MEDICAL CONTROL COMMITTEE

MINUTES

MARCH 2, 2001

Members Present:	Others Present:
Ed DesChamps, MD, Chairman	Lewis Moore, Spartanburg Co. EMS
Cliff Staggs, MD	Doug Rorie, FirstHealth EMS
Richard Rogers, MD	Ernest Autry, FirstHealth EMS
Doug Norcross, MD	Amy Brinke, FirstHealth EMS
Carol Burger, MD	Randy Kearns, FirstHealth EMS
Steve Shelton, MD	John Molnar, MD, Grandstrand Hosp.
Ron Fuerst, MD	Collette Farrelly, RN, Grandstrand Hosp.
John Sorrell, MD	Garrett Clanton, MD, Spartanburg Co. EMS
	Chris Cothran, Midlands Regional EMS
	Mark Phillips, Wyeth-Ayerst Labs
	Russ Brahmer, Greenville Co. EMS
	Jo Sousa, MD, Med Trans One
	Thomas Howard, Laurens County EMS
	Alonzo Smith, DHEC EMS
	Phyllis Beasley, DHEC-EMS

APPROVAL OF MINUTES FROM 9/13/00

A motion was made to approve the minutes from the September 2000 Medical Control Committee meeting, with no changes or additions. The motion was seconded; the motion passed.

REDESIGNATION OF GRANDSTRAND REGIONAL MEDICAL CENTER AS A LEVEL III TRAUMA CENTER

Dr. Norcross, chairman of the Trauma System Committee explained that Grandstrand Regional Medical Center's second review for redesignation as a Level III trauma center was much improved and that the Trauma System Committee had voted to approve the hospital's redesignation as a Level III trauma center, based on the report and information provided by the site reviewers at the meeting.

Dr. Norcross made a motion to approve the redesignation of Grandstrand Regional Medical Center as a Level III trauma center under Redesignation Option # 1 (To designate the hospital as a trauma center. The hospital has everything required and is designated with no question or problems.) Dr. Baker seconded the motion.

Dr. Molnar, representing Grandstrand Regional Medical Center said that from an Emergency Department standpoint, the review has improved the physician response and was a good exercise for the hospital.

The motion was approved.

Dr. Norcross provided an update on the trauma system activity. He said that the public opinion survey is now being conducted and it is a strategy to determine the public's knowledge and expectations of the trauma system. This information will be used to determine what actions should be taken to develop support with the public and the legislature for the trauma system.

PILOT PROJECTS

CPAP

Thomas Howard with Laurens County EMS presented the 6-month data report for the Continuous Positive Airway Pressure pilot project. Nine patients were treated, most of the patients were ruled out for COPD or asthma. Fifty-five percent had positive results, 10% had to be intubated later. Mr. Howard asked to change the standing order to include some patients with COPD or asthma with direction of on-line medical control. He said that if they do that, they can change the PEEP that they are using with some patients and that would lower their risks.

Dr. Shelton made a motion to allow the on-line medical control physician to make adjustments for COPD and asthma patients.

Dr. Fuerst said that it is hard to tell the difference between COPD and CHF. He didn't think that an on-line physician could tell without a chest x-ray. There was much discussion on the complication rates for these patients. Dr. Fuerst said that he is unfamiliar with the complication rate on using CPAP with COPD or asthma; he said it could be that the benefits would outweigh the risks.

Mr. Howard suggested that their medical director could research the complication rates. The Committee decided to postpone the motion and continue with the standing orders as is, until there is information about those complication rates. The Committee will review this request at the next meeting when information is available. Staff will send a letter to Laurens County, requesting this information.

PREHOSPITAL THROMBOLYTIC THERAPY (RETAVASE):

This pilot project is being conducted by Greenville County EMS. Dr. Burger explained that 27-30 patients have received thrombolytics. There have been no adverse outcomes. Two patients were defibrillated between the first and second doses and were successfully defibrillated. She said that more patients are getting thrombolytics in the field than in the ED; she said the project is going well.

Dr. Burger also explained that administering prehospital thrombolytics has not increased scene time more than 10 minutes. A 12-lead is conducted on the scene, and then approval is received by medical control to administer the thrombolytics.

Dr. Burger asked the Committee if they foresee taking this off pilot project status. There was some discussion about cost. Dr. Burger said that the biggest cost has been the initial outlay of the drug for each truck.

Dr. Norcross asked if there had been any occasions where a patient received the drug and did not need it; Dr. Burger responded "no." She said that the on-line medical control physician must review the 12-lead results, follow a thrombolytic checklist and still has the authority to decide not to administer the drug. She said that with hospitals where there are cath labs, many physicians prefer to send the patient to the cath lab and this means that thrombolytics end up being given more often at night.

Dr. Sorrell said that this project would probably work even better in other parts of the state where there is no cath lab. He said that we ought to begin to consider allowing this.

Dr. Baker said that this project is not difficult to train or to add things to do. The checklist eases training needs and there are not many steps to have to take. But if you are starting from square one and don't even have telemetry, it is a big deal. Dr. Norcross said that the drug must be added to the drug list. He said that if there is any interest in doing this, someone should submit a proposal to add the drug(s) to the list at the next meeting.

Dr. Sorrell said the new ACLS guidelines recommend thrombolytics.

Dr. Burger suggested surveying the services to see if they are interested in adding thrombolytics and Dr. DesChamps said that Dr. Burger should develop the "financial picture" so services know if they can afford it. Dr. Shelton asked if a survey was necessary--he said that it is already recognized that prehospital thrombolytics is effective.

Dr. Sorrell suggested asking the drug companies to pay for the first doses in all the trucks.

Dr. DesChamps said that first we need to decide whether we want to do this, and then over the new few months decide which drug and other details. He said that Dr. Burger should come up with thoughts on the protocols, cost, training program, which thrombolytics, prices, etc. and bring to next MCC meeting.

Dr. Sorrell said that local option should decide which drug and to allow all choices.

Dr. DesChamps said a data collection method needs to be developed. Dr. Sorrell said that, as far as training, if the EMTs have been certified in ACLS, they are qualified to treat with thrombolytics and all that is needed is protocols and guidelines for the medications. Dr. DesChamps agreed that we should not duplicate training. Dr. Staggs said that the decision is actually being made by the on-line medical control physician. The EMT-P's are gathering and submitting the data and the physician is making the decision.

It was decided that a subcommittee made up of Dr. Shelton and Dr. Burger would determine which thrombolytic drugs to use, prices, and establish guideline for the next MCC meeting.

PROPOSAL FOR STERNAL INTRAOSSEOUS INFUSTION AS A STATE SKILL:

Dr. DesChamps explained that sternal intraosseous infusion was presented several months ago as a proposed pilot project by Spartanburg County EMS, but at the time the sternal IO was not FDA approved, so the proposal was delayed.

