# MEDICAL CONTROL COMMITTEE

# JANUARY 7, 1997

# MINUTES

| Members present: | Others present: |
|---|---|
| Ed DesChamps, MD, Chairman | Joe Fanning |
| Bill Gerard, MD | Phyllis Beasley |
| Doug Norcross, MD | Judy Jones, RN |
| John Sorrell, MD | Debbie Couillard, RN |
| Carol Baker, MD | Joe Bianco, MD |
| Richard Rogers, MD | Marie Segars, RN |
| | Hart Smith, RN |
| | Diane Howell, RN |
| | Doug Warren |
| | Alonzo Smith |

To begin the meeting Ms. Beasley introduced Dr. Joseph Bianco from Orangeburg who has been nominated to be the SCEP representative on the Medical Control Committee (MCC), filling the position left vacant by Dr. Phillips' resignation. His nomination (to the Medical Control Committee and EMS Advisory Council) must be approved by the DHEC Board. He was welcomed by the Committee.

## RECOMMENDATIONS FROM TRAUMA SYSTEM COMMITTEE

Dr. Norcross, chairman of the Trauma System Committee (TSC), presented the report of actions from his committee which met just prior to Medical Control. There were several motions from that committee which needed action from Medical Control. Dr. Norcross presented a list of motions.

Dr. Norcross explained that several trauma center designations were considered and needed Medical Control Committee action. The first was the final approval of Self Memorial Hospital. Self Memorial Hospital as a Level III trauma center. Self had been designated under Designation Category #2 (to designate the hospital as a trauma center, but with the understanding that the hospital will correct the problems noted and report them to the Committee within 90 days. The hospital has the important essential items, but needs some minor changes/improvements.) Dr. Norcross explained that the trauma committee had reviewed a letter from Dr. Richard Bell which verified that the hospital had sufficiently provided evidence of a working trauma QI program and that he supported full designation. **He put the TSC's motion**

**to the Medical Control Committee, "to move Self Memorial Hospital to a Category I designation (designated the hospital as a trauma center. The hospital has everything required and is designated with no questions or problems.) Dr. Baker seconded the motion. The motion passed.**

Then Dr. Norcross explained that McLeod Regional Medical Center was considered for a similar verification. He said that a report verifying improved nursing documentation had been submitted by Carolyn Foley, RN and Division of EMS staff. **He then put the TSC's motion to the Medical Control Committee: "to move McLeod Regional Medical Center to Designation Category I. The motion was seconded by Dr. Baker. The motion passed.**

The next motion for consideration involved the designation of Piedmont Medical Center as a Level III trauma center. Dr. Norcross explained that he had served as team leader for the site review in December. A report had been presented to the TSC which summarized the team's findings for criteria and from the chart review. The team and the TSC had several concerns about the trauma center functioning at Piedmont. Therefore, the TSC had decided not to recommend designation at this time. The designation actions concerning Piedmont were broken down into several different motions, which he put before the MCC. **The first motion ( a combination of two TSC motions) was "to place Piedmont Medical Center in Designation Category #3 (that designation should be withheld until the hospital can correct the deficiencies in the essential areas noted. The hospital has deficits in some important essential areas. These areas are not likely to be easy to correct and will probably require up to six months to correct. At the time of re-review, the hospital may be categorized according to Options #1, 2, or 4.) At the time of re-review the following items would be considered:**

1) **Documentation of appropriate use of the trauma alert system;**

2) **Evidence of surgical involvement in the workup and management of the seriously injured patient in the emergency department;**

3) **Evidence of multidisciplinary involvement in the QI process throughout the trauma continuum (including the emergency department);**

4) **Evidence of efforts to increase trauma continuing education to nurses and allied health personnel;**

5) **Evidence of improvement of nursing documentation, particularly in the emergency department.**

**Dr. Baker seconded the motion. Dr. Norcross abstained from voting. The motion passed.**

Dr. Norcross explained that, following the approval of the above motion, the TSC determined that more specific deadlines for meeting deficiencies should be included in the designation category options. **He asked the MCC to consider the motion that Designation Category #3 be changed to include the wording " the hospital will be reviewed again in no less than 6**

**months and no more than 12 months after notification in letter to the hospital and subject to availability of team members." Dr. Rogers seconded the motion. The motion passed.**

**Another motion specifically related to Piedmont's designation was put forth by Dr. Norcross, "That the hospital would be reviewed again in no less than six months and no more than 12 months." Dr. Baker seconded the motion. The motion passed.**

As a point of information, Dr. Norcross told the committee that the TSC decided as a matter of designation policy that any team which "re-reviews" a hospital (following assignment in Designation Category #3) will be composed of at least one member of the original site review team.

Dr. Norcross then briefed the committee on the TSC's discussion about trauma consultants, paid and volunteer, and possible conflict of interest issues. He explained that the TSC had discussed issues such as whether or not a trauma consultant could be a member of the site review team for the hospital with which he consulted, or whether the consultant could even be present at the time of the review. This discussion led to two motions which Dr. Norcross put before the MCC. **The first motion by Dr. Norcross was "if a hospital has asked or hired a consultant to review its trauma organization, then, at the time of the consideration of the hospital's application in committee, the consultant will be invited to attend the meeting. Dr. Rogers seconded the motion. The motion passed.**

**The second motion by Dr. Norcross was "that trauma consultants cannot serve as a member of any site review team which reviews that institution." The motion was seconded. The motion passed.**

*There was then discussion about whether paid consultants should be allowed to attend site reviews or committee meetings in which the designation is discussed. These issues were referred to the Trauma System Committee to develop policies regarding consultants.*

## TRAUMA TRANSFER POLICY

At the last EMS Advisory Council meeting, the Council passed a motion requiring the 1997 Level III trauma application to carry wording which would require the hospital to adopt a policy allowing emergency department to emergency department transfers. Following the passage of this motion, EMS staff conducted a phone poll of currently designated trauma centers and discovered that none of the hospital's had a similar policy. The main reason cited for not having this policy was that insurance companies did not allow two emergency department charges in one day.

Dr. DesChamps brought this issue to the MCC for their opinion. The Committee considered asking the EMS Advisory Council to rescind this policy. There was much discussion about why the policy should be rescinded, most of which centered around the disallowance of two emergency department charges and the fact that emergency department physicians do not always know the availability of specialists which might be needed by the transferred patient. The Committee also debated about whether the problem of delayed interhospital transfers was real or

perceived? They agreed that there was little data to review. Ms. Segars of McLeod explained that the Advisory Council had passed this motion because of the issue of delayed transfers which came up in the discussion of the designation of her hospital. She said that her hospital had conducted surveys with sending hospitals and found that the problem was part perception and partly based in fact. She said that her hospital had since passed an emergency department transfer acceptance policy. The Committee recognized the basis of the EMS Advisory Council's decision to pass this motion as an effort to ensure that trauma patients received appropriate care as quickly as possible. However, the Committee felt that the issue had not been examined closely enough to warrant the passing of such a policy at this time.

