

MEDICAL CONTROL COMMITTEE

Minutes

February 25, 1994

Members	Others
Bob Malanuk, M.D.	Mike Stein, M.D.
Richard Bell, M.D.	Al Futrell
Ed DesChamps, M.D.	Dale Hutto
Carol Baker, M.D.	Alonzo Smith
Douglas Norcross, M.D.	Phyllis Beasley
John Sorrell, M.D.	Joe Fanning
Bill Gerard, M.D.	Mary Ann Cox
Debra Perina, M.D.	

Dr. Perina served as chairman for this meeting. She opened the meeting by asking for a review of the minutes of the November meeting. **There being no suggested changes the minutes were declared approved.**

Dr. Perina introduced Dr. Bill Gerard, the newest member of the Medical Control Committee, who is a representative of S.C. ACEP on the Committee and the EMS Advisory Council.

Dr. Perina then asked Dr. Sorrell to present the recommendations of the Designation Review Committee.

Dr. Sorrell explained the process which the Designation Review Committee took in determining its recommendations. He presented the Designation Review Committee's adaptations of the original designation options for use in the redesignation process. (See attached.) **A motion was made to accept the redesignation options as presented by Dr. Sorrell. The motion was seconded (by DesChamps). The motion passed.**

Dr. Sorrell then presented the Designation Review Committee's recommendation regarding the redesignation of the Level I trauma center for Richland Memorial Hospital, including the deficiencies which must be corrected. (See attached.) Concern was expressed regarding the authority and relationship of both the trauma team and trauma director to the hospital. The committee discussed whether redesignation option #3 was a strong enough directive to institute the needed changes in authority or whether the designation should be rescinded. Dr. Stein reiterated that the state needs for the current Level I trauma center to remain active and the recommendation should

be written so that the hospital wants to remain a trauma center, yet is required to make the needed changes.

Dr. Norcross made a motion to amend redesignation option #3 to add "Should these deficiencies not be acceptably corrected, the designation will expire." The motion was seconded by Dr. DesChamps. The motion passed.

Then Dr. Malanuk suggested that the last phrase in redesignation option #4 be changed to read "Its current level of designation has expired." The motion was seconded. The motion passed.

Dr. Norcross then made a second motion to accept the amended redesignation option #3, including the deficiencies to be corrected, for Richland Memorial Hospital. The motion was seconded. The motion passed. Drs. Perina and Bell abstained from voting.

Dr. Sorrell then asked the Committee to address the recommendation for the redesignation of Greenville Memorial Medical Center's Level I trauma center, using redesignation option #2 (see attached). Dr. Norcross asked how Greenville Hospital could respond to item #c of the Designation Review Committee's recommendation, asking the hospital for "documentation of hospital administrative support for trauma research." Dr. Stein responded that by allowing the trauma service to hire an additional trauma surgeon, the hospital will make it possible for him to conduct more trauma research. He stated it would not be a problem to respond to #c.

In following the changes made to redesignation recommendation #3 regarding acceptable correction of deficiencies, Dr. Malanuk made a motion to change the phrase in option #2 from "hospital will correct the problems" to "hospital will acceptably correct the problems." The motion was seconded. The motion passed. Dr. Baker abstained from voting.

Dr. Stein asked that the Committee address two problems listed in the redesignation committee's recommendation that he felt should be changed. First, he stated that under #e, he believed the deficiency to be in outreach, not public education programs. He stated that in his application for redesignation he submitted pages of public education programs which his service had conducted. He also explained that in #b, he believed the site team referred to a lack of physician certification and education in error. He said that the need for education was at the nursing level, including a need for training in courses such as TNCC.

Dr. Malanuk made a motion to strike the words "public education" in #e in the redesignation recommendation for Greenville Memorial Medical Center. Dr. Norcross seconded the motion. The motion passed. Dr. Baker abstained from voting.

Dr. Malanuk then stated that although Dr. Stein may disagree with the report's comment regarding physician education, the Committee has to go by the summary report. Dr. Stein stated that CME

requirements are clearly outlined in the written protocols for trauma surgeons. Dr. Sorrell pointed out that in the report, the problem regarding physician education was for the emergency physicians; there was no documentation regarding their education or a plan to fulfill CME requirements.

Dr. Perina made a motion to redesignate Greenville Memorial Hospital as a Level I trauma center, but with the understanding that the hospital will acceptably 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. (Redesignation alternative #3). See Attachment.

Dr. DesChamps seconded the motion. The motion passed.

Dr. Sorrell then presented the recommendations of the redesignation committee regarding MUSC Hospital. He noted that the site team made a commendable report regarding their findings at MUSC.

Dr. Bell then made a motion to redesignate MUSC Hospital as a Level I trauma center, that the hospital has everything required and is redesignated with no questions or problem. (Redesignation option #1).

Dr. Bell also requested that the minutes note that Dr. Norcross should be commended for an absolute superb job of turning the trauma center around at MUSC.

