

# MEDICAL CONTROL COMMITTEE

## MINUTES

**March 4, 2004**

<u>Members present:</u>	<u>Others present:</u>
Dr. Ed DesChamps, Chairman	Timothy A. Pitko, Berkeley County
Dr. Rich Rogers	Alice Ammons, RN, Palmetto Richland
Dr. Bill Gerard	Jim Catoe, DHEC EMS
Dr. John Sorrell	Paul King, Fort Mill Rescue
Dr. Doug Norcross	Phyllis Beasley, DHEC EMS
Dr. Raymond Bynoe	

### MINUTES FROM NOVEMBER 20, 2003

**There was a motion to approve the minutes of November 20, 2003, with the correction of a typographical error on page 5. The motion was seconded. The motion was approved.**

### RSI AGE LIMITATIONS AND REVISION

The question about age limits for RSI had been raised by Dorchester County EMS. Dr. DesChamps said that the age limits for pediatric are different for many organizations; some set the limit at 21, some based on physical appearance.

Ms. Beasley noted to the Committee that Dr. Fuerst, the pediatric representative on the Committee who was not in attendance, had sent an email to be shared with the Committee that he did not feel that RSI should be used on pediatric patients. But, she noted, he did not provide his definition of a pediatric patient.

Since Dr. Fuerst was not present, the Committee decided to wait to address a definition of pediatric. They then began to address some general changes in the RSI program.

Dr. Sorrell said that when services call for RSI information, the old Lancaster County pilot project information is what is being sent out and it needs to be revised. He said that he and Dr. Gerard addressed several points that needed to be updated. He said that both he and Dr. Gerard felt that the original 12 hour training requirement should be reduced to 4 to 5 hours of training with an optional airway component, if needed.

Drs. Sorrell and Gerard recommended the following RSI training requirements:

- Art of RSI - one hour
- Airway Management/Rescue Airway Devices- one minimum to four hours maximum (local option based on previous airway training)

- Decision making and evaluation - two hour

Drs. Sorrell and Gerard commented that the previous requirements to practice RSI would not change: have to be a paramedic for one year; and have to practice intubation skills for two years.

*Drs. Sorrell and Gerard provided additional changes to the RSI protocols, including corrections to the drugs and doses in the original Lancaster County proposal. Changes include the dosages for Midazolam and Etomidate and the systolic pressure indications. The EMS staff will make those corrections and mail out the changes. Corrections will also be made in the RSI drug notes in the state formulary to match these changes.*

There was then much discussion about monitoring O<sub>2</sub> sats and reporting. Dr. DesChamps suggested that a QA spread sheet should be developed to be emailed to participating services for them to fill out periodically and send back to the EMS Division.

*Dr. DesChamps reiterated that on the review sheets already used, adding beginning SPO<sub>2</sub>, ending SPO<sub>2</sub>, lowest SPO<sub>2</sub> and time of procedure. He said that he would get with Mr. Catoe to develop the spreadsheet and send it out to the services with a memo requiring them to complete the information.*

**Dr. Norcross made a motion to accept the RSI changes proposed, (see attached document) including modifications proposed by the Committee, by Dr. Sorrell and Dr. Gerard. The motion was seconded. The motion passed.**

The Committee agreed to leave the RSI age limit at 18 until the statewide data has been reviewed. Dr. DesChamps said that an overall age definition for pediatrics needs to be established for EMS. It was suggested that DHEC contact Dr. Greg Meares in NC regarding the age limit for RSI, and to post on listserves to see what other states are doing.

### CANNA KITS

Dr. DesChamps introduced Wilbur Harling, Director of the Drug Control Division of DHEC to answer questions concerning drug regulations as they relate to the CANNA kits being distributed by the BT planning programs.

Mr. Harling said that his division has already developed procedures for the distribution and storage of COBRA kits. For EMS, the same rules apply as for regular controlled drugs. To transfer the drugs from the BT program, records should be kept about the transfer. Mr. Harling provided a document with guidelines.

The record of transfer of CANNA kits to EMS services should include: the DEA registration from the source; and the DEA registration form to the receiving agency. EMS should maintain these records for two years, monitor the temperature of the drugs, and the drugs must be secured and inventoried quarterly.

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## TRAUMA SYSTEM REPORT

Dr. Norcross reported that three of the Level I trauma centers had undergone redesignation reviews during December and January with out-of-state site review teams. At its meeting just prior to the Medical Control Committee meeting, the Trauma System Committee reviewed the site reports for Spartanburg Regional Health Care Center, Palmetto Richland Hospital and Greenville Memorial Medical Center.