Since that time the sternal IO has received FDA approval and FirstHealth EMS (Chesterfield) submitted a pilot project for consideration. Lewis Moore of Spartanburg County EMS was also in attendance at the meeting and presented a sample of the Sternal IO. Dr. Staggs, who is also familiar with the sternal IO, provided information on its use. Mr. Moore and Dr. Staggs explained that it had relatively low complication rates and can be used in patients down to 12 years old.

Dr. DesChamps asked which patients Chesterfield and Spartanburg perceived using this device. Mr. Rorie explained that it would be used on non-traumatic cardiac arrest patients for whom EMS could not get another IV; it is not a first line procedure. Mr. Moore further explained that the patients could be medical cardiac arrest where vascular access can not be established, status epileptic where vascular access is delayed, or unconscious hypoglycemic in which no other IV line could be obtained. He said it would be a last resort for trauma patients with no sternal injuries.

Dr. Staggs said that he is in support of this device and that if it is opened as a state skill for use on patients who are basically dead, then you can't hurt anyone and you may save a life. He said that he feels that it is a reasonable alternative, but was more leery about its use in hypoglycemic cases and should be considered more as a pilot project. He said it is less invasive than other procedures.

Dr. DesChamps and Mr. Moore said that there is a training module created by the company that deals with the device, contraindications, and malfunctions and is a four-hour training program. Dr. Staggs asked if a device had ever been approved without first being a pilot project. Drs. Norcross and DesChamps said it would have to go on the device list first, before being allowed for use. Then Dr. DesChamps said that perhaps it would not have to be on the device list because intraosseous infusion is an approved skill for peds, not on the device list and this is just another form of vascular access. Dr. Staggs asked if there were any studies out on the sternal IO.

Dr. Norcross made a motion to approve the use of the FastOne Sternal IO exclusively with adult cardiac arrest patients when no other vascular access is available, as a statewide local option and that after data collection for one year of use that it be reevaluated for use in other situations.

Dr. Sorrell asked if other states had begun using the sternal IO. He said that usually South Carolina is not the first or the last in any skill. Amy Brinke, a representative of FirstHealth said that the sternal IO was just FDA approved and not available on the market until November 2000.

Dr. Staggs said that if the Committee limits the use of the sternal IO to patients suffering from non-traumatic cardiac arrest, then no damage can be done and possibly someone can be saved.

Dr Fuerst questioned approving the sternal IO when there is no data regarding complications. Dr. DesChamps said that in these patients with no vascular access, it would be better to save 20% of those patients with a complication, than not to be able to save them. Dr. Fuerst again expressed concern over the public's questioning the approval of a device with unknown complication rate.

Mr. Smith suggested that the data collection sheet in FirstHealth's proposal be used.

Dr. DesChamps asked how much of a problem would it be to gather information regarding complications after the IO is removed, even after the patient has been discharged. The FirstHealth representatives said there would be no problem in gathering that data from the hospital after the patient has been discharged.

Dr Norcross withdrew his motion.

Dr. Sorrell also wanted to know what rhythm the patients were in when the IO was used. Mr. Moore said the Committee might want to ask how many attempts to establish an IV were made before the IO was used.

Dr. Shelton noted that the pilot project should be changed to collect data every six months and to allow it only on non-traumatic cardiac arrest patients. Dr. Rogers said that the Committee would be on safe grounds to use PALS guidelines for IO use.

Dr. Shelton made a motion to approve First Health's sternal IO pilot project proposal, adding Spartanburg County, for non-traumatic cardiac arrest patients only, and submitting data every six months. Dr. Rogers seconded the motion.

Dr. DesChamps said that, as part of the project's data collection the time the IO was taken out (on surviving patients) and the complications up to discharge should be added.

The motion was approved. ***Amy Brinke agreed to make the suggested changes to the data collection form for the pilot project and resubmit it to the Committee. The form will be changed to add: 1) what rhythm the patient was in at the time of the use of the sternal IO; and 2) if there were any complications.***

A question was asked about what drugs could be administered with the sternal IO, Dr. DesChamps replied that any state approved drug could be administered by IV can be administered by that route.

RE-CONSIDERATION OF CRICOTHYROTOMIES AS A STATE SKILL

Dr. DesChamps explained that the EMS Advisory Council would not pass the Medical Control Committee's earlier motion to "open up cricothyrotomies, or surgical airways, to the state level as an optional skill and the EMS Section and Training Committee will develop a training module and a data collection and CQI packet with 100% state audit of all cricothyrotomies and all services who wish to perform cricothyrotomies must already have functioning RSI and LMA skills and training." He said that the Advisory Council asked to send the motion back to the Medical Control Committee for reconsideration to separate the cricothyrotomies from requiring LMA skills and training.

Dr. DesChamps asked that other members of Medical Control Committee attend the next EMS Advisory Council meeting, specifically Dr. Norcross, to explain the Medical Control Committee's stance.

Dr. Shelton said that he felt that the concerns with the motion were that we were requiring LMA as the only blind intubation technique that can be used when, for example PTL and combi-tubes were available. Dr. Burger suggested amending the motion to allow another approved blind technique such as combi-tube in combination with the surgical crics. Dr. Sorrell reaffirmed that he felt that if a service is going to perform crics, they should be trained in LMA's.

Dr. Burger said that many people in her area were concerned with aspiration problems with the LMA. She asked, if there were two backup airway options that were advocated by ACLS, why would we mandate use of LMA? She asked if you have combi-tube skills, do you have to have both.

There was much discussion over the benefits of the LMA and the combi-tube.

Dr. Norcross made a motion to reaffirm the first motion: if a service is going to use cricothyrotomies, they must have functioning LMA and RSI skills. There was then discussion regarding whether carrying LMA's on the trucks was mandated. **Dr. Sorrell seconded the motion. The motion passed.**

Then Dr. DesChamps asked the Committee to return to the discussion about whether to require all services that perform RSI to have required LMA training, and to require them to carry LMA's on the trucks.

Dr. Shelton made a motion that LMA's be moved from local option to required training for all levels EMTs who intubate, as recommended by AHA guidelines. Dr. Staggs seconded the motion. The motion passed.

Dr. Burger asked, in services using RSI, are we going to mandate that the only backup is LMA? The Committee agreed that "no, if they use RSI, they must also have LMA, but can use combitube." This means that they don't have to use LMA, but they will have to carry it on the trucks.

Dr. Shelton made a motion that all services performing RSI are required to purchase LMA's, and that a letter should be sent to all services doing RSI clarifying that they must have LMA's, but can use other backup airway options such as the combitube or PTL. Dr. Burger seconded the motion. The motion passed.