The next item on the agenda related to trauma was the presentation by Dr. Stein of the site team report from the in-state site team's visit to Orangeburg Regional Medical Center in response to their application as a Level III trauma center. Dr. Stein explained to the Medical Control Committee that an in-state site review team visited Orangeburg on February 14, 1994. Team members were Dr. Michael Stein, surgeon and trauma director of Greenville Memorial Medical Center's Level I trauma center, Dr. Ken Dehart, emergency physician at Grandstrand General Hospital's Level III trauma center and Ann Nunn, nurse manager of the emergency department at Trident Regional Medical Center's Level III trauma center. Joe Fanning and Phyllis Beasley of the Division of EMS staff were also present at the site visit.

Questions were raised regarding full-time staffing of the emergency department at Orangeburg. The Committee was reassured by Dr. Stein and Dale Hutto, Orangeburg's emergency department administrator, that there was always a full-time emergency physician present and a part-time physician sometimes assisted him. Mr. Fanning remarked that since the last site team visit to Orangeburg in 1991, there have been significant changes in the emergency department, especially in regard to training. Mr. Hutto stated that there is now tremendous support and enthusiasm from the hospital administration for becoming a trauma center.

A question was raised regarding the comment on the lack of follow up in the QA process at Orangeburg. Dr. Stein stated that the follow up may be there, but evidence of it was not presented at the visit.

Dr. Norcross asked about delays of patients in the emergency department before admission and transfer. Dr. Stein responded that it appeared that the majority of delays were created because of a need to transfer patients out and a lack of EMS vehicles to make those transfers. There was much discussion regarding the shortage of vehicles, especially if Orangeburg is approved as a trauma center and begins accepting more patients from areas of outlying counties such as Barnwell and Bamberg. Dr. Perina asked the representatives from Orangeburg if the hospital can assist in bringing about any changes, since this is basically an EMS problem. Ms. Cox responded that the two medical control officers, as representatives of the hospitals, could have an effect on policy changes. Dr. Norcross added that the hospital, in seeking trauma center designation, could not be faulted for a problem over which they have no control.

Dr. Bell made a motion to accept designation option #3, "That designation should be withheld until the hospital can correct the deficiencies in the essential areas noted. The hospital has deficits in some important essential areas. These areas are not likely to be easy to correct and will probably require up to six months to correct." Orangeburg should correct the deficiencies noted in the site team's report. The motion was seconded by Dr. DesChamps.

The vote was interrupted by discussion regarding whether the committee should accept a written response regarding the correction of the deficiencies or whether another visit would be made. Dr. Norcross suggested that a site visit be conducted, including a physician representative, to ensure that the emergency physicians and surgeons are working together. Dr. Stein stated that during the visit another chart review should be conducted to determine that the changes have been made and that there be a team of two physicians.

There was also much discussion about how long Orangeburg would need to effect these changes. It was decided that in order for the changes to be reflected in QA, the hospital would need 9 to 12 months, which would reflect 3 to 6 months of charts showing protocols in place.

Dr. Perina asked the hospital representatives to contact the Division of EMS when they are ready for a second site visit. Following that discussion, a vote on the above mentioned motion was taken. **The motion passed.**

Dr. Sorrell requested that it be noted that he opposed the motion, because he felt the that the hospital should be approved as a trauma center.

Dr. Sorrell stated that the Committee felt that this was a very positive meeting regarding Orangeburg's status as a proposed trauma center and that the Committee is very pleased with the changes that have occurred at the hospital.

The next agenda item was "proposed regulations on insect stings."

Don Whitely presented a set of proposed regulations under a state law enacted several years ago

allowing certain persons to administer epinephrine in incidence of insect stings. These regulations allow the lay person to obtain training and then possess epinephrine and administer it for anaphylaxis. The proposal is meant for those responsible for groups as the result of their volunteer or paid status.

The committee was given copies of the regulations and the law. Dr. Perina then suggested that the committee withhold further discussion until the next meeting to allow each person to study the laws and the regulations. Mr. Futrell explained that the Commissioner presented the Division of EMS with the job of developing the regulations and curriculum for this law, although it does not relate to the EMS legislation and EMT's under that law.

Dr. Perina then recognized Al Smith who presented the proposed changes to the State Drug List. The first proposal was the addition of Reglan for the nurse formulary. Dr. Norcross stated that no action was needed in that it was inappropriate for the Medical Control Committee to consider something outside its area of responsibility. Dr. DesChamps then made a motion **stating that the proposal is not acceptable for any paramedic and that would also be inappropriate for nurses. Dr. Bell seconded the motion. The motion passed.**

The next proposal was to add IV antibiotics as a class of medications to be added to the interfacility transport drug list. The indications listed were general and the complications listed was anaphylaxis. **Dr. DesChamps made the motion that the committee accept antibiotics as a general category of medications for the interfacility drug list only. Dr. Baker seconded the motion. The motion passed.**

Dr. DesChamps made the motion that calcium gluconate be added to the pre-hospital drug list in a dosage of 5-20 ml., and that it be removed from the interfacility drug list. The motion was seconded and passed. The indications are for calcium channel blocker overdose, magnesium toxicity, and cardiac arrest. Procedures are to follow ALS protocols.