**A motion was made by Dr. Norcross to submit a letter to the Advisory Council requesting that they consider rescission of that policy until further studies about the problem can be conducted. The motion was seconded by Dr. Rogers. The motion passed.**

(Two days following this meeting, the EMS Advisory Council agreed to rescind this policy until further studies could be conducted.)

As a last matter concerning trauma centers, Dr. Norcross reported the discussion within the TSC about the concerns regarding the designation of pediatric trauma centers and the formation of a subcommittee to meet with the EMSC Committee to resolve those concerns.

## PROTOCOLS

Dr. Gerard introduced the adult protocol document which had already been mailed to Medical Control Committee members. A phone poll vote had been taken during December regarding acceptance of those protocols and had passed. However, some comments regarding suggested changes had come in, through the mail with EMS services and regional directors, and during the vote. Ms. Beasley read through the list of suggested changes. All were considered (see attached), but it was determined that those type changes could be made on a local basis, since the protocols were being submitted for use as guidelines only.

**Dr. Gerard made a motion to adopt the adult protocols document with the note added that they are presented as guidelines and their use is not required. The motion was seconded by Dr. Rogers. Dr. Gerard added that he would make annual changes to the document. The motion passed.**

The pediatric protocols were submitted with explanations about the process of developing those protocols and checking them against the current drug list. The protocols were developed by Dr. Debbie Woolard of the EMSC Committee and had received EMSC Committee approval. She had also worked with Dr. Gerard and Dr. DesChamps to ensure their viability.

**Dr. Sorrell made a motion to accept the pediatric protocols. Dr. Rogers seconded the**

**motion. The motion passed.**

## PROCEDURES

Dr. DesChamps brought up for discussion the need to add certain procedures, particularly for pediatrics, as approved procedures. Several procedures had been included in the pediatric protocols, but were not "approved" in this state. Dr. DesChamps stated that Dr. Woolard and the EMS Committee felt that these procedures were necessary for appropriate care of the pediatric patient. He said that all were either already being taught in the curricula or could be taught with minimal effort. These skills would be "local option" skills. The local medical control physician could choose to provide training and allow his paramedics to use the skills, but they would not be required to train or use them.

The first procedure which was considered was rectal administration of drugs. Questions were raised about the number of pediatric patients who were used in the rectal valium pilot project. Dr. Baker responded that at least 200 patients were involved in the project. Dr. Norcross asked if acceptance of this procedure would increase training time and Mr. Smith responded that it would not increase training time. The procedure could be taught within the allotted time frame.

**Dr. Baker made a motion to add the rectal administration of drugs for pediatric patients as an approved route of administration. The motion was seconded. The motion passed.**

The second procedure considered was vagal maneuvers. Mr. Smith explained that vagal maneuvers for adults and pediatrics are already taught in the curriculum, but have not been used.

**Dr. Sorrell made a motion to add vagal maneuvers as an approved procedure. Dr. Rogers seconded the motion. The motion passed.**

The last procedure considered was needle thoracostomy for pediatrics. Mr. Smith said that the procedure was already being taught. Dr Baker emphasized that this procedure is considered essential for pediatric patients and meets the needs for immediate and effective rescue attempts.

**Dr. Baker made a motion to approve needle thoracostomy as an approved procedure for pediatric patients. Dr. Norcross seconded the motion. The motion passed.**

## DRUG ISSUES

Dr. DesChamps noted that there had been questions about **pediatric drug dosages** which were included on the protocols and whether the pediatric dosages on the current drug list are correct. The Committee expressed concern about approving a mass of changes without a complete review. They decided that they wanted a copy of the new drug list (which is currently being re-formatted and updated by Dr. DesChamps and Mr. Smith) with the changes highlighted and a

summary sheet.

*Staff agreed to conduct a phone vote on the pediatric drug dosages.*

Dr. DesChamps then brought up an issue related to **interfacility drugs**. He said that a letter had been received complaining about the inability for an EMT to increase an interfacility drug when asked by an on-line physician. The basis for that policy was explained--that it was passed originally to protect the EMT in instances when a physician may not be familiar with policies and training of EMTs.

The Committee expressed concern about making "wholesale changes" in the interfacility list when there have only been one or two complaints. The comment was also made that the list was developed when stable patients were the only ones being transported--now unstable patients are routinely being transported.

*It was decided that staff will determine who and how to poll EMS services to see if this is a problem and, if so, how much of a problem.*

The next point of discussion was regarding a non-state approved drug being kept on a special purpose ambulance. Policy is that a non-approved drug can be used on a special purpose ambulance if a nurse is in attendance, but the drugs are not supposed to be stored on the ambulance. The drugs must be carried on and taken off as needed. A comment was made that sometimes the drugs are stored on the ambulance, but in a locked container.

Dr. Sorrell said that the medical control physician should be responsible for how and where the drug is stored. Dr. DesChamps suggested that Dr. Norcross and Dr. Sorrell work together as a subcommittee and come up with a recommendation for policies regarding these drugs and non-approved equipment.

## ICD'S

A letter from a EP lab supervisor at Providence Hospital had been sent to the Heart Association and was submitted to the Medical Control Committee for discussion by Dr. Gerard. This letter cautioned about an instance in which a man with an ICD had become overexcited, resulting in a high ventricular response rate which resulted in a total of 46 shocks before he could be transported for definitive treatment at Providence.

The concern for the Committee was whether EMTs should carry magnets to use in situations like this to prevent continuing shocks.

**The consensus of the Committee was that this should be care administered at a hospital, that the hospital should be required to stock these magnets, not EMS services.**

## PILOT PROJECTS

Ms. Beasley reported that Oconee Memorial Hospital had withdrawn its request for a pilot project to participate in the Pursuit Study, using Integrilin.

However, Mr. Smith brought up another subject related to pilot projects. He asked the Committee that if a pilot project has already been approved and another service wants to use the same project and guidelines, etc., could staff be allowed to approve a second service's participation?

Dr. Norcross had concerns that a small rural service might request to participate in a project being conducted by another service which might have more paramedics, training, etc. **However, the consensus of the Committee was that staff should be allowed to approve a second service's participation in a pilot project at their discretion, but should inform the Medical Control Committee of their decision.**

## FDA AND PERMITTED DOSAGES

Dr. Gerard had provided for the Committee a copy of an article from the "Emergency Medicine and Acute Care Essays" regarding the use of drugs in dosages that were not at the approved FDA dosage. Dr. Gerard said that this was passed out for informational purposes only. The conclusion of the article was that the "FDA relationship in this context is between the manufacturer and itself--it does not involve the prescriber or end-user. Physicians are authorized to prescribe drugs based on available information supporting their efficacy in concert with the exercise of sound judgment and prudence."

Dr. Bianco mentioned that he would like the lights and sirens issue on the agenda next time. However, Dr. DesChamps said that this was not the type of issue that is addressed in Medical Control and that it had been referred to the Equipment and Standards Committee.

The Committee agreed that it would like to hold the annual "drug meeting" at the EMS Symposium in March. (However, later it was determined that key staff, specifically Mr. Smith, would not be available for a meeting during that time.)

