Others present:
Jim Raymond, M.D.	Mike Stein, M.D.
Doug Norcross, M.D.	Doug Warren
John Sorrell, M.D.	Joe Fanning
Carol Baker, M.D.	Jim Catoe
Ed DesChamps, M.D.	Al Futrell
Debra Perina, M.D.	Phyllis Beasley
Richard Bell, M.D.	

Dr. Raymond opened the meeting and called for approval of the minutes of the last meeting. Joe Fanning requested an amendment to the minutes be made to include a report from Mr. Futrell regarding the conditions under which nurses on the ambulances might legally carry drugs beyond what is authorized for prehospital use. This report was added on the fourth page of the minutes. The minutes were approved as amended.

Staff asked the committee to revisit their decision regarding **redesignation** of trauma centers, specifically the three Level I trauma centers that have been designated for a number of years. The discussion centered around the scope and nature of the redesignation process. Should these hospitals which have already been through a designation review be subjected to another complete review, or should the review process involve only the quality assurance data and activities? If a full review is not required, would an out of state review team be necessary or would an in-state team be adequate. What specialty areas are needed for redesignation, the full team as used before, or could one or two team members alone accomplish the task? Finally, when should this redesignation process begin?

In discussion it seemed to be the consensus of all that these hospitals should have the benefit of a thorough out of state site visit based on the complete ACS standards as outlined in the resource guide published by the Committee on Trauma.

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10 October 1992

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Dr. Bell made the motion that an out of state team be used for redesignation of these hospitals, and that the team be composed of a surgeon, an emergency medicine physician, and a nurse. The motion was seconded then it was passed.

The committee, by consensus determined that the redesignation process should be completed by the end of calendar year '93.

Staff reported on the status of Spartanburg Regional's trauma center. The president of the hospital wrote Mr. Futrell a letter stating that he understood the requirement that the committee be notified of any change in major requirements like trauma surgeons, and that they would do so when the occasion arises. Dr. Colvin, director of surgical education, reassured staff by telephone that Dr. Barbara Keonig had accepted the responsibility on an interim basis, from January 1 until another director could be found to replace Dr. Weigle.

Jim Catoe presented the committee with an orientation of the trauma grant's purposes and activities. He said the purpose of the grant is to upgrade the statewide trauma systems plan. This plan would be written using the guidelines presented in the Model Trauma Plan that was developed by the committee of trauma professionals under the auspices of the U.S. Department of Health and Human Services. The Model Trauma Plan provides a number of mandatory components to include human resources, communications, transfer and triage protocols and evaluation.

Mr. Catoe said that the grant had four broad objectives. They are: (1) To develop an updated trauma systems plan composed of four regions, (2) To complete a network of designated trauma centers in all appropriate locations, (3) To develop a coordinated data base with linkages between all trauma incident data, trauma care data, trauma outcome data, and (4) To evaluate the current configuration of trauma centers. Objectives 2,3,&4 are necessary activities to complete a comprehensive trauma systems plan.

A document on triage and by pass was distributed for discussion. This document was an attempt by staff to begin addressing the variables that should be considered at the regional and local level in developing protocols for:(1) situations requiring triage and bypass of local, non-participating hospitals, (2) situations where the level III hospital may wish to triage patients to the Level I hospital, and (3) the situations where the Level III hospitals should rapidly refer patients to the Level I hospital after they have been stabilized and assessed. The Committee felt, that triage and by pass protocols could not be developed at the state level.

Dr. Sorrell made the motion that each region should develop their own trauma plan, with broad guidelines, that includes triage and by-pass. Dr. -??- seconded the motion. The motion passed. (Was this a motion, a consensus or just discussion?)

Discussion followed regarding how this should be handled in the state plan, since this is one of the components that must be addressed. The model state trauma plan speaks specifically to this. The

state office of EMS has the authority to develop a plan, but nothing can be implemented in this area until a plan has been developed and presented to the community in a hearing for their information, reaction and input.

