MEDICAL CONTROL COMMITTEE

Minutes

May 26, 2005

Members Present:	**Others Present**:
Dr. Ed DesChamps, Chairman	Alonzo Smith
Dr. Doug Norcross	Jim Catoe
Dr. Carol Burger	Phyllis Beasley
Dr. Bill Gerard	Greg Kitchens
Dr. John Sorrell	Teddy K. Griffith
Dr. Mac Nowell	
Dr. Raymond Bynoe	
Dr. Jim Mock	

Agenda Item	Discussion	Action
Review of Minutes – 11/04	No approval needed; no quorum at that meeting.	
OLD BUSINESS		
IO Protocol – Dr. Gerard	There had been discussion at earlier meetings about allowing the use of all IO procedures, but a final decision had not been made. The Committee	Motion was made by Dr. Norcross to approve the local option use of any FDA-approved osseous device, used per

	reviewed earlier discussions and a motion was passed.	manufacturer's instructions. The site of cannulation to be determined by FDA approval. Dr. Burger seconded the motion. The motion passed. Staff to update the training protocol.
Blood Exchange Subcommittee Report – Dr. Norcross	Dr. Norcross stated that he never heard anything from the Meducare committee that had brought up this issue. The committee tabled the discussion until there is interest in the issue again.	None needed.
Consideration of Critical Care Paramedics as a State Skill/Certification – Dr. Burger	The Committee discussed the fact that Critical Care Paramedic is only being used by one service statewide, Meducare in Charleston. Dr. Burger said that Greenville stopped doing it because of a monetary issue. There was much discussion about certification (2 year) issues and skill issues.	A motion was made by Dr. Sorrell to take Critical Care Paramedic off pilot and make it local option. Any service participating in the Critical Care Paramedic program must send a yearly summary of the program's activities to the Division of EMS. The summary should include a roster of paramedics participating, verification of the paramedics current certification as a Critical Care Paramedic, which skills are being used in the program and documentation of CQI. The motion was seconded by Dr. Burger. The motion was passed.

Approval of COBRA protocols – Dr. Burger	Committee members said that this issue has been on the Medical Control agenda for several years. The person at the Emergency Management Division who had initially sought the approval of the Committee for their protocols has been gone from that Division. Dr. Burger said that the protocols looked fine to her, but would resend them. She said that since COBRA is a federal team, they really don't need the approval of the MCC. Dr. Gerard said he would like to review the protocols and offer approval. Dr. Sorrell agreed that the Committee should review the protocols and make suggestions.	Dr. Burger to send the proposed COBRA protocols to MCC members (or to Ms. Beasley for distribution to MCC members).
Discussion of Dosage of Versed in RSI – Dr. Gerard	The Committee discussed the use of succinylcholine and etomidate for sedation in RSI. Dr. Sorrell said that there is a county in the lowcountry that is just using etomidate and succinylcholine in RSI, and not Versed, if they can. He suggested that services should be allowed to not use Versed if the patient is unconscious. Dr. Gerard said that in textbooks, the use of paralytics is encouraged because the odds of intubation are better with paralytics. There was much discussion about the use of paralytics and sedation for head injured patients. Dr. DesChamps suggested that the Committee look at the literature and the New York protocols on this issue. The Committee agreed to table the discussion until Dr. Gerard could provide copies of studies conducted on this issue. There was also discussion about correcting	The Committee agreed by consensus that the RSI protocol should be corrected for Versed dosage based on the current drug formulary (.02 - .05 mg/kg, not to exceed 5 mg, after successful ET, may give up to 10 mg IV). The Committee agreed to re-visit airway management and use of Versed at the next meeting, after Dr. Gerard has provided literature on field intubation using sedatives/hypnotics without paralytics for intubation.

	the RSI protocol for Versed dosage based on the formulary.	
Pediatric Definition – Dr. Fuerst	Discussion tabled until Dr. Fuerst is available.	No action until Dr. Fuerst can present recommendation.
Updates of State Protocol Guidelines	The Committee agreed to hold the review until the next meeting.	No action taken.
Cyanide Poisoning Drug (Hydroxycobalamin)	A request was made for this drug, which is used in Europe, to be added to the list of Special Purpose Drugs. However, the Committee, by consensus, agreed that until it was FDA approved, it cannot be considered for addition to the drug list. The Committee recommends that services who need cyanide antidotes continue to use the approved Lilly kit.	Drug not approved.
Question re: RSI On-Line Order	At an earlier meeting the following question had been sent to the MCC: "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 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	Staff to notify Marlboro County Rescue Squad of answer to question.

	EMS feels a patient should go to a trauma center (within transport distance) instead of the local ER, but, an order for an online procedure has already been taken from the local ER." By consensus the Medical Control Committee agreed that no, the patient does not have to go to that (local) hospital prior to the Medevac transport. RSI can be standing order if it is okay on local protocol.	
Use of Nitro Paste (pads) for CPAP patients	A request had come from Lancaster County EMS to be able to use NTG paste when a patient is on CPAP because of the difficulty of spraying NTB in this situation. This would just be a change of route of a currently approved medication.	A motion was made by Dr. Sorrell to approve Nitro paste as a new route of administration for NTG, local option. Dosage would be ½ to 1" of paste in lieu of the Nitro spray. Dr. Gerard seconded the motion. The motion was approved.
NEW BUSINESS Drug Requests:		
Vasopressin (Pitressin) – Change in Use	A request was made by Dr. Dieringer of Kershaw County Medical Center EMS to allow the use of vasopressin for VF/asystole.	Dr. Gerard made a motion to allow the use of Vasopressin for asystole for any ACLS indication. Dr. Burger seconded the motion. The motion passed.
Ondansetron hydrochloride (Zofran) - Addition	There was a request to add Zofran by Greenville County EMS for the prevention of nausea and vomiting. There was much discussion about the high cost of Zofran and the number of drugs that	The request was tabled until the price of Zofran comes down.

	EMT-P's are already required to learn. Dr. Burger said that it is an option to phenergan that doesn't sedate and is alright for pregnant women to use. Dr. Sorrell suggested that it could be added as local option. The question was raised about whether the drug is really needed and that the DHEC Board would have to approve its use.	
Albuterol Sulfate (Ventolin / Proventil) – change in use	A request was made by Jasper County Fire/Rescue to allow the use of albuterol sulfate by handheld nebulizer or nebulizer mask or via ET tube with online medical control or standing order by EMT Basics. There was discussion that if this drug was allowed for Basics then other drugs would have to be opened up for use by Basics. The comment was made that albuterol has the potential to cause tachycardia and EMT-Basics are not trained to deal with this. The Committee also commented that the state should stay with national curriculum guidelines. Dr. Sorrell said that the request comes from a small service that does not have access to paramedics like the larger services. The comment was made that if this were allowed, it would re-define the scope of practice of EMT-B's and that their training is not adequate to allow this.	Dr. Norcross made a motion to approve the change of use of albuterol sulfate by allowing EMT-B's to initiate its use in the field. Dr. Bynoe seconded the motion. All were opposed; the motion failed. The suggestion was made that Jasper County Fire/Rescue submit a pilot project for the initiation of albuterol sulfate in the field by EMT-Intermediates.
Heparin – change in indication	Charleston County EMS submitted a request to add Heparin for use with patients with EKG-proven STEMI who are expected to undergo	Dr. Norcross made a motion to add Heparin to the drug formulary for patients with EKG-proven STEMI and with online

	PTCA or surgical revascularization (Class I) or are expected to receive TPA or Retavase (Class IIa) and to be administered only by direct order of a physician. Charleston County asked for this addition on the basis that heparin is administered to almost all STEMI patients who undergo PTCA or TPA or Retavase therapy. Most cardiologists recommend giving heparin as soon as possible. In regions of the state where transport times are long (>than 30 minutes), administering heparin to patients with proven STEMI may be life-saving. Dr. Sorrell said that this request was submitted on request by a cardiologist in Charleston. He said that since EMS is now able to send 12-leads to hospitals and since EMS is starting aspirin, this cardiologist suggested starting heparin. The recommendation for its use would be for ST elevation with online EKG transmitted to online medical control. Dr. Mock asked if we have a checklist for contra-indications for thrombolytics? There was discussion about the proper dosage.	medical control. The dose is a maximum of 4,000 IU. The use of heparin will be added to 12-lead and contraindication checklist. Dr. Burger seconded the motion. The motion passed. (Checklist to come from original pre-hospital thrombolytics pilot project.)
Request to carry magnets for malfunctioning ICD/pacer units	A request was made by Dr. Dieringer of Kershaw County EMS to allow EMS to carry magnets for malfunctioning ICD/pacer units. A recent case in Kershaw county where the ICD fired inappropriately and repeatedly was not able to be stopped until the unit reached the hospital. Dr. Dieringer provided a proposed protocol for the use	Dr. Sorrell made a motion to allow paramedics to carry magnets and to adopt Dr. Dieringer's protocol for the use of magnets for malfunctioning ICD/pacer units. The motion was seconded by Dr. Norcross. The motion was approved.

	of magnets. She stated that the patient would be on defibrillator/monitor and if the patient were to experience a dysrhythmia that required defibrillation, it could be done externally by the paramedic or the magnet could be removed and allowed to fire for the appropriate dysrhythmia. She also said in her request that the drug company is willing to provide the appropriate magnet for deactivation. The Committee agreed that this is a needed and appropriate request.	
Requirement of ambulances to keep medications in a controlled environment	This issue was brought up at a prior date, but was never resolved. Dr. Sorrell requested that the MCC re-address the issue of keeping medications in a controlled environment. Dr. Sorrell requested that Division of EMS mandate that ambulances keep medications in a controlled environment in new or refurbished ambulances and in a year or so, mandate this controlled environment for all ambulances. There was much discussion about climate controlled storage—that this does not necessarily mean the whole unit must be climate controlled. IT was discussed that drugs can move with the paramedics.	A motion was made by Dr. Sorrell that the Division of EMS mandate that all drugs will be kept in a climate controlled environment based on the manufacturer's recommendations and that it is recommended that new and refurbished units will include a requirement of climate controlled drug boxes in all ground ambulances. Dr. Burger seconded the motion. The motion passed.

Allow medics to respond as Good Samaritans when off-duty	Dr. Ralph Shealy and Dr. Sorrell submitted a request that a certified EMT be authorized to utilize all of the skills which he/she normally exercises under the authority of his/her employing agency on a Good Samaritan basis anywhere within the state, without necessarily having online medical control. Implicit in this proposal is the assumption that both the EMT and his/her employer are protected under the SC Good Samaritan law. Mr. Smith clarified that currently EMTs can help out of their own county at the Basic level, and anything above that (for which they are certified) can be done with online medical control. There was much discussion about providing ALS procedure away from their regular MCP. It was suggested that paramedics should call the online physician for the county in which they were "visiting." There was discussion about the definition of Good Samaritan—that it refers to someone who "happens on to an accident", not someone who is at home listening to their radio and responding from that. The Committee suggested that they would need legal direction to compare the Good Samaritan and paramedic law. There was much discussion about possible scenarios. Dr. Mock suggested the method used at the racetracks---that the EMT's MCP sends a sheet to the other physician verifying that the EMT is certified and in good standing, then the racetrack	The Committee agreed by consensus to pose this question to the DHEC legal department.

	MD takes responsibility for the EMT.	
Use of Magill forceps by EMT-B's	Mr. Smith said he believes that Magill forceps were added to the regulations that are in the process of being revised. The suggestion was made to add the use of Magill forceps to the airway training module for EMT-B's.	Dr. Norcross made a motion to allow EMT-B's to use Magill forceps. Dr. Gerard seconded the motion. The motion passed. Mr. Smith said that he would check the EMT-B airway module and make sure that Magill forceps use was added.
Use of Traumadex for rapid hemostasis	A request was made by Florence County EMS to allow the use of Traumadex for rapid hemostasis at wound sites. Dr. Norcross said that the best use of these agents is when the patient is cold and coagulopathic. Dr. DesChamps questioned the use of the agent in lieu of 4 x 4's. There was also concerned expressed that the agent would hinder the surgical repair of the wound site.	There was no motion made to approve the use of Traumadex.
Use of ventilators by EMT-Basics	The Committee discussed whether ventilators referred to home ventilators. There was discussion that bagging is safer than ventilators and that even physicians are not allowed to adjust ventilators. The committee suggested that the EMTs take the patient off the home ventilator and bag the patient while enroute or until they can rendezvous with an	No approval.

	EMT-Paramedic.	
Protocol to allow EMS units to NOT transport patients	Dr. DesChamps presented a protocol that had been developed by Charleston County EMS that allows EMTS in certain instances to NOT transport patients. He said this is offered as a guideline to other services that might wish to develop such a protocol. It was suggested that if this is implemented, then we might not need as many ambulances and crews. Dr. DesChamps suggested that this protocol be considered with the other state protocols at the next meeting.	Consensus to include a version of the Charleston County non-transport protocol in the revision of the state protocol guidelines.
Medical Control at Disasters	Ms. Beasley asked that this issue be brought up because of complaints received by the Medical College of Georgia that they were not aware of the disaster and the patients that would be arriving until they showed up. The Committee said that the Incident Command System (NIMS) should be followed and would clarify this.	No action or recommendations taken.

Trauma Advisory Council report	Dr. Norcross reported that the new Trauma Advisory Council met on April 28. Among other actions, a requirement for designated trauma centers to participate in the bed capacity website was passed. Another motion was passed to make trauma regions the same as EMS regions. Another motion was passed to hold at least one regional trauma meeting to be coordinated by DHEC staff, EMS region staff and Level I and II trauma staff. He reported that $4 million in Medicaid match funding was approved for designated trauma centers and physicians who serve those centers. He said that the next meeting of the Trauma Advisory Council is July 28.	Report only-no action needed. No further discussion; meeting adjourned. The next MCC meeting will be determined by majority vote.

MEDICAL CONTROL COMMITTEE

Minutes

December 7, 2005

Members Attending:	**Others Attending**:
Dr. Ed DesChamps, Chairman	Alonzo Smith, DHEC EMS
Dr. Raymond Bynoe	Ashley Biggers, DHEC Legal
Dr. Bill Gerard	R. Allen Haynes, Dorchester Co. EMS
Dr. Ron Fuerst	Dr. Ian Reight, Palmetto Richland
Dr. John Sorrell	Dr. Ralph Shealy, SCMA
Dr. Doug Norcross	Jim Catoe, DHEC EMS

Agenda Item	Discussion	Action
Approval of Minutes from May 26, 2005	none	Dr. Sorrell made a motion to approve the minutes. The motion was seconded. The motion passed.
Old Business		
Medics Responding as Good Samaritans – Dr. Sorrell/SCDHEC Legal Staff (Ashley Biggers)	Drs. Shealy and Sorrell reviewed the issue that had been raised at a previous Medical Control Committee meeting. They stated that they felt that a paramedic should be able to respond (at their skill level) if they hear a call on the radio or if they come across an accident in another county. This happens occasionally when a paramedic lives in one county and works in another. The issue was the paramedic's ability to use	A Subcommittee was formed to address the issue of paramedics responding to an out of county call and using advanced skills. The members of that subcommittee are: Dr. Shealy, Dr. Sorrell, Ashley

	advanced skills in the absence of medical control. Dr. Gerard expressed concern that a policy that allowed this might create "call jumpers". Dr. Sorrell stated that paramedics use their skills and training without direct medical control when operating under standing orders. Dr. DesChamps questioned what would happen if a lower level service responded to the call, when the paramedic from another county was on the scene. Ms. Biggers (DHEC Legal representation) stated that there were 2 issues: one is the Good Samaritan law issue (which deals with this if there were a lawsuit) and the other is the concern about DHEC taking action against a paramedic from the regulatory standpoint. She said the Good Samaritan Act only covers you if you are off duty. She said there is no pure line that says you are off duty and covered. She said the issue would get murky if the employer told you it was okay, then it may be acting as part of the duty, or if the employer told you to listen to the radio. She said that one way to clarify the issue is to put in regulations that no action would be taken against a paramedic in this situation. She said that, generally, the Good Samaritan Act would kick in if the paramedic was out of county and it was an emergency situation. She said that now regulations would require an investigation, but don't require action. There was then discussion about the issues related to signing documentation and the use of drugs.	Biggers and Jim Catoe. Mr. Catoe will research the law and find out why and when it was changed.

	Dr. DesChamps asked if there should be a subcommittee to address this and make sure that we are not authorizing paramedics to go against the law. Dr. Sorrell, Dr. Shealy, Ashley Biggers and Jim Catoe agreed to serve on that subcommittee. Dr. Sorrell said that the Medical Control Committee needs to stand behind the paramedics---if they are good enough to take care of patients in their own counties, then they are good enough to take care of patients in other counties.	
Discussion/Adoption of State Approved Protocols	The Medical Control Committee had been provided with a copy of the Lee County Protocols, the Charleston County Do Not Transport protocol and the Richland County Do Not Resuscitate protocol for consideration of adoption as the state approved guidelines for protocols. Dr. Gerard said that the Committee should tweak the new ECC guidelines. After some discussion, the Committee agreed to approve the protocols in principle and have Dr. Gerard and Mr. Catoe tweak the ECC guidelines for inclusion.	Dr. Gerard and Mr. Catoe will adapt the ECC guidelines for inclusion in the state approved guidelines for protocols. Dr. Norcross made a motion to accept the Lee County Protocols, the Charleston County Do Not Transport protocol, and the Richland County Do Not Resuscitate protocol as a template for the state approved guidelines for protocols. Dr. Sorrell seconded the motion; the motion was approved.
Airway Management and the Use of Versed – Dr. Gerard	Dr. Gerard explained that there are problems with the RSI protocols. He said that there needs to be a way to give the drug and sedate without paralyzing the patient. He said that some places, particularly aeromedical, just use etomidate. Dr. Bynoe questioned if all services could afford etomidate and	Dr. Sorrell made a motion to modify the RSI protocol to make succinylcholine local option, but all must be trained in its use. Dr. Gerard seconded the motion. Dr.

	the Committee agreed that they could Dr. Sorrell said that the protocol currently requires the use of etomidate AND succinylcholine. Dr. Gerard asked that we allow the option of either using etomidate OR etomidate and succinylcholine. Dr. Sorrell said that there is the argument that the use of succinylcholine gives a better chance of intubation. Dr. DesChamps reiterated the discussion by saying that there are 3 possible options: do nothing and intubate; try a little etomidate and intubate; or do all the drugs and intubate. Dr. Sorrell suggested calling all of the options RSI and go through the entire training, but have the option of just using etomidate. He said that the RSI protocol should be changed to allow for either option.	Sorrell made the clarification that EMS providers may choose to carry succinylcholine or not, but they must be trained in using it. The motion passed.
Magill Forceps: Add as Local Option Skill	The Committee agreed that Magill forceps are not in the Basic curriculum, but will be added. Magill forceps will be included in the equipment list for removing foreign bodies.	Magill Forceps to be added in training for Basic curriculum.
D50W for EMT-I's as State Skill	Mr. Haynes from Dorchester County stated that in 2003, they had 108 patients needing D50W and only 5 that a paramedic rode with. They did 100% QA on the project and there were no negative outcomes. He said that Dorchester County put an age limit of 12 for the patients (they did not have any pediatric hypoglycemic patients). He said that the only negative was a high rate of refusal (about 50%) for transport after administration of D50W; they followed up with these patients. The paramedic refusal rate was about the same.	Dr. Gerard made a motion to allow D50W for Intermediates as a state skill, for use in adult patients only. Dorchester County's protocols would be adopted. Use of D50W would be added to the curriculum for state training and would be local option to use. Dr. Bynoe seconded the motion. The motion passed.

Pediatric Age – Dr. Fuerst	Dr. Fuerst said that 65 kg is the normal weight maximum for consideration as pediatric. He said that he would recommend that the definition of a pediatric patient be ≤ 12 y/o or ages 13-18 and >55 kg, but less than 65 kg.	The Committee agreed to accept Dr. Fuerst's recommendation for the definition of a pediatric patient: ≤ 12 y/o or ages 13-18 and >55 kg.
Intra-aortic Balloon Pump as Critical Care Skill.	Mr. Catoe said that the intra-aortic balloon pump was on the original Critical Care curriculum, but not on the approved list of equipment. No representative from Meducare was present	No action taken; discussion postponed until more information received from Meducare
New Business		
Trauma Advisory Council Report – Dr. Norcross	Dr. Norcross reported that the $4 million allotted to DHHS for trauma Medicaid reimbursement (to be split between hospitals and physicians) had not yet been distributed. He reported that attempts to conduct regional meetings had begun and that the Midlands Region would have a meeting on January 17. He said that the TAC had also addressed QA between helicopter and ground service providers. Dr. Bynoe said that there is a need to control air ambulances. He said that there were weather issues in Columbia and the Conway helicopter said they would fly, but couldn't make it to Augusta and ended up landing in Columbia. He said that this Committee needs to make recommendations/regulations for helicopters. There was much discussion on helicopter crews signing protocols, patient care and standard of care. The Committee said that DHEC should review the "iffy" cases. Dr. Gerard said that helicopter activation guidelines are needed. Dr. Norcross said he would take that issue to the TAC	Dr. Norcross will take issue of need for helicopter activation guidelines to the TAC.

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EMS Research	Dr. Norcross said that MUSC is looking at a study using artificial blood substitute in the field. He asked if DHEC needs to approve this project; do the EMS providers need an IRB? If this is an IRB approved project, does MUSC and the EMS provider need permission? The committee agreed that this needs further investigation because this project calls for a paramedic to do a skill or administer a medication that they don't normally do or administer. Mr. Smith said that DHEC Legal would probably say these issues must be taken to the DHEC Board. Dr. Norcross asked if we could see what other states do> Dr. Shealy said that Washington State has exempted Dr. Copas and his EMS/Rescue to do experimental procedures/drugs. Dr. Sorrell said that this committee should receive IRB requests, then, if the Medical Control Committee approves, they should go to the Bard. Dr. DesChamps suggested that we ask the Board to issue a blanket approval for IRB-approved projects, if the Division Director approves. He said that it is the duty of the committee to provide technical expertise or the ability to learn technical expertise to carry on projects. Dr. DesChamps said that the Medical Control Committee needs to make a general presentation to the board about research. Any participation by EMS in hospital research should be contingent on the research having IRB or pending IRB approval.	Mr. Smith and Mr. Catoe will ask Dr. Norcross and Dr. Bynoe to help fill out a Board information sheet on the issue of EMS involvement in hospital IRB-approved projects. The Committee agreed to form a subcommittee to discuss EMS Research and take appropriate steps.

Change of Use of Etomidate – Dr. Michael Smith	A request had come from Dr. Michael Smith of Carolina LifeCare to allow a change of use for Etomidate for procedural sedation, for cases of realigning and splinting severely angulated fractures. The Committee discussed this issue, and Dr. Bynoe made a motion to approve etomidate for procedural sedation. Dr. Norcross seconded the motion. The motion failed.	
Request for Pilot Project for Chest Tubes – Dr. Michael Smith	The Committee could not consider the request at this time. Requests for pilot projects must be submitted in the correct format with all applicable information. Dr. Bynoe made a motion to approve the request for a pilot project for chest tubes. Dr. Norcross seconded the motion. The motion failed.	Staff will contact Dr. Smith and explain that pilot project requests must be submitted in the required format with all applicable information.
Update on Regulation Changes	Mr. Smith and Ms. Jennifer Paddock briefed the Medical Control Committee on the proposed changes to the EMS regulations. They said that the changes include a new section for enforcement and fines, addressed all sections to comply with other sections of DHEC regulations. The regulations also include new definitions for items such as revocation and suspension and other updated definitions. A point value is assigned to problems found on inspectors' reports. Ambulance color scheme requirements are relaxed. A section is added on radio communications. For training and certification, a regional officer is added as an option?? to teach Basic and all approved training institutions can teach all three levels. Updates were added for air ambulances. The new regulations also address the content of the ambulance run reports and the retention of copies.	

	Dr. Sorrell requested the option for input on the medical side.	
Use of Cardiac Lidocaine for local anesthesia in adult IO	Pelzer EMS requested the use of cardiac lidocaine for local anesthesia purposes in adult IO. They specifically reviewed the protocol for the use of the EZ-IO adult IO system and have put in place a QI program for this. This request involves a change in use of lidocaine. The EZ-IO is 30 mg of a pre-filled syringe. There was a question about the use of IO in conscious and unconscious patients. Mr. Catoe said it would have to be incorporated into the existing IO protocol.	The Committee tabled this discussion until they could find out why the service is requesting this, the manufacturer's recommendation and why Lidocaine should be used rather than morphine. Staff will conduct Pelzer EMS for additional information.

MEETING ADJOURNED.