The committee next revisited the conditions surrounding the administration of calcium. Since calcium chloride offers three times the effect of calcium gluconate it was suggested that calcium chloride be allowed to be administered in the dosage range of 5-10 ml. under direct on line medical control. The committee agreed that Dr. Perina could research and suggest the dosage.

Dr. Baker made the motion that calcium gluconate be administered for calcium channel blocker overdose, this indication only under on line medical control. Dr. DesChamps seconded the motion. The motion passed.

Discussion surrounding the motion included the indications for calcium channel blocker overdose, magnesium drip toxicity, and certain types of cardiac arrest. The dosage would be 1 mg. per kg. according to ACLS guidelines.

The next drug presented was naloxone. Mr. Smith said that it was suggested that the administration be changed to IM or SubQ for everybody. It was also suggested that pediatric dosage be changed.

Dr. Baker made the motion that this suggestion be adopted as presented. Dr. Bell seconded the motion. The motion passed.

Mr. Smith then presented a revision which he had made on the administration of epinephrine. Dr. Perina also read Dr. Taylor's comments regarding epinephrine, pediatrics and indications. He suggested that it be added "that all three indications be present before epinephrine be given IV to a child." It was also suggested that anaphylaxis in association with hypotension be a requirement for an indication for both pediatrics and adults. Another instruction of the committee was that it be made very evident that this procedure requires on line medical control (put in box "Requires On Line Medical Control"). It was also suggested that adult dosage be used "only with on line medical control." Al Smith was requested to make the changes and send to the members of the committee for approval.

The subject of the "Interfacility Transport Form" was brought to the attention of the committee at the request of a letter from Dr. Brian Kellerher. He was requesting that "potential complications" be changed to "observational parameters" to reduce the possibility of legal ramifications for the sending physician. The committee agreed to make the changes.

The pediatric use of Albuterol, and the procedure required by the DHEC Board in response to legal opinion of DHEC Counsel. The Board had refused to approve albuterol for pediatrics because there was no F.D.A. approval for such indications. However the Board later approved albuterol for pediatrics under certain conditions as outlined by Mrs. Bullard, DHEC legal counsel, that is under specific written orders in the patient's chart (medical record) or direct on line orders by a physician. Dr. Sorrell felt that albuterol should be given by standing orders to pediatrics for asthma. Dr. Perina suggested that the issue be tabled until we have significant additional information. However, the group felt that these limits do not assure optimal medical care.

EMS staff was requested to let the ambulance services and field paramedics know that they should not be using standing orders for this drug.

The next agenda item was a review of the procedures for radio orders, "Verbal orders of the Physician are required before the paramedic can follow on line instructions for administration of drugs or advanced procedures." This is what is written in the law and regulations. Some discussion ensued regarding the great difficulty placed on many emergency rooms under such a requirement. Some suggested that an alternative might be that the nurse must say that Dr. "White" says specifically that the directions must be.....

Others said that the on line physician is responsible for whatever is said over the radio from that hospital. Another suggestion was a memo to the M.D./ER and the Nurse Manager explaining the problem and necessary alternatives to cope with the problem. The committee agreed that a subcommittee should be formed to help Mr. Futrell draft a memo regarding appropriate procedure

for radio medical direction.

Under other business, Dr. Norcross asked the Medical Control Committee to address one more issue related to trauma system development. He stated that there were some changes that needed to be made in the membership of the Trauma System Committee.

The first change was the need for the addition of a position to represent quality assurance perspectives. Dr. Norcross also suggested that the position might be filled by Ann Nunn, nurse manager of the Emergency Department of Trident Regional Medical Center. Ms. Nunn has already served unofficially on the Data Linkage Subcommittee, attended the Trauma System Committee meetings regularly, and has assisted in other matters related to trauma system development.

Secondly, Dr. Norcross suggested that a position representing the Level I trauma nurse coordinators be added. He stated the Level I trauma nurse coordinators are important participants in the trauma system and, to date, have not been represented on the Committee. He suggested that their input will be especially valuable as trauma system development advances and more emphasis is placed on outreach and public education.

Dr. Norcross then asked that the Committee consider adding a position to represent matters related to organ procurement. He said that this area of trauma system development had not been previously represented on the committee and it is an important component.

Lastly, Dr. Norcross asked that the position for a media representative be deleted. The Division of EMS had made several attempts to locate a media person to fill the position and all whom had been contacted had cited conflict of interest.

A motion was made to accept the addition of a quality assurance position, a Level I trauma nurse coordinator position, an organ procurement representative position and to delete the media position on the Trauma System Committee. The motion was seconded. The motion passed.

Staff reported that the "Do Not Resuscitate" legislation has been sent to a legislative committee for sponsor and drafting. At this time there is no bill yet.

Dr. DesChamps suggested that we are not making optimal use of the data which we have accumulated on EMS in our state. He suggested that we approach a Masters or PHD candidate who might assemble our data into some very meaningful reports which might also be deserving of publication.

Dr. Norcross made a motion that the meeting be adjourned. It was seconded and passed.

