OFFICE OF PREHOSPITAL CARE NEWSLETTER

VOLUME 12

OCTOBER 2007

The Ideal Medical Control Interaction

Terry Fairbanks, MD, EMTP

What is medical control for? Medical Control, which comes in two forms (off-line and on-line), provides authorization for EMS providers to administer medical care. Off-line medical control comes in the form of protocols, both BLS and ALS, and on-line medical control is provided via direct communication with a physician who has been authorized by the regional authority (MLREMS) to provide medical control. Today I will focus the discussion on on-line medical control. In the MLREMS region, physicians are authorized to provide medical control after they pass an exam to demonstrate a familiarity with the regional protocols. All medical control physicians practice in an emergency department which has been authorized by REMAC as a medical control facility.

On-line Medical control is a resource available to any EMS provider (first responder, basic EMT, intermediate, level 3, or paramedic), who needs emergency physician assistance for any reason. Although ALS providers use this service most often, BLS Providers are encouraged to call when they need assistance.

Only MLREMS-certified physicians are authorized to provide medical control. EMS providers may not accept orders or advice from any other ED staff, including physician assistants, nurse practitioners, interns, or registered nurses. At the University of Rochester/SMH, Senior (second or third year) emergency medicine residents are authorized.

The ideal medical control report. Medical control is provided by physicians who are staffing busy EDs, and they are often called out of patient rooms to answer the call. When they answer the phone, they hope for an efficient, direct, and effective communication. Here are some tips on giving the optimal medical control report:

- *The first statement sets the stage.* Start out with who you are, your agency, *and the purpose of the call.* Many EMS providers forget to say the purpose, and instead start describing the patient. The details of the patient are much less meaningful if the physician is unable to frame them in the context of the purpose of your call. The purpose can be very directed (such as “calling to ask for morphine orders,” or “calling to notify you that we are en route with a major trauma”), or it can be open ended (such as “calling to request your guidance in a situation where a patient is refusing transport and her family wants her to go”).
- *Stick to the business at hand.* Don’t include a “how are you” or “how you doin’ today.” This requires a break in the flow (because they have to say “Fine thanks, how are you?” and then you have to say “fine thanks” etc, etc). This hurts the efficiency of the communication, and most physicians would like to get on with it.
- *“Just the facts, Jack.”* Stick to the bare minimum of relevant facts. Tell them just what they need to know to make a judgment about the best thing to do. If this is a request for an order, then try to stick to the facts relevant to the specific protocol. Some providers have the perception that they need to say a lot to establish credibility with the medical control physician. This is not the case, and in fact, saying too much can hurt your credibility because it will appear that you don’t know what is relevant. For example, don’t recite the patient’s medication list. In certain circumstances, it might be relevant to mention one or two of their medications, but there are few times when it will be helpful to list them all.
- Give a *focused* history and exam (pertinent negatives and positives only). If you have an asthma call, you don’t need to report the cranial nerve exam. You should always include vital signs (this is a common complaint of physicians- that they have to ask for vitals, which is concerning since physicians consider this a critical piece of information, particularly when

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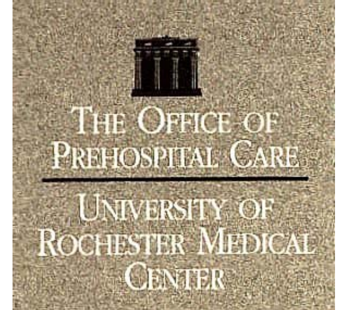

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Are you sure they're dead?

Jeremy Cushman, MD, MS, EMT-P

Determining that a patient does not require resuscitation is often a difficult decision, and certainly not one to be taken lightly. As you are aware, your Protocols allow any level of care provider (EMT-B and up) to withhold resuscitation when certain criteria are met.

First, they have to be pulseless. Sure, it's pretty obvious, but recall that you should take plenty of time to confirm that there is no pulse, particularly when the patient has been in a cool environment for a long period of time. In cold environments, you should take 60 seconds to check a carotid and femoral pulse before confirming that there is truly no pulse, as heart rates can drop dramatically (but still be present!) when exposed to prolonged cold.