Mr. Futrell said that regional catchment's areas with boundaries for each need to be outlined for each of the Level I Trauma Centers. When assembled as part of the state plan, the plan could also include those counties not covered in any region and those counties included in the regions of Level I trauma centers outside the state. The Committee requested that staff complete a study of the referral patterns, based on ambulance run report data. This information will be mailed to the committee members prior to the next meeting, or the meeting of the trauma committee, whichever comes first.

Mr. Fanning introduced Phyllis Beasley, who will be working on the trauma grant. She read the staff's proposed composition of the Trauma Systems Committee. She explained that the federal model trauma plan, which the state will use in developing its plan, did not give specific guidelines for the trauma committee. It stated that the committee should be composed of a "multidisciplinary group of providers and consumers whose interest and expertise are the development of a statewide trauma system," and that a "community coalition of consumer groups and networks already in place, such as MADD and the American Red Cross, can assist in support and development of the trauma system."

Ms. Beasley asked that the Medical Control Committee submit nominations for the committee to her following the meeting.

Mr. Fanning stated that this is a large committee, but the staff had envisioned the formation of regional subcommittees to act as the working committees. After a request from Dr. Deschamps for an explanation of the relationship of the committees, Mr. Fanning said that the federal model trauma plan required a trauma systems committee, even though the Medical Control Committee has addressed these issues in the past. He suggested that the Trauma Systems Committee would act as a subcommittee to the Medical Control Committee for the purpose of getting input from all the trauma players and receivers of trauma services. Regional committees, subcommittees of the Trauma Systems Committee, would be the source for input from regional groups.

Dr. Norcross expressed concern over the large number of committees that seemed to be developing.

Dr. Sorrell noted that the composition of the Trauma Systems Committee appeared to be 90% of the Medical Control Committee. He suggested that the Trauma Systems Committee be composed of the Medical Control Committee plus some additional members.

The Committee then considered the suggested composition of the Trauma Systems Committee. Concern was expressed by Dr. Perina that the Level III trauma centers were not adequately represented.

Dr. Stein proposed that the Trauma Systems Committee be composed of the Medical Control Committee plus additional interest groups. He explained that the committee could meet in the morning to discuss trauma issues, and then the Medical Control Committee could meet afterwards to vote on EMS-related issues. Dr. Perina moved to accept Dr. Stein's proposal. The motion was seconded. Dr. DesChamps asked for clarification regarding the status of this committee to the Medical Control Committee. Dr. Raymond responded that the Trauma Systems Committee would be a subcommittee of the Medical Control Committee. The motion passed.

Dr. Raymond then asked the Committee to consider the constituency of the Trauma Systems Committee.

Dr. Sorrell suggested that, in addition to the membership of the Medical Control Committee, the trauma committee add:

- three Level III emergency department physicians
- three Level III emergency department surgeons
- three Level III emergency department nurses
- EMS Directors Association member
- delete the pediatric surgeon representative
- hospital administrator from each level trauma center
- S.C. Medical Association representative
- SC Rehabilitation Association representative
- MADD representative
- American Red Cross representative
- Highway Department representative
- law enforcement representative

Dr. Perina suggested that a representative of the media also be added to the membership roster and that instead of a representative from the EMS Directors Association, there should be a field medic from each region designated by the regional director. Mr. Futrell stated that this would bring the membership of the Trauma Systems Committee to 33.

The additions and deletions to the Trauma Systems Committee were passed by acclamation by the Committee. Dr. Raymond or his designee will serve as chairman of the trauma subcommittee.

Dr. Raymond asked if the listed objectives of the committee came directly from the model plan. The objectives are: 1) review components of the statewide trauma plan and give general direction for overall development; 2) define system criteria; 3) establish system standards (or guidelines); and 4) review system performance. Mr. Fanning responded that the objectives were influenced by our objectives to develop the grant. Dr. Raymond then asked the Committee if anyone knew of any other objectives that the Trauma Systems Committee should encompass. Dr. Norcross responded that it should address all aspects of trauma formally addressed by the Medical Control Committee.

