MEDICAL CONTROL COMMITTEE

February 28, 2002

Minutes

Members Present:	Others Present:
Ed DesChamps, MD, Chairman	Alonzo Smith, Director, EMS
Ron Fuerst, MD	Phyllis Beasley, EMS
Bill Gerard, MD	Randy Reinhardt, MD, Laurens Co.
Jim Mock, MD	Richard Campbell, LREMSC
Rich Rogers, MD	Russ Brahmer, Greenville Co. EMS
Carol Burger, MD	Doug Warren, Dorchester Co. EMS
John Sorrell, MD	Dave Hobbs, MD, Jasper Co. EMS
Doug Norcross, MD	Scott Garrett, Upstate EMS Council
Cliff Staggs, MD	Bill Shiver, Upstate EMS Council

INTRODUCTION OF NEW MEMBERS

Dr. DesChamps introduced two new members to the Medical Control Committee. Dr. Jim Mock is the new representative of the SC Medical Association, replacing Dr. Bob Malanuk after his retirement. Dr. Bill Gerard is the new representative for the Midlands Regional EMS. Dr. Gerard has served on the Committee in the past and has replaced Dr. Steve Shelton.

BUCK FOR LIFE: Don Lundy

Don Lundy, spokesperson for the Buck for Life Campaign and the EMS Association, appeared at the Medical Control Committee meeting to ask for the physician support for this effort. This campaign proposes to add $1 to the vehicle registration to raise money for equipment and training for EMS providers. Mr. Lundy asked the physicians to contact their senators and representatives in support of this program.

MINUTES FROM NOVEMBER 2001

Changes suggested to the minutes were: on Page 4, change WPS to WPW and change Dr. Sorrell's name to Dr. Fuerst on the information about the revision of the tachycardia protocol.

Dr. Sorrell made a motion to approve the minutes with the above changes. The motion was seconded by Dr. Burger. The motion passed.

DNR RESEARCH REPORT: DR. GERARD

Dr. Gerard reported that Drs. Shelton and Kasmarek had surveyed medical control physicians and EMS providers regarding DNR protocols and determined that there is much

misunderstanding. Dr. Gerard passed out the protocols he developed for Richland County EMS based on guidelines produced by North Carolina that are intended to clarify gray issues surrounding prehospital DNR. *He asked that the MCC members review this and discuss it at the next meeting.* Dr. Burger asked that in the case of DNR and heart issues, "Do you try a drug once and then stop if it doesn't work? Dr. Gerard said that the intent is that no cardiac drugs should be used.

Dr. Sorrell suggested that the DNR/palliative care protocol and discontinuation of CPR protocol be combined and to emphasize "contact medical control." *Ms. Beasley said that she would send out another copy of Dr. Gerard's proposed protocol in the next mailing.*

LMA SIZE REQUIREMENT CONCERN – MR. SMITH

The EMS Division had received a letter from Dr. Cindy Dieringer, medical control physician for Kershaw County EMS, asking for reconsideration of the requirement to carry all sizes of LMA's on trucks since RSI is only allowed in adults ages 18 and over.

The Committee began discussing EMS providers' options on using combitubes instead of LMA's. There was also discussion on combitube sizes.

Dr. Fuerst said that the Medical Control Committee, by adding LMA option, had sought to improve the airway skills of paramedics.

Dr. Burger said that if an EMS chooses to use combitubes as backup airway for RSI instead of LMA's, then the Committee does not have the right to tell them that they are required to carry equipment they won't be using. She also said that the Committee does not have the right to tell services that they have to use LMA's if they want to use combitubes as backup airways. She said that they should just be required to have training in an adjunct airway.

Dr. Norcross said that the Committee should say that services must have a back up airway and that the medical control physician can determine which type airway to use.

Mr. Smith suggested that the Division send out another memo stating that services can choose which airway to use as backup for RSI, but make them aware that the combitube will not work for pediatric patients.

Dr. Fuerst commented that the pediatric issue is not relevant to the use of RSI anyway and the pediatric airway issue should be addressed separately. Dr. Norcross asked if the EMS-C Committee should address this issue. Dr. Fuerst agreed that the Committee could do that.

Dr. Fuerst then made a motion to remove the requirement for services using RSI to carry pediatric sizes of LMA as backup airway for RSI. Dr. Staggs seconded the motion. There was further discussion about this requirement and pediatric sizes and Dr. Fuerst withdrew the motion.

Dr. Fuerst commented that the size 3 LMA requirement was actually a size suitable for small adults, 30-50 kilos.

Dr. Norcross then made a motion that services using LMA's as backup airways for RSI must at least carry sizes 3, 4, 5 LMA's. There was more discussion about the LMA requirement with RSI, even if the medical control physician's prefer the combitube. Dr. Norcross said that the issue of whether they should require LMA vs. combitube should be resolved before the Committee addresses a motion regarding sizes. Dr. Burger said that she did not believe that three sizes were needed; the only sizes really needed were a 4 and 5. Dr. Norcross withdrew the motion.

Dr. Sorrell said that when the Committee passed the requirement to carry LMA's the Committee was concerned about implementing RSI and wanted to insure that services had necessary backup intubation skills and equipment.

Dr. DesChamps asked if the Committee wanted to have LMA's as local option. Mr. Smith suggested that DHEC could send a memo "strongly suggesting" the use of LMA's.

Dr. Sorrell made a motion that the Committee should not change the current policy requiring that LMA's be carried on trucks by services performing RSI. Dr. Norcross seconded the motion. Dr. Sorrell said that this motion does not address the pediatric size issue. Dr. Gerard said that there will be many services who carry the LMA's because they are required and will spend all the money, then not use them, yet will have to endure that expense.

Dr. DesChamps asked that DHEC EMS staff put together a report which will include:

- *The number of services doing RSI*
- *The number of RSI events*
- *The number of times LMA was used*
- *The number of times the combitube was used*
- *The number of failures of endotracheal intubation*
- *The number of failures to ventilate by any means*

Dr. DesChamps then suggested that since such a finite number of services are using RSI, the questions should be put together in a questionnaire and just sent to the services conducting RSI.

Dr. DesChamps asked if there were anything else to address with RSI/LMA. Mr. Smith directed the Committee back to Dr. Dieringer's original question about the requirement to carry pediatric sizes of LMA's when RSI cannot be conducted on pediatric patients.

Dr. Norcross made a motion that services using RSI should carry at least LMA sizes 4 and 5 until the question of the LMA requirement is resolved. Dr. Sorrell seconded the motion. The motion passed.

PROPOSED CHANGES TO THE DRUG FORMULARY

Dr. DesChamps passed out copies of the newly revised drug formulary. He credited John Dobson for changing the old WordPerfect document to Word format. He said that the changes approved at this meeting will be incorporated into the formulary following their approval.

The following drugs were submitted for consideration at this annual "drug" meeting of the Medical Control Committee.

ADENOSINE:

A change in use for Adenosine (Adenocard) was requested by Greenville County EMS. The request was to increase the initial bolus to 12 mg to allow the chemical cardioversion of the rhythm to be more effective (initial adult bolus is currently 6 mg.).

The suggestion was to change the wording of the formulary for adult dosage of Adenosine to read "initial dosage up to 12 mg, up to a maximum of 30 mg."

There was discussion about changing the maximum dosage to 36 mg., based on the dosage increments.

A motion was made by Dr. Burger to change the adult dosage of Adenosine to "Initial dose of up to 12 mg. rapid IV with subsequent dosages of 12 mg within 1-2 minutes of continuing SVT rapid IV bolus to a total of 36 mg." The motion was seconded by Dr. Fuerst. The motion passed.

MORPHINE SULFATE

Greenville County EMS also requested a change in use for Morphine Sulfate to eliminate the maximum dose to allow for long distance (time) transports.

Dr. Burger said that they have run into problems with running out of the allowable dosage maximum of Morphine Sulfate before a transport is over. She would like to allow for further dosages "with online medical control."

Dr. DesChamps clarified that Morphine Sulfate had been recently changed to allow for dosing either by online medical control or by direct (written) order. He said that this would allow for continuing dosages for interhospital transfers, but with prehospital injuries dosages must still be online.

Dr. Burger requested that with prehospital online medical control, she is still requesting removal of the maximum dosage. The Committee agreed that since the drug must be administered with online medical control, then the maximum dosage could be removed.

Dr. Burger made a motion to incorporate a change in use of Morphine Sulfate to "up to 5 mg initially, additional dosages require direct medical control order and remove the maximum dose of 15 mg." Dr. Rogers seconded the motion. The motion passed.

There is no change in the wording for the pediatric dosage.

NITROGLYCERIN

Greenville County EMS submitted a request for a change in use for Nitroglycerin to eliminate maximum dose limit to allow long distance treatment of patients. However, Dr. Burger asked to withdraw this request since the current drug formulary allows for continued dosage with direct medical control.

DIAZEPAM (and changes in Ativan and Versed)

Greenville County EMS submitted a request for a change in use of Diazepam to eliminate maximum dose to allow long distance transports and to add an IM route to allow for administration in acute anxiety without establishing an IV.

Dr. Burger explained that the request for a change to Diazepam is basically the same request as for Morphine, to eliminate the maximum dose.

Dr. Burger made a motion for the change in use of Diazepam, for the dosage to read "Adults: To 15 mg. initially, slow IV administration, titrated to effect. For doses over 15 mg, direct medical order required." Dr. Fuerst seconded the motion.

Dr. DesChamps asked the Committee if a similar change should be made for Ativan, also. The Committee agreed.

Dr. DesChamps suggested that the wording for Ativan should read: (Adult) Dosages greater than 4 mg require direct medical order." The Committee agreed that this should be a motion and it was seconded.