MEDICAL CONTROL COMMITTEE

Minutes

May 26, 1994

<u>Members</u>	<u>Others</u>
Bob Malanuk, M.D.	Mike Stein, M.D.
Caughman Taylor, M.D.	Joe Fanning
Ed DesChamps, M.D.	Doug Warren
Carol Baker, M.D.	Alonzo Smith
Douglas Norcross, M.D.	Phyllis Beasley
Debra Perina, M.D.	Don Whiteley

Dr. Perina served as chairman for this meeting. She opened the meeting by asking for a review of the minutes of the February meeting. **There being no suggested changes the minutes were declared approved.**

Dr. Perina then asked Phyllis Beasley to present a report of the activities in the development of trauma systems.

Mrs. Beasley gave a report of the status of trauma system development, regional trauma plans, and plans for an application for a trauma grant for FY 94-95. She reported that most of the segments of the trauma plan were completed in first draft and that she hoped to have all completed soon. Also, the EMS regions have held numerous meetings in the process of developing regional trauma plans. She said that in addition to the development of trauma systems and plans, staff has also developed an application for an EMS for Children grant.

Dr. DesChamps suggested that the budget for the proposed trauma grant contain monies to support the development of trauma software that is readily accessible for everyone to operate and has the capability to allow easy development of reports. That **anyone** who can operate a computer can access the data and develop reports. It should have a user friendly adhoc report generator with the capability to develop the reports, especially the Q.A. reports required of the level III trauma centers.

Mrs. Beasley said that other objectives include developing the state trauma system plan and regional trauma system plans. Implementation of triage and bypass protocols should be included under regional trauma system plans.

Dr. Stein suggested that the application should also include pediatric referral plans and specifications

for pediatric trauma centers.

Dr. Norcross suggested that developing legislation for trauma systems to include funding for trauma care should also be an objective. Dr. Perina added that another idea would be statewide disaster plans specifically for response for trauma so that hospitals would be able to assist each other. Communications improvement was suggested, but Mrs. Beasley said that this evidently is not a fundable area in that it was deleted from the previous grant by the grantor.

After Mrs. Beasley's report Dr. DesChamps requested that the state develop software that can handle trauma data and provide the user of trauma data the capability to instantaneously retrieve data for evaluation, either locally or statewide. In this he suggested that the trauma register be modified to enable ad hoc report generation capacity, and also to give quick and easy access to the data required for Q.A. filters.

Dr. Perina then recognized Al Smith to present modifications to the State Drug List. The changes he presented were in response to the directions given at the last medical control committee meeting. He had prepared a sheet (for each of the drugs to be discussed) showing all the information about that drug that would be included in the state drug list document.

First he presented proposed instructions for antibiotic infusion.

The proposed instructions for (general) antibiotic infusion were modified under "dosage" to make it read: "determined by the sending physician and indicated on the interfacility transport form." "Side effects" were changed to read: "local reactions, anaphylaxis, and fever.

Next he presented the changes as proposed for calcium gluconate. There was some discussion as to which the committee preferred, calcium gluconate or calcium chloride. The consensus was that they would stick with calcium gluconate.

After some discussion the committee agreed to make only one change, in indications, that would include dialysis patients under cardiac arrest. (attached as amended)

For the drug naloxone the committee accepted Mr. Smith's proposal with the pediatric dosage of "up to 0.1 mg/kg. (attached as amended)

The committee discussed a proposal to use lidocaine for head injuries, the advantages and disadvantages. **The committee's instruction for lidocaine was not to add head injuries as an indication, and to make sure under "special information" that the wording is consistent with new JAMA guidelines.**

The committee's instruction for Epinephrine was modified to put S Q in Bold print under Adult Dosage regarding Bronchospasm and general urticaria. The committee also advised

that S Q be put in Bold print under Pediatric dosage for Bronchospasm. They also requested that I V be added in Bold print to clarify the route of administration under pediatric anaphylaxis. They requested that we move specific instructions concerning medical control from "special information" to a location under "dosage." (attached as amended) The committee also requested that dosages should be consistent, either mg or ml.

Mr. Lewis Moore was recognized to present both a question and a position reflecting the opinion of Spartanburg EMS and its medical control physician. First he asked if the responsibility and/or authority of the medical control committee went further than the approval or disapproval of drugs for prehospital use. For example, did the committee have responsibility for limiting dosages? He stated that his medical control physician preferred the flexibility to determine what dosages should be used, without the limits placed by the medical control committee. He stated that there were some drugs for which they would like to provide dosages higher than the set limits under protocols and standing orders.

The committee discussed the questions Mr. Moore presented in light of the role they saw the committee's responsibility to be. It was offered that concern over the administration of unconventional dosages of drugs in the field such as high dose epinephrine before it became a standard, emphasized the committee's responsibility to the Board. **The committee members concluded that it was the task of the medical control committee to study and recommend all situations surrounding the use of approved drugs for prehospital use.** They pointed out that the drug list could be interpreted as a standard of care, not a set of guidelines, and as such needs to follow acceptable recommended FDA dosage guidelines. Any dosages outside this standard may be used as a part of any pilot project.

Mr. Smith reported that the "Interfacility Transport Form" had been changed according to the committee's instructions and that the field will be notified of these changes.