With no further discussion, the meeting was adjourned.

# MEDICAL CONTROL COMMITTEE

## MARCH 18, 1997

## MINUTES

| Members Present | Others Present: |
|---|---|
| Ed DesChamps, MD, Chairman | Joe Fanning |
| Bill Gerard, MD | Phyllis Beasley |
| Doug Norcross, MD | Al Futrell |
| John Sorrell, MD | Alonzo Smith |
| Carol Baker, MD | Tony Wynn |
| Richard Rogers, MD | Tekethia Washington |
| Bob Malanuk, MD | Susan Collins |
| | Joe Bianco, MD |
| | Steve Shelton, MD |
| | Debbie Woolard, MD |

### OXYLATOR

To begin the meeting Mr. Smith, introduced Mr. Tom Cleveland of PALCO who gave a quick presentation on the oxylator. After the presentation, Mr. Smith asked Dr. DesChamps and the Committee for approval to use the oxylator in the field. The oxylator is FDA approved, costs $700.00 and has a 5 year warranty. The Committee referred this decision to the Equipment and Standards committee.

### READING/APPROVAL OF MINUTES FROM 1/7/97

Dr. Malanuk asked to refer to the issue of trauma center consultants which had been discussed at the last meeting.

Dr. Malanuk stated that he did not feel it was appropriate for members of the Medical Control Committee to serve as trauma consultants for hospitals seeking trauma center designation. Dr. Malanuk suggested that staff contact the DHEC Legal Office and find out if committee members serving as consultants can be paid. Dr. Malanuk then asked the committee to reconsider if members should be paid consultants.

Dr. Sorrell stated that he felt that no one on the Committee should be paid and that hospitals that have representatives on this Committee have an advantage. Dr. Baker stated that she felt that anyone who does serve as a consultant should definitely not be on the designation review team for the hospital for which they consulted. The question came up that if hospitals were not allowed to solicit consultants from the Medical Control, where would they get trauma consultants? The suggestion was made that hospitals could get for-pay consultants from the

American College of Surgeons.

Dr. Sorrell said that he didn't think it was unethical if the consultant (referring to a Medical Control Committee member) was unpaid and didn't vote on the designation and didn't participate in discussions during the site review or during Committee discussions.

Dr. Malanuk reiterated that he felt that Committee members should be disallowed as paid consultants and that the DHEC Legal Office opinion should be obtained.

Dr. Norcross stated that upon contacting the DHEC Legal Office, staff should get a clear definition of what constitutes payment. He also stated that the members of the Trauma Committee be informed of any information regarding paying consultants.

Dr. Sorrell made a motion that no one on the Trauma or Medical Control Committee can serve as a paid consultant for the designation process to any hospital seeking designation as a trauma center in South Carolina. The motion was seconded. The motion passed.

Motion was made to approve minutes from 1/7/97. The motion was seconded. The motion passed.

*Staff is to contact DHEC Legal Office and find out what constitutes payment and whether committee members can serve as paid consultants. Staff is to relay the aforesaid minutes to the Trauma Committee.*

## DRUGS

### NIFEDIPINE

Dr. Baker stated the Nifedipine given to lower blood pressure has severe side effects such as stroke and death. Dr. Baker expressed that keeping Nifedipine on the drug list will cause physicians to continue its use thus causing bad results in patients. Dr. Baker made a motion to remove Nifedipine immediately from the drug list. The motion was seconded. The motion was passed.

### LABETALOL

Dr. Baker's second request was to add Labetalol to the drug list. She stated that as of now, TPA is given for strokes in the ER but a method to allow more control of blood pressure reduction in the field is needed. Dr. Baker stated her reason for suggesting Labetalol is because it is safe and easy to administer and is not used in conjunction with any other drug. Dr. Sorrell recommended giving Labetalol in a drip.

Dr. DesChamps stated if Labetalol is not approved as a prehospital drug it can probably be added as an interfacility drug given if it's routine and increasing in utilization. Dr. Baker agreed and suggested it should be up to each medical control facility to decide how to administer Labetalol.

Dr. Gerard asked that the contraindications to receive Labetalol need to be clarified. It was stated that cocaine induced hypertension should be a contraindication.

Dr. DesChamps stated that Labetalol also be added under as only with online medical control. Dr. DesChamps also asked if this was an IO approved drug. Dr. Baker responded that it is not an IO contraindicated drug. Dr. DesChamps stated that Labetalol dosage should read (see chart on next page);

LABETALOL
Normodyne, Trandate

| | |
|---|---|
| INDICATIONS: | Control of Blood Pressure in Severe Hypertension |
| ADMINISTRATION: | IV Push(Slow); IV Infusion; IO |
| DOSAGE: | |
| ADULT | IV PUSH:<br>➢ Initial: 10-20mg (0.25mg/kg) IV/IO Slow (at least 2 minutes)<br>➢ Repeat: May administer additional IV Slow boluses of 10-80mg at 10 minute intervals to a Maximum of 300 mg IV Total.<br><br>IV DRIP:<br>➢ 2-8 mg/min maintenance |
| PEDIATRIC | ➢ 0.2-0.5 mg/kg/dose to a MAXIMUM of 20 mg/dose as intermittent bolus (slow).<br>➢ MAY GIVE PEDIATRIC IV BOLUS ONLY WITH ON-LINE MEDICAL CONTROL ORDER<br><br>IV DRIP:<br>➢ 0.2-1.0 mg/kg/hr<br>➢ MAY GIVE CONTINUOUS IV INFUSION ONLY WITH ON-LINE MEDICAL CONTROL ORDER |
| THERAPEUTIC EFFECTS: | Dose related decrease in Blood Pressure with out reflex tachycardia and without significant decrease in Heart Rate. Also has less decrease in cerebral perfusion pressure than with nitroprusside. |
| CONTRAINDICATIONS: | Asthma; Cardiogenic Shock;<br>Heart Block - Greater than 1st Degree;<br>Sever Bradycardia; Hypotension<br>Cocaine Induced Hypertension |
| SIDE EFFECTS: | Mild and Transient Hypotension;<br>Postural Hypotension if patient allowed upright within first 3 hours. |

Dr. Baker a motion to add Labetalol. The motion was seconded by Dr. Rogers. The motion passed.

IBUPROFEN

Ibuprofen was considered as the next drug for addition.

Dr. Woolard gave a brief overview of the use(s) of Ibuprofen. She stated that it should be administered during long transports and for mild fever and pain.

Dr. Norcross asked about contraindications. Dr. Woolard stated that bleeding disorders or any GI bleeding would be a contraindication. Dr. Sorrell recommended making Ibuprofen for pediatric use only. The committee set the age limit as 12 and under with prior dose less than 6 hours.

Dr. DesChamps made a motion to add Ibuprofen. The motion was seconded by Dr. Malanuk. The motion passed.

ORAL GLUCOSE

Dr. Norcross posed a question that had been asked of him at the symposium, regarding the administration of oral glucose by Basic or Intermediate EMTs. The question was in two parts, first is oral glucose regarded as a drug and, if so, are Basic and Intermediate EMTs authorized to administer oral glucose.