There was then discussion about changing the pediatric dosage to read "Doses greater than 4 mg require direct medical order."

Dr. Burger then asked that, for Diazepam, could IM be added as a possible route of administration? Dr. DesChamps said that IM is included in Ativan, but Dr. Burger said it was not included for Diazepam. There was some discussion by the Committee regarding the fact that IM administration of Diazepam is painful. The discussion was dropped with no addition to the motion.

Dr. DesChamps said that he has been asked on several occasions about EMS providers who are approved to conduct RSI wanting to use Versed to sedate a combative patient. He said that he has responded that Versed is only approved when used in combination with RSI. Dr. Gerard pointed out that both Diazepam and Ativan are already approved as anxiety controlling drugs. There was discussion that Versed is a good drug for short term effects of sedation.

The Committee then discussed the verbiage for using Versed for sedation. Dr. DesChamps asked for clarification from the Committee about which services could use Versed. The Committee agreed that the use of Versed should be opened up for any service, not just those doing RSI, for use as a sedative. Dr. Fuerst then suggested that before other discussion, the

Committee should refer back to the proposed discussion about the use of Versed as a premedication.

Dr. Burger made a motion to add indications under Versed the same verbiage as used in Diazepam for services using RSI, "medication for major motor seizures, status epilepticus, pre-medication prior to cardioversion, transcutaneous pacing, skeletal muscle relaxant, acute anxiety states, premedication for combative patients and difficult intubations." Dr. DesChamps clarified that the Committee wants Diazepam, Lorazepam, and Midazolam to have the same indications. The motion was seconded. There was discussion about using Versed in patients with kidney problems or patients using alcohol. Dr. Norcross expressed his disagreement about allowing Versed to be used for combative patients**. The motion passed.**

There was discussion about allowing the use of benzo's outside of RSI without medical control**. A motion was made to add the following statement for all benzo's: "For indications <u>other than</u> RSI and seizures, contact online medical control. Dr. Rogers seconded the motion. The motion passed.**

Dr. DesChamps then asked the Committee if they wanted to release Versed from use only with RSI so that any service could use Versed. **Dr. Gerard made a motion to add Versed to the general formulary, not requiring RSI, and add renal failure as a contraindication. Dr. Staggs seconded the motion. The motion passed.**

The Committee then discussed the dosage for Versed.

Dr. Sorrell made a motion for a change in use in Versed for dosage: "For non-RSI indications, initial dose of 0.5 mg – 2.5 mg, higher doses require direct medical order. For RSI indications, initial dose of 0.5 mg – 5.0 mg, other doses require direct medical order." Dr. Burger seconded the motion. The motion passed.

Dr. Sorrell said that he would write up a comparison of the Benzo's to ensure that the verbiage is consistent and appropriate.

<u>PYRIDOXINE HCl</u>

Greenville County EMS submitted a request to add Pyridoxine HCl as an addition to the "Tox Box" for Hydrazine poisoning. Dr. Burger explained that Hydrazine is used in local industries that perform aircraft maintenance. She said that if a patient is seizing from Hyrdrazine or if there are multiple patients, the immediate use of Pyridoxine is needed.

Dr. Sorrell made a motion to approve the addition of Pyridoxine as a special purpose drug in the "Tox Box." (10% solution; 1g/10mL or 3g/30mL vial; IV only; adult dose, 25 mg/kg, over 5 minutes; pediatric dose, 25 mg/kg, over 5 minutes; Therapeutic effects-provides a required synthetic cofactor that enables the brain to regenerate GABA and stop seizures; Indications-Hydrazine poisoning; Contraindications-none; adverse/side effects-none acutely, peripheral neuropathy with chronic, excessive dosing, Pyridoxine withdrawal seizures in neonates of mothers who took chronic, excessive doses of pyridoxine during

pregnancy) The motion was seconded. The motion was approved. (Since this is an addition to the drug list and not a change, it must also be approved by the DHEC Board.)

ETOMIDATE (Amidate)

Life Reach Helicopter submitted a request through Dr. Gerard to add Etomidate (Amidate) to the prehospital drug formulary for use in RSI protocol for anesthesia induction. It is a hypnotic drug with no analgesic activity. Dr. Gerard said that CareForce's nurses use it instead of Versed. He said that it doesn't depress the respiratory rate, maintains ICP and BP and is low on side effects. He said it is requested to be added to the RSI drugs, not to replace any. Dr. Sorrell said that it is the drug of choice for intubations.

Dr. Gerard made a motion to add Etomidate to the special purpose drug list as an RSI drug: 2 mg/ml in 20 mg (10ml) or 40 mg (20ml) vials; IV; adult dosage - .3mg/kg; therapeutic effects-hypnotic drug (no analgesic activity); indications – for use in RSI protocol, for anesthesia induction; contraindications – known sensitivity to drug; adverse/side effects – transient venous pain, skeletal muscle movement. Dr. Rogers seconded the motion. The motion passed.

USE OF EPINEPHRINE BY BASIC EMTS

Dr. DesChamps asked the Committee to again address the issue of administration of Epinephrine (Epi-pens) by EMT-Basics, at the request of Senator John Courson, who is responding to a request by a constituent, Mrs. Beth Dworjanyn. Dr. DesChamps said there is a push to allow anyone to administer Epinephrine. A copy of this letter, an article from JEMS and a staff report regarding epinephrine use and respiratory distress for the year 2000 was passed out to Committee members.

Dr. DesChamps said that there are 1.5 calls per 1000 when epinephrine is used for respiratory distress and anaphylactic shock.

The Committee discussed the difficulties of recognizing signs of anaphylactic shock. It was also pointed out that Basic EMTs are not allowed to administer any other drugs. Dr. Sorrell expressed concern over the misdiagnosis of anaphylactic shock and the dangers of administering epinephrine.

Dr. Norcross made a motion that the Medical Control Committee draft a letter from the Committee to Mr. Smith expressing the unanimous opinion that epinephrine NOT be administered by all levels of EMT's, only paramedics. Dr. Sorrell seconded the motion. The motion passed.

PROTOCOLS

The Committee decided to address the remaining protocols at the next meeting. *Dr. Norcross asked Ms. Beasley to send him a copy of the trauma protocol for review at the next meeting.*

MALPRACTICE INSURANCE FOR MEDICAL CONTROL PHYSICIANS
(Since this meeting, this issue has been clarified and a notice sent from DHEC to EMS providers and their medical control physicians. See attached)

Dr. DesChamps explained that a medical control physician had questioned whether medical control physicians were covered under their malpractice insurance. This issue had been addressed earlier, but with recent changes in JUA, Dr. DesChamps had written another letter requesting confirmation of coverage. After requests for information by Dr. Danny Brake, on the Board of JUA, the vice-president of JUA-Marsh, Richard Lane, responded that he was not certain of coverage and said that he would investigate. Initial reports from him indicate that on-line medical control physicians operating within the hospital setting are covered, but that off-line medical control physicians may not be. Mr. Lane recommended that off-line medical control physicians send a letter to their insurance carriers advising that they are serving as offline medical control and outlining those responsibilities. Mr. Lane said that he would send a letter of response documenting that the issue is being addressed and would develop a checklist for medical control physicians to send back.

Dr. Sorrell said that DHEC needs to tell services that they must cover their medical control physicians. There was also discussion about having DHEC get an umbrella policy for medical control physicians.

Dr. DesChamps suggested that if medical control physicians are covered under JUA, they should call Mr. Lane and send a letter to other insurance carriers. Dr. Sorrell suggested not waiting on a checklist to be developed, but to send a letter of notification now.

Dr. Sorrell made a motion that DHEC send a letter to all services requesting them to make sure that their medical control physicians have appropriate insurance coverage and that the services should provide documentation that their medical control physicians have appropriate coverage. The motion was approved by consensus. Dr. Norcross said that this issue needs to be brought to the DHEC Board.

With no further discussion, the meeting was adjourned. The next Medical Control Committee meeting is scheduled for Thursday, May 16 at 1 p.m. in the second floor conference room of the Heritage Building, 1777 St. Julian Place, Columbia.

AGENDA ITEMS NOT ADDRESSED/RESOLVED AT THIS MEETING:

PROTOCOLS:

- DNR/Palliative Care: Dr. Gerard
- Trauma Protocol: Dr. Norcross
- Tachycardia Protocol: Dr. Fuerst
- Additional Suggested Protocols (from AHA): Dr. Sorrell

STAFF/SUBCOMMITTEE ACTIONS NEEDED:

- Protocols, see above
- Determine if Spartanburg County wishes to participate with FirstHealth's sternal IO project.
- Report of usage frequency of all state-approved drugs
- Report from staff on RSI (from survey), including:
  - Number of services doing RSI
  - Number of RSI events
  - Number of times LMA was used
  - Number of times the combitube was used
  - Number of failures of endotracheal intubation
  - Number of failures to ventilate by any means
- Comparison of Benzodiazepine drugs for consistent and appropriate verbiage in the drug formulary: Dr. Sorrell
- Letter from Medical Control Committee to EMS Division with recommendation to NOT allow EMT-B's or I's to administer epinephrine
- Letter to Dr. Dieringer and EMS providers clarifying that services performing RSI should only carry sizes 4 and 5 of LMA

TRAUMA SYSTEM COMMITTEE

May 16, 2002

MINUTES

Members Present:	Others Present:
E. Douglas Norcross, MD, Chairman	Thomas Ashley, MD, SRMC
Cathy Stokes, RN	Gerald Wilson, MD, SCMA
Barbara Bryant, RN	Rene Kilburn, Palmetto Richland
Ed DesChamps, MD	Teressa Neill, RN, Greenville Med.
John Stewart, MD	Bill Gerard, MD, Palmetto Richland
Andre Creese, MD	Cindy Lee, RN, Carolinas Hospital
Brian Weaver, MD	Brenda Parnell, RN, Carolinas Hosp.
Jim Walker	Cindy Kinney, RN, Self Hosp.
Michael Dawkins, RN	Phyllis Beasley, DHEC-EMS
Richard A. Schmitt, MD	
Diane Howell, RN	
Mark Reynolds, MD	

(Members of the Trauma Grant Committee were also invited to participate in this meeting.)