The committee requested that staff send out the revised "Interfacility Transport Form" to all, to include appropriate hospital personnel.

The committee also requested that staff make the above suggested changes, let Dr. Perina review and approve them and send them out to the field, except for those changes involving antibiotics and calcium gluconate, which must be sent first to the DHEC Board for approval.

The next agenda item was "proposed regulations on insect stings."

Don Whiteley reviewed the proposed regulations under a state law enacted in 1990 allowing certain lay persons to administer epinephrine in incidence of adverse reactions to insect stings. These regulations allow the lay person to obtain training and then possess epinephrine and administer it for anaphylaxis. The proposal is meant for those responsible for at least one other person as the result of their volunteer or paid status.

The committee gave considerable discussion to the appropriateness of such a law and the problems which they felt should be resolved before we try to implement the law, as proposed. They felt that the next step was to research some questions rather than proceed with implementation without investigation.

Dr. DesChamps made a motion that this committee make ACEP, SCMA, the allergist association and the State Board of Medical Examiners aware that this law was passed in 1990 and given to DHEC to implement. Also that staff should inform them that we are attempting to implement and develop a training program for persons who might administer this drug and that we desire their input. Dr. Norcross seconded the motion. The motion passed.

Dr. Norcross made a motion that the committee express concern for the liability of instructors and those responsible for developing the instruction. Also, this concern should be reported to the Board. Dr. DesChamps seconded the motion. The motion passed.

The next agenda item was medical control and the basic EMT. Several members stated the need for medical control to have more direct control over the direction and reprimand of an EMT who works in an ambulance service for which the physician has medical control. Presently the medical control physician has to rely on the service director to place restrictions on an EMT. The medical control physician presently has no authority to place any restrictions on the basic EMT. The committee felt that the medical control physician should be able to remove the basic EMT from service if they felt it was necessary.

Discussion regarding the proposed national curriculum for the basic EMT suggested that this curriculum will be modified significantly. These modifications will also have significant impact on the basic EMT and medical control. It will include procedures that are now considered advanced life support. EMS staff was asked to send committee members an outline of the new national basic EMT curriculum with the proposed additions in the national curriculum.

Dr. DesChamps made a motion that EMS staff review the laws and regulations to see if they enable medical control for basic EMTs. If such control doesn't exist, staff is to investigate the impact of the new curriculum on medical control for basic EMTs and also possible routes/alternatives to make changes that require medical control for all basic EMTs. Dr. Baker seconded the motion. The motion passed.

Dr. Perina asked the status on the letter regarding medical direction under radio medical control. A letter is to be drafted by staff but with the help of a subcommittee of this group.

Dr. Perina also provided an update on the status of the House Bill on DNR. Although it had been killed in the Senate it had been added to another bill that would probably get passage. This bill was House Bill #3678 as amended. (As of this writing the bill was passed, waiting the Governor's signature.)

Dr. Perina presented the issue of priority dispatch. First she asked how many hours of EMS training is included in dispatch training, and what dispatch training is available. Doug Warren said that there is presently a 40 hour dispatch course, of which 12 hours are dedicated to emergency medical needs. He said that a number of the county prehospital EMS personnel would like the support from a body like the Medical Control Committee for the development of dispatch protocols.

Dr. Perina said that she wanted to know if the committee should look at the idea of priority dispatch protocols. Should South Carolina write our own standardized dispatch protocols? **The committee agreed to make this an agenda item. Dr. Perina appointed Dr. Sorrell, Dr. Baker and Al Smith to a subcommittee to study the issue.**

Dr. Perina also suggested that S.C. might want to participate in a statewide research project. A colleague in California had called her with a proposal for a joint grant in which two unlike states with unlike structure for first responder use would pair up to develop first responder curricula. They would then determine the differences between urban and rural results and its impact on rural communities. California would develop the "RFP" and do most of the work, but with information from South Carolina. California will do the work in developing the grant, S.C. will need to corroborate with provision of data. The committee gave general support to the idea.

The next agenda item was the discussion of new prehospital procedures on the horizon. Dr. DesChamps suggested that the committee should be proactive rather than reactive regarding new ideas in the prehospital setting. He suggested that EMTs and paramedics will be caring for patients with AICD's and other like situations that will require that the EMT know how to respond to the different needs of that type of patient. He suggested that educational programs might be developed to meet these needs as they arise. He is getting the assistance of another physician to develop a video tape on the procedures for caring for patients with AICDs. Procedures such as this could be presented as part of in-service education by video tape or teleconference. Other procedures discussed as possibilities for this type of training included arterial lines, transplant and renal patients. The consensus of the discussion supported this concept.

EMS staff was asked to get the assistance of regional EMS councils to assess the type of training that needs to be addressed. What type of innovative training is presently being done? What are some of the areas where training is needed as the result of new developments? A letter needs to be sent to the field to acquire necessary input. Al Smith agreed to follow up with what is proposed to be done to include getting the regions to send out questionnaires and get the committee together.

Staff reported that they were interested in developing the capability for producing useful reports based on data in the prehospital ambulance run report data system and the trauma register. In response to Dr. DesChamp's request in the last meeting and the necessity in developing a trauma plan -- a subcommittee of the committee is needed to deal with data needs. They can assist with developing ideas for reports that would be helpful on local, regional and state levels, in both the

prehospital and hospital settings. A subcommittee should be appointed to assist this effort.