2000 GUIDELINES FOR CPR AND ECC

Dr. DesChamps said that the Committee may not want to make any decisions on the changes at this time, but possibly appoint a subcommittee to address the changes. He said that the issue of Amiodarone and Vasopressin has come up in the new guidelines.

Committee members questioned the use of Vasopressin in the new guidelines. Mark Phillips, representative from Wythe drug company, explained that he believes that Vasopressin was included in the new guidelines because the AHA is trying to adopt international guidelines and Vasopressin is used more commonly in Europe.

Dr. DesChamps responded to a question about this issue by saying that the Committee will be looking at the AHA guidelines as part of the effort to update the state approved protocols; and that as the protocols are reviewed for changes, the drugs related to those protocols must be addressed. He said that no one has submitted a proposal to add Vasopressin to the drug list.

Mr. Smith added that any changes to the protocols/guidelines would affect the state testing.

Dr. Rogers and Dr. Sorrell stated that the state should go along with the ACLS guidelines and that Vasopressin should be added to the drug list as local option.

Dr. DesChamps asked if the Committee wanted to accept the ACLS guidelines as written. The consensus of the Committee was that nothing in the guidelines appears to be objectionable and services could choose which drug they preferred to use.

Mr. Phillips then discussed at length the correct dosage of Amiodarone and studies regarding the use of Lidocaine as a second line drug.

Dr. Norcross pointed out that the Committee will be looking at approving the ACLS protocols as guidelines and this would allow local medical control to decide what to do. Mr. Smith asked if this would include the deletion of bretylium (after the adoption of the new protocols); the Committee said "yes."

There was much discussion about adopting the ACLS guidelines and clarifying that these would be adopted as guidelines only and that medical control physicians could choose to use whatever drugs they wished, but that those drugs would be on the drug formulary for mandatory training.

Dr. DesChamps restated and summarized the Committee's discussion: The Medical Control Committee agreed that it will adopt the new ACLS algorithms for SC state-approved protocols to be used as guidelines by the services and that the Committee will

review the drug list to ensure that the list matches the drugs and dosages as reflected in the new ACLS algorithms.

Dr. Garrett Clanton asked the Committee if Amiodarone was going to be left as a second line drug to Lidocaine. Dr. DesChamps said that the statement about Amiodarone being second line to Lidocaine should be deleted. ***Dr. Norcross suggested not making those changes now, but having a subcommittee look at the ACLS algorithms and all the other protocols and determining all the drug and other changes which should be made for the next Committee meeting. Drs. Sorrell and Fuerst agreed to serve on that subcommittee.***

DRUG LIST CHANGES

Dr. DesChamps said that there were five requests for changes to the drug list. He asked the Committee if they wanted to address the changes now, or when the changes related to the protocols were addressed. He said the changes cannot go to the Board until the other changes are ready.

(From this point until into the discussion on the RSI drugs, there was no taping available for reference on background discussions.)

The Committee decided to address the drug requests at this meeting.

ADD ACETAMINOPHEN FOR TREATMENT OF FEBRILE PEDIATRIC PATIENT:

The first request came from Greenville County EMS to add Acetaminophen (liquid and suppository) for treatment of the febrile pediatric patient.

Dr. Burger made a motion to add Acetaminophen/Tylenol/Feverall/Panadol in all forms as a local option drug for pediatric dosage up to 15 mg per kg PO/PR for fever reduction and relief of mild to moderate pain. The motion was seconded. The motion passed.

REMOVAL OF ASTHMA AS CONTRAINDICATION FOR ASPIRIN IN CARDIAC PTS.

This request was also made by Greenville County EMS.

Dr. Burger made the motion to remove asthma as a contraindication for the administration of Aspirin to the cardiac chest pain patient. Dr. Fuerst seconded the motion. The motion passed.

ALLOW REPEAT DOSES OF MIDAZOLAM FOR SEDATION OF PTS. RECEIVING RSI:

Greenville County EMS requested a change to allow repeat doses of Midazolam for sedation/continued sedation of the patient receiving RSI.

Dr. Burger made a motion to allow repeat doses of Midazolam up to a maximum of 10 mg based on medical control order, written or online.

There was then discussion on the appropriate maximum dosage. The motion was amended to read to allow up to 10 mg by direct order, then requiring repeat online medical control order for each additional dose. There was further discussion about the dosage and involvement of medical control.

After much discussion, the following dosage recommendations were considered for inclusion at the time of the updating of the drug formulary:

> For RSI: Administer initial dose of Versed 2.5-5 mg IV (consider decreased dose if systolic BP is 80-100 mg)
>
> After successful intubation/airway control, additional IV Versed may be administered based on the patient effect up to a total of 10 mg IV.
>
> Repeat doses may be administered with the direction of online medical control.

ADDITION OF KETORLAC TROMETHAMINE/TORADOL FOR PAIN:

Chester County EMS has requested the addition of Ketorolac tromethamine/Toradol for the treatment of moderately severe acute pain. The Committee agreed that they could see no real use for it in the field when morphine or Nubain was available.

Dr. Norcross made a motion to not approve the addition of ketorlac tromethamine/Torado. Dr. Rogers seconded the motion. The motion passed.

ADDITION OF MAGNESIUM SULFATE FOR VENTRICULAR FIBRILLATION REFRACTORY TO LIDOCAINE (ACLS update):

The Committee reiterated that Magnesium Sulfate had already been approved at an earlier meeting and any further action is being delayed until the protocols are revised.

ADDITION OF MORPHINE SULPHATE AND LIDOCAINE FOR COMBATIVE HEAD INJURIES:

The Committee agreed to allow the use of Morphine Sulfate and Lidocaine for combative head injuries. They agreed that it will be added as an indication for Lidocaine, before intubation.

ASTHMA AS CONTRAINDICATION FOR MORPHINE SULFATE:

The Committee agreed that asthma should be added as a relative contraindication for Morphine Sulfate. The Committee then began discussing the need to review contraindication

for the entire drug formulary. Dr. DesChamps commented that all contraindications should be marked as relative. He also said that pain from head injury is an indication for morphine sulfate. *The Committee agreed that all contraindications should be reviewed at the time of the review of protocols/drug formulary.*

ALLOWING CONTROLLED SUBSTANCES BY STANDING ORDER:

Dr. DesChamps said that as the drug list has been reviewed for updates, it was noted that for controlled substances all included the statement that online medical control must be contacted. However he discovered that there was nothing in the EMS law or regulations that stated that online medical control is necessary for administering controlled drugs and that the requirement for verbal orders had been taken out of the Drug Control regulations. He said that this means that a medical control physician could write a standing order, particularly for RSI, to allow the EMTs to begin administering the controlled substance.

Dr. DesChamps asked if the Committee wanted to leave instructions open to allow physicians to set a dosage maximum.