STAFF REPORT

Prior the arrival of the Committee Chairman, Ms. Beasley began the meeting by providing a staff report on trauma system activities.

Ms. Beasley reported that the Trauma Resource Network had relayed information that a new trauma revenue code has been approved and, beginning in Fall 2002, designated trauma centers will be able to bill for instances in which a trauma alert was called and trauma team resources were used.

She also reported that DHEC EMS has applied for a (roughly) $35,000 grant from HRSA to create a 7- to 10-second video geared to the general public to explain the difference between a designated trauma center and a non-designated hospital. The grant, if approved, would also provide funds to produce a 30-second public service announcement for distribution statewide to television stations. This grant activity would be part of the movement to promote legislation to support the trauma system. DHEC EMS would ask for help from all the trauma center personnel in taking the video out into their communities and educate the public on the importance of having an organized trauma system.

Ms. Beasley also said that DHEC will be receiving federal funds to create many positions related to bioterrorism; one position of which may be a full-time administrator for the trauma system. No further information is available at this time.

She then reported that staff is nearly done with the "old-style" Level III redesignations. Piedmont Hospital was reviewed a couple of months earlier and the review for Self Memorial Hospital is still being organized. Marion County Medical Center is scheduled for its initial Level III designation review later in the month.

Ms. Beasley estimates that the Level I and Level II redesignations may begin in Winter or Spring of 2003. She says that the application must be revised and a listing of potential reviewers must be developed.

She also reported that the transition to the new "Collector" trauma registry software is nearly complete. A two-day training session was held in April. It is hoped that once all the hospitals have finished conversion to the commercial software and have begun dumping the data to DHEC, that activities to establish filters to monitor the statewide trauma system can resume. Activities to develop state audit filters were halted when the decision to change to commercial software was made last spring.

MINUTES FROM 12/00

Dr. Norcross made a motion to approve the minutes of the last Trauma System Committee meeting in December 2000. The motion was seconded. The motion was approved.

REDESIGNATION OF CAROLINAS HOSPITAL SYSTEM AS LEVEL III TRAUMA CENTER

Dr. Norcross was the team leader for the redesignation review of Carolinas Hospital System in January 2002. There were no other team members present. The review was based on the "old style" redesignation review using the 13 required audit filters and was based on their quality improvement activity in 1999, the last year the audit filters were required. At that time, Carolinas Hospital System was serving as a Level II trauma center.

Dr. Norcross said that Carolinas Hospital System QA process should serve as a model for how other Level III trauma centers, and even Level I and II, trauma centers should conduct their QA. Ms. Beasley, who had represented DHEC EMS staff at the review, said that she agreed with Dr. Norcross' comments and that the hospital's QA program was very well organized. She asked if the Carolinas staff attending the meeting would like to make any comments; they declined.

Dr. Schmitt asked why Carolinas dropped from a Level II to Level III designation. Cindy Lee, representing Carolinas Hospital System, said that it was mainly the stricter demands of the surgeons for Level II designation. Dr. Norcross added that around this time their trauma director, Dr. Russ Jaicks, left.

Mr. Walker made a motion to redesignate Carolinas Hospital System as a Level III trauma center under Redesignation Option 1 ("To designated the hospital as a trauma center. The hospital has everything required and is designated with no question or problems.") The motion was seconded. Dr. Schmitt asked if the change in level would affect the volume and

transports to the hospital. Responses from Ms. Lee from Carolinas and Dr. Reynolds and Ms. Howell from McLeod indicated that the patient, if conscious, can request what hospital to be transported to, but major trauma patients are assessed in the field by EMS and generally transported to McLeod, although in some instances to the closest hospital. Pediatric trauma patients are transported to McLeod. Dr. Norcross asked the Committee to vote on the above motion**; the motion was passed.**

GEORGETOWN HOSPITAL'S RESIGNATION – OTHER SYSTEM ISSUES

Dr. Norcross then asked if the Committee had heard the news about Georgetown Memorial Hospital. Ms. Beasley said she had not included that in her staff report. Dr. Norcross explained that, in early March, Georgetown Memorial Hospital had given up its Level III trauma center designation. He said that The Regional Medical Center of Orangeburg and Calhoun Counties is also still have problems with orthopedic surgery coverage. Dr. Bynoe said that they now have two orthopedic surgeons, but still have problems with coverage.

Dr. Gerald Wilson, Chairman of the Trauma Subcommittee of the SC Medical Association said that the SC Medical Association House of Delegates recently passed a resolution to support trauma legislation and plans on pre-filing trauma legislation in mid-November. (Dr. Wilson passed out a copy of this resolution.) He also said that the Legislative Black Caucus had agreed to sponsor trauma legislation - specifically that Representative Joe Brown - Chairman of the 3M Committee had agreed to sponsor legislation.

Jim Walker said that there are hopes that the legislation will be introduced in both the Senate and the House of Representatives, to prevent problems if the legislation gets bogged down on either side. He also recommended that the legislation be modeled after other recent state legislation, especially in regards to funding. He said that the Hospital Association is working on a "primer" of key trauma information to assist the legislators in understanding the issue. He said that the day before this meeting, a group of hospital CEO's met and talked about the financial survey which the Hospital Association has contracted Bishop and Associates to conduct. He said it will be an extensive study, including transfers, financial issues and resources. He said the study will allow us to understand costs associated with making a system whole and in putting together legislation

Dr. Norcross asked if Bishop and Associates was going to include in their study figures related to Loss of Wages and Productivity. Mr. Walker said that there was some of that in the study but that is not Bishop and Associates' area of expertise.

Dr. DesChamps suggested that when the study is complete, representatives from this Committee, Dr. Wilson and Mr. Walker should present the findings to the DHEC Board.

DR. BYNOE – DIVERSION, ETC.

Dr. Bynoe asked to address the Committee on issues related to trauma diversion. He passed out a handout showing how the Chattanooga, TN, area trauma centers deal with diversion issues. Dr. Bynoe said that recently, Palmetto Richland has had to call McLeod Regional Medical

Center twice to alert them that PMH has gone on diversion. He said it will get worse in the summer. Dr. Bynoe asked the question, "What is the purpose of a trauma system?" when there are no standards that the system is being held by and issues become very complicated when there are transfers in the middle of the night from hospitals that are designated as Level III trauma centers.

Dr. Bynoe said that another major problem occurs when it is time to make back transfers after care at a Level I has been provided and, because the sending hospital will not take back the patients they transferred, there is no room to accept new trauma patients.

He said that hospitals that say they want to be designated trauma centers should evaluate what patients they say they can care for and should be obligated to take back patients that they transfer out.

He said that there needs to be a forum to discuss trauma care.

Dr. Norcross asked Dr. Bynoe to put forth a specific proposal on how the Committee can deal with these issues. Dr. Norcross suggested that one thing that could be done is to assess the capabilities of all the Level III trauma centers.

Dr. Wilson suggested that the problem be approached with local education and get local cooperation to start fixing the problems.

Dr. Wilson asked what authority this Committee has. Ms. Beasley responded that the Committee can set policy, but there is no regulatory authority, other than to designate trauma centers.

Dr. Stewart asked if the Committee could set a policy requiring a patient to be seen by a surgeon before they are transferred out. Dr. DesChamps said that the problem with that would be that if an emergency physician sees the patient and decides that this patient needs to be transferred out to another trauma center, then waiting on a surgeon would delay appropriate care.

Dr. Schmitt summarized some of the problems and discussion to this point. He said there are two or three points that the Committee has touched on:

1) That there needs to be specific designation benchmarks/parameters at each level of care, but particularly for Level III trauma centers since they are the ones that are transferring patients;
2) That site visit teams should address and review back transfers, this should be a requirement for designation (Ms. Beasley added that in the last revision of the Level III application, she added in the requirement that the Level III trauma center have a plan in place for accepting back transfers.);
3) The question regarding requiring surgeon to surgeon contact would be a breaking point for many Level III trauma centers in the state

Dr. Norcross said that part of the problem is that we have no way of tracking which patients are transferred, type of injury and funding source.

Dr. Wilson said that there are many complex problems on why the trauma system isn't working, but we need to have information on what problems the hospitals can handle. He asked if this information was available somewhere. Ms. Beasley said that in the original application the hospital must say which requirements they can meet; but Dr. Norcross said that information is more structural. Dr. Wilson said he meant more specific injury information. He said there should be one number where someone can call and see that if a patient is from ***X*** Hospital, than they should be able to handle ***X*** problem and EMS should have the same information.

Drs. Wilson and Norcross made a motion to form a subcommittee to develop a survey instrument to determine the capabilities of trauma centers to be kept on file at DHEC and at each hospital. The motion was seconded.

Dr. Schmitt asked about having the same subcommittee investigate models on back transfers; but Dr. Wilson reminded the Committee that back transfers would be a regulatory issue and there are no regulations for the trauma system.

Mr. Walker said that some of the capability and back transfer information would be collected by Bishop and Associates in their study.

Dr. Ashley expressed concern that some hospitals might downgrade their capabilities in answering the survey so they won't get into trouble.

There was some discussion about what type questions should be asked in the survey. Dr. DesChamps said that in addition to specifying capabilities, the survey should address how often the trauma center can handle the different types of injuries—i.e. all the time, 50% of the time, etc.