It was suggested that the committee members be polled for the best date for a meeting in July.

Since there was no other business Dr. Perina declared the meeting adjourned.

Note: There are four subcommittees that need to meet and report to the medical control committee.

1. Radio Medical Control: To develop a procedure and a letter that will allow medical direction via radio without the on line medical control physician having to speak directly with the paramedic.
 - i. (Members of this subcommittee are Doctors Sorrell, Baker, Perina, and also Al Futrell.)
2. Committee on Trends and Optional Skills: From the May 94 meeting: To develop protocols for procedures that are presently being done in the field, such as arterial lines and chest tubes. Also to look at new trends and how to deal with them in a proactive fashion, such as AICD. This same idea was also presented in the Nov. 93 meeting: that the committee come up with treatment protocols in lieu of training modules for each procedure that is approved.
 - i. (Members of this subcommittee are Doctors Baker, Norcross, and DesChamps, and a training committee member and Al Smith.)
3. Committee on Dispatch Protocols: To look at the idea of priority dispatch protocols for EMS and to determine if South Carolina should write its own standardized EMS dispatch protocols.
 - i. (Members of this subcommittee are Dr. Perina, Dr. Sorrell, Dr. Baker and Al Smith.)
4. Committee on utilization of data: To develop ideas for analysis that will be useful in the prehospital and the hospital setting -- and for statewide and regional planning. This committee will give guidance to the Division in development of research and reports.

MEDICAL CONTROL COMMITTEE

MINUTES

JULY 25, 1994

2:30 P.M.

Members Present	Others
Debra Perina, M. D.	Al Smith
Ed DesChamps, M. D.	Al Futrell
Doug Norcross, M. D.	
John Sorrell, M. D.	
Robert Malanuk, M. D.	

The chairman, Dr. Perina, opened the meeting by asking for a review of the minutes of the May meeting. Hearing no corrections she declared them approved.

This meeting followed the meeting of two subcommittees which met at 1:00 p.m. These subcommittees met to discuss: (1) medical control via radio orders and also EMS dispatcher training and (2) trends and optional skills in EMS.

Dr. Perina asked for a report from the subcommittee on trends and optional skills. First, Al Smith reported on the changes in the national basic EMT curriculum. He reported that automatic defibrillation was added as a basic skill. So were bronchial inhalers and epinephrine injectors. Indications for MAST trousers have changed. The new indications are only for lower extremity injuries and pelvic fractures associated with shock. AED was also added to the curriculum. Ipecac was deleted. An advanced (12-hr.) airway module was offered for local decision for inclusion.

Dr. DesChamps said that the subcommittee was concerned about the need for medical control over the basic EMT and that the changes in curriculum might require the medical control physician to have both responsibility and authority over the basic EMT.

Dr. Norcross said that he felt the medical director must have the ability to remove an EMT from service if the medical director has a patient care problem with that EMT.

The regulations are worded that the medical control authority over the basic EMT is as deemed appropriate by the ambulance service director.

Mr. Futrell then stated that this request would necessitate a rules change. He then outlined the process necessary to change the rules.

Dr. DesChamps said that he felt it was important for the committee to go on record that they suggest that the regulations be changed to give medical control physicians authority over the Basic EMT.

Dr. Sorrell agreed that he felt that any EMT should have medical control if they are to provide patient care.

Mr. Futrell said that in conjunction with requirements of the new curriculum we will want to have medical control over the basic EMT.

Dr. Norcross made the motion that current EMS regulations, Section 302, part C, be changed to read, "that the medical control physician must give authorization before any EMT may perform any type of patient care and will have disciplinary authority sufficient to oversee the quality of medical care; and may retain other responsibilities as may be negotiated by agreement with the service. Dr. DesChamps seconded the motion. The motion passed.

Dr. Perina suggested that we may wish to issue a directive, noting the change, but at the same time proceed to change the regulations.

Dr. DesChamps made the motion that staff look at other areas of the regulations that may be impacted by this first change and any other changes necessitated by the upcoming new basic EMT curriculum. Dr. Sorrell seconded the motion. The motion passed.

The present regulations speak to levels at or above basic EMTs. We need to go back and include basic EMTs in the regulations. Also, authority rests only with licensed providers, to include the authority for quality control.

Dr. DesChamps made the motion that the state adopt the new language of the new curriculum for all three provider levels for use of MAST trousers, and to be used only with on-line medical control for other causes of hypotension. Dr. Malanuk seconded the motion. The motion passed.

Dr. DesChamps made the motion that Ipecac be approved to be administered only with on-line medical control at all levels and that a letter be sent out to show why the change has been made. Dr. Malanuk seconded the motion. The motion passed.

The optional skill as proposed by the new EMT curriculum was oro-tracheal intubation. It is proposed as a possible separate module within basic EMT training.

There was considerable discussion on the best way to include oro- tracheal intubation in the basic EMT skills and training. After several attempts to develop a motion to include this skill as part of the basic curriculum, all agreed that present regulations did not insure adequate medical control and uniform standards.