Dr. Sorrell said that he would hesitate to give a standing order for a controlled substance, except for RSI. Dr. Shelton said that he might consider it for a patient who was actively seizing. Mr. Smith said he has heard reports of radio problems that prevented EMTs from beginning treatments.

Dr. DesChamps said he wasn't sure if EMS would benefit by allowing controlled substances to be administered without online medical control, except in the case of RSI.

Dr. DesChamps said that if the Committee decides to allow this, a notice should be sent to Drug Control.

Dr. Sorrell made a motion to allow local option to decide whether to permit the first dose of RSI and the benzodiazepine drugs without online medical control on standing order, additional doses must be online. Dr. Rogers seconded the motion.

There was then much discussion about changing the term "online" to direct physician order, which would allow written physician order and about dosages.

Dr. Sorrell then amended the motion to read "to allow local option for all RSI drugs for patients undergoing RSI written in standing order or protocol to administer the first dose without online medical control." Dr. Norcross seconded the motion. The motion passed.

Dr. Rogers asked about the dosage change of Versed. Dr. DesChamps said when the drug formulary is changed; the dosages of Versed will be changed as based on the earlier discussion.

Dr. DesChamps made a motion that in addition to the RSI protocols, other state approved Benzodiazepines may be administered for the first dose per standing order or protocol and

additional doses must be administered by direct medical order, online or written. Dr. Rogers seconded the motion. The motion passed.

Dr. Sorrell then made a motion to require that the administration of Nubain and Morphine must have direct medical order (written, radio, or online), not be standing order, and that Nubain must be inventoried like any scheduled drug. Dr. Rogers seconded the motion. The motion passed.

Dr. Staggs reported on the SCCEP reaction to the activities of today's meeting (SCCEP was meeting in the next room). He said that SCCEP is opposed to releasing prehospital thrombolytics statewide. They felt there needs to be more study done. They also felt that the sternal IO needs more study. They are in favor of the LMA.

Dr. Staggs said that SCCEP felt that end tidal CO2 should be on the required equipment list. Dr. DesChamps said that can only be added by amending the regulations and that the Committee is looking at many pieces of equipment that should be recommended, such as McGill forceps.

Dr. Staggs then brought up the issue of bypass and what can the Committee do to recommend bypass for cardiac patients. Dr. DesChamps said that the nearest thing we have like that is triage and bypass for trauma. The Committee agreed that bypass is a local issue.

Dr. Staggs said that SCCEP also was concerned about emergency medical dispatch. Dr. DesChamps clarified that there is not one authority to be responsible for EMD, it is not under the authority of DHEC.

Dr. Rogers then requested that the Committee consider setting a standing meeting date, since meetings have been so hard to schedule. Dr. DesChamps said that he has considered trying to schedule Committee meetings to coincide with EMS Advisory Council meetings. *Dr. Norcross asked Ms. Beasley to send out a calendar to determine what days Committee members could not ever meet.*

With no further discussion, the meeting was adjourned.

AGENDA ITEMS NOT ADDRESSED AT THIS MEETING:

None

AGENDA/OTHER CONTINUING ITEMS NOT RESOLVED/CONCLUDED AT THIS MEETING:

- Change in CPAP Pilot Project to all for adjustments for COPD and asthma patients
- To allow prehospital thrombolytics as a state skill
- State Approved Protocols delayed for subcommittee

SUBCOMMITTEE/STAFF/OTHER ACTIONS DUE AT NEXT MEETING:

- Laurens County Medical Director to research complication rates on CPAP to present at next MCC; at that time consideration will be given to allow changes in the standing orders for COPD and asthma patients -- Staff to send letter to Laurens County requesting this research
- Prehospital Thrombolytic Subcommittee (Drs. Shelton and Burger) to determine drug types, prices and guidelines for next meeting
- Subcommittee (Drs. Sorrell and Fuerst) to review ACLS algorithms and other protocols for drug and other changes for next MCC

STAFF ACTIONS NEEDED:

- Letter to Grandstrand Regional Medical Center regarding MCC's action and informing them of the EMS Advisory Council meeting date
- Letter to Laurens County EMS regarding the need for information on CPAP complication rates
- Letter to FirstHealth EMS and Spartanburg County EMS with approval for sternal IO pilot project *(Needs EMS Advisory Council approval)*
- Memo to services conducting RSI explaining that LMA's must be carried on trucks, but alternative airway use is acceptable *(Present to EMS Advisory Council first)*
- Send out calendar to MCC members to attend to schedule regular MCC meetings

MEDICAL CONTROL COMMITTEE

MINUTES

June 21, 2001

Members Present:	Others Present:
Ed DesChamps, MD, Chairman	Al Futrell, DHEC
Steve Shelton, MD	Alonzo W. Smith, DHEC EMS
John Sorrell, MD	Phyllis Beasley, DHEC EMS
Ron Fuerst, MD	

No quorum was reached for this meeting. Therefore, any decisions that required a vote were postponed.

REPORT ON MEDICAL CONTROL PHYSICIANS WHO HAD NOT RECERTIFIED FOR 2000

Ms. Beasley reported that, as of the date of the Medical Control Committee meeting, seven medical control physicians representing seven EMS providers had not recertified for calendar year 2000. Of these services, four have active in-service training programs. Ms. Beasley explained that several memos had been sent to services and medical control physicians throughout the year with updates on means of recertification and reminders about the need for recertification. The last memo had been sent specifically to the seven services and physicians mentioned, reminding them of the noncompliance and stating that they had until July 31, 2001 to comply.

In discussion about recertification methods, **the Committee agreed by consensus that physical attendance at one of the two Medical Control Physician workshops (at the EMS Symposium and at Palmetto Richland Hospital) should count as a two-year recertification**. The Committee felt that the time put into attending this workshop and the direct discussions involved warranted extra credit for recertification.

The Committee also agreed that Ms. Beasley should send each of the above mentioned EMS directors and medical control physicians a certified letter stating that as of July 31, 2001, the services will need to find a new medical director (if their director has not recertified) and the service's license would be suspended. The Committee said that, in the letter, the means of recertification should be listed and that if a service/physician does not comply, in order to be reinstated, the service must bring on a new medical director who has already attended the workshop.

UPDATE ON TRAUMA SYSTEM ACTIVITIES

Ms. Beasley reported that there were 20 attendees at the Site Reviewers Training Workshop in June. Four surgeons (three from the PeeDee, one from Midlands), four emergency physicians (three from the Midlands, one from the Lowcountry) and twelve nurses attended. Ms. Beasley stated that she would probably have to hold another training workshop because that attendance was not great enough for a pool of site reviewers. The Committee asked that an attempt be made to hold a site reviewers workshop in each region.