There was also discussion about keeping up with changes in the capabilities. IT was suggested that the survey be conducted and revised quarterly, but Ms. Beasley said that there is not staff available to conduct the survey on a quarterly basis. She suggested that the hospitals be required to notify DHEC of changes when they occur. Dr. Norcross said that the subcommittee would develop a method to track changes.

Dr. Norcross called for a vote on the motion; **the motion passed**.

Dr. Norcross asked who would volunteer to serve on this subcommittee. *The subcommittee will be: Dr. Doug Norcross; Dr. Raymond Bynoe; Diane Howell; and Dr. Richard Schmitt*.

Ms. Stokes asked if DHEC could track transfers from the state registry. Dr. Norcross asked if TASC could come up with a set of state system filters to track. Ms. Beasley reminded the Committee that there is a subcommittee of the Trauma System Committee charged with developing state system filters. She said that the Committee first determined that the data in the trauma registry was not "good" and two workshops were held to improve the consistency and accuracy of the data being sent to the registry. Then the subcommittee couldn't agree on system filters. Then the state began the conversion to a new commercial software registry and is still in that process. She said that Dr. Reynolds is the chairman of the subcommittee and that, if the

subcommittee is willing to continue, the state registry will soon be available to begin producing data. *There was no decision made on whether to continue this subcommittee.*

Dr. Norcross asked staff to investigate the procedures and regulations related to back transfers for neonatology.

Dr. DesChamps suggested that another trauma forum, like the one that was held in Greenville, be planned. He said it was a good forum for discussing issues. There was some discussion on this, but no resolution.

There was a request to add a question to the proposed capability survey addressing how often a hospital has gone on diversion.

It was determined that the next meeting of the Trauma System Committee should be sometime in late July or August (actual date set is Thursday, August 15 at 10:00 a.m.). With no further discussion, the meeting was adjourned.

AGENDA ITEMS NOT ADDRESSED AT THIS MEETING:

None

AGENDA ITEMS PROPOSED FOR NEXT COMMITTEE MEETING:

none

AGENDA ITEMS NOT RESOLVED/CONCLUDED AT THIS MEETING:

None

STAFF REPORTS/ACTIONS DUE AT NEXT MEETING:

- Staff to contact Dr. Reynolds to determine whether to continue with current structure of Trauma QI subcommittee.
- Staff to research procedures and regulations related to back transfers for neonatology

SUBCOMMITTEE ACTION NEEDED:

- Subcommittee (Drs. Norcross, Bynoe, Schmitt and Diane Howell) to develop a survey instrument tool to determine the capabilities of trauma centers.

MEDICAL CONTROL COMMITTEE

August 15, 2002

MINUTES

Members Present:	Others Present:
Dr. Ed DesChamps, Chairman	Alonzo Smith, EMS
Dr. John Sorrell	Phyllis Beasley, EMS
Dr. Bill Gerard	Jeannie Brummett, EMD
Dr. Carol Burger	Greg Kitchens, EMT-P
Dr. Doug Norcross	Chad Bevan, AHA
Dr. Jim Mock	
Dr. Rich Rogers	

MINUTES FROM 5/02

Dr. Sorrell noted a misspelling of TPA and of Dr. Greg Sans name on Page Two. **Dr. DesChamps made a motion to approve the minutes with these corrections. The motion was seconded. The motion passed.**

PREHOSPITAL THROMBOLYTICS

Dr. Burger said that she had come up with some information as requested. She said that the cost to implement prehospital thrombolytics would be about $12,000 per truck, if starting from scratch with 12-lead equipment. Dr. DesChamps asked how they transmit the information and Dr. Burger said that they had used LifePaks, but now they are faxing and it works well.

Dr. Burger presented a checksheet when they give thrombolytics. She presented another checklist that is a thrombolytic inclusion/exclusion checklist to determine if the patient is a candidate for thrombolytics. She said that training is out of Miami, one of the first places to use prehospital thrombolytics

Dr. Burger said that she has reviewed materials on prehospital thrombolytics and recommends that Retavase seems to be the best drug. It is not weight based and there is an option to give one dose and not both doses, for patients going directly to the cath lab. She said that TPA would not be amenable to EMS because it is difficult to use—it is weight based. She said there is less chance of error with Retavase. Overall, she said, all three thrombolytics are similar—side effects and efficacy are about the same.

Dr. DesChamps asked if the Committee wanted to open up the skill to multiple agents or restrict it to Retavase.

Dr. Sorrell asked if anyone would want to use anything besides Retavase—what if someone wanted to give a system TPA?

Dr. DesChamps said that Dr. Burger's and Centacor's point was good about the simplicity (non-weight based) of Retavase.

Dr. Sorrell said it might be better if the state determined which drug should be used with no other option.

Dr. Sorrell made a motion to approve only Retavase as the prehospital thrombolytic. Dr. Burger seconded the motion. The motion passed.

Dr. DesChamps then asked the Committee to look at the training and checklists. He asked if the Committee just wanted to adopt Greenville's training and checklists as the standard.

Dr. Sorrell asked about stroke and TIA as a contraindication for prehospital thrombolytics. Dr. Sorrell suggested that they allow for local input for use of thrombolytics. Dr. DesChamps said that another option is a more lenient protocol to adapt to the local service.

Dr. Sorrell suggested that Greenville's protocol be adopted as guidelines only. Dr. DesChamps said that the skill should be opened up conservatively at first, then as more data is available, the age limits, etc. can be taken off later. He suggested that he and Ms. Beasley would put together the protocols, check lists, etc. based on Greenville's and would get these out to the Committee members to vote on at the next meeting (November 14).

Dr. Sorrell asked Dr. Burger if Greenville gives Heparin immediately after the Retavase. She responded "***yes***", they give the bolus of Heparin (5000). Dr. DesChamps said that Heparin would have to be approved by the Board, also.

RSI REPORT

Dr. DesChamps asked if there was a report on services doing RSI (following a survey from the last meeting). Ms. Beasley said that she left the folder with the responses in her office (in a different building than the meeting), but she thought there had been only three or four responses.

Dr. Norcross asked if there were a place on the ARR to report RSI use. Dr. Norcross said that the Committee might want to retrospectively check the ARR data to make sure that services performing RSI are approved to do so.

The information below was unavailable at the time of this meeting, but was the only responses to the RSI survey conducted in summer '02:

- Does your service conduct RSI in the field, or have you begun the training process to use RSI in the field? (date begun)
    - Fort Mill Rescue Squad – 02/13/00
    - Lancaster County EMS – 07/01/97 (pilot project)

  - Life Reach - 1998
  - Chester County EMS – 04/02
  - Kershaw County EMS – 12/29/2000
  - Piedmont EMS – 02/01

- Since your service began using RSI, how many times have you successfully and unsuccessfully conducted RSI?
  - Fort Mill R.S . – successful 10 times; non unsuccessful
  - Lancaster Co. EMS – 202 successful; 18 unsuccessful
  - Life Reach – 43 successful; no unsuccessful
  - Chester Co. EMS – no attempts
  - Kershaw Co. EMS – 6 successful; 1 unsuccessful
  - Piedmont EMS – 17 successful; 2 unsuccessful

- Since your service began using RSI, how many times has your service used an LMA?
  - Fort Mill R.S . – none
  - Lancaster Co. EMS – none
  - Life Reach - none
  - Chester Co. EMS – once (non-RSI related)
  - Kershaw Co. EMS – none
  - Piedmont EMS – none

- Since your service began using RSI, how many times has your service used a combitube?
  - Fort Mill R.S. – 2nd page of fax missing
  - Lancaster Co. EMS – none
  - Life Reach – none
  - Chester Co. EMS – do not use
  - Kershaw Co. EMS – twice
  - Piedmont EMS – twice

- Since your service began using RSI, how many (number of) failures has your service experienced in attempting endotracheal intubation?
  - Fort Mill R.S. – second page missing
  - Lancaster Co. EMS – none
  - Life Reach – four since 1998
  - Chester Co. EMS – none
  - Kershaw Co. EMS – none
  - Piedmont EMS – none

- Since your service began using RSI, how many (number of) failures has your service experienced in ventilation by any means?
  - Fort Mill R.S. – second page missing
  - Lancaster Co. EMS – none
  - Life Reach – four since 1998
  - Chester Co. EMS – none
  - Kershaw Co. EMS – none

- Piedmont EMS – none

DNR/PALLIATIVE CARE PROTOCOLS

Ms. Beasley reported that they received field resuscitation protocols from two services, Upstate Carolina and Greenville County EMS. No service provided samples of any palliative care protocols. Copies of these protocols are attached to these minutes.

Dr. DesChamps said that perhaps we should also have a protocol for cessation of resuscitation. Dr.Gerard said he thought that this Committee has said that by 2003, services must have protocols for both of these scenarios. Dr. DesChamps agreed; he said that services must have guidelines if they are going to allow their EMT's to cease resuscitation.

IN-SERVICE TRAINING

Dr. Sorrell first stated that having the IST option is a good program for services; however he felt that there could be improvements. He said that points that aren't good include having to meet every month (it costs his system $10,000/month in pay and overtime). Dr. Sorrell said that this was discussed in the Training Committee and it was felt that IST programs could meet 10 months of the year. Mr. Smith said that the Training Committee actually voted on 9 months, but from a staff perspective, they preferred that ISTs be held for 10 months, in order to maintain the integrity of the program.

Dr. Gerard said that in the past, the program was 12 months and an EMT could miss two sessions. Mr. Smith said that now the program would be 10 months and an EMT could miss two sessions, which would bring minimum attendance to 8 sessions.

Dr. DesChamps clarified that in the past the service had to offer IST for 12 months and the individual EMT could miss 2 months. Now the service can opt to offer IST for 10 months of the year, rather than 12 months AND the student can miss two months of training, but he still has to meet the required hours of training.