OK, so they don't have a pulse. Next, is there a DNR? Looking at our Protocols we see that we may withhold resuscitation if there are any one of the following:

- Signed New York State approved document, bracelet, or necklace
- Properly documented nursing home or hospital DNR form
- Properly completed Medical Orders for Life Sustaining Treatment (MOLST) form

So lets say there is a DNR, but you are not sure if its valid or not. When in doubt, start CPR and call medical control and explain your circumstances and the document you have in front of you. Chances are, whenever there is doubt, medical control will have you begin full resuscitative efforts and transfer the patient to the emergency department. Obviously you can understand why: we certainly don't want a patient that wants to be resuscitated left for dead.

So, what if there isn't a DNR? Well, then we revert to the "Obvious Death" Protocol. In that, any ONE of the following criteria suggest that there is no possibility of resuscitation due to mechanism or presumed time since they last had a heartbeat:

- Body decomposition
- Rigor mortis with warm air temperature
- Dependent lividity
- Injury not compatible with life (i.e. decapitation, burned beyond recognition, massive open or penetrating trauma to the head or chest with obvious organ destruction)

If the patient meets any one of the above criteria (they certainly should be pulseless) and therefore you need not begin resuscitation. Two important caveats: Cold and water. In the case of hypothermic cardiac arrest (or more likely, a patient in arrest found in a cold environment) it's important to begin CPR and resuscitative measures. As we have been taught, "they're not dead until they're warm and dead." Many individuals can be resuscitated and be neurologically intact due to the therapeutic value of hypothermia. In fact, some hospitals (including Strong) initial a therapeutic hypothermia protocol in patients resuscitated from cardiac arrest as initial evidence suggests that it improves neurologic outcome. Not quite ready for EMS use yet, but there may be a day in the not so distant future when we are putting the chill on a patient whom we have resuscitated in the field.

The second caveat: water. It's often very difficult to accurately determine both submersion time and water temperature for drowning victims - both of which are essential to determine survivability. The longer the time in the water, the worse the prognosis, but the colder the water, the better. It's impossible to know where the patient is along that continuum, and therefore your Protocol requires that any provider must contact medical control before withholding resuscitation for any patient who has been submerged for greater than one hour in any water temperature.

Lastly, what happens when you get to the scene and someone (police officer, firefighter, EMS colleague, etc) has been performing CPR but you realize that one of the criteria in "Obvious Death" has been met. You MUST contact medical control before terminating resuscitation. The reason for this is to help protect you. The person performing CPR believed that the patient was salvageable and therefore started CPR and you feel that the person is "Obviously Dead." Medical Control is there to verify your findings and stop resuscitative efforts because the patient exhibits signs (rigor mortis, dependant lividity, etc) of obvious death. So yes, you may withhold resuscitation but you must do it in conversation with Medical Control for patients who have CPR in progress on arrival.

Determining when to withhold resuscitation is an important skill that requires a thorough understanding by every level provider. Reviewing these protocols from time to time is essential to ensure familiarity with the documents that outline this important decision.

Reminder

As of January 1, 2008, OPC will no longer be printing PCRs and will be changing back to the NYS forms. If you still need PCRs or transfer PCRs after the 1st, they can be picked up at our office.

Ideal Medical Control

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medications are requested).

- On the other hand, don't leave out relevant facts, particularly if they might effect the physician's decision.
- If you believe that a patient needs a certain treatment, then make a case for it in your report. Be deliberate about stating your case.
- *When you know what you want, say it.* You have much more credibility if you show confidence in your request. For example if you know you want to give morphine to a kidney stone patient, don't say "so I was wondering if you think I should give him some morphine." Instead say "I am requesting permission to give 5mg Morphine IV for pain relief."
- *Don't shop for an order.* If an order is denied by medical control it is not appropriate to call a different facility to ask for the same order.
- *When you're describing your ETA, give the number of minutes.* Do not do it by telling medical control where you are. Few emergency physicians know the roads as well as the average EMS provider, so much of the time it will be meaningless to say something like "we're just passing Lake and Ridge."
- *Read back the order.* This is an important patient safety feature, and it protects you from a misunderstanding. After you read back the order, the physician should confirm that it is correct.
- *Call the receiving facility.* If the receiving facility has medical control, then in general you should use them for medical control. In extenuating circumstances, it is alright to call alternate facilities, but you should let them know why. Also, if you only intend to give notice of an impending arrival, and there is no need for medical control, then you should use 340, not medical control.

If the patient is 18 years old or less, call pediatric medical control.