Dr. Sorrell responded by stating it had been decided at an earlier Medical Control Committee meeting that EMTs could administer any sugar containing substance. That would also include administration by methods of PO, NG and oral gastric tubes. *(Staff clarification: Only EMT-P's can administer sugar containing substances by NG and oral gastric tubes.)*

Dr. DesChamps closed the annual review of drugs. Dr. DesChamps stated that at the next meeting there will be an annual review of the device list.

## AUTOMATIC EXTERNAL DEFIBRILLATOR (AED)

Mr. Joe Fanning gave a brief overview of the National Association of EMS Directors' position regarding AEDs. The final decision from the Directors was to slow down the use of AEDs until more studies can be done.

*Dr. Norcross suggested that staff contact the LLR and ask them to make a recommendation on who can use this equipment. The Committee also wants staff to bring this issue to the attention of the LLR.*

## PILOT PROJECT: RAPID SEQUENCE INDUCTION INTUBATION

Dr. Bill Gerard explained the project proposal for Rapid Sequence Induction. He also gave reference to research and projected data found in the pilot project manual.

Dr. Norcross stated that he felt this project needs to be done. He then suggested that all data (positive and negative) be shown to the committee. Dr. Norcross asked about the ability to perform a cricothyrotomy if an EMT can not get an airway. Dr. Gerard stated that cricothyrotomy is not a state approved procedure.

Dr. Bianco suggested approving this project with a one or two year review date of all data.

Dr. Norcross expressed that all children should be excluded from this project. He then suggested the age limit be set at eighteen (18) and above. Dr. Norcross repeated concerns as to whether this project is considered an experiment. Dr. Gerard assured him that the pilot project was in no way an experiment.

Dr. Baker made a motion to accept the pilot project for Lancaster for a six (6) month trial period and thereafter return all data to the committee for review. The age limit for individuals treated in this project must be eighteen and over. The motion was seconded by Dr. Richard Rogers. There was then discussion regarding whether this motion precludes the addition of other services who may wish to apply for the same pilot project. It was agreed that after a six month trial period and project approval, other services - e.g. Richland and Greenville- who have expressed interest would be allowed to join in under the EXACT SAME protocols. Committee members also agreed that a DHEC representative should attend and review a training session at Lancaster and report back to the committee. The motion passed, pilot project approved.

## PEEP VALVE/ PULSE OXIMETER CONCERNS

Mr. Smith passed out a report of an incident in which a patient was being transported from one county hospital to another and upon examination at the new location; the attending respiratory therapy department deduced that the patient should have received a PEEP valve during transport. The receiving hospital stated they felt the patient did not receive proper care during transport to keep patient respiratory functions viable. Mr. Smith stated that Paramedics do not carry PEEP valves, nor are they trained in the use of PEEP valve administration. Mr. Smith then stated that there were several questions brought about after this incident such as:

- Should all ambulances have pulse oximetry?

- Should all ambulances have battery powered ventilatory capabilities so that patients on mechanical ventilation being moved from one hospitals ICU to another can bypass being bagged and continue to receive powered ventilation?

- Should all ambulances be required to carry PEEP valves?

Dr. DesChamps asked what the legal and licensure applications are to the medic if the patient expires during transport and the EMT accepted the transfer. Dr. Norcross stated that it is up to the referring physicians to assure that a patient is stable for transfer and to assure the method for transportation is appropriate.

It was agreed by the Committee that the PEEP valve, pulse oximeter and oxylator concerns should be addressed during the device list review.

## CRUSH INJURY

Mr. Smith stated he received a letter from Mark Register, EMS Director at the Savannah River site regarding writing a protocol for using sodium bicarbonate for crush injuries.

Dr. Norcross asked if Mr. Register was requesting that the use of sodium bicarbonate be added as a state protocol or should the indication be changed to use sodium bicarbonate in crush injury situations. Mr. Smith stated that Mr. Register was requesting sodium bicarbonate be added only to his county protocol.

Dr. Norcross then replied that he strongly feels sodium bicarbonate should not be given so soon after a crush injury, and there should not be a state protocol to administer such.

Consensus of the Committee was that the use of sodium bicarbonate could be handled at a local level.

## LOWER EXTREMITY IV's

The question was raised about whether lower extremity IV's could be given.

Dr. Gerard stated that the curriculum does not state that it could not be done. It only says ***"extremities"*** and does not specify upper or lower.

The committee agreed to approve the decision to use lower extremity IV's as local protocol.

## DNR FORMS

Dr. Norcross stated that during a recent workshop, a statement was made that copies of an original signed order of a DNR from could be copied and used. Dr. Norcross explained that the problem with allowing this is that the law states, to invalidate a DNR order, it must be destroyed. If copies of an original have been disbursed to various facilities, each copy would have to be tracked and destroyed, which would be a very difficult and extensive process.

Mr. Futrell explained that it has been clarified in the revised regulations that a facility can send

the original DNR form or leave a certified copy of the original. Either one of these are acceptable.

## WEBPAGE

Dr. DesChamps discussed the idea of developing a EMS webpage. He then asked the committee for any suggesting regarding putting together this type of project.

Dr. Norcross stated that this is a great idea but asked who would do it and who would pay for it? Dr. Woolard said that there is someone interested in putting together an EMSC webpage and EMS information could be added to it.

Dr. DesChamps ask the committee to review the idea and come up the other suggestions that would help to make this project feasible.

## POLICIES RE: NON APPROVED EQUIPMENT AND DRUGS ON AMBULANCES

Dr. Sorrell and Dr. Norcross stated that during a subcommittee meeting it was decided that an ambulance should be able to carry drugs and equipment medical control physician approves of, with the condition that it would not be used by EMTs.

Dr. DesChamps asked if this could be done only on special purpose ambulances.

Dr. Sorrell stated that it was originally approved for special purpose but now applies to all ambulances. Dr. Norcross added that only drugs and equipment with the physician's approval can be carried.

## ITEMS FOR NEXT MEETING

Dr. Sorrell discussed an article in the NASEMP newsletter regarding a medical control physician's violation of a patient's civil rights.

*Dr. DesChamps stated staff needs to develop a method for capturing (signal) and maintaining records of births in pre-hospital setting on the run reports. Dr. Norcross suggested adding a line for physicians' signature.*

Meeting was adjourned by Dr. DesChamps.

# MEDICAL CONTROL COMMITTEE

## Wednesday, November 19, 1997

### Minutes

| Members Present: | Others Present: |
|---|---|
| Ed DesChamps, MD | Doug Warren |
| Richard Miller, MD | Cindy Lee, RN |
| Carol Baker, MD | Lea Dean, RN |
| John F. Sorrell, MD | E.S. Weinstein, MD |
| Ron Fuerst, MD | Greg Robinson |
| Bill Gerard, MD | Lanny Bernard |
| Bob Malanuk, MD | Steve Shelton, MD |
| Joe Bianco, MD | Russ Jaicks, MD |
| E. Doug Norcross, MD | Chris Cothran |
| | Cathy Wendell |

### REVIEW OF MINUTES

**A motion was made to approve the minutes of the last Medical Control Committee (MCC) meeting of March 18, 1997. The motion was seconded. The motion passed.**

Dr. Ron Fuerst, representing pediatric specialists, was introduced as the newest member of the MCC.