Dr. Sorrell clarified that 16 hours/year of core curriculum must be offered through the year. You can have an in-service that doesn't include one of the topics and the IST program would still be okay. Dr. Sorrell said that if a service does BTLS or ACLS, the service's hours go way up on the month's that those courses are offered; and the service will have a lot of flexibility.

Mr. Smith then reviewed other recommended changes in IST:

- The Training Committee recommended that the IST program stay with 48 hours of didactic instruction.

- The Training Committee recommended that all training officers, current and new, attend a 40-hour DOT methodology course.

- The Training Committee recommended that new IST training officers should take an IST Policy training course within 90 days of appointment.

- The IST subcommittee recommended that there be one written exam each calendar year as an option and there should be a minimum of 100 written questions and students should maintain a written average of 70%. Motion was to use this as an option, not a requirement. Dr. Norcross expressed concern about quality of test and standardization. Mr. Smith that this was not a viable option at this time.

- The Training Committee recommended that the IST program maintain a skills competency checksheet for EMT-Basics. There was much discussion over this recommendation by the Medical Control Committee, but the Committee agreed to support this recommendation. The Training Committee had not yet approved this recommendation. The Medical Control Committee recommended condensing some elements of the checksheet (i.e. lumping bandaging and fractures).

Dr. Norcross made a motion that the Medical Control Committee supports the concept of an IST concise skills checklist for the EMT-B. Dr. Mock seconded the motion. The motion passed.

Mr. Smith continued to review the remaining recommendations:

- The Training Committee recommended that the medical control physician has the authority to sign off on transferring IST credit for an EMT who is transferring to a new service (providing the medical control physician has taken the medical control physician workshop)

- The Training Committee recommended that these policy changes be incorporated once an EMT has completed the IST requirements. Mr. Smith said that he and Dr. DesChamps felt like there would be a way to transition in the changes, rather than waiting to incorporate them and having some EMT's on one program and some on another. There was general agreement that the IST program is the same and the changes are only administrative; EMT's should not be penalized for the program changes. The Medical Control Committee agreed that the policy changes should be made immediately and not phased in only with new cycles.

Dr. Sorrell pointed out another policy recommendation. He said that in the past, policy called for a wait period of 6 months when a new medical control physician took over an IST program before the physician could sign off for an EMT's recertification. The Medical Control Committee agreed that this policy should be changed, *as long as the medical control physician has already attended a Medical Control Physician's Workshop*.

Discussion regarding the role of associate medical control physicians signing for IST (not allowed) brought up another discussion regarding situations in which a medical control physician is a distance from the service they work with and the difficulties in getting necessary signatures (i.e. Dr. Burger in Greenville serving as medical control physician for Spartanburg). The general

consensus was that associate medical control physicians should be allowed to have more involvement with the EMS provider. There was discussion about whether an associate medical control physician who is not actively involved in the IST program might sign off for EMTs he/she is not familiar with. Consensus was that the main and the association medical control physician must communicate regularly and work out signing off EMTs together.

Regarding an earlier recommendation, Dr. DesChamps made a motion to allow services to conduct IST programs for 10 out of 12 months. Dr. Burger seconded the motion. The motion passed.

Dr. Mock made a motion to allow associate/assistant medical control physicians to sign off on IST training and recertification.

Dr. Norcross expressed his concern that this action might be a mechanism for an associate medical director to bypass the wishes of the primary medical control physician, unless some system is in place to ensure that doesn't happen. Dr. DesChamps said the burden to prevent that should be on the primary medical director. Dr. DesChamps said that when the memo is sent out notifying EMS of this change, the memo should say that it is incumbent on the primary medical director to have a verifiable system in place to document that the primary medical control physician agrees with anything the association medical director has signed.

The motion was amended to include the requirement that a system is in place to ensure that the primary medical director is aware of and agrees with anything signed by the associate medical director. Dr. Burger seconded the motion. The motion passed.

Dr. Norcross asked about a comment in the last minutes about medical control representation on the Training Committee. Mr. Smith said that this is a matter of what physician on this committee would also be willing to serve on the Training Committee, or to work out a schedule where there could be alternating representation. There was a question about how often the Training Committee meets. Mr. Smith said it is about once a quarter.

Dr. DesChamps said that staff would get a list of Training Committee meeting dates and these would be sent out and then Medical Control Committee members could sign up for the dates.

TEXT PROTOCOLS

Dr. DesChamps said that the text versions of the protocols are almost complete and they will be mailed out for approval when completed.

MEDICAL CONTROL DURING DISASTERS – JEANNE BRUMMETT, EMD

Ms. Brummett asked for input from the Committee related to medical control during disaster situations and the COBRA (Chemical, ordinance, biologic, radiological) teams, the rapid response teams being put together in SC. The teams are specifically equipped and trained to deal with incidents of mass destruction. The purpose of the teams is to provide specialized operational assistance to local fire, law enforcement, EMS and public health responders once it's

recognized that local assets will be overwhelmed. The teams are designed to supplement local resources. The abilities being trained are hot zone agent detection and identification, medical management operations, decontamination operations and law enforcement functions. The advance teams are in Greenville, Richland, and Charleston. Basic teams support them and there are three or four teams in the region. All teams are working together developing protocols. The teams are made to leave their local jurisdictions and go wherever there is a need for assistance. This is where one of the issues developed.

It is intended that during a terrorist incident, the position will oversee all team medical operations including triage, treatment, transportation and coordinator with and advising local hospitals. EMD wants physicians to train with the team and will be equipped with the team. The physicians would go out with the team. When the teams do leave their jurisdictions, they want to avoid having the teams have to fall under Charleston's medical control physician because that medical control physician might not be there. EMD needs to insure that there is a backup. EMD and Ms. Brummett have been working the Dr. DesChamps and Mr. Smith and had determined that the physicians on these teams should attend a medical control physician's workshop. These physicians would only be medical control for the COBRA teams. All the teams would have the same protocols.

Dr. Sorrell asked how these teams fit in with the state and DHEC. Ms. Brummett said that local response would be first, then the COBRA (state) team, then DMAT. Ms. Brummett clarified that DMAT teams may go out of state, but COBRA teams will only serve in-state. She also said that DMAT, at this time, does not have WMD capabilities. The team leader of COBRA would fall in under incident command. The advance team leader would be in charge of the basic teams and that one advance team leader would go to incident commander.

Ms. Brummett said the EMD needs buy-off from the different areas and teams to get physicians willing to do medical control. But issues have to be settled first. The biggest issue is the liability malpractice and workman's comp. Ms. Brummett said they have been going around about this. She said that if the state is calling the teams up, the liability falls under the state and they are unsure of malpractice. She asked for input from the Committee about their malpractice. One member responded that the way JUA and PCF is set up, they don't specify an institution or don't specify that you have to be within an institution, you are covered as a physician/surgeon with anything you do within the state. Ms. Brummett asked about workman's comp. It was felt that if the physician is covered under the hospital's workman's comp, it would not cover that physician for incidents away from the institution. Ms. Brummett suggested possibly an MOU could be worked out with the hospital. The Committee felt that probably wouldn't be possible.

Ms. Brummett said the other issue was that the teams could be called up county by county and through the mutual aid agreement it is said that the liability will be picked up through the agreement. DHEC legal opinion (not official) is that as long as the work is volunteer and the teams are not getting paid (except expenses) the liability is covered by the state and the mutual aid fund through the insurance reserve fund. Ms. Brummett said they will still meet with the insurance reserve fund.

Ms. Brummett then asked the Committee what they think the biggest issue is that they need to work out before the physicians will buy into it. Committee members said they think disability would be the main issue. They said it would be unlikely that it wouldn't fall under Good Samaritan. Ms. Brummett said it does.

Dr. Norcross said that most physicians aren't covered under workman's comp because they are considered independent contractors. Dr. Mock recommended talking to the SCMA about this issue.

Dr. DesChamps said there was another, administrative, problem that involves the teams being made up from different services, even from within the same county, and that those services have different medical oversight. Dr. Gerard suggested that there be statewide approved protocols. Dr. DesChamps said there was still the issue of one medical director needed for the team. Dr. DesChamps said that creates an administrative hurdle in that the team itself is not a licensed service.

Dr. Burger asked if there could be a special license or could it be done since it was an emergency. Dr. DesChamps said that if an emergency happened tomorrow and they put a team together, they could do that because it was an emergency, but since activities now are planning activities these issues have to be addressed. The solution will call for a change in law/regs. Dr.DesChamps pointed out that for these teams to be licensed; they have to carry certain equipment. Mr. Smith said he would have to take this question to the DHEC legal department. Dr. DesChamps said there was general agreement that there should be statewide protocols for disasters that all are required to know and follow. Ms. Brummett said that these orders should be given to hospitals and followed, but Dr. Norcross said that wouldn't be possible.

Dr. Norcross said that if legislation is going to be drafted to allow for these teams and their medical control, then the legislation needs to encompass an exemption from malpractice. Ms. Brummett said that perhaps the malpractice exemption could also be included in the governor's executive order they are seeking for authority for these teams.

The issue was also brought up about malpractice/liability for the teams themselves. The physicians may be covered, but the teams are not operating under their regular medical control physician and therefore would not be covered under the normal insurance coverage. Ms. Brummett said that is a new issue that has not been discussed, but will be addressed.

Ms. Brummett said that another issue is the development of standards: who will develop those standards? Dr. DesChamps asked if there weren't federal standards. Ms. Brummett said there are federal standards; would the Medical Control Committee be willing to review those standards and adapt them if necessary. The Committee agreed to do that. *Dr. DesChamps agreed to email the current state protocols to Ms. Brummett when they are completed*.