Ms. Beasley then briefly reviewed the results of the public opinion survey conducted by the University of South Carolina on the trauma system. She summarized the results stating that it was no surprise that the public had very little idea about the trauma system. She said that there were expectations that different hospitals provided different levels of care but the public thought their community hospital could provide the necessary level of care for a trauma patient. She said the survey also determined that the public considers emergency medical care to be a "public good" such as fire and police services. She said that a surprising result of the survey was that the public said they would small increases in certain fees to support the trauma system. Dr. Norcross said that the survey showed that the public would support an increase in fines for motor violations or in fees for ammunition. She said that the public even responded that they would support a one cent increase in gas taxes and Dr. Norcross felt that this would be the only increase that would stand a chance of passing. Ms. Beasley said that Jim Walker with the SC Hospital Association and the Trauma System Committee is "leading the charge" to find support for the trauma system in the legislature. She said that it has been determined that the next step is educating the public about the importance of the trauma system. She said that the trauma centers have been asked to gather information about "good saves" for use in illustrating the importance of the trauma system. She also said that a canned presentation on the trauma system is being developed for use by all trauma center personnel for presentations in their own communities. Dr. Norcross said that we need to make sure that when support is asked for the trauma system, then it needs to be made clear what the funds will be needed for.

Dr. Norcross then briefed the Committee on other activities of the trauma system, the primary activity being the efforts to bring attention to the plight of the trauma system.

ACTION ON POSSIBLE NARCAN SHORTAGE

Dr. DesChamps asked if anyone had experienced the Narcan shortage that he had heard about; no one responded. He said he had received an email from someone in Maryland who had experienced a Narcan shortage, but he had not heard of anyone having difficulty getting Narcan in South Carolina. (Several months before, a mailing had been sent to the Medical Control Committee asking for a vote on whether to approve Nalmefene as a substitute for Narcan in anticipation of a shortage. The Committee had voted by a slim margin to do that, but no further action had been taken.) Dr. DesChamps suggested that the Committee wait before taking any action to see if adding Nalmefene is necessary.

Mr. Smith reported that he had heard from a service in the Florence area that they were having trouble getting Narcan, but when he checked with other services in the state, he could not find anyone else who was experiencing the same problems.

Dr. DesChamps said that if a shortage of the drug arises, it takes about six months to get all Committee and Board approval for a new drug. Mr. Futrell said that if it were necessary, immediate action could be taken by going directly to the Board; the Division would take the request directly to the Board and not go through the EMS Advisory Council.

The consensus of the Committee was to wait and see if that action becomes necessary.

OTHER DRUG ISSUES

Dr. DesChamps asked Mr. Smith what other drugs need to go to the Board. Mr. Smith said that magnesium sulfate, vasopressin (in ACLS protocols, but not yet approved by the Committee), Tylenol and any of the ACLS drugs listed in the new protocols will need Board approval. Mr. Smith said there won't be too many new drugs with the new protocols.

Dr. DesChamps asked the Committee to review a draft from the National Association of EMS Directors of the appropriate use of guidelines in EMS. He passed out the document and said that part of this should probably be used when we revise our state-approved protocols. He also said that the AAEM and Georgia medical directors recommended that amiodarone and lidocaine be included as local option and that we not recommend one over the other.

REPORT FROM PROTOCOL SUBCOMMITTEE (Drs. Sorrell and Fuerst)

Dr. Fuerst explained that several "boxes" such as "do CPR for 3 minutes" had been added to the new ACLS protocols and that the Committee needs to decide whether to accept the protocols verbatim or to simplify them. He and Dr. Sorrell said that we should only add what is scientifically important and are new interventions. Dr. Sorrell said he didn't see many changes.

Drs. Sorrell and Fuerst said that they will present the changes at the next meeting.

Dr. DesChamps said that he had had requests to create text versions of the protocols as well as flow charts. He said that he and EMS staff would attempt to do that. Dr. DesChamps said that John Dobson has agreed to assist staff in updating the drug list in Word, and then it will be placed on the educators' website. *Dr. DesChamps also said that he wants to scan all the memos that are issued in PDF form and put them on disk for distribution at the next Medical Control Physician Workshop.*

REPORT FROM PREHOSPITAL THROMBOLYTIC SUBCOMMITTEE (Drs. Burger and Shelton)

Dr. Burger was not present at this meeting. Dr. Shelton reported that they have divided up the issues to present, but had not met yet.

There was discussion over restricting the approved thrombolytic drugs to certain ones and that some can become expensive to use. There was also discussion about the fact that services would have to have telemetry or a cell phone to send EKG strips from the 12-lead, so that is another expense for services wishing to conduct prehospital thrombolytics. It will be expensive for services to set up.

Dr. DesChamps said that a whole class of thrombolytics should be sent to the Board for approval.

Dr. Shelton said that SCCEP is concerned that some of the smaller emergency departments with moonlighting physicians may end up giving the thrombolytics inappropriately. Dr. Shelton said he tried to explain that if a service goes to the trouble to set up this program there is a lot of effort prior to implementation and training would be provided.

Dr. DesChamps said that at the next meeting the Committee will take a vote and possibly approve the thrombolytics as a class, rather than specific agents, for presentation to the Board.

IMPLEMENTATION OF AHA GUIDELINES

The Committee paused to look over the new AHA guidelines. Dr. DesChamps asked Mr. Smith when the vasopressin, magnesium sulfate and Tylenol could be taken to the DHEC Board. Dr. DesChamps said that at the March meeting, the Committee gave blanket approval to add any new drugs in the new ACLS. He said that the deletion of Bretylium could be taken to the Board at the same time.

Dr. DesChamps said that the EMS Advisory Council approved the sternal intraosseous pilot project and they also approved the cricothyrotomy with the requirement for a service to also use LMA's and RSI.

SETTING REGULARLY SCHEDULED MEETINGS

Dr. DesChamps reminded the Committee that a regular schedule of meetings had been discussed and a survey of the Medical Control Committee members established that the third Thursdays were the only days that members did not have other set meetings.

After some discussion, the Committee agreed to try and set regularly scheduled Medical Control Committee meetings for the third Thursday of the second month of each quarter (February, May, August, and November). Meetings will not be held unless there are a sufficient number of agenda items. Ms. Beasley will send out this information with the proposed dates in a memo; the Committee may decide to hold the February meeting at the EMS Symposium.

With no further discussion, the meeting was adjourned.