Dr. Norcross made the motion that basic EMTs should not be allowed to perform intubation until such time that there is a change in the regulations that insures medical control has authority over basic EMTs, and also that the 12-hour module for this procedure be allowed to be included in the curriculum. Motion passed.

The committee decided that "insect stings" should be first on the agenda of the September meeting.

A request for approval for paramedics to insert oral gastric tubes in infants was denied. It was recommended that this procedure be submitted as a pilot project proposal.

It was suggested that the committee hold its next meeting in September so as to not conflict with the ACEP or surgery meetings.

The meeting was then adjourned.

MEDICAL CONTROL COMMITTEE

Minutes

September 16, 1994

<u>Members Present:</u>	<u>Others present:</u>
Dr. Debra Perina, Chairman	Dr. Richard Miller
Dr. Doug Norcross	Albert M. Futrell
Dr. Ed DesChamps	Alonzo W. Smith
Dr. Bob Malanuk	Doug Warren
Dr. Caughman Taylor	Jimmy Greene
	Phyllis A. Beasley
	Lisa R. Smith
	Sandy Hunter
	Don Whiteley

Dr. Perina opened the meeting by asking for a motion to accept the minutes of the July 25, 1994, Medical Control Committee meeting. Dr. DesChamps made motion to accept the minutes as written. Dr. Norcross seconded the motion. The motion passed.

Dr. Perina then asked the Committee to change the order of the agenda and address the issue of the definition of the state drug list as a standard. She introduced Jimmie Greene who is the Director of Spartanburg County EMS and who has asked that the wording in the introduction to the state drug list be changed from "Any other use of these drugs is not the approved standard and will be considered as non-compliance." Mr. Greene requested that the sentence be re-phrased to allow for some deviation from the state standard of care. Mr. Greene presented a statement from the legal counsel of the S. C. Insurance Reserve Fund which, in summary, said that guidelines should allow some provision for the local medical control physician and EMS Service to deviate the scope of treatment in a "planned and protected manner" since the legal responsibility for standard of care rests with the local medical control physician. (See attachment.)

Dr. Norcross questioned a statement made by Mr. Greene that he didn't want to change the drug list, since a wording change allowing for deviations would give authority for changes in the drug list. Dr. Malanuk and Dr. DesChamps stated that the guidelines for drug dosages are strict for the protection of the paramedics and, ultimately, the protection of the patients. A suggestion was made by Dr. Perina that DHEC's lawyers review the statement. At this time, however, Mr. Greene explained that in 40% of the time, it is not possible to achieve radio contact in Spartanburg County. He said that even with the future installation of 800 MHz, there would still be areas with no ability

to make contact. Therefore, treatment of the patient would be delayed when the paramedics could not reach medical control, as required by the drug protocols.

Mr. Greene, however, stated that his service's concern was simply the situation in which they needed to administer a drug that calls for direct on-line medical control and the paramedics could not make radio control. Dr. Perina said that the Medical Control Committee's main concern with changing the introduction was that a moonlighting physician in an emergency department may not fully understand the rationale for prehospital drug dosages and/or may substitute newly reported research dosages with unproven efficacy and thus potentially put the paramedic and patient in jeopardy.

Dr. Malanuk pointed out that the legal statement asked for the ability to change the drug protocols for medical control physicians who want to "be more progressive." He said that this is in direct conflict with the purpose of the drug list and addresses more than just the problem of lack of radio contact.

Dr. DesChamps suggested that Spartanburg Co. EMS propose a pilot project for areas noted with specific radio problems which would address the instances in which radio contact could not be achieved. The direction of such a pilot project would be that if attempts are made to get on-line medical control and these attempts are not successful, the paramedics would proceed with the treatment consistent with the drug list. He said that these cases would be flagged and documented for quality assurance.

Mr. Greene agreed that a pilot project of this nature would meet his legal and procedural concerns. Dr. Taylor asked if the legal aspect should still be addressed. Mr. Futrell said that he would proceed with DHEC's legal examination of the statement in case the pilot project is successful and its terms are incorporated into the preamble of the drug list. Therefore, the Medical Control Committee recommends to Mr. Greene and Spartanburg County EMS that they submit this proposal as a pilot project.

The Committee then addressed the agenda item related to the draft letter regarding the proposed procedures for radio medical control orders. A subcommittee had rewritten the policy/procedure for radio medical control orders and had drafted a letter for approval. (See attached.) A motion was made by Dr. Malanuk to send the letter to the field. Dr. Norcross seconded the motion. The motion passed.

The next agenda item was the subcommittee report on dispatch training ideas. Dr. Perina asked Doug Warren to present this report. At the last meeting of the subcommittee, it was discovered that the dispatch training procedures were near completion and Mr. Warren was involved in the 911 training steering committee of the S.C. Criminal Justice Academy which was developing the dispatch curriculum. The subcommittee had sent some recommendations related to dispatch training to the 911 committee via Mr. Warren. Dr. Perina explained that the current medical segment of dispatch course involved only 6 out of the total 34 hours of training. The subcommittee had asked

that components of the Claussen system or some form of a medical decision tree dispatch responses be considered for that curriculum. Mr. Warren said that he had not received word of a response to the subcommittee's request and that he did not have information concerning the date by which the dispatch curriculum development would be completed by the staff at the Criminal Justice Academy. Mr. Warren will investigate this further and advise the medical control committee at the next meeting.