Ms. Brummett asked if there would be a problem training the physicians on the team. The Committee said there would be no trouble—there are two workshops offered each year already.

Dr. DesChamps asked about other training these physicians might need. Ms. Brummett said there is a 40-hour operations-level course they would need. She said all training would be offered free of charge.

A question was asked about hospital reciprocity when physicians go to another hospital environment to help. Ms. Brummett said they haven't dealt with that yet, that their primary focus had been on physicians assisting outside the hospital in a D-con environment.

AHA STROKE PROTOCOLS –CHAD BEVAN, AHA

Mr. Bevan introduced himself as the Director of High Risk and Strokes for the AHA. He said that he has been charged with implementing stroke programs in Columbia and Charleston called Operation Stroke. This program addresses the issues of stroke from acute onset to rehabilitation. He pointed out that SC is number one in the country for strokes. He said that EMS in the Columbia area has developed a protocol and checklist for strokes. He said that checklists are valuable to insure that the appropriate questions are being asked in the field and so that the hospital is receiving the correct information before the patient arrives.

Mr. Bevan said that their medical subcommittee had taken Miami's Emergency Neurologic Deficit exam and modified it, reformatted it to pocket size and adapted it for use here. He said that nothing from Miami has been changed or added; he said that a couple of things have been deleted, such as name, date, etc. (He passed out the prehospital card for identification of strokes.) He said that the AHA would like to make this available for statewide distribution.

Dr. Norcross asked if he just wanted the Committee's approval on this card for EMS to carry. Mr. Bevan said that was what he was requesting. Greg Kitchens said that were just trying to establish a uniform system for identifying stroke victims.

Dr. Gerard, on the Stroke Committee, said that right now they were just in the prehospital education phase. He said eventually decisions will have to be made about designating hospitals as stroke centers and issues of bypass will have to be addressed.

Dr. Gerard suggested adding this to the state protocols as recommended guidelines. Dr. Norcross said he had a problem with mandating this before stroke centers are even established.

Dr. Gerard made a motion to adopt the stroke identification chart as a recommended guideline for state protocols and add to the CVA guidelines and also send this to the Training Committee to incorporate in the training curriculum. Dr. Sorrell seconded the motion. The motion passed.

AMIODARONE

Dr. Burger asked for clarification from the Committee. She said that they had finally decided to put Amiodarone on the trucks in Greenville. When she began to write the standing orders, she could only remember the Committee approving a 300 bolus in cardiac arrests, followed by 150 ten minutes later. She asked if anything had ever been approved for stable v-tach or a drip. She

said that the problem is that if you decide to use Amiodarone and you have a patient with stable v-tach and you want to give them Amiodarone, you can't give that, you have to give Lidocaine. Then you have to carry Amiodarone and Lidocaine.

Dr. Sorrell said he thought the intent was to use Amiodarone as recommended by the AHA.

Dr. Burger said her main concerns were if the transport time is longer than the 2nd dose of Amiodarone, then do you use Lidocaine next and you are not supposed to switch medications. She said also if you have a stable v-tach, you would have to carry two different drugs. She asked if the Committee could expand the uses of Amiodarone.

Dr. Sorrell said he didn't think the Committee meant to exclude Amiodarone for any use.

Dr. Burger said she would like Amiodarone opened up to use straight out of the ACLS protocols (add use in drip and for stable v-tach). The Committee agreed by consensus to make the changes in the drug list for Amiodarone to be consistent with AHA ACLS guidelines.

TRACHEOSTOMY TUBE EXCHANGE

Dr. DesChamps said that there is a question about EMT's being about to change tracheostomy tubes in cases of a tube being clogged, when the patient has a replacement tube. He said that technically the EMT is not trained specifically to take out a trach tube and replace it with another trach tube. He said that they can take out a trach tube and replace it with an ET tube, but not a trach tube. He said that he was referring to trach tubes that have been in place long term. He said the family is allowed to change the tube, but the EMT is not.

The Committee agreed it was safer for the EMT to put in another trach tube, rather than an ET tube. The Committee agreed by consensus that it is permissible for an EMT to put in replacement trach tubes, as long as the trach tube (the inner-cannula) has been in long term.

ARR PHYSICIAN SIGN-OFF

Dr. Gerard said there has been a problem for EMTs to chase down MD's in hospitals to sign ambulance run reports when there is nothing on the run report that is a variant from standing orders.

Dr. Norcross said that he has the same concerns when he signs an ARR for ALS provided by the EMT when he had no input at all in the patient's care; when it was done by standing order.

The question was raised about whether getting the physician's signature was a regulation. Dr. DesChamps also asked if there were some billing question about getting a physician's signature on a billing order for reimbursement. Dr. Gerard said that if an EMT puts "PSO" (per standing order) at the physician's signature box, then that implies that the actions were done under a physician's order.

Mr. Smith said that the ARR is being revised now and he will look into the billing issue before they decide to add a box for "PSO". Mr. Smith said he would fax out the revised ARR to the Committee members for approval before the contract for the ARR is revised. Dr. Sorrell said that he would like the Medical Control Committee to review the ARR before any changes are made.

There was then discussion about going to a "chief complaint" form for ARR's, similar to the T and Poseidon systems in hospitals.

REQUIRED EQUIPMENT

Dr. DesChamps said that the issue had been brought up about the fact that there is no differentiation in required equipment on the different types of ambulances, including air ambulances. He said that much of the required equipment is too bulky and heavy to be used on helicopters, including spine boards and lug wrenches.

Dr. DesChamps said that the Committee needs to review the regulations for making changes in equipment requirements. He said it will take a while to change regs. He said this should also be an opportunity to add equipment like McGill forceps. He said that it would probably be best if equipment requirements could be moved to policy, instead of regulation, so it could be changed more easily. However, the Legislature had not allowed that in the past. He said that the Committee could add this to the agenda for the next meeting.

MARK 1 KIT

Dr. Gerard said that he is the tactical EMS Director for SLED. He said that there is a lot of BT activity and training going on. He said that SLED is acquiring the Mark 1 kits with the atropine and 2-Pam to administer to the team, not to the general public. Technically, however, they cannot administer this, they are EMT-I's. He said they could administer this to themselves, but not team members.

Dr. DesChamps said that this situation would be out of DHEC's authority; they are not administering to the public. They are state employees in the "line of fire."

Dr. Gerard said that the Committee will need to look at this and similar WMD issues; the group is planning to store 30,000 of these kits at Richland County EMS. *It was agreed that these issues should be put on the next agenda (team use for immediate first aid*).

TRAUMA

Dr. Norcross said that the best thing to happen to the trauma system in the past ten years is the closure of the MUSC Burn Center—it has gotten a lot of public and media attention. Dr. Norcross said there was just a big article in the Post and Courier and that he and Dr. Ashley have been asked to write editorials for the Spartanburg paper (and Sen. Peeler's office called Ms. Beasley for a rebuttal, which she could not provide). He said that some legislators are starting to pay attention to the problem.

Ms. Beasley informed the Committee that Self's redesignation review had been scheduled for June, then the hospital asked to cancel the redesignation. The hospital later called back a few weeks later and asked to reschedule the review again. She said this confusion is coming about because the hospital does not have a trauma director and has not yet been able to find one.

Ms. Beasley also told the Committee that DHEC has just received a $38,000 grant to produce a video to explain to the public about the difference between a trauma center and a non-designated hospital. Dr. DesChamps suggested that the local media might do one of their public service programs on this issue. Ms. Beasley asked for input on information to be included in this video.

Dr. DesChamps asked if there were any other items that need to be added to the next agenda. Dr. Sorrell asked that there be discussion about medication storage.

The next meeting of the Medical Control Committee is Thursday, November 14. With no further discussion, the meeting was adjourned.

AGENDA ITEMS NOT ADDRESSED/RESOLVED AT THIS MEETING:

NONE

STAFF/SUBCOMMITTEE ACTIONS NEEDED:

- Prehospital thrombolytic protocols/checklist (based on Greenville Co. EMS) organized for vote by Committee
- Present list of Training Committee meeting dates for Medical Control Committee members to sign up to attend
- Completion of text version of protocols
- Send out memo to field re: permissibility to change tracheostomy tubes
- Add box to ARR to allow exemption of physician signature in cases of "per standing order"
- Send copy of proposed changes to ARR for Medical Control Committee approval

ITEMS FOR NEXT AGENDA:

- Review regulations for changes in equipment requirements
- Team use for immediate first aid (WMD issues)
- Medication storage

OTHER

- Heparin and Retavase to Board (following approval of EMS Advisory Council)

MOTIONS FROM MCC AUGUST 15, 2002

Prehospital Thrombolytics:

- Approve Retavase as the only prehospital thrombolytic

IST

- Motion that the MCC supports the concept of an IST concise skills checklist for the EMT-B.

- Motion to allow services to conduct IST programs for 10 out of 12 months.

- Motion to allow an assistant/associate medical control physician to sign off on IST training and recertification, as along as there is a system in place to ensure that the primary medical control physician is aware of and agrees with anything signed by the association medical control physician.

Stroke protocols

- Motion to adopt the stroke identification chart as a recommended guideline for state protocols and add to the CVA guidelines and also send this to the Training Committee to incorporate in the training curriculum.

Change of use in Amiodarone

- Consensus agreement to open up the use of Amiodarone as recommended by the ACLS protocols (add for use in drip and for stable v-tach).