### TRAUMA SYSTEM COMMITTEE ISSUES

Information from two Trauma System Committee (TSC) meetings was reviewed.

DESIGNATION OF PIEDMONT MEDICAL CENTER (LEVEL III):

Dr. Norcross (chairman of the Trauma System Committee) presented the TSC's recommendations for designation of Piedmont Medical Center as a Level III trauma center. Piedmont Medical Center had been reviewed a second time, following an initial review which resulted in a recommendation of Option #3 (serious deficiencies which prevent designation and require a second review after 9 to 12 months). He reviewed the issues which were examined by the re-review team led by Dr. Norcross (original team leader) and assisted by Dr. Stephen Halus of McLeod Regional Medical Center and Barbara Greene of Allen Bennett Hospital.

The issues which were reviewed included:

1) (Need for) Documentation of appropriate use of the trauma alert system;
2) (Need for) Evidence of surgical involvement in the workup and management of

the seriously injured patient in the emergency department;
3) (Show) Evidence of multidisciplinary involvement in the QI process throughout the trauma continuum (including the emergency department); and
4) (Show) Evidence of improvement of nursing documentation, particularly in the emergency department.

The TSC recommended Designation Option #1 (To designate the hospital as a trauma center. The hospital has everything required and is designated with no questions or problems.)

**Dr. Norcross made a motion to accept the TSC's recommendation to designate Piedmont Medical Center as a Level III trauma center under Designation Option #1. The motion was seconded by Dr. Gerard. The motion passed.**

DESIGNATION OF MCLEOD REGIONAL MEDICAL CENTER (LEVEL II):

Dr. Norcross explained that both McLeod and Carolinas Hospital were recently reviewed by out-of-state review teams. Both teams were headed by Dr. Kimball Maull, Professor and Chairman of the Department of Trauma at Loyola University in Chicago. Dr. Larry Mellick, Chairman of the Department of Emergency Medicine at Medical College of Georgia and Pam Blackwell, RN, Director of the Georgia Office of Trauma also reviewed McLeod. The team used the standard report format of the American College of Surgeons.

Dr. Norcross stated that there was a strong recommendation for designation by the team, but that the state can choose whether to accept that recommendation. The TSC felt that the report was good and the designation of McLeod as a Level II trauma center under Category 1 (no problems) had been accepted unanimously with two abstentions.

Dr. Bianco commented that on the weaknesses listed in the report, not all the hospital's emergency physicians were ATLS certified. Dr. Norcross responded that this issue had been addressed before and that ATLS certification is optimal and indicates commitment, but that as long as the emergency physicians are board certified, it is not a requirement. Dr. Norcross commented that the hospital was reviewed by a national ACS reviewer who had been briefed regarding our designation options and that he felt that this should not affect designation.

**Dr. Norcross made a motion that the MCC should accept the TSC's motion to designate McLeod Regional Medical Center as a Level II trauma center under Category 1 (no deficiencies). The motion was seconded by Dr. Baker. A vote was taken by Dr. Bianco. The motion passed. (There were 2 abstentions, Dr. DesChamps and Dr. Gerard.)**

DESIGNATION OF CAROLINAS HOSPITAL SYSTEM (LEVEL II):

Dr. Bianco asked about the requirement for in-house trauma surgeons. Dr. Norcross stated that in-house surgeons are not required at a Level II trauma center (or Level I, 4th or 5th year residents can fulfill that), just that surgeons should be available at the time of the arrival of the

trauma patient. Dr. Norcross said that the issue of surgical response at a Level II center was discussed earlier. He said that the ACS "Blue Book" footnotes say that the surgeon should be at "the bedside" at the time of the arrival of the trauma patient, but there is a reality involved with this. If a patient arrives at the doorstep of the hospital, you can't expect the surgeon to be there if he hasn't been called. The committee's feeling is that if the hospital is reviewing the response of the surgeons and that the surgeon is consistently available within an appropriate time given appropriate notice that the response meets the intent of the criteria. Dr. Weinstein (audience) clarified that there are no numbers attached to what is considered an appropriate time for response or percentages. Dr. Bianco stated that he thought that both Level I and II were required to have in-house surgeons. Dr. Norcross reiterated that the Level I is required to have in-house surgeons and anesthesia, but the requirement can be met by residents and that Level II's do not have to have in-house coverage, but can meet the requirement by having coverage at the time of the arrival of the trauma patient. Dr. Norcross said that it is important that Level II's track the surgical response. Dr. Norcross reassured the MCC that Dr. Maull reviews Level I and II hospitals nationally and, as a surgeon is particularly concerned with surgical response times, and he felt that surgical response at both McLeod and Carolinas was appropriate.

**Dr. Norcross made a motion to accept the TSC's recommendation that Carolinas Hospital System be approved as a Level II trauma center, Category I (no problems). Dr. Malanuk seconded the motion. Dr. Bianco asked for a vote. The motion passed unanimously with 1 abstention (Dr. DesChamps).**

Dr. Norcross said also that in the TSC meeting that morning, the issue was brought up about an out-of-state review team's awareness of S.C.'s different options for designation. He said that Ms. Beasley (staff) informed both teams of the designation decision options which would be used and that the TSC voted to ensure that out-of-state review teams would be informed of the state's decision options and given a copy of those options.

Dr. Weinstein (audience) asked the question about who chose the out-of-state teams. Ms. Beasley (staff) responded the teams were selected from a list of surgeons given by Dr. Bell and Dr. Norcross and by calling state offices for recommendations on emergency physicians. Dr. Maull was highly recommended by both Dr. Bell and Dr. Norcross and was willing to lead both site reviews. The team's availability must also match the availability dates provided by the hospital. Unfortunately, it was not possible to find an emergency physician who could do both Florence reviews. As Ms. Beasley was attempting to locate emergency physicians, Ms. Blackwell, a former Level II trauma center nurse, flight nurse and current Trauma Director for Georgia, volunteered to assist with both reviews.

REDESIGNATION PROCEDURE PROPOSAL:

Dr. Norcross reviewed the general plans for a quality assurance redesignation review every three years, based on the audit filters approved in 1995. Every 6th year would be a full, application based redesignation.

At the last TSC meeting, the redesignation process outlined step by step and a chart review form were reviewed and approved. Dr. Norcross explained that the Level III redesignation reviews are to be conducted by in-state teams and the Level I and II reviews will be conducted by out-of-state teams. Dr. Norcross explained that he had asked that Level III reviews be conducted before Level I and II reviews to be sure that the process works before people are brought in from out-of-state and the hospitals spend a great deal of money. He also said that the TSC felt that if a hospital wanted to go through a full ACS review that it would serve the same purpose as a state review. The report from ACS would be filed back to DHEC and the committees.