The Trauma System Committee had earlier passed a recommendation to redesignate Spartanburg Regional Healthcare Center as a Level I trauma center based on the site report provided by the out-of-state review team from the hospital's review in December.

**Dr. Norcross made a motion to redesignate Spartanburg Regional Health Care Center as a Level I trauma center. The motion was seconded by Dr. Rogers. The motion was approved.**

Also based on the recommendations of the Trauma System Committee from its earlier meeting, **Dr. Norcross made a motion to approve the redesignation of Palmetto Richland Hospitals as a Level I trauma center under redesignation option 2 (to designate the hospital as a trauma center, but with the understanding that the hospital will correct the problems noted and report them to the Committee within 90 days. The hospital has the important essential items, but needs some minor changes/improvements. After 90 days, the evidence submitted by the hospital of effort(s) to correct the problems will be reviewed and the hospital will be placed in category 1 or 3) Within 90 days, the following weaknesses should be addressed by the hospital:**

- **Show that the trauma PI has a link and is part of the hospital PI process**
- **Show that the Trauma Multidisciplinary Committee is a formal standing committee and has authority in the hospital.**

**The motion was seconded. The motion passed. Drs. Gerard and Bynoe abstained from voting.**

The last hospital to be reviewed for redesignation was Greenville Memorial Medical Center.

**Dr. Norcross made a motion (based on the recommendation of the Trauma System Committee) to recommend the redesignation of Greenville Memorial Medical Center as a Level I trauma center under redesignation option 2 (to designate the hospital as a trauma center, but with the understanding that the hospital will correct the problems noted and report them to the Committee within 90 days. The hospital has the important essential items, but needs some minor changes/improvement. After 90 days, the evidence submitted by the hospital of effort(s) to correct the problems will be reviewed and the hospital will be placed in category 1 or 3.) Within 90 days, the hospital should submit a plan for addressing the PI issues cited in the site report:**

- **The trauma program’s performance improvement program is basic; there are problem identification issues. The basics are in place, but the next steps need to be taken. Corrective action planning and resolution is not being accomplished. In trauma M&M’s, there are cases left blank with no documentation of resolution (or “closing the loop”). The issues that are identified should be used to make the system of trauma care delivery better.**
- **The hospital is only looking at deaths and the few required state audit filters. A system needs to be in place to identify filters so that the means to make the system better can be implemented. Missed injuries should be reviewed through the M&M Committee.**
- **The program needs to begin reviewing complications.**

There was discussion by the Committee about the site report and the recommendations to expand the hospital’s PI process.

- **The motion was amended to include evidence of support for a multidisciplinary approach to PI.**

**The motion was passed.**

## **PILOT PROJECTS**

### **SOLUMEDROL**

Dr. Gerard said that Solumedrol either needs to be on the state formulary or not; it does not need to be conducted as a pilot project.

Dr. Sorrell said that the drug takes five hours for effect and the philosophy is to start the drug in the prehospital setting as soon as possible.

The Committee was in agreement to add Solumedrol to the drug formulary and discussed the dosage.

The Committee determined that the dosage should be: 125 mg IV for adults and 1 mg/kg for pediatrics. Dr. Sorrell reiterated that the use of the drug should be local option.

**Dr. Gerard made a motion to add Solumedrol as a local option drug for use with standing order, 125 mg IV for adults and 1 mg/kg IV for pediatrics. Dr. Sorrell seconded the motion. The motion passed. Dr. DesChamps reiterated that the indication for its use is asthma, bronchospastic airway disease, and anaphylaxis.**

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## INTRAOSSIOUS CANNULATION

Berkeley County has proposed the use of intraosseous cannulation as a last ditch effort for IV's in adults, specifically the use of the Bone Intraosseous Gun (B.I.G.) device. They have already begun training for it and the cost is \$60.

The only other intraosseous procedure that was being used was the pilot project for sternal intraosseous, and that pilot project is no longer being conducted.

Timothy Pitko from Berkeley County explained that the B.I.G. device has the 18 gauge and the 15 gauge. He estimated that the service might use the device once a month.

Dr. DesChamps asked what cc's can be infused. Mr. Pitko responded that 5 cc and 2cc, with an average of 3cc. A representative from the company that manufactures the device said that under pressure infusion you can administer 100cc an hour. She said that all medications that be administered by this route.

The intraosseous cannulation is appropriate for use in arrest or hypovolemic shock.

The 18 gauge device is for pediatric use and the 15 gauge is for adults. The adult device cannot be adjusted and it is blue, making it easy to identify. The device is designed for pediatric use ages 12 and under.