AGENDA ITEMS NOT ADDRESSED/RESOLVED AT THIS MEETING:

- Change in CPAP Pilot Project to allow for adjustments for COPD and asthma patients (Laurens County EMS)
- Prehospital thrombolytics as a state skill (Drs. Shelton and Burger)
- State approved protocols (Drs. Sorrell and Fuerst)

STAFF ACTIONS NEEDED:

- Reminder to Laurens County EMS to gather data on CPAP complication rates for November MCC meeting
- Memo to MCC members re: schedule of meetings

MEDICAL CONTROL COMMITTEE

MINUTES

November 15, 2001

Members Present:	Others Present:
Dr. Ed DesChamps, Chairman	Bobbi Jo Killham, SCEPD
Dr. John Sorrell	Jeanne Brummett, SCEPD
Dr. Cliff Staggs	Russ Brahmer, Greenville Co. EMS
Dr. Ron Fuerst	Alonzo W. Smith, DHEC EMS
Dr. Rich Rogers	Phyllis Beasley, DHEC EMS
Dr. Carol Burger	Doug Rorie, FirstHealth EMS
Dr. Doug Norcross	Amy Beinke, FirstHealth EMS
	Ernie Autry, FirstHealth EMS

MINUTES FROM JUNE 21, 2001

Dr.Sorrell made a motion to accept the minutes of the Medical Control Committee meeting from June 21, 2001 with no changes. Dr. Fuerst seconded the motion. The motion passed.

COMMITTEE ANNOUNCEMENTS

Dr. DesChamps announced two changes in the membership of the Medical Control Committee. Dr. Bill Gerard, formerly a member of the Committee, will be returning to replace Dr. Steve Shelton. Dr. Shelton and Dr. Gerard filled the slot of the regional medical director for the Midlands EMS Region. Dr. DesChamps also announced that Dr. Bob Malanuk has resigned as the SC Medical Association representative on the Committee. Dr. Malanuk has been a member of the Medical Control Committee since 1986. The SCMA has appointed Dr. Jim Mock to replace Dr. Malanuk.

REPORT ON STERNAL IO PILOT PROJECT

Ernie Autry of FirstHealth EMS presented the six month report. He said that 140 personnel have been trained in the use of the sternal IO, including nurses and physicians. He reported that there have been four sternal IO procedures conducted: three unsuccessful and one successful attempt. He said that they have run into problems with using the sternal IO on obese patients, those who have a weight range of 270 + pounds. Mr. Autry said that he recommended continuing the project, but adding a section about body mass to the data collection sheet, and adding another county EMS to the pilot project. He said it is hard to make conclusions about the failures because of the small number of patients that they have had involved in the project.

Dr. Sorrell asked, what happens when there is a problem? Mr. Autry replied that when there is a failure, there is swelling from fluid, and in one instance the probe bent. He said that the

company has said that the more obese a patient is, the higher incidence of failure. Mr. Autry said that on the successful attempt, fluids were infused and there was no resuscitation of the patient.

In their report, Mr. Autry said, First Health recommends continuing the pilot project, but adding a body mass index to the data collection sheet and also including an additional county to the project to increase the numbers of patients.

The Committee discussed the need to address obesity guidelines in the use of sternal IO and the best way to determine body weight. *The Committee also asked staff to check and see if Spartanburg County EMS still intends to participate in the project and where they are with it.*

Dr. DesChamps reiterated that this is the 6 month report and that the Committee needs to decide whether to extend or terminate the project. Ms. Beinke, of FirstHealth, commented that the up front cost of the project is a problem. She said that the F.A.S.T. 1 's cost $100 each, but can be bought in volume for $84. They carry two per truck, but it is a billable piece of equipment.

Dr. Burger made a motion to continue the project for another 6 months, but attempt to involve another, larger service and add body mass index as required reporting. Dr. Norcross seconded the motion. The motion passed.

REVISIONS TO ADULT PROTOCOLS

Drs. Sorrell and Fuerst were the subcommittee to review the AHA guidelines and the earlier state-approved protocols. Dr. Fuerst explained that they divided up the protocols to review.

Dr. Sorrell began the review of the changes with the suggested AHA protocols from the 2000 Guidelines for Cardiac Life Support. He said that algorithm (from the AHA) I30-BLS Stroke and I26-BLS Acute Coronary Syndrome were covered by a universal algorithm covering BLS. He said that because of that I30 and I26 were not needed. The Committee agreed by consensus.

Dr. Sorrell then directed the Committee's attention to AHA's I143-Universal Algorithm and I144 for **adult cardiac arrest**. He passed out a handout he developed which combines the two protocols (see attached). Dr. Sorrell said that the Universal Algorithm covers the "ABC's" and there was no need to repeat these steps in every protocol. In this handout, Dr. Sorrell eliminated the activated response system and added vasopressin. He also took out CPR at 1 or 3 minutes to simplify the protocol. His changes and the combined protocol were agreed upon by consensus by the Committee.

Dr. Sorrell then passed out his revision for the **PEA** protocol (see attached). He said he changed it a good bit by simplifying it. He elaborated on the primary and secondary survey. He also said that the block for "Consider Causes" is the most important. The Committee approved his revision by consensus.

Dr. Fuerst reviewed the AHA protocol for **asystole**. He said that the main issue of this protocol is the "withhold or cease" activity. He said that the AHA does recommend that there be personnel at the scene to assist the family with counseling if the body is left. Dr. DesChamps

commented that we already have guidelines for not starting CPR. Dr. Sorrell suggested that the Committee condense the primary and secondary survey, leave transcutaneous pacing and add epinephrine, and not include the part about whether to start CPR. Dr. DesChamps said that we should encourage services to have a written protocol on how to determine when to stop resuscitation and encourage them not to terminate resuscitation without written backup.

Dr. Sorrell asked if it was possible to make it mandatory that each service come up with a protocol on how to determine when to stop resuscitation.

Dr. DesChamps suggested that we ask services to take a position on whether they will always resuscitate or allow termination of resuscitation under certain circumstances. This could be made one of the service's required protocols and the Committee could provide the guidelines (that are already established).

The Committee agreed that staff will send out the resuscitation protocol to the Committee members for discussion at the next meeting.

Dr. Burger said that the Committee should address mass casualty situations and how to determine when not to start resuscitation.

Dr. DesChamps said that the Committee should develop a protocol about cessation.

Additionally, Dr. DesChamps reiterated earlier discussion and said that on the asystole protocol, the Committee should use Dr. Sorrell's first two boxes, like in PEA. Under the section "asystole persists", add "contact medical control."

It was also agreed that on these protocols, have boxes that simply say "Conduct primary and secondary assessments (ABC's), without listing all those steps."

Regarding the **Bradycardia protocol**: Dr. Sorrell said that he did not recommend many changes. He said that the assessment information should be changed to match the other protocols. Also, under "serious signs-yes" a box listing administration of Atropine, Dopamine and Epinephrine with dosages and external pacing, if available. Under the section for "Block", if Type 2 or 3rd degree block is identified, then add "observe and prepare for external pacing." **The Committee agreed with those changes.**

Regarding **AHA Tachycardia protocol**: Dr. Fuerst illustrated the complex AHA protocol. He said that he and Dr. Gerard had discussed this protocol and said that there should be a statement: "If the patient is not unstable, leave them alone!!!" There was discussion about which drugs should be listed, procainamide, amiodarone, adenosine. Dr. Burger stated that she felt that adenosine was the safest, especially with the narrow tachycardias and it can be given quickly, with no side effects, no down side. She said that it is not given for broad complex tachycardias. Dr. Staggs said that in the AHA protocols, it is asking for a diagnosis, and that should not be done in the field.