At this point, Mr. Smith returned to concerns related to the drug list. He stated to the committee that he would send out the drug list as adopted and would also send out the interfacility drug transport form with the change adopted earlier. Also, a statement will be added to the preamble indicating hyperalimentation infusion is the only exception to transporting a patient with a central line.

The next item on the agenda was the review of Greenville Memorial Medical Center's response to the redesignation requirements. Greenville Memorial had presented to the Division of EMS staff a letter delineating their actions to remedy the identified weaknesses/deficiencies. Prior to the Medical Control Committee meeting the Division of EMS staff had reviewed the letter and appendices and had prepared a letter stating that "The hospital has well addressed the deficiencies noted in the Committee's review, to include a very complete appendices of background material....They should be commended for an excellent trauma program." Dr. Norcross made a motion to approve Greenville as a designated Level I trauma center. The motion was seconded by Dr. Malanuk. The motion passed.

Dr. Norcross then reported on the activities and recommendations from the Trauma System Committee held earlier in the day. The Trauma System Committee had addressed the issues of designation of pediatric trauma centers and adoption of the 1993 ACS criteria for the designations of Level I, II, and III trauma centers. The Trauma System Committee chose not to address Level IV criteria at this time. Dr. Norcross made a motion to accept the Trauma System Committee's recommendation to adopt the 1993 ACS criteria for Levels I, II, and III trauma centers. Dr. Malanuk seconded the motion. The motion passed. Dr. Norcross then explained that the Trauma System Committee had formed a subcommittee to pursue the issue of designations of pediatric trauma centers or adult trauma centers with special pediatric capabilities and to possibly develop special pediatric trauma criteria for Level III hospitals. Dr. Taylor commented, regarding pediatric criteria for Level III, that any attempt to upgrade care of the pediatric patient is important.

The next item on the agenda was the proposed regulations on insect stings. Don Whiteley reported that, following the Committee's requests, he had obtained copies of the laws from Tennessee and North Carolina, and had sent the S.C. law to S. C. Medical Examiners, the S.C. Allergy Association, the Pharmacy Board, the S.C. Medical Association and the S. C. Chapter of ACEP for comment. Concerns of the Medical Control Committee are the liability of the instructors who train the lay people to use epinephrine and the fact that lay people will be able to obtain this drug to have on hand even if there is no known patient under their supervision. DHEC has been charged with developing the rules and regulations related to this law. Dr. Norcross pointed out that the other state's laws did

not address the protection of instructors. Dr. Taylor also stated his concern that persons who have undergone a brief training will be allowed to possess a drug that has so many side effects. He said that he felt the law should be changed to prevent the misuse of epinephrine. He said that the S. C. Chapter of the Academy of Pediatrics, of which he is a member, will write a letter expressing its disapproval over the possession issue. Mr. Futrell explained that the DHEC Board could be made aware of the problems associated with this law. Dr. Taylor said that, as legislative liaison for the S. C. Chapter of Pediatrics, he would contact a legislator and attempt to introduce legislation. At this point, the discussion was tabled.

The Committee then asked Sandy Hunter, Training Coordinator for Anderson EMS/Medshore, to present his pilot project proposals. Mr. Hunter gave an overview of the project to use aspirin in the prehospital setting to improve the outcome of cardiac patients. Discussion of the Committee supported this pilot project, but suggested that the dosage used in the project may be increased to 325 mg, which is a regular dosage of aspirin, providing there is no history of a reaction. The Committee agreed to allow the pilot project with the aspirin dosage range to be up to 325mg. Dr. Deschamps made a motion to approve the pilot project, with an amendment to suggest that studies have shown that dosages of up to 325mg of aspirin have been effective and that they may wish to consider altering the dosage up to this amount which would be allowed in this pilot project without re-approval. Dr. Malanuk seconded the motion. The motion passed.

Mr. Hunter explained the Zantac pilot project. In summary, at Anderson there are frequently not enough nurses available to transport patients with duodenal ulcers receiving Zantac drips. The physicians must then cease the Zantac drips while waiting for an available nurse or to allow a paramedic to transport the patient. The wait, in combination with transport times which can be several hours to Atlanta, sometimes ran up to four or six hours. The Committee expressed concern that the number of drugs being added to the transport drug list is too cumbersome and that the drugs included on the list should be limited to only the essential ones. The Committee also stated that Zantac could be administered by some other means such as NG, bolus or p.o. The Committee determined that although the pilot project could be approved for a limited time and might not necessarily be added to the interfacility transport drug list, there are other reasonable alternatives of administration of Zantac which could be used by the physician that would not result in transport delay. Dr. Taylor made a motion that the Zantac pilot project be rejected. Dr. Norcross seconded the motion. The motion passed. Dr. Perina made note that Mr. Hunter