**Dr. Norcross made a motion to approve intraosseous cannulation for all ages with an age appropriate FDA-approved device as a local option. Indications for its use are any life-threatening situation and for approved method of use. Dr. Gerard seconded the motion. The motion passed.**

**The state will develop training modules for each device.**

## DIVERSION ISSUES

Dr. DesChamps explained that there have recently been a lot of problems with hospitals going on diversion and telling EMS they are not accepting patients.

He said that many years (1989) the EMS Division issued a memo that said that a hospital that is encoded by a service is required to accept that patient or to find an appropriate facility to accept that patient.

Dr. DesChamps said that recently Mr. Smith and Ms. Beasley met with Flo Tomboken of DHEC who handles EMTALA complaints. Ms. Beasley said that one of the questions they addressed to Ms. Tomboken was whether the 1989 memo was appropriate. Ms. Beasley reported that Ms. Tomboken said that the EMS Division does not have the authority to tell hospitals that they have to locate other hospitals for EMS to transport to. She said that they are now waiting for verification on that from the Legal Department.

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There was discussion about the fact that if EMS shows up on the hospital's doorstep, they must accept the patient, but if EMS encodes the hospital, there is no EMTALA or other legal requirement that the hospital call around and find another hospital for EMS to transport to.

There was also discussion about hospitals being closed to outside counties, but taking patients within their own counties. Ms. Beasley and Mr. Smith reported that, according to Ms. Tomboken, if a hospital is accepting patients at all, they must accept from any county; it is an "all or nothing" requirement.

There was discussion about the fact that hospitals go on diversion for a variety of reasons. Dr. Sorrell said that hospitals should not be allowed to unilaterally go on diversion because there is not a standardized reason of why hospitals go on diversion; some legitimate, some not. He said that a patient is better off at an ER than in the back of an ambulance and that the EMTs should encode the hospital and if the hospital cannot take the patient, they should find another hospital that can. It should not be up to the medics to have to ride around and find another hospital.

Dr. Bynoe said that his hospital is called by many counties, often for injuries and illnesses that are not severe or appropriate for bypassing local hospitals. He said that it is appropriate for his hospital to be called for severe traumatic injuries, but not for the lesser injuries or illnesses.

Dr. DesChamps said that what can not happen is for smaller services, particularly small services in counties without hospitals, to be locked into a situation where they have nowhere to go.

Dr. Norcross reiterated that in the case of Dr. Bynoe and Palmetto Richland, if there is a Level III trauma center in a county, then EMS should not bypass the Level III to go to a Level I.

Dr. Norcross asked about the policy that was implemented several years ago about the trauma directors signing off on EMS trauma protocols.

Paul King from Fort Mill cited problems associated when a hospital does not go on diversion and continues to accept patients. He said there have been incidents when Piedmont Medical Center does not go on diversion and EMS has long waits at the hospital until a nurse can take over care of the patient.

There was much discussion about all the issues/requirements surrounding hospitals going on diversion.

Ms. Beasley pointed out that diversion is one of the main reasons that the bed capacity tracking web site is being implemented; as a communication tool for hospitals and EMS.

There was discussion that the Hospital Association should be involved in coming up with a solution to this problem. The Committee agreed, though, that direction needs to be provided to EMS and when the hospitals realize that EMS will come to them unless other arrangements have been met, and then the hospitals may begin to work on solutions for these issues.

The Committee determined although the EMS Division cannot require hospitals to address diversion, the EMS Division can provide direction to the EMS providers.

**The Committee agreed by consensus that a memo should be sent to the EMS providers telling them that they should take the patient to the nearest appropriate hospital unless the receiving hospital has made other arrangements.**

### **MEDICAL CONTROL PHYSICIAN RECERTIFICATION**

Ms. Beasley asked the Committee to address the issue of the annual recertification requirement for medical control physicians. She said that since she took over the Trauma/BT planning job, she does not have the ability to monitor the recertifications and staffing at the EMS Division has been cut/frozen. She said that during the last six months, when the conscientious physicians call her about recertification, she has been telling them that she can not monitor and has not been keeping up with it, so that they do not take time out of their busy schedules to attend a workshop or read minutes for a requirement that no one will ever monitor. She said that she felt like the conscientious physicians were being penalized for their efforts, but the majority of physicians who have been traditionally difficult to track were not being penalized.

Ms. Beasley suggested an alternative to keep medical control physicians up to date on policy changes. She suggested that a medical control physician email group be formed so that memos and medical control committee minutes could be sent out electronically to keep physicians up to date, but not attach a requirement that would have to be monitored to this.