FOR INFORMATION

- Poll showed only 6 services in SC using RSI (Fort Mill R.S., Lancaster County EMS, Life Reach, Chester County EMS, Kershaw County EMS, Piedmont EMS)

- Only two services submitted sample protocols for DNR/Palliative Care

- Agreement that it is allowable (and safer) for an EMT to replace a trach tube than an ET tube, as long as the trach tube (the inner cannula) has been in long-term

- MCC will address the use of atropine and 2-Pam in Mark 1 kits

MEDICAL CONTROL COMMITTEE

November 14, 2002

MINUTES

Members Present:	**Others Present**:
Dr. Ed DesChamps, Chairman	Dr. Gabe Simpson, Palmetto Richland
Dr. Doug Norcross	Jim Catoe, DHEC EMS
Dr. Bill Gerard	Susan Ashcraff, Piedmont Med. Ctr.
Dr. Ron Fuerst	Kim Nathan, Marion Co. Med. Ctr.
Dr. John Sorrell	Terry Horton, DHEC EMS
Dr. Richard Rogers	Phyllis Beasley, DHEC EMS

MINUTES FROM 08/02

Dr. DesChamps mentioned that he noticed in the minutes the request to add a place for signature by EMS personnel for "per standing order/protocol" (PSO) . The Medical Control Committee had requested that this space be added so that EMT's would not have to track down physicians if there were no care provided that varied from their standing orders. He said that Alonzo Smith had told him in the EMS Advisory Council meeting that morning that the space could not be added until the next revision of the ambulance run report next January (2004). Dr. DesChamps asked EMS Division to issue a statement allowing EMTs to acknowledge PSO immediately and just write it on the ambulance run reports, then the form can be changed at the next opportunity.

There were no other comments or changes to the minutes.

Dr. Gerard made a motion to approve the minutes. The motion was seconded by Dr. Norcross. The motion passed.

DISCUSSION ON SCENE TIME

Dr. DesChamps said that there has been a question about the appropriateness of 20 minute scene times. He said that this understanding had come from reports in California for trauma cases that cited that said cases with 20 minute scene times had better survival rates.

He said that the question has come up with QI issues that warrant scrutiny of greater than 20 minute scene times, especially in respiratory arrest cases. Is it better to load and go or keep trying on the scene to intubate?

Dr. Sorrell said that if the travel time to the hospital is short, then transport should be expedited. In cases of long transport time, the EMT should spend more time on the scene.

Dr. Gerard said that trauma cases should be scrutinized if they are longer than 15 minutes. Dr. DesChamps agreed and said that medical cases could be won or lost on the scene. Dr. DesChamps said this should be a local issue and on-scene times longer than 15 minutes should be reviewed.

Terry Horton said that in the old days, paramedics were not allowed to stay on the scene longer than 15 minutes and after that, paramedics were expected to try and get IV lines, etc., en route. He said this question is coming up more and more in the Division and he would like the opinion of the Medical Control Committee. He said there seems to be a general trend away from "scoop and run."

Dr. Sorrell said that there really can't be a set rule, but services should look at the distance of the hospital. Dr. DesChamps said that the stability of the scene should be considered, too.

Dr. Rogers said that the decisions should be up to medical control. **The Medical Control Committee agreed by consensus that scene time determinations should be a local, individual policy and decisions.**

TRAUMA SYSTEM REPORT: DR. NORCROSS

Piedmont Medical Center Level III Trauma Center Redesignation

Dr. Norcross said that, at its meeting immediately prior to this meeting, the Trauma System Committee voted to recommend the redesignation of Piedmont 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.")

Ms. Beasley told the Committee that Piedmont Medical Center was designated under the old system of 13 audit filters. She said that the review team found that the hospital wasn't following all the required audit filters, but documented that other, appropriate trauma quality improvement was being conducted. She also said that the administrative was very supportive of the trauma efforts.

Dr. Norcross made a motion to redesignate Piedmont 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. Gerard seconded the motion. The motion passed.

Marion County Medical Center Level III Initial Designation

Dr. Norcross said that the recommendation from the Trauma System Committee was to designate Marion County Medical Center as a Level III trauma center under Designation Option #1 ("To designate the hospital as a trauma center. The hospital has everything required and is designated with no questions or problems.")

Ms. Beasley explained that Marion County Medical Center is a small hospital and has an emergency physician (Dr. Richard Schmitt) serving as its trauma director (per state approved criteria). She said that the team's only comments were minor; the hospital was still evolving as a trauma center.

Dr. Norcross made a motion to designate Marion County Medical Center as a Level III trauma center under Designation Option #1 - 1 ("To designate the hospital as a trauma center. The hospital has everything required and is designated with no questions or problems.") Dr. Gerard seconded the motion. Dr. DesChamps asked about a comment on the site review report which stated that a couple of charts showed that when the surgeon was called, he did not come in and physically see the patient. He asked about loop closure for those instances. Kim Nathan said that the surgeons are aware of these instances and the Trauma Committee is following such instances. **The motion was approved.**

Other Trauma Issues

Ms. Beasley reported that the trauma conference sponsored by a federal grant and attended by legislative lobbyists, DHEC personnel, hospital personnel and others were alerted to the problems of our trauma system. This Conference included presentations by representatives from the trauma systems of Mississippi, Washington State and Maryland. She said that the same day of the conference, the DHEC lobbyist went to the Commissioner and convinced him that this is an issue that DHEC should tackle.

Ms. Beasley said that now the role of developing and sponsoring trauma legislation has shifted from the Hospital Association to DHEC, by agreement. It will be sponsored by DHEC since trauma is a public health issue. She said the first meeting of a new stakeholders group to put together legislation will meet on November 25. Ms. Beasley said that this is an amazing development. She said that DHEC even submitted a budget to the state for staff support and direct money to the hospitals.

Ms. Beasley said the next Trauma System Committee meeting was set for December 10.

Dr. Norcross volunteered his PowerPoint presentation for use by anyone who wants to do presentations to gain support for the trauma system. Ms. Beasley also mentioned that the video explaining to the public the differences between a hospital and trauma center will be completed soon and available for presentations.

SCCOT REPRESENTATIVE

Dr. DesChamps said that there is still no SCCOT representative on the Medical Control Committee (to fill the vacancy left by Dr. Miller, then Dr. Arrillaga). Dr. Norcross said that is because there is no chairman of the SCCOT—it was Dr. Miller, but he is no longer in state.

PREHOSPITAL THROMBOLYTIC PROTOCOLS

Dr. DesChamps presented the Retavase checklist developed by Greenville during the pilot project. He said that is an "inclusion/exclusion checklist", a "thrombolytic therapy" text page, and two flow sheets. He said that when the Committee approved statewide thrombolytics, that Greenville's protocols and checklists would be adapted and used statewide.

The was discussion about if there is a "yes" answer to any of the above in the checklist, then medical control should be contacted for instructions.

Dr. DesChamps said that the Committee agreed that the Reteplase (Retavase®) recombinant check sheet will be amended to say that any "yes" must be reported to medical control and a direct order must be received for thrombolysis. Dr. Gerard said that the title should be changed to "checklist" instead of "inclusion/exclusion".

Dr. Fuerst made a motion to accept the checklist as amended. Dr. Sorrell seconded the motion. The motion passed. Dr. Norcross abstained from voting.

CHANGE IN USE OF VALIUM

Jim Catoe said that Jeannie Brummett with the Emergency Management Division is setting up COBRA teams to prepare for chemical, radiation and bioterrorism events. These COBRA teams will be using CANA kits in which Diazepam is administered by autoinjector, 10 mg IM. Mr. Catoe said that this request is for a change of use and method of administration since Diazepam is already on the drug list. This change would be made with the stipulation that this is for use by "special consideration" by the COBRA teams only. There is a physician, nurse and paramedic on each COBRA team.

Dr. Gerard suggested putting the kits in the "Tox Box" section of the drug formulary, like the Mark I kits. Dr. Sorrell suggested approving Valium for IM use. He said there have been instances in which it could not be administered by another means.

Dr. DesChamps said that IM could be amended and also add in the special section that the CANA kit is approved for one-time use by COBRA teams. Dr. Rogers asked if this would be blanket approval for the use of the kit by COBRA teams. Dr. DesChamps said that the COBRA teams will be presenting their protocols to the Medical Control

Committee. Mr. Catoe added that the kits are used for treatments for convulsions from the nerve agent Solanz.

Dr. Sorrell repeated that the Committee agreed to change the route of administration of Diazepam to add IM and put under special notes to add the CANA 10 mg autoinjector for neurotoxin exposure, one-time dose without on-line medical control. Dr. Fuerst added that it would only be for use by COBRA teams or paramedics in the setting of neurotoxin exposure. Dr. Norcross asked, in the setting of use of the autoinjector by paramedics not on COBRA teams, who would determine that a neurotoxin had been used. Dr. DesChamps said the indication would probably be that there wouldn't be one case, but would be multiple cases.

Dr. Sorrell then made a motion to change the route of administration of Valium to add IM, and add CANA kit autoinjector or 10 mg IM as a one-time dose in suspected terrorist event. Dr. Rogers seconded the motion. The motion passed.

EQUIPMENT IN THE REGULATIONS

Dr. DesChamps asked if staff had determined whether the repair equipment required of ambulances could be taken off the requirement list for helicopters. Mr. Catoe said that Mr. Horton had been checking into that, but they had not made a determination.

There was discussion about how difficult it is to make changes in equipment requirements when they are in regulation, not policy, but that in the past, legislators have wanted to leave the equipment requirements in regulations.

The Committee agreed by consensus that the EMS Division should try again to convince the legislators to change equipment to policy rather than regulations.

Mr. Catoe commented that his only concern with taking equipment from regulation to policy would be that it would be harder to enforce if there were a violation related to equipment.

TEAM USE FOR IMMEDIATE FIRST AID – DR. GERARD

The Committee agreed that this item should not have been on the agenda; it refers to the approval already granted for team members to administer Mark 1 kits to each other.