Dr. Norcross explained that at the TSC meeting a discussion arose that during redesignations of Level I and II trauma centers a full team of surgeon, emergency physician and nurse would be used, but during Level III redesignations the proposal only called from a surgeon and a nurse on the review team. He said that there had been quite a bit of discussion on this matter. He explained that the reason for the decision, whether it was right or wrong, is that emergency physicians have been difficult to recruit for site surveys in the past, especially since the requirement for attendance at that site reviewers workshop was established. He said (based on discussions during the TSC meeting) that only about 6 emergency physicians and 8 surgeons have attended the workshop. (Research following this meeting showed that 13 emergency physicians, 11 of whom are still in S.C. attended the workshop.) The Committee was concerned that it would not be possible to find enough emergency physicians to conduct the redesignations.
Dr. Gerard stated that he has never been asked to serve on a designation review, even prior to the workshop requirement. Dr. Norcross explained that the Committee made a motion that an emergency physician be mandated to be on redesignation review teams, but for the first time, a motion was voted down. The Committee then made an alternative motion that said whenever possible an emergency physician who has completed the reviewers' workshop would be included in the redesignation reviews. In addition, another site reviewers' workshop will be held at the EMS Symposium on Wednesday afternoon in an effort to train more emergency physicians and then it would be more possible to have an emergency physician on all the review teams. *Dr. Gerard asked about how the scheduling of teams would be conducted. Ms. Beasley said she had not worked it out completely, but thought that the best method would be to get several available dates from each hospital then circulate these dates to each emergency physician who has attended a workshop and ask them to indicate which reviews they could participate in.*

Dr. DesChamps pointed out the further restriction of teams being composed of physicians who are not in the hospital's service area. Mr. Fanning (staff) also pointed out that another difficulty in scheduling is that members of teams should not review each other's hospitals, i.e. a nurse from Beaufort should not review Allen Bennett, and then have a nurse from Allen Bennett review Beaufort). Mr. Fanning (staff) suggested that at least 3 or 4 dates for reviews should be given by each hospital. Then Ms. Beasley (staff) said that hopefully, the physicians will then respond by signing up for dates to assist as team members. She said she then will get on the phone and start calling to confirm.
Dr. Norcross said that another issue that came up at the last meeting is whether or not a physician who does not currently practice at a designated trauma center should be allowed to conduct site reviews. Dr. Norcross said that his feeling were that a review team member should

work at a trauma center to understand how it functions. Mr. Fanning (staff) said that this had been the policy from way back, albeit unwritten. Dr. Norcross said it was the consensus of the Committee that all members of the site review team should be employees of a designated trauma center. Dr. Gerard then asked if there were any reason for a physician or nurse who is not an employee of a designated trauma center to take the course. Ms. Beasley (staff) responded that the workshop is open to anyone and is a good educational experience about the trauma system and also prepares participants to be reviewers if they do start working at a designated trauma center. Dr. Norcross explained that the workshop offers participants a chance to understand the process in case their hospital decides to seek designation.

Dr. Weinstein (audience) asked how far back in one's career does the committee go to say that they don't know what a Level III is about? Dr. Norcross responded that there are indeed knowledgeable physicians who were former trauma surgeons or emergency physicians who left a trauma center for private practice. He explained that, in developing the trauma designation process, the Committees have attempted to keep everything as black and white as possible. He said that it appeared the best way to keep things black and white is to say that at the time of the review, the volunteer team member must be working at a designated trauma center. Dr. Miller said that he agreed, that he knows of surgeons who participated in the care of trauma patients three or four years ago, but now are completely "out of the loop"; they have no idea of how to handle trauma. He said that if we are going to have strict criteria, we should adhere to this requirement for all members of the team. Dr. Norcross said that this Committee should vote on this issue.

**Dr. Norcross made a motion that all members of an in-state site review team should be practicing in a designated (at any level) trauma center at the time of the selection of the team. The motion was seconded by Dr. Fuerst. The motion passed.**

There was then discussion on how ACS selects their teams and who their teams consist of, with no answers available at the meeting. Dr. Miller stated that he could find out and Ms. Beasley (staff) thought she had that information in her files.

Mr. Fanning (staff) then pointed out that when the PI redesignation process was approved several years ago, it was with the intent of simplifying the redesignation and saving the hospital trouble and expenses. Initially, the Committees had talked about having only one team member. The changes are fine, but if full teams are brought in, particularly the out of state teams for the Level I and II hospitals, it will be costly for the hospitals.

Dr. Norcross asked the Committee to address the option of ACS verification. He said that if a hospital chooses ACS verification, they will get what is sent and it may not include an emergency physician. He asked if the Committee wanted to table this aspect until more information about the ACS team structure is available. Dr. Miller then said that the Blue Book states that ACS will send two surgeons, unless otherwise requested. They will choose their own multidisciplinary team. The multidisciplinary team may be made up of two trauma surgeons plus other members of the trauma care team such as any one or more of the following:

neurosurgeon, orthopaedic surgeon, anesthesiologist, emergency department physician, trauma coordinator, medical records coordinator, or hospital administrator. *Dr. Miller agreed to follow up for more information, but the rules are also changing soon.* He said that the ACS verification team goes through an extensive three-day training session. He said that if you can get through a strict ACS verification and they recommend the hospital, he thinks we should accept it. **Dr. Miller then made a motion that if a hospital chooses ACS verification and is approved, then S.C. should accept it. The motion was seconded.** Dr. Norcross then asked again about the inclusion of an emergency physician on the ACS teams. Dr. DesChamps said that ACS verification is a voluntary decision on the part of the hospital. Dr. Norcross said that ACS will be a lot stricter than any team developed by DHEC. Dr. Norcross asked if the ACS report will be sent to the Committees, or if confirmation by ACS that the hospital meets the criteria is enough to designate the hospital. Dr. Gerard said that if ACS gives a recommendation for designation that should be enough. Dr. Miller said the ACS verification should be reviewed by the Committees, in case ACS is too strict. Dr. Norcross said that verification can be done by ACS, but designation in the state belongs to the Committees. He said that if the ACS paperwork is not presented to the Committees, then the hospital can not become designated by the state. Dr. Gerard asked about how ACS would feel if they verified a hospital, but the hospital was not designated by the state. Dr. Norcross responded that ACS clearly states in the Blue Book that ACS is not a designating agency. There was then discussion and general agreement that S.C. tries to follow ACS criteria, but in some cases has been more lenient. There could be a situation in which ACS will not verify a hospital, but SC might choose to designate that hospital.

There was then discussion that should a hospital choose to be verified by ACS, a copy of the ACS verification report must be submitted to SCDHEC for review by the appropriate Committees. It was also agreed that part of the requirement for designation, in addition to meeting ACS criteria is that the hospital should participate in the state trauma registry.