Dr. Perina moved that the objectives of the Trauma Systems Committee as outlined be adopted by

the Medical Control Committee. The motion was seconded. The motion passed.

The next agenda item was a report on the progress on the formation of a committee for prehospital "Do Not Resuscitate" (DNR) protocols. The organizations to be represented on this committee have been requested to provide a designee to serve on the committee by November 15, 1992.

A set of standing orders for "DNR" dealing with procedures for terminating resuscitation, and requirements for continuing resuscitation under certain criteria was discussed. It was determined that several larger EMS services are already operating under similar guidelines but call procedures rather than protocols. It was determined that these protocols might be a good base for discussion in the DNR subcommittee.

Staff presented the Pilot program for EMT-Defibrillator (EMT-D), a summary of studies written nation-wide was previously mailed out for study. A compilation of EMT-D activities within the state shows that 15 programs are approved with 10 of those programs active. There have been six EMT-D resuscitation attempts in the last year with no saves. Though there is no evidence of great success in S.C., staff recommended that EMT-D be removed from the pilot status and that we should allow all those services desiring to provide automatic defibrillation to do so. The national data and the movement to place the automatic defibrillators everywhere indicate that we must recognize its potential and attempt to deal with it.

All services providing EMT-D would be required to continue operating under the same standards under which they are currently operating.

Dr. Perina made a motion that EMT-D be removed from its pilot status and allowed to be implemented by all services who desire to do so and who meet the qualifications. The motion was seconded and passed.

The next agenda item was the discussion regarding the review of drug lists, which is underway, and the impact of the changes made by the Emergency Cardiac Care Committee. The guidelines from this committee were printed in the "Journal of the American Medical Association" (JAMA).

Dr. Perina recommended that changes not be taught for the next six months to give adequate time for review of the "guidelines" published in JAMA and for the subcommittee to study the present drug list in light of the suggested changes. She suggested that the staff send out the subcommittee's review summary to the full Medical Control Committee to make review and decide at it's February meeting. The Committee agreed with this recommendation.

Staff requested that the committee assist in clarification of an earlier decision regarding the approval of EMT's for transport of homebound patients with self administered medication pumps. The committee had earlier decided the following: **Medication pumps in home bound patient transfers are considered patient-administered medication. Paramedics may transport such patients, as long as the pump is self-contained, and the Paramedic does not have to do anything to it, and the route of administration is a venous line.** The committee affirmed by consensus that Basic and

Intermediate EMT's should also be allowed to transport patients with medication pumps as described above. The training committee is expected to develop training for central line maintenance at all Levels.

Mr. Al Smith requested clarification from the Committee regarding the approved routes of administration for terbutaline. Was it approved for administration by nebulizer? The Committee, by consensus approved this route of administration for terbutaline.

The Committee agreed to meet again at the Symposium in February of 93, realizing that all will be brought together in a Trauma Committee meeting to be held as soon as that committee can be formed and mobilized. This meeting is planned for February 19, 1993 at 9:00 a.m. at the Radisson Resort Hotel at Kingston Plantation at Myrtle Beach.

There being no further business the meeting was adjourned.

# Medical Control Committee

## Minutes

November 11, 1992

<b>Members present:</b>	<b>Others present:</b>
Jim Raymond, M.D.	Mike Stein, M.D.
Doug Norcross, M.D.	Doug Warren.
John Sorrell, M.D.	
Carol Baker, M.D.	<b>Staff included:</b>
Ed DesChamps, M.D.	A. M. Futrell
Debra Perina, M.D.	Jim Catoe
Richard Bell, M.D.	Phyllis Beasley
	Joe Fanning
	John Zirkle
	Al Smith
	Tony Wynn

Dr. Raymond opened the meeting and called for approval of the minutes of the last meeting. Joe Fanning requested an amendment to the minutes be made to include a report from Mr. Futrell regarding the conditions under which nurses on the ambulances might legally carry drugs beyond what is authorized for prehospital use. This report was added on the fourth page of the minutes. The minutes were approved as amended.