There was discussion about whether the Committee has authority to approve or disprove the use of Mark 1 kits. The Committee agreed it was important to make a statement in support of the use of the kits and of the bioterrorism planning efforts.

Dr. Fuerst made a motion to approve the use of Mark 1 kits by team members for self rescue. The motion was seconded. The motion passed.

MEDICATION STORAGE – DR. SORRELL

Dr. Sorrell said that Florida passed a regulation that drugs must be kept in a controlled environment, and that maybe it is time for South Carolina to consider doing that. Dr. Sorrell said that the issue is not whether the drugs should be kept in a controlled environment, but what is the cost and how hard is it to do this?

Dr. Sorrell suggested contacting Florida regarding their guidelines. Dr. Rogers said that Earl Floyd with Marion County EMS reported that it costs about $300-400 to buy a storage unit. Dr. DesChamps said there would be additional costs in separating controlled and non-controlled drugs.

Dr. Rogers volunteered to ask Earl Floyd to bring the information to the Symposium. The Committee asked DHEC EMS to contact Florida about their regulations.

EMS ADVISORY COUNCIL AND TRAINING COMMITTEE ATTENDANCE

Dr. DesChamps said that there are five slots on the EMS Advisory Council which are held by physicians and members of the Medical Control Committee. The slots are: MUSC, currently filled by Dr. Norcross; USC currently filled by Dr. Fuerst; SCCEP (slot open); SCMA, currently filled by Dr. Mock; and SCCOT (slot open). He also said that these positions serve on the Medical Control Committee. Dr. DesChamps said that the EMS Advisory Council encourages these members to attend. Dr. Fuerst said that he was not aware of his membership in the EMS Advisory Council; he said he got notices about it, but was not aware that he was actually a member. Dr. Sorrell said that when he was the SCCEP rep on the Medical Control Committee, he was not made aware of his role on the EMS Advisory Council either.

Dr. Norcross said the Dr. Karl Byrne is chairman of the SC Chapter of the American College of Surgeons.

Dr. Fuerst asked for the number of Paul Lucas, current chairman of the EMS Advisory Council. Ms. Beasley said their offices have moved and she did not know the new number off the top of her head. Dr. Fuerst said he would contact Ms. Beasley later and get the number.

Dr. DesChamps also reminded the Committee that they had said they wanted regular representation on the EMS Training Committee and that they had agreed to take turns attending the meetings.

Dr. DesChamps asked for signups for the scheduled meeting dates:

January 9, 2003
April 10, 2003
July 10, 2003
October 9, 2003.

Dr. Rogers agreed to attend the April 10 date. *Dr. Fuerst asked that the dates be emailed to the Committee member so they can check their schedules and sign up.*

The Committee then discussed the next meeting date and decided to hold the "drug meeting" at the EMS Symposium in Myrtle Beach.

With no further business, the meeting was adjourned.

AGENDA ITEMS NOT ADDRESSED OR CONCLUDED:

None

SUBCOMMITTEE ACTION NEEDED:

None

STAFF ACTION NEEDED:

- Make changes to thrombolytic checklist; notify field of approval
- Attempt to convince legislators to put equipment requirements in policy, rather than regulation
- Contact Florida about medication storage regulations
- Ask Earl Floyd to bring medication storage equipment information
- Email Training Committee dates to Medical Control Committee members for signup

MEDICAL CONTROL COMMITTEE MOTIONS

NOVEMBER 2002

- **(Information Only) The Medical Control Committee agreed by consensus that scene time determinations should be a local, individual policy and decisions.**

- **(Information Only)** The following redesignation decisions were confirmed by the Advisory Council by fax vote:

Dr. Norcross made a motion to redesignate Piedmont 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. Gerard seconded the motion. The motion passed.

Dr. Norcross made a motion to designate Marion County Medical Center as a Level III trauma center under Designation Option #1 1 ("To designate the hospital as a trauma center. The hospital has everything required and is designated with no questions or problems.") Dr. Gerard seconded the motion. The motion was approved.

- Prehospital Thrombolytics

Dr. DesChamps presented the Retavase checklist developed by Greenville during the pilot project. He said that is an "inclusion/exclusion checklist", a "thrombolytic therapy" text page, and two flow sheets. He said that when the Committee approved statewide thrombolytics, that Greenville's protocols and checklists would be adapted and used statewide.

The was discussion about if there is a "yes" answer to any of the above in the checklist, then medical control should be contacted for instructions.

Dr. DesChamps said that the Committee agreed that the Retaplase recombinant checksheet will be amended to say that any "yes" must be reported to medical control and a direct order must be received for thrombolysis. Dr. Gerard said that the title should be changed to "checklist" instead of "inclusion/exclusion".

Dr. Fuerst made a motion to accept the checklist as amended. Dr. Sorrell seconded the motion. The motion passed. Dr. Norcross abstained from voting.

- **Change of Administration of Valium**

Motion to change the route of administration of Valium to add IM, and add CANA kit auto-injector or 10 mg IM as a one-time dose in suspected terrorist event. Dr. Rogers seconded the motion. The motion passed.

- **Changes to required equipment (esp. re: helicopters)**

Dr. DesChamps asked if staff had determined whether the repair equipment required of ambulances could be taken off the requirement list for helicopters. Mr. Catoe said that Mr. Horton had been checking into that, but they had not made a determination.

There was discussion about how difficult it is to make changes in equipment requirements when they are in regulation, not policy, but that in the past, legislators have wanted to leave the equipment requirements in regulations.

The Committee agreed by consensus that the EMS Division should try again to convince the legislators to change equipment to policy rather than regulations.

- **Equipment storage (Information Only)**

Dr. Sorrell said that Florida passed a regulation that drugs must be kept in a controlled environment, and that maybe it is time for South Carolina to consider doing that. Dr. Sorrell said that the issue is not whether the drugs should be kept in a controlled environment, but what is the cost and how hard is it to do this?

Dr. Sorrell suggested contacting Florida regarding their guidelines. Dr. Rogers said that Earl Floyd with Marion County EMS reported that it costs about $300-400 to buy a storage unit. Dr. DesChamps said there would be additional costs in separating controlled and non-controlled drugs.

Dr. Rogers volunteered to ask Earl Floyd to bring the information to the Symposium. The Committee asked DHEC EMS to contact Florida about their regulations.

FEBRUARY 2003

- **Motion to add the use of amiodarone for clearly unstable and pulseless v-tach and v-fib in pediatrics in the appropriate pediatric dose. The motion was seconded. The motion was approved.**

- **Motion to add the use of amiodarone for stable and perfusing rhythms in both adults and pediatrics. He said that indication would require direct medical order. Dr. Burger seconded the motion. The motion passed.**

- **Motion to approve Xopenex in the same format as Albuterol. Dr. DesChamps seconded the motion. The motion was approved.**

- **Motion to add Atrovent as written, for all ages and groups. In note section add "can be mixed with Xopenex and albuterol", one dose per standing order; any repeat doses with Atrovent require direct medical order. Dr. Sorrell seconded the motion. The motion passed.**

- **Change in Interfacility Form**

There was discussion that EMS providers should understand that if their EMT's do not have a signed interfacility form or direct medical orders to titrate drugs, then they should refuse to transport or the EMS provider could lose their license.

Dr. Norcross made a motion to change the language of the interfacility form to allow medications begun prior to transport to be titrated up or down for effect only with direct medical order (written or verbal). Dr. Sorrell seconded the motion. The motion passed.

- **Solumedrol Pilot Project (Information Only)**

Fort Mill Rescue Squad submitted a request for a pilot project using Solumedrol in the prehospital setting to begin early treatment of bronchoconstriction, since transport times for Fort Mill Rescue Squad can be lengthy. Fort Mill's average transport time is 25 minutes. The medical control physician, Dr. Joel Haling, would like to determine if early administration of Solumedrol would keep chronic asthma patients from being admitted.

The discussion to approve the pilot project was tabled until a Medical Control Committee meeting with greater attendance and until further information was available about the use of Solumedrol in the prehospital setting in other parts of the country.

- **Changes to Special Purpose Drugs**

Dr. DesChamps said that Dr. Ralph Shealy had asked the Medical Control Committee to review revising a few drugs. Dr. DesChamps said that under Cyanide Poisoning both sodium nitrite and sodium thiosulfate call for direct medical order. He said that if someone had cyanide poisoning, the EMS personnel don't need to wait for a physician's approval to administer the antidotes. **Dr. DesChamps asked Dr. Sorrell and the Committee if this requirement should be removed and it was agreed to do that. He said that for organophosphate poisoning, atropine sulfate, sodium nitrite and sodium thiosulfate and also pralidoxime should also be changed to standing order. All are drugs listed on the special purpose drug list. The Committee agreed by consensus to put these drugs on standing order.**

- **Question re: blood transfusion (information only)**

Mr. Winn of Meducare said that twice in the last month, trauma patients that they had been transporting ran out of the blood that was hung and even though they were carrying additional blood that had been cross typed and matched, they couldn't hang it.
Mr. Winn said that he was told that under the nursing act in state law only RN's can initiate blood, but he said that he could not find that law.

Dr. DesChamps asked staff to contact other states to find out what their policies are. One of the guests (unable to identify voice from tape) volunteered to do a net search on other states' policies.

- **Change to Interfacility List (Surgically Implanted Tubes)**

Mr. Winn said he had another issue that he was requesting a response for. He said that in transporting continuous feeding tubes, in the protocol it says that continuous feeding should be discontinued. He said that they transported a 5 year old who was paralyzed to Atlanta, a four to five hour drive (air transport not available). The child had a tube and trach and had to be continuously hydrated. Mr. Winn said he couldn't find why this was restricted.
The Committee agreed to change the interfacility list to reflect that NG tube feeding should be discontinued during transports and that surgically implanted tubes can be continuous feed.