Dr. Sorrell said that on atrial fib/flutter, the first box should be skipped and add a box that says "if the patient becomes unstable, contact medical control and consider cardioversion." He said that on the narrow complex tachycardia; add "if the patient is unstable give the adenosine order and if the patient remains unstable after adenosine, contact medical control."

Dr. Sorrell then suggested that there be a general overview and include fib/flutter and narrow complex tachycardia for treatment to the end, then for the other two (three and four tachycardia), refer to another sheet and put the wide complex tachycardias together.

Dr. Fuerst said that basically, we should leave our old protocols alone.

Dr. Burger said that we should keep the old supraventricular tachycardia protocol and separate out the wide complex ones (perfusing ventricular tachycardia, but take out bretylium and add amiodarone).

Dr. Sorrell asked again about adapting the AHA guidelines.. He suggested that the Committee keep the AHA guideline as is until four boxes across, then under 1 & 2 , refer to the narrow complex tachycardia, like our "Perfusing Vtach" protocol. He said that a note should be added "If known or suspected WPS, contact medical control." Dr. DesChamps said that the title of the protocol should be changed from "Perfusing Vtach" to "Perfusing Wide Complex Tachycardia" and change the drugs. There should also be a note "if patient stable, watch", "if patient unstable, treat."

The Committee agreed that Dr. Sorrell should draw up the protocol again, based on the discussion and they would review the fast rhythm protocols again at the next meeting.

Dr. Fuerst suggested that, on SVT in an unstable patient, the dosage of adenosine should be changed from 6 mg. to 12 mg. There was much discussion about the drugs that should be included in the protocol and whether procainamide should be taken out.

The Committee agreed by consensus to keep the old protocols, but take out bretylium and procainamide and add amiodarone or lidocaine. The Committee also agreed to change the title of the protocol from "Perfusing Vtach" to "Perfusing Wide Complex Tachycardia." Additionally, the Committee agreed that Dr. Sorrell would make the changes discussed and bring the protocol back to Committee.

Re: **AHA Stroke Protocol (I205**), Dr. Sorrell passed out a suggested revision (see attached). He said this is a complicated protocol that can be narrowed down. He said the CT scan is in the middle of the protocol, so we can eliminate after that. HE said that the protocol should include that the EMT should reassure the patient and conduct the basic ABC's. In the next box is targeted physical examination. Dr. Sorrell said that we need to emphasize to EMTs that they do not need to do a comprehensive head to toe exam; that time is of the essence for a stroke victim. They have to determine whether to conduct a stroke exam, "perform an appropriate stroke exam." He said the only thing he deviated from in this protocol was to take out "take to stroke center", as SC does not have designated stroke centers.

Consensus of the Committee was to go with Dr. Sorrell's version of the protocol.

Re: **AHA Chest Pain protocol (I178)**: Dr. Sorrell suggested only a minimal revision of the current state protocol. He likes to have contact medical control as soon as possible (on all protocols). He wanted to include the statement "If pain not relieved, consider contacting medical control for morphine." The AHA strongly recommends morphine for treatment of chest pain. He said a box should advise to use 12-lead if available. The Committee suggested that administration of aspirin and nitroglycerin be switched (put aspirin above nitro).

The Committee agreed to these changes by consensus.

Re: **Hypothermia protocol**: Dr. Fuerst said that the current state protocol is good. The AHA calls for treatments (lavage) that are not prehospital. The AHA also calls for taking a patient's temperature, but ambulances are not required to carry thermometers. Dr. Fuerst suggested that on the state protocol; take out "early use of bretylium." He said there needs to be a side box for "take off wet clothes to prevent further chilling."

The Committee agreed with these changes by consensus.

Re: **AHA Submersion protocol** (I235): Dr. Sorrell said that the AHA protocol is really a reporting scale, not an algorithm for treatment. Dr. Fuerst said, however, that the reporting scale is very useful for prognosis and it is important for paramedics to garner information about how long the patient was under, how quickly they responded to resuscitation, etc. Dr. Sorrell said that the state protocol is good but uses the term "near drowning" and AHA doesn't like to use that phrase. Dr. Fuerst said that he would like to add a box about "gather historical data about drowning." Dr. Sorrell also said that he would like to add a box about noting whether the patient's submersion time was greater than one hour and not hypothermic.

The Committee agreed with these changes by consensus.

Dr. Sorrell said that he would review some of the other AHA recommendations, such as Lidocaine therapy for incorporation in state guidelines and present at next meeting.

*Re: **Trauma protocol**: Dr. Norcross will review for next meeting.*

Dr. DesChamps said that the changes that were just discussed will be added and sent out to Committee members in advance of the next meeting.

EMERGENCY PREPAREDNESS PRESENTATION

Jeannie Brummett, RN, with the Critical Incident Management Group dealing with WMD, of the Emergency Preparedness Division, said that they will be working with three trauma centers to set up equipment and training for those hospitals to have regional response teams. The teams have been set up, but don't have equipment yet. She will be "selling" the hospitals on this project. The hospitals are: Greenville Memorial Medical Center, Palmetto Richland Hospital and MUSC. The teams are not set up officially yet, that is why there is not much knowledge about them yet.

This is not the same as DMAT. The teams would be coordinated by the local emergency preparedness director. Eventually this will involve EMS medical directors, so she wanted to let the Committee know in advance about the formation of these teams. These teams will specialize in dealing with HAZMAT situations. She passed out a "Field Operating Guide" that provides information about EMS, Fire, Police, ER's, decontamination, etc.

THROMBOLYTICS AS A STATE SKILL

Dr. Burger said that she was responsible for developing the costs associate with starting up a prehospital thrombolytic program. (Dr. Shelton was the other subcommittee member and he is no longer serving on the Medical Control Committee.) She said she developed the costs based on Greenville County EMS' experience with the pilot project.

The 12-lead EKG machine (MAC-PC) is $6,000.00
The analog cellular phone needed for transmission of data is $150.00
The training of the paramedics (16 *hours@$30/hr*) is 3,840.00
The packaging for Heparin and Retavase is $20.00
Medications are $2,500.00
Total of $12,510.00 per truck.

Dr. Burger said that they already had some of these things (the 12-lead, cell phone) and they got the drug company to set them up with medicine. She said they repackaged the medicine for one dose because they didn't get to the second dose and were losing it.

She said the cardiologists in their hospital wanted to implement this program. They have had great success—from October 1, 2000 to September 30, 2001, the drug was given 31 times (29 times prehospital and 2 times interfacility) and they had no adverse outcomes. She said that doing thrombolytics did not increase scene time much, since they were already doing 12-lead.