**She requested that the Medical Control Committee allow her to send out a memo to the medical control physicians explaining that the recertification requirement had been suspended until there is adequate staff in the EMS Division to monitor the requirement, but offering medical control physicians the opportunity to receive pertinent information by email.**

**The Committee agreed that Ms. Beasley could send out the memo and that it should be signed by both Mr. Smith and Dr. DesChamps.**

Dr. DesChamps expressed his disagreement with this decision and felt that staff should be dedicated to continuing to implement this requirement. Mr. Smith explained that he does not even have adequate staff to inspect ambulances and services. He said that the Division should be blunt and express in the memo that the reason the policy has been suspended is because of continuing budget and staffing cuts.

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**VERAPAMIL**

Dr. Rogers asked to bring up a request by one of the small services that presented to his ER. He said that they requested that verapamil be put back on the state formulary because adenosine is so expensive. Dr. DesChamps pointed out that no one had submitted a drug request to do that this year. The Committee could consider that request if a drug request is received.

**IST SIGNOFF**

Mr. Smith asked the Committee about instances in which the medical control physician and the assistant medical control physician of an EMS service with an IST program resign. He said that a new medical control physician can serve, but until he has taken the medical control physician workshop, he cannot sign off on the IST program. The medics that have been in that IST program for three years would lose their credits. He asked the Committee if it would be possible to look at these issues on a case-by-case basis to allow medical control physicians, depending on the circumstance, to sign for IST even if they have not had the workshop. Dr. DesChamps said that this is a DHEC administrative policy and the Committee has never governed that kind of decision.

With no further discussion, the meeting was adjourned.

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**AGENDA ITEMS NOT ADDRESSED/RESOLVED:**

- Consideration of blood exchange by EMT-P's
- Consideration of Critical Care Paramedics as a state skill/certification
- Approval of COBRA protocols

**COMMITTEE ACTIONS/REPORTS NEEDED:**

None

**STAFF REPORTS/ACTIONS NEEDED:**

- Present list of Critical Care Paramedic skills/drugs for Committee to review
  - Find out if those skills need Board approval
  - Find out how long Critical Care Paramedic certification lasts
  - Find out the recommended Critical Care Paramedic course
- Revise RSI document with protocol and drug changes
- Update drug list to include Solumedrol

- Develop training module(s) for intraosseous cannulation devices
- Send memo to field re: approval of intraosseous cannulation devices as local option
- Send memo to field regarding transport of patients when hospital goes on diversion
- Send memo to field regarding suspension of recertification requirement for medical control physicians

# Medical Control Committee

August 19, 2004

## Minutes

<u>Members Present:</u>	<u>Others Present:</u>
Dr. Ed DesChamps, Chairman	Alonzo Smith, DHEC EMS
Dr. James Mock	Jim Catoe, DHEC EMS
Dr. Mac Nowell	Robert Winn, Meducare
Dr. Raymond Bynoe	Russell Ward, Meducare
Dr. Doug Norcross	Doug Rorie, First Health
Dr. Ron Fuerst	Matt Morris, Lee County EMS
Dr. John Sorrell	Greg Kitchens, Lee County EMS
	Sharon Powell, Life Reach
	Debbie Couillard, RN, MUSC

### PEDIATRIC AGE DETERMINATION

The discussion regarding allowing RSI to be used on pediatrics had been postponed from an earlier meeting, because no pediatric medical representative was present. Dr. Fuerst was present at this meeting and was asked to address what the pediatric age/weight cutoff was considered. He responded that, generally, less than 55 kg/112 lb. He said that he would come back with a recommendation at the next meeting.

### MINUTES

There were no corrections to the minutes from the meeting of March 4, 2004. **Dr. DesChamps made a motion to approve the minutes. The motion was approved by consensus.**

### STATE APPROVED PROTOCOLS

Dr. DesChamps passed out the old protocols for adult patients to Committee members and asked them to review the protocols for discussion at the meeting that is usually held at the EMS Symposium. He asked Committee members to send comments and additions to Ms. Beasley.

Dr. Fuerst said that the pediatric protocols were revised five years ago and that they may need to be reviewed also. He said that those protocols are also included in the handout.

### LEGAL PROTECTION FOR COBRA TEAMS

The question had been raised about whether COBRA teams had legal protection. Ms. Beasley explained that since COBRA teams are not a DHEC function, it is out of DHEC's realm to

provide legal protection for those teams. Mr. Catoe suggested that EMD would be the agency responsible for providing legal protection. Ms. Powell said that she was removed from the COBRA team because of a lack of legal protection.