Staff asked the committee to revisit their decision regarding **redesignation** of trauma centers, specifically the three Level I trauma centers that have been designated for a number of years. The discussion centered around the scope and nature of the redesignation process. Should these hospitals which have already been through a designation review be subjected to another complete review, or should the review process involve only the quality assurance data and activities? If a full review is not required, would an out of state review team be necessary or would an in-state team be adequate. What specialty areas are needed for redesignation, the full team as used before, or could one or two team members alone accomplish the task? Finally, when should this redesignation process begin?

In discussion it seemed to be the consensus of all that these hospitals should have the benefit of a thorough out of state site visit based on the complete ACS standards as outlined in the resource guide published by the Committee on Trauma.

Dr. Bell made the motion, seconded by Dr. Baker, that an out of state team be used for redesignation

of these hospitals, and that the team be composed of a surgeon, an emergency medicine physician, and a nurse. The motion was seconded then it was passed.

The committee, by consensus determined that the redesignation process should be completed by the end of calendar year '93. **Completed** means that the committee will have reviewed the applicants and made their decision regarding redesignation.

Staff reported on the status of Spartanburg Regional's trauma center. The president of the hospital wrote Mr. Futrell a letter stating that he understood the requirement that the committee be notified of any change in major requirements like trauma surgeons, and that they would do so when the occasion arises. Dr. Colvin, director of surgical education, reassured staff by telephone that Dr. Barbara Keonig had accepted the responsibility on an interim basis, from January 1 until another director could be found to replace Dr. Weigle.

Jim Catoe presented the committee with an orientation of the trauma grant's purposes and activities. He said the purpose of the grant is to upgrade the statewide trauma systems plan. This plan would be written using the guidelines presented in the Model Trauma Plan that was developed by the committee of trauma professionals under the auspices of the U.S. Department of Health and Human Services. The Model Trauma Plan provides a number of mandatory components to include human resources, communications, transfer and triage protocols and evaluation.

Mr. Catoe said that the grant had four broad objectives. They are: (1) To develop an updated trauma systems plan composed of four regions, (2) To complete a network of designated trauma centers in all appropriate locations, (3) To develop a coordinated data base with linkages between all trauma incident data, trauma care data, trauma outcome data, and (4) To evaluate the current configuration of trauma centers. Objectives 2,3,&4 are necessary activities to complete a comprehensive trauma systems plan.

Staff distributed a document on triage and by pass for discussion. This document was an attempt by staff to begin addressing the variables that should be considered at the regional and local level in developing protocols for:(1) situations requiring triage and bypass of local, non-participating hospitals, (2) situations where the level III hospital may wish to triage patients to the Level I hospital, and (3) the situations where the Level III hospitals should rapidly refer patients to the Level I hospital after they have been stabilized and assessed. The Committee felt, that triage and by pass protocols could not be developed at the state level.

Dr. Sorrell made the suggestion that each region should develop their own trauma plan, with broad guidelines, that includes triage and by-pass. The state could either adopt it or modify it in some way.

Dr. Bell suggested that we allow each region to identify the issues in each of the regions, bring these issues from each of the regions, and from that develop some guidelines.

Discussion followed regarding how regional and/or local plans should be handled in the state plan,

since this is one of the components that must be addressed. The model state trauma plan speaks specifically to this. The state office of EMS has the authority to develop a plan, but nothing can be implemented in this area until a plan has been developed and presented to the community in a hearing for their information, reaction and input.