**Dr. Miller's motion was then amended to say that a hospital can choose to have the state select a verification team or have ACS verify them, with designation being determined by the state. The motion was seconded by Dr. Bianco. The motion passed.**

Dr. Norcross then returned to the issue of the make up of the in-state site review team. He reiterated the concerns of some of the emergency physicians present, that an emergency physician should be represented on all site review teams, whether for initial or for redesignation. He explained that the Trauma Committee had concerns about the availability of trained emergency physicians who have attended the required workshop and that the Committee felt that the best resolution for now was to attempt to include an emergency physician, but not make that a requirement. He reviewed the proposed process of sending hospital's available dates for redesignations to all emergency physicians who have received the training and have them respond with their availability. **Dr. Norcross then made a motion that, through the process described above, DHEC should attempt to have an emergency physician on all Level III site reviews. Dr. Baker seconded the motion. The motion passed.**

The Committee then continued reviewing the proposed redesignation process and forms (see

attached). Dr. Norcross asked the Committee to review the minimum trauma registry patient numbers which would be required to maintain designation (Level I- 600; Level II - 150; Level III - 50). It was agreed that these numbers were reasonable and that most hospitals could easily maintain them. Dr. Miller pointed out that the new ACS Resource book would have changes in philosophies regarding minimum patient numbers. **Dr. Miller made a motion to keep the numbers as cited in the process report. The motion was seconded. The motion passed.**

Dr. Norcross then reviewed the revised redesignation decision options. There is no Category 3 listed. See attached. **Dr. Norcross made a motion to accept the redesignation decision options as outlined. Dr. Miller seconded the motion. The motion passed.**

Then Dr. Norcross directed the MCC to look at the remaining process information, as well as the chart review form which would be used by the reviewers (see attached). **Dr. Norcross made a motion to accept the redesignation process as outlined, including the chart review form. Dr. Baker seconded the motion. The motion passed.**

CHANGES IN THE STATUS OF A TRAUMA CENTER:

Dr. Norcross then explained that a subcommittee of the Trauma System Committee had addressed the need for a written policy on notifications when there are changes in a designation trauma center. The subcommittee had adapted a JCAHO policy statement (see attached) to address changes in trauma centers. It was the belief of the Trauma System Committee that the state policies for notification should not be more strict than those required by JCAHO. There was some discussion about the situation of a change in services. The MCC decided that there should be a requirement to also notify DHEC in the case of a reduction of services provided by a trauma center. **Dr. Norcross made a motion to accept the JCAHO document, adapted for trauma centers and with a requirement to notify SCDHEC in instances of a reduction in the category of services. Dr. Gerard seconded the motion. The motion passed.**

TRAUMA REGISTRY DEFINITIONS:

Dr. Norcross explained that the Trauma Association of South Carolina (TASC) began an effort to clarify certain trauma registry definitions. At their meetings they came up with proposed clarifications which have also been reviewed by the TSC. Dr. Norcross asked that the MCC look at each definition individually.

1. *Trauma Deaths: If a decision is made in the prehospital setting to resuscitate a trauma patient, and the patient dies at any time upon arrival at a designated trauma center, the patient must be included in the trauma registry.*

Dr. Norcross said that was some discussion at the TSC about this, but it was generally agreed upon. **He made a motion to use this definition as a guideline on what deaths to include in the registry. Dr. Gerard seconded the motion.** There was some discussion about what is done about EMS resuscitation in different counties. Dr. Baker

said that if EMS starts resuscitation on the scene, they must continue until they reach the hospital. Dr. Bianco said that in his county, he can tell the EMS to discontinue resuscitation over the radio. Dr. Norcross clarified that the issue was not who was resuscitated but who would be included in the registry. He said that of the seven hospitals who responded to a survey about the proposed definitions, all agreed with this definition. A vote was then taken. **The motion passed.**

2. *Length of Stay in the Hospital: Any injured patient (identified by ICD-9 codes 800-959.9, plus the inclusions below), whose disposition is anything but home, should be entered in the trauma registry, regardless of the length of stay in the hospital.*

Dr. Norcross explained that the discussion got difficult when the issue of patients admitted for 23-hour observation were included in this group. He said that the TSC felt that those patients should be included because hospital resources are being expended to care for these patients. **Dr. Norcross made a motion to accept this definition as written. The motion was seconded by Dr. Miller. The motion passed.**

3. *Inclusions Outside of ICD-9 Codes 800-959.9: Burns, drownings, near-drownings, hangings, and smoke inhalations should be included in the trauma registry.*

Dr. Norcross explained that the only concerns would be that injuries such as burns and drownings might get kicked out of the audit filters because they may not be seen by surgeons, and that is not really a problem because the care would be appropriate. Dr. Norcross said the general feeling is that more data is better than less data. The other possible difficulty is that an ISS code cannot be assigned to hangings unless the neck is broken. **Dr. Norcross made a motion to accept the definition of inclusions as written above. Dr. Bianco seconded the motion.** Dr. Miller stated that the expansions of all these definitions will add probably 300-400 patients to his registry. A vote was taken. **The motion passed.**

Dr. Norcross mentioned that the inclusion of snake bites was tabled because it led to possible inclusions of spider bites, Lyme disease, etc. He said TASC would re-address this. *He said that the other issue that was tabled and sent back to TASC related to date of injury*. The TSC discussed how far back and for what reasons should a patient be included. Is a wound infection from a wound at work a trauma?

SYSTEM QI REPORT:

Dr. Norcross explained that several years ago a subcommittee, including him and Dr. Stein from Greenville came up with some statewide system filters. The report was passed to MCC members. He said the question now is "how are we going to use these filters?" A subcommittee was appointed by TSC to determine this. No action is needed now by the MCC. Dr. Norcross suggested that each hospital should compare its numbers to statewide numbers and that they can do this themselves, or DHEC can provide the numbers. Ms. Beasley (staff) noted that the three reports passed out to the TSC and MCC are draft copies.

OTHER ISSUES:

*Dr. Weinstein (audience) asked if the MCC was going to talk about the composition of the Trauma System Committee. Dr. DesChamps said that would be on the agenda for the next MCC meeting.*

Mr. Fanning (staff) said that the Committee should now begin thinking about instituting a mechanism for hospitals to pay the cost of Level III designations. This could wait till after the round of redesignations. However, the trauma system has matured enough to support this. Either the TSC or MCC should come up with a long-range plan for this.

*Mr. Fanning (staff) also pointed out that three data reports were handed out. He asked the MCC members to review these reports and comment on them for expansions or changes.*

Dr. Norcross said that pediatric trauma center designations were brought up at the EMSC meeting and that current suggestions were impractical for the state. There have been concerns that if impossible criteria would be put in place, then no one could participate. Dr. Fuerst commented that a subcommittee met for several hours earlier and will come up with a plan which will offer a way to designate centers of pediatric excellence. The plan will be sent to other committees once it is completed.