Dr. Burger said that since most of these patients go directly to the cath lab, she would like to see thrombolytics left open as an option, but certainly not to push it.

There was some discussion about the cost and about cell phone accessibility. Dr.Burger said that once the program is up and running, there are no further costs since the drugs are swapped out.

Many of the costs are one-time, Dr. Burger said. Unfortunately, many of the services with long transport times that really need the program won't be able to afford it. Dr. DesChamps pointed out that there is a grant-in-aid program to help with the costs.

Dr. Sorrell asked why Greenville didn't use TNK. Dr. Burger said that they went with Retavase because the drug company provided it free of charge, but there is really not much difference in the drugs.

Dr. Sorrell made a motion to open prehospital thrombolytics as an optional skill. Dr. DesChamps said he would get the protocols, training guidelines and checklist and limit the

program to bolus drugs; approving those drugs as a class. Dr. DesChamps said that the program should be opened as a statewide pilot project to gauge EMS response and avoid going to the Board, until there are more numbers of patients. Dr. Norcross agreed and said that it could be reassessed in a year and taken to the DHEC Board then.

Dr. Sorrell amended his motion to say to open prehospital thrombolytics as a statewide pilot project. Dr. Rogers seconded the motion. Dr. DesChamps said he would put together the training guidelines and acceptable drugs. The motion passed.

STATE DRUG FORMULARY

Dr. DesChamps said that the formulary is done and being finalized. It should be going out soon. There was a question about medical control and Ativan and Valium. Dr. Sorrell said that the Committee had decided to allow services to administer the controlled substances by standing protocol, up to a point. The allowable dosage under standing protocol *was up to a total of* 4 mg, and then medical control must be contacted.

Dr. Norcross asked if there had ever been a study done on how often the drugs have been used, in order to get rid of drugs that aren't being used. The Committee asked that Victor run a report tracking the use of all approved drugs.

REPORT ON SURGICAL CRICOTHYROTOMIES

Dr. DesChamps said that the guidelines for surgical crics has been developed (handouts were given to the Committee). Dr. Norcross commented that a horizontal incision should not be done, because of the difficulty in determining the location of the cricothyroid membrane and the risk of cutting veins. *He said that the initial skin incision should be vertical*. He also said that on the front page the picture in the manual shows someone putting in a tracheostomy tube, but says that it is an endotracheal tube. He said that the endotracheal tube is a lot harder to put in than the tracheostomy tube. *Dr. Burger suggested saying "or". Dr. Norcross suggested adding that an endotracheal tube no larger than a "4" should be used.*

Dr. Sorrell suggested leaving dosages out of the manual, since the dosages are specified in the formulary, and that Ativan needs to be added to the manual.

A question was asked if any services have requested to do this. Mr. Smith said that MedTrans was the only service to request using the skill yet.

REPORT ON THE TRAUMA SYSTEM

Dr. Norcross explained that the SCHA's efforts to develop trauma legislation and address problems of the trauma system are ongoing. Dr. Norcross has developed a "Cadillac" proposed legislation that has been initially reviewed by all interested groups and now must be approved by the groups' legislators. He said that with the state budget like it is, he is unsure how likely a new program is to be approved.

DISCUSSION ON EMT'S ADMINISTERING EPI-PENS

Dr. DesChamps said that there has always been a policy of allowing EMTs to administer patient-assisted medications, where the patient has a medicine and the EMT just assists in administering the medication. He said that some years ago a law was passed to allow lay persons to administer epi-pens (like camp counselors, teachers), but the reason this has not been widely used is that the law required DHEC to set up the training and administer the program and to write the regulations. It was put on the back burner to see about the need for this. Dr. DesChamps said that a question is being raised about this issue again. They want EMTs to carry epi-pens and decide when to administer them (to first time anaphylaxis patients). Dr. Staggs expressed concern over the cardiac risks. Dr. DesChamps said that basic EMTs have never been allowed to administer drugs de nova. **The Committee decided by consensus to leave this issue as status quo and not allow EMTs to carry epipens or administer them to first time anaphylaxis patients.**

SCHEDULING OF NEXT MEETING

Dr. DesChamps said that the next regularly scheduled Medical Control Committee meeting (3rd Thursday of the second month of each quarter) fell on February 21, 2002. He asked the Committee if they wanted to hold the next meeting then or at the EMS Symposium. **The Committee agreed to hold the next Medical Control Committee meeting on Thursday afternoon, February 28, 2002, at the EMS Symposium in Myrtle Beach.**

STATUS OF CPAP PILOT PROJECT

Mr. Smith announced that Laurens County EMS has withdrawn from conducting the CPAP pilot project, but Berkeley County EMS has picked it up.

AMBULANCE RUN REPORTS AND CQI

Dr. Staggs commented that, in trying to do CQI, the space available on the ambulance run report is not adequate for documentation. He asked if EMS would be allowed to use a second sheet for further comments. There was much discussion about whether sending in a second sheet was allowed. Staff said that the only thing that is recorded in the database is the information that is recorded in the boxes, not written comments.

NEXT AGENDA

Dr. Burger requested that there be a discussion on the dosages of Versed (can we adapt those?) at the next Committee meeting.

AGENDA ITEMS NOT ADDRESSED/RESOLVED AT THIS MEETING:

None

STAFF/SUBCOMMITTEE ACTIONS NEEDED:

- Staff: Find out if Spartanburg County EMS still wants to participate in the Sternal IO project
- Staff: Send out resuscitation protocol to Committee members for next meeting
- Protocol Subcommittee (Dr. Sorrell): Dr. Sorrell to revise the Tachycardia protocol to review the fast rhythm sections again.
- Protocol Subcommittee (Dr. Sorrell): Dr. Sorrell will review other AHA recommendations, not addressed at this meeting (such as Lidocaine therapy) for incorporation in state guidelines.
- Dr. Norcross: Will review the Trauma Protocol for revision and presentation at next meeting
- Dr. DesChamps: Changes in protocols approved at this meeting will be incorporated and mailed to Committee members prior to the next Committee meeting.
- Staff: Letter to the field to announce that the prehospital thrombolytic pilot project is open statewide.
- Staff: Run a report on usage frequency of all state-approved drugs

AGENDA ITEMS FOR NEXT MEETING:

- Presentation of revised protocols: Dr. DesChamps
- Review of trauma protocol: Dr. Norcross
- Review of resuscitation protocol and development of "cease resuscitation" protocol
- Review of additional suggested protocols (developed from AHA): Dr. Sorrell
- Review of further changes to Tachycardia protocol: Dr. Sorrell
- Presentation of report on frequency/type of formulary drugs used in the field
- Review/Approval of new drugs for formulary