Mr. Futrell said that regional catchment's areas with boundaries for each need to be outlined for each of the Level I Trauma Centers. When assembled as part of the state plan, the plan could also include those counties not covered in any region and those counties included in the regions of Level I trauma centers outside the state.

Dr. Raymond suggested that the Trauma Committee should deal with the issue and protocols for bypass. The Committee requested that staff complete a study of the referral patterns, based on ambulance run report data. This information will be mailed to the committee members prior to the next meeting, or the meeting of the trauma committee, whichever comes first.

Mr. Fanning introduced Phyllis Beasley, who will be working on the trauma grant. She read the staff's proposed composition of the Trauma Systems Committee. She explained that the federal model trauma plan, which the state will use in developing its plan, did not give specific guidelines for the trauma committee. It stated that the committee should be composed of a "multi-disciplinary group of providers and consumers whose interest and expertise are the development of a statewide trauma system," and that a "community coalition of consumer groups and networks already in place, such as MADD and the American Red Cross, can assist in support and development of the trauma system."

Ms. Beasley asked that the Medical Control Committee submit nominations for the committee to her following the meeting.

Mr. Fanning stated that this is a large committee, but the staff had envisioned the formation of regional subcommittees to act as the working committees. After a request from Dr. DesChamps for an explanation of the relationship of the committees, Mr. Fanning said that the federal model trauma plan required a trauma systems committee, even though the Medical Control Committee has addressed these issues in the past. He suggested that the Trauma Systems Committee would act as a subcommittee to the Medical Control Committee for the purpose of getting input from all the trauma players and receivers of trauma services. Regional committees, subcommittees of the Trauma Systems Committee, would be the source for input from regional groups.

Dr. Norcross expressed concern over the large number of committees that seemed to be developing.

Dr. Sorrell noted that the composition of the Trauma Systems Committee appeared to be 90% of the Medical Control Committee. He suggested the Trauma Systems Committee be composed of the Medical Control Committee plus some additional members.

The Committee then considered the suggested composition of the Trauma Systems Committee.

Concern was expressed by Dr. Perina that the Level III trauma centers were not adequately represented.

Dr. Stein proposed that the Trauma Systems Committee be composed of the Medical Control Committee plus additional interest groups. He explained that the committee could meet in the morning to discuss trauma issues, then the Medical Control Committee could meet afterwards to vote on EMS-related issues.

Dr. Perina moved to accept Dr. Stein's proposal. The motion was seconded. Dr. Deschamps asked for clarification regarding the status of this committee to the Medical Control Committee. Dr. Raymond responded that the Trauma Systems Committee would be a subcommittee of the Medical Control Committee. The motion passed.

Dr. Raymond then asked the Committee to consider the constituency of the Trauma Systems Committee.

Dr. Bell suggested that, in addition to the membership of the Medical Control Committee, the trauma committee add:

- Two Level I surgeons
- three Level III emergency department physicians
- three Level III surgeons
- three Level III emergency department nurses
- EMS Director's Association member
- hospital administrator from each level trauma center
- SC Rehabilitation Association representative
- MADD representative
- American Red Cross representative
- Highway Department representative
- law enforcement representative

Dr. Perina suggested that a representative of the media also be added to the membership roster and that instead of a representative from the EMS Directors Association, there should be a field medic from each region designated by the regional director. Mr. Futrell stated that this would bring the membership of the Trauma Systems Committee to 33.

The Trauma Systems Committee membership as presented by Dr. Sorrell and amended by Dr. Perina was passed by acclamation by the Committee. Dr. Raymond or his designee will serve as chairman of the trauma subcommittee. Attached is a roster of the membership of the full committee.

Dr. Raymond asked if the listed objectives of the committee came directly from the model plan. The objectives are: 1) review components of the statewide trauma plan and give general direction for overall development; 2) define system criteria; 3) establish system standards (or guidelines); and 4) review system performance. Mr. Fanning responded that the objectives were influenced by our

objectives to develop the grant. Dr. Raymond then asked the Committee if anyone knew of any other objectives that the Trauma Systems Committee should encompass. Dr. Norcross responded that it should address all aspects of trauma formally addressed by the Medical Control Committee.

Dr. Perina moved that the objectives of the Trauma Systems Committee as outlined be adopted by the Medical Control Committee. The motion was seconded. The motion passed.

The next agenda item was a report on the progress on the formation of a committee for prehospital "Do Not Resuscitate" (DNR) protocols. The organizations to be represented on this committee have been requested to provide a designee to serve on the committee by November 15, 1992. This committee will have the objective of developing policies, protocols, and legislation, if necessary, to enable prehospital use of "DNR" procedures.

A set of standing orders for "DNR" dealing with procedures for terminating resuscitation, and requirements for continuing resuscitation under certain criteria was discussed. It was determined that several larger EMS services are already operating under similar guidelines but call procedures rather than protocols. It was determined that these protocols might be a good base for discussion in the DNR subcommittee.

Staff presented the Pilot program for EMT-Defibrillator (EMT-D), a summary of studies written nation-wide was previously mailed out for study. A compilation of EMT-D activities within the state shows that 15 programs are approved with 10 of those programs active. There have been six EMT-D resuscitation attempts in the last year with no saves. Though there is no evidence of great success in S.C., staff recommended that EMT-D be removed from the pilot status and that we should allow all those services desiring to provide automatic defibrillation to do so. The national data and the movement to place the automatic defibrillators everywhere indicate that we must recognize its potential and attempt to deal with it.

All services providing EMT-D would be required to continue operating under the same standards under which they are currently operating.

Dr. Perina made a motion that EMT-D be removed from its pilot status and allowed to be implemented by all services who desire to do so and who meet the qualifications. The motion was seconded by Dr. DesChamps, and passed.

The next agenda item was the discussion regarding the review of drug lists, which is underway, and the impact of the changes made by the Emergency Cardiac Care Committee. The guidelines from this committee were printed in the "Journal of the American Medical Association" (JAMA). The subcommittee requested that we wait until the February meeting to hear its report.

Dr. Perina recommended that changes not be taught for the next six months to give adequate time for review of the "guidelines" published in JAMA and for the subcommittee to study the present drug list in light of the suggested changes. She suggested that the staff send out the subcommittee's

review summary to the full Medical Control Committee to make review and decide at it's February meeting. The Committee agreed with this recommendation.

Staff requested that the committee assist in clarification of an earlier decision regarding the approval of EMTs for transport of homebound patients with self administered medication pumps. The committee had earlier decided the following: **Medication pumps in home bound patient transfers are considered patient-administered medication. Paramedics may transport such patients, as long as the pump is self-contained, and the Paramedic does not have to do anything to it, and the route of administration is a venous line.** The committee affirmed by consensus that Basic and Intermediate EMT's should also be allowed to transport patients with medication pumps as described above. The training committee is expected to develop training for central line maintenance at all Levels.

Mr. Al Smith requested clarification from the Committee regarding the approved routes of administration for terbutaline. Was it approved for administration by nebulizer. The Committee, by consensus approved this route of administration for terbutaline.

The Committee agreed to meet again at the Symposium in February of 93, realizing that all will be brought together in a Trauma Committee meeting to be held as soon as that committee can be formed and mobilized. This meeting is planned for February 19, 1993 at 9:00 a.m. at the Radisson Resort Hotel at Kingston Plantation at Myrtle Beach.

The Trauma Committee will meet before then if it is at all possible. Dr. Norcross suggested that staff develop a report/presentation to share with the Trauma Committee its purpose, where we began before development of the trauma system, what we have done in development of the trauma system, and the immediate and long range objectives for further trauma system development.

A report on data identifying the referral patterns and the present trauma regions boundaries based on this data will be developed by staff for presentation to the Trauma Committee.

There being no further business the meeting was adjourned.