**RSI PILOT PROJECT**

Dr. DesChamps explained that several months ago a pilot project using rapid sequence induction of anesthesia prior to intubation was approved for Lancaster County EMS. Dr. Gerard and Dr. Bostick (Lancaster County medical control physician, not present) sponsored this. Training has been completed. A report in the form of a letter was handed out. Fourteen attempts at RSI have been completed to date. Dr. DesChamps asked Lanny Bernard (audience) to comment on this. Mr. Bernard said there have now been 19 attempts. Eight of the cases went to Carolinas Medical Center by air and the other 11 went to Springs Memorial Hospital. Fourteen of the cases have been discharged either to home or a nursing center and are doing well. Five were deceased, but none related to RSI. He reported that they are pleased with the results to date. He said one surprise has been that there have been as many respiratory patients as trauma patients. Dr. Bostick said that at the emergency department at Springs, these patients are not crashing like they used to because EMS is managing the situation earlier than they used to. In response to a question by Dr. Norcross, Mr. Bernard said that they are only trying RSI on patients who are not apneic, from a suggestion by CMC. CMC said that if you are going to use RSI, their data shows that even if the patient is unconscious and has no gag reflex it is better to go ahead and do it because it becomes too late if you have to go back and use RSI. Mr. Bernard felt that most of the people in the project could not have been intubated without RSI.

Dr. Weinstein (audience) asked when the project would be complete and when it would be incorporated into protocol. Dr. DesChamps explained that the project had been approved for a

six month period to terminate on December 31, 1997. Then a vote would be taken to end or extend the project. He asked that a subcommittee be appointed to review the data and that the MCC vote to approve the project to continue until the next MCC meeting, so it would not have to be interrupted, then continued again. **The work of Lancaster County EMS was applauded and a motion was made to extend the program until the next MCC meeting and that a subcommittee look at the data and report back to the next MCC with their recommendations. Dr. Malanuk seconded the motion.** The question was clarified that this is only being currently conducted by one service. Dr. Fuerst suggested that a minimum number, possibly 30, be set before the project could be approved further. A vote was taken. **The motion passed.**

Dr. DesChamps asked Dr. Bianco, Dr. Gerard, Dr. Baker, and Alonzo Smith to form the subcommittee to review the data and report back to the next MCC. Dr. Sorrell said he would like to see a report on who and why RSI was used. Dr. DesChamps asked the subcommittee to do that type of QI on the data. Dr. Gerard was asked to spearhead this.

## TRANSPORT OF PATIENT ON NORCURON

A question had been raised because an EMS service had refused to transport a patient on Norcuron because it is not on the state-approved list of interfacility drugs. Dr. Norcross said that this is true frequently, but the list addresses only drugs which are allowed to be given enroute. He said that this is a non-issue. Dr. DesChamps said the question was more one of generic question about the use of medications which EMS has no training in. Dr. Gerard said that the physician who administers these medications assumes complete responsibility. The consensus of the committee was that as long as the EMS is not regulating or administering the drug, they can transport and that it should be emphasized that it is the transferring physician's responsibility.

## ADDITIONS TO INVASIVE/IMPLANTED DEVICE MANUAL

Dr. DesChamps reported no responses to the requests for additions, deletions or changes to this list.

## AED USE

Dr. DesChamps explained that the use of the automatic external defibrillator is being encouraged by the Heart Association. The question has been raised of what responsibilities does this Committee have or what actions should it take, and whether the use of AED's constitutes the practice of medicine.

Dr. DesChamps has asked the Board of Medical Examiners to present this issue at its next board meeting to determine if they should regulate AED's. Mr. Fanning (staff) said that he felt that the EMS Advisory Council does not have the authority to regulate AED's. The nationwide EMS Director's Association is trying to determine where the responsibility lies. North Carolina's EMS Council has said that it is not an ALS function and anyone can do it.

Dr. Weinstein (audience) said that SCCEP is looking at this issue. Dr. Gerard said the Florida legislation said that anyone who takes a first responder course can use it. SCCEP is putting together legislation addressing training for using AED's. Dr. Sorrell said he would like to see recommendations on their use.

Mr. Fanning said that there are two different first responders: licensed EMT first responders and the general first responder course. EMS would have control over the training of the licensed first responders. He said that the appropriate populations should be the ones to have the AED's or that they should be placed at locations where they are most appropriately needed. There was then discussion about their cost ($3-5,000).

Mr. Warren (audience) said that there are two concerns: one is that licensed services must have training, but the general population first responders can do what they want. Legislation from the Department should be pushed which would regulate all first responders, not just first responder agencies. This was a recommendation of the NHTSA assessment a couple of years ago. Mr. Fanning (staff) agreed as long as financial support is provided to do this.

Dr. DesChamps said this could not be resolved at this meeting, but would be addressed again. Dr. Gerard said he would keep the Committee updated on the SCCEP actions/discussions on the AED issue.

**TRANSPORTS TO HOSPITAL STAND-ALONE EMERGENCY DEPARTMENTS**

Dr. DesChamps said the issue of appropriate transport to stand-alone emergency departments of established hospitals has come up recently. Hospitals have directed EMS to transport to these stand alone facilities. Ms. Beasley (staff) explained that when this issue came up about trauma transports, the licensing division said that these facilities should be bypassed unless it provides full-service care, including surgical care, in case the patient crashed while there. Then later, it was said that these were full-service facilities. Mr. Fanning (staff) said that these facilities are not designated trauma centers.

Dr. Norcross said that in Charleston County, the Medical Society discussed this. In the case of Roper Northwoods it is a full-service emergency department. The issue is going to be addressed further, including where do you draw the line between "doc-in-the-boxes" and stand-alone emergency departments. Dr. Norcross asked if this were a local issue. Ms. Beasley (staff) said that EMS services have been calling up to the Division of EMS asking if it were okay to transport trauma patients there. Dr. Bianco said that, clearly, trauma should not be transported there. Mr. Warren (audience) said that the marketing people of Roper have been telling EMS that they should transport there, that it is part of the trauma center. Dr. Norcross asked what the EMS regulations say about ambulance transport. Mr. Fanning and Mr. Futrell (both staff) said that there is no regulation stating where patients can be transported. Any transport restrictions are local mandates. Dr. DesChamps asked if the EMT would be responsible for bad outcomes if the patient is transported to some place other than a hospital. This was not resolved in

discussion. Discussion ended with no resolution and no further discussion.

## PEDIATRIC TRAUMA SCORE

Dr. Norcross said that his local EMS issue as part of his trauma centers QI brought to their attention that there is no place on the ambulance run report to record pediatric trauma score. He asked that the next time the run sheet was revised, there should be a place to record this score. Mr. Fanning (staff) said that it would be another year before this would be possible, the run sheet was just recently revised. He also noted that several years ago, it had been determined that pediatric trauma score was not necessary, but the Committees might want to revisit this issue.

## NEXT MEETING

Dr. DesChamps asked if the members wanted a Committee meeting at the EMS Symposium in late February. *The consensus of the Committee was that the meeting should be Wednesday evening after 5 p.m. after the site reviewers workshop. Suggested time was 6-8 p.m.*

*The subcommittee to review the RSI results agreed to meet some time in mid-January or early February, probably Wednesday, January 14 after 2 p.m.*

With no further discussion, the meeting was adjourned.