### **COBRA PROTOCOLS**

This approval was delayed because of the absence of Dr. Burger. Dr. Burger was to get with Dr. Steve Shelton and determine whether they both felt that the protocols were appropriate.

### **CRITICAL CARE PARAMEDIC (CCP)**

The question had been brought up at an earlier meeting about whether to remove Critical Care Paramedic from pilot project status to approval as a state skill/certification. Mr. Smith recommended that EMS incorporate the CCP skills and allow anyone to take the course, but not set up a separate certification until “advanced practice” paramedic standards are developed nationally.

Mr. Winn commented that his services require five years’ experience as a paramedic to become a CCP, but that the didactic training required in the course is minimal and that worries him.

There was much discussion about the requirements and the skills related to CCP.

**A motion was made to approve the CCP as a state certification using the protocols and standards of the pilot project. Dr. Sorrell seconded the motion.**

**There was further discussion. Dr. Norcross then clarified the motion to allow EMS services to train providers based on establishing a CCP service. The motion was tabled until the Committee can review the original CCP documents.** *Staff was asked to send the original documents and reports related to CCP. Staff was asked to request that Dr. Burger present the information.*

### **TRAUMA SYSTEM COMMITTEE REPORT**

**Redesignations of Greenville Memorial Medical Center, Palmetto Richland Hospital and MUSC.**

Dr. Norcross reviewed the actions/motions of the Trauma System Committee that included a motion to proceed with the development of the Trauma Advisory Council, as outlined in the Trauma Care Act. This Council would be on equal “footing” as the EMS Advisory Council and act in an advisory capacity directly to the EMS Director. He also reported that Mr. Frishman, deputy commissioner of Health Regulations, presented the process for developing regulations. He advised that the Committee begin reviewing regulations and start the groundwork for developing regulations prior to the approval of funding for the system because of the length of time it takes to go through the formal regulatory approval process.

(Although not mentioned in the Medical Control Committee meeting, the Trauma System Committee also agreed to form a BT/Mass Casualty subcommittee after the Trauma Advisory Council is established.)

Dr. Norcross then addressed the recommendations to approve the redesignations of Level I trauma centers. Dr. Norcross explained that Greenville Memorial Medical Center and Palmetto Richland Hospital provided documentation at the Trauma System Committee to meet the earlier requirements to fix the deficiencies listed. The Trauma System Committee felt that both hospitals met the requirements and voted to finalize the Level I redesignations for both hospitals.

**Based on the motions/recommendations of the Trauma System Committee, Dr. Norcross made a motion to approve Greenville Memorial Medical Center as a Level I trauma center under Redesignation Option 1 (the hospital has everything required and is designated with no question or problems), after presenting the corrections requested by the Trauma System Committee. The motion was seconded. The motion passed.**

**Also based on the motions/recommendations of the Trauma System Committee, Dr. Norcross made a motion to approve Palmetto Richland Hospital as a Level I trauma center under Redesignation Option 1 (the hospital has everything required and is designated with no question or problems), after presenting the corrections requested by the Trauma System Committee. The motion was seconded. The motion passed. Drs. Fuerst and Bynoe abstained from voting.**

Because the next area of discussion involved his hospital, Dr. Norcross excused himself from further discussion.

Dr. DesChamps then explained to the Committee that at the last Trauma Committee meeting, the Committee had reviewed the site report for MUSC and had made a recommendation for redesignation under Redesignation Option #2 (to redesignate the hospital as a trauma center, but with the understanding that the hospital will correct the problems noted and report them to the Committee within 90 days. The hospital has the important essential items, but needs some minor changes/improvement. After 90 days, the evidence submitted by the hospital of effort(s) to correct the problems will be reviewed and the hospital will be placed in Category 1 or 3). The Committee cited the following as weaknesses that needed to be addressed:

- Comply with the documenting of attending surgeons response to the ED
- In the PI process, show documentation regarding the need for action and what actions were taken for a specific case".

Dr. DesChamps then explained to the Committee that MUSC submitted their responses to this redesignation requirement and staff had asked that the Trauma System Committee vote by email regarding the resolution of the requirements. This was requested because of the transition between the Trauma System Committee to the Trauma Advisory Council. This transition would cause an extensive delay to resolving the redesignation of the hospital, if further action by the Trauma Committee/Council had to wait until the next called meeting. Dr. DesChamps reported

that a majority of Trauma System Committee members responded by email that they approved MUSC's written responses to the requirement.

Based on the responses of the Trauma System Committee members, Dr. DesChamps asked if the Medical Control Committee would consider the redesignation of MUSC under redesignation Option 1 (the hospital has everything required and is designated with no question or problems).

Dr. Sorrell said that he had filled in for Dr. DesChamps at the site review, and reported that the site team's comments during the review were very positive.

**Dr. Bynoe made a motion to redesignate MUSC as a Level I trauma center under Redesignation Option 1 (the hospital has everything required and is designated with no question or problems). Dr. Fuerst seconded the motion. The motion was approved. Dr. Norcross abstained from voting.**

### **BLOOD EXCHANGE DURING TRANSPORTS**

This was a continuation of a discussion begun several meetings earlier. Dr. DesChamps reviewed the comments about this issue provided by the Red Cross. Those comments were:

- Is there enough staffing to monitor the patient on the ambulance?
- Is the ambulance the best place to handle an adverse reaction that may occur such as a trolley(??) or bacterial infection?
- Suggest that the Medical Control Committee get a copy of a hospital protocol for blood transfer and see if EMS could handle all the steps.

Mr. Catoe said that North Carolina does not allow blood transfer, but Alabama does. Alabama is sending a copy of their protocols.

Dr. Bynoe said that the weight of okaying the transfer should be on the sending hospital, as well as the EMT-P.

Dr. DesChamps summarized the discussion by saying that there does not appear to be a lot of objections to the procedure, just requests to develop QI and protocols, especially related to reporting, nurses signing off on the blood, etc. Dr. DesChamps suggested that a subcommittee be developed to make recommendations.

**Dr. Norcross volunteered to be on that subcommittee with Robert Winn of Meducare and a hospital blood bank representative from MUSC.**

### **IO PROTOCOL – Dr. Gerard**

This agenda item was postponed until Dr. Gerard is present.

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**ADMINISTRATION OF ALBUTEROL BY MDI OR HANDHELD NEBULIZER BY EMT-B**

Mr. Smith said that, with current approved skills; EMT-B's can only "assist patients" in administering drugs that the patient already has.

Dr. Mock asked if EMT-B's can treat complications of arrhythmia from the treatment. The Committee answered "**no.**" Then, he said, the EMT-B's should not be allowed to administer albuterol.

Dr. DesChamps emphasized that there needs to be clear cutoffs between certification levels.

**Dr. Norcross made a motion to allow EMT-B's to administer albuterol by MDI or handheld nebulizer. Dr. Mock seconded the motion. All opposed; the motion failed.**

**SAFETY OF NITROGLYCERIN FOR ARTERIAL HYPERTENSION**

Dr. DesChamps said that awhile back hypertension was taken off as an indication for nitroglycerin. However, lately he has gotten several requests to reinstate this indication.

Dr. Norcross said that Labetalol is the drug to treat hypertension and it is in the formulary.

Dr. DesChamps said that most of the time, hypertension does not need to be treated, even in instances of stroke.

**Dr. Mock made a motion to allow hypertension as an indication for nitroglycerin. Dr. Norcross seconded the motion. All opposed; the motion failed.**

Dr. DesChamps said that there is no need to bring down hypertension just because. He said that if there is pain, then nitroglycerin is used anyway.

*The Medical Control Committee asked staff to send out a memo regarding this motion and why it was declined (for education).*

**LIDOCAINE VS. AMIODARONE**

Dr. DesChamps said that the question had come up about the expense and difficulty of using Amiodarone for ventricular arrhythmia. Dr. DesChamps said that both drugs are on the state formulary and which to use is a matter of choice by the individual service.

**Dr. Sorrell said that he thought that in protocols amiodarone is listed. The Committee agreed by consensus that the protocols are guidelines only---lidocaine can be used if preferred by the service and works as well as amiodarone.**

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### **LABETELOL BY STANDING ORDER**

Dr. DesChamps said that he has gotten inquiries about allowing Labetalol by standing order. He said that the drug formulary calls for Labetalol to allow “infusion only with direct medical order.” He said he doesn’t remember why the Committee required direct medical order for the initial bolus. He asked if the initial injection should be opened up to standing order.

Dr. Sorrell said that he is worried that people would be giving it for high blood pressure only.

Dr. DesChamps asked if the Committee should amend the indications to include acute coronary syndrome.

Dr. Mock asked if Labetalol is indicated in the acute therapy for severe hypertension? The Committee answered “yes”.

**The Committee agreed by consensus to leave the formulary as is: leave Labetalol use for severe hypertension and acute coronary syndrome restricted to direct medical order.**

*Dr. DesChamps said that he would check with AHA and ACC.*

### **DISCUSSION OF DOSAGE OF VERSED IN RSI**

Mr. Allen Hayes brought up the issue that there is conflicting information regarding the Versed dosages in the RSI protocol and the formulary. He said he would like to see Versed stay at 5 mg for the initial does in RSI. He said the RSI protocol says 2.5 mg maximum dose.

Dr. DesChamps said that the revised RSI protocol should be 5 mg.

Mr. Haynes said he wants to see the age limit for RSI lifted or expand it to pediatrics as a pilot project, or the Committee needs to readdress allowing LMA’s on patients under age 12.

Dr. Sorrell recommended using Etomidate over Versed because of blood pressure problems with Versed.

Dr. DesChamps said he will ask Dr. Gerard to review the RSI protocols for consistency with the drug formulary.

This will be brought up at the next Medical Control Committee.

*The next meeting of the Medical Control Committee is scheduled for Thursday, November 18 in the second floor conference room of the DHEC Building at 1777 St. Julian Place, Columbia.*

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**AGENDA ITEMS NOT ADDRESSED/RESOLVED:**

- IO Protocol – Dr. Gerard
- Consideration of Blood Exchange by EMT-P's
- Consideration of Critical Care Paramedics as State Skill/Certification
- Approval of COBRA Protocols
- Discussion of dosage of Versed in RSI

**COMMITTEE ACTION/REPORTS NEEDED:**

- Report regarding recommendations of implementation of Critical Care Paramedic as State Skill/Certification: Dr. Burger
- Blood Exchange Subcommittee Report: Dr. Norcross
- Report regarding Labetalol for severe hypertension and acute coronary syndrome according to AHA and ECC: Dr. DesChamps
- Corrections to RSI protocols: Dr. Gerard

**STAFF REPORTS/ACTIONS NEEDED:**

- Ask Dr. Burger to report recommendations regarding implementation of Critical Care Paramedic as state skill/certification. Mail copies of original critical care paramedic pilot project to Committee members.
- Send memo to field regarding decline of motion to allow hypertension as an indication for nitroglycerin, explaining why the motion was not approved.

# MEDICAL CONTROL COMMITTEE

## MINUTES

November 11, 2004

<b><u>Members Present:</u></b>	<b><u>Others Present:</u></b>
Ed DesChamps, MD, Chairman	Alonzo Smith
Mac Nowell, MD	Jim Catoe
Bill Gerard, MD	Leslie Woods
John Sorrell, MD	Greg Kitchens, NREMT-P
(Raymond Bynoe, MD)	

*At the time of the meeting, no quorum was achieved. Dr. Bynoe arrived just prior to the end of the meeting; therefore, no action was enabled on the agenda items. The minutes presented below are for information only.*

### MINUTES FROM AUGUST 19, 2004

A motion was made to approve the minutes as presented. The motion was seconded. The motion passed.

#### **OLD BUSINESS:**

##### **IO PROTOCOL: DR. GERARD**

Dr. Gerard made a motion to approve the IO protocol as presented, but there was no quorum to act on the motion. Item postponed to next Medical Control Committee meeting.

##### **BLOOD EXCHANGE SUBCOMMITTEE REPORT: DR. NORCROSS**

Dr. Norcross was not present to give the report. The item was postponed to the next Medical Control Committee meeting.

##### **CONSIDERATION OF CRITICAL CARE PARAMEDICS AS STATE SKILL/CERTIFICATION: DR. BURGER**

Dr. Burger was not present to give the report. The item was postponed to the next Medical Control Committee meeting.

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**APPROVAL OF COBRA PROTOCOLS: DR. BURGER**

Dr. Burger was not present to give the report. The item was postponed to the next Medical Control Committee meeting.

**DISCUSSION OF DOSAGE OF VERSED IN RSI: DR. GERARD**

Dr. Gerard said that the dosage should be .5 mg up to 2.5 mg for the initial dose in RSI.

Dr. Sorrell suggested that if the patient is unconscious, the use of Versed may be omitted or you may use Versed and Etomidate only on conscious patients.

Dr. Gerard suggested that there be additional training for the use of Versed and Etomidate. Dr. Nowell said the use of Versed is common in Massachusetts; systems in the north could offer input on training.

Dr. Sorrell said that Etomidate is easier to use than Versed.

Dr. Gerard said he would bring additional information to the next meeting.

**REPORT REGARDING LEBETALOL FOR SEVERE HYPERTENSION AND ACUTE CORONARY SYNDROME, ACCORDING TO AHA AND ECC: DR. DESCHAMPS**

Dr. DesChamps stated that he was against the use of nitroglycerine for hypertension and that Labetalol should be left as a drug to be used only with on-line medical control.

This issue will be addressed again at the next meeting.

**PEDIATRIC DEFINITION: DR. FUERST**

Dr. Fuerst was not present to assist the Committee in defining the pediatric patient; the issue was postponed until the next meeting. The committee said that the definition of a pediatric patient must address age versus weight.

**NEW BUSINESS:**

**UPDATES OF STATE PROTOCOL GUIDELINES**

Mr. Catoe asked that if anything in the protocols needs changing to please forward those changes to him.

Dr. DesChamps said he will assign sections for each member to review and comment on. This issue will be addressed again at the next meeting.

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**CYANIDE POISONING DRUG (HYDROXOCOBALAMIN)**

This issue will be addressed again at the next meeting.

**QUESTION RE: RSI ON-LINE ORDER**

“A MEDEVAC has been called for a critical patient in the field. This patient’s condition is such that aggressive airway control is necessary (RSI). Our (Marlboro County Rescue Squad) protocol for RSI is only with on-line order. If we call our local ER and get the order for RSI, does this in turn mandate that the ordering ER physician assess the patient prior to a MEDEVAC transport? This would apply, of course, to any procedure requiring on-line order. It may also apply in the event that EMS feels a patient should go to a trauma center (within transport distance) instead of the local ER, but, an order for an on-line procedure has already been taken from the local ER.”

This issue will be addressed again at the next meeting.

**NITRO PACKS**

This issue will be addressed again at the next meeting.

**MCP’S SIGNATURES ON DHEC CERTIFICATION FORMS: DR. SORRELL**

Dr. Sorrell said that he was bringing this issue up because the medical control physician’s signature on the DHEC certification forms is too time consuming to sign and date every page. He asked if the physician could sign the first page. Mr. Smith said it would be possible to make this change and that he would look at the signature issue and get back with the Committee.

**MEETINGS**

Dr. DesChamps asked how often the Committee should have meetings. He asked that the members confirm their email addresses. He said that the next meeting would be set up by email and that it would probably be late January or early February for the annual drug meeting. *(An attempt was made to set up a meeting for late April, but staff was unable to confirm quorum. Another request has been set out by email to receive available dates from the members for a meeting in May or June. To date, March 31, 2005, no responses have been received.)*

**DIVERSION**

Dr. Sorrell asked to bring up the topic of diversion. He proposed that the Committee have a policy regarding diversion. He said that it is the hospital’s responsibility to take the patient, not the medics’ responsibility to find a place; it is wrong for a hospital to go on diversion.

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Dr. Bynoe said that other hospitals are refusing to take the overflow patients. He said that if you are a trauma center, then you are obligated to take these trauma patients. He asked that the diversion issue be brought to the next meeting. Dr. Bynoe said that these discussions must take place at hospital meetings as well as EMS meetings.

Dr. Bynoe also said that his hospital is having difficulty obtaining the run report sheets.

With no further discussion the meeting was adjourned.

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**AGENDA ITEMS NOT ADDRESSED/RESOLVED:**

- IO Protocol – Dr. Gerard
- Consideration of Blood Exchange by EMT-P's
- Consideration of Critical Care Paramedics as State Skill/Certification
- Approval of COBRA Protocols
- Discussion of dosage of Versed in RSI
- Blood Exchange Subcommittee Report-Dr. Norcross
- Report regarding Labetalol for severe hypertension and acute coronary syndrome according to AHA and ECC: Dr. DesChamps
- Pediatric definition: Dr. Fuerst
- Consideration of Updates of State Protocol Guidelines
- Cyanide Poisoning Drug (Hydroxycobalamin)
- Question re: RSI on-line order
- Nitro packs

**COMMITTEE ACTION/REPORTS NEEDED:**

- Report regarding recommendations of implementation of Critical Care Paramedic as State Skill/Certification: Dr. Burger
- Blood Exchange Subcommittee Report: Dr. Norcross
- Report regarding Labetalol for severe hypertension and acute coronary syndrome according to AHA and ECC: Dr. DesChamps
- Corrections to RSI protocols: Dr. Gerard

**STAFF REPORTS/ACTIONS NEEDED:**

- Send memo to field regarding decline of motion to allow hypertension as an indication for nitroglycerin, explaining why the motion was not approved.
- Report regarding MCP's signatures on DHEC recertification forms