Example:

EMS: "This is Paramedic Terry Fairbanks with ABC Ambulance, calling for morphine orders. I have a 28 year old male patient with no medical history who presents with severe colicky left flank pain radiating to his groin. It has been getting worse for the past 2 hours, and he now reports a 10/10 pain score, and he is pale and sweaty, bent over in pain. His vitals are pulse 100, BP 120/80, and RR 18. He has no allergies to medications and has tolerated morphine in the past. We have an ETA to your facility of 15 minutes. I would like permission to give him 5mg IV and to repeat the dose if there is no relief in 5 minutes, assuming his systolic blood pressure remains above 100."

Medical Control: "that sounds fine. Go ahead and give up to two doses of 5mg morphine, 5 minutes apart, as long as the systolic blood pressure is above 100. Please re-contact us if there is any change."

EMS: OK, I understand you've authorized morphine 5mg times one with a second dose 5 minutes later if the blood pressure is above 100 and the patient is still in pain.

Medical Control: That is correct. See you when you get here.

Electronic PCRs—an Update

Sheri Strollo, BSN, EMTP

Many agencies are either already using electronic charting or have made a commitment to a vendor to starting using electronic charting. We will be able to run numerous timely reports for the system. However, as the December 31, 2007 deadline approaches, there are still agencies that have not yet made a decision about how to comply with electronic data submission.

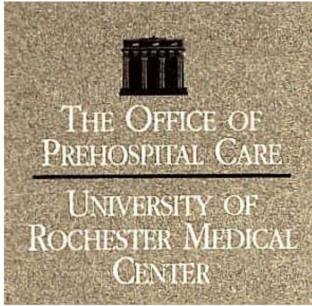
For those agencies that haven't figured out how they will comply there are two options available:

- **Commercial vendor software** – on the MLREMS website is a comprehensive list of vendors that were scored by the PCR Review committee. The committee spent a great deal of time looking at vendors so that each individual agency didn't need to do all the legwork themselves. This is a good place to start looking at choices.
- **OPC database** – OPC has created a database that will be made available within the month for agencies that want to input their PCR information at the agency level and send it electronically to OPC. Accuracy and completeness will be important as the "safety net" features of electronic charting won't be there.

We have had multiple calls for clarification on what the BLS FR agencies are required to do.

- If a BLS FR agency gives a medication (activated charcoal, albuterol, aspirin, Epi-pen, or Nitro) the EMT is required to complete a full PCR for that call, not the transfer PCR that they currently use. It is importation for patient safety and continuity of care that this is done. Once completed, these PCRs are faxed to OPC @ 463-2966 for submission to the State. Agencies would have to be compliant starting 1-1-08.
- If a BLS FR agency wants to do blood glucose testing in the field, they will be required to be compliant with all the MLREMS system rules that a transporting agency would have to follow. This would include full PCRs for every call and electronic data submission. Agencies would have to be compliant as of 1-1-09.

As you choose a vendor, please be sure to contact OPC to let us know. In addition, if you have any questions, please feel free to contact us.



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If your agency needs PCRs contact OPC @ 463-2900

Reminder—if your agency has switched to an ePCR system,
the PCRnet PCRs should no longer be used.
Cheat sheets will be available for agencies to use instead.

Specific Hospital Issues—Contact Information

OPC receives numerous phone calls for specific hospital issues. We encourage agencies to contact the hospital directly. Below is the contact information, which is also listed on the MLREMS website.

Highland Hospital—Dr. Hilmi or Dr. Cunningham
John_Hilmi@urmc.rochester.edu
Michael_Cunningham@urmc.rochester.edu

Lakeside Hospital—Dr. Kasaraneni
395-6095 ext 4205 OR
Manmadharao.kasaraneni@lakesidehealth.com

Rochester General Hospital—Dr. Elsen
922-3846 OR
Stephanie.elsen@viahealth.org

Strong Memorial Hospital– Pam Parnapy, RN
275-1106 OR
Pamela_Parnapy@urmc.rochester.edu

Unity Hospital– Dr. Biernbaum
723-7035 OR
rbiernbaum@unityhealth.org

Upcoming Events

ALS Meeting—October 8, 2007—5:30pm

MLREMS/REMAC meetings—October 15, 2007, 4:00pm & 5:30pm

Certified Instructor Update—Sat October 6, 2007

Certified Lab Instructor Course—Starts October 1, 2007

Visit our website @ www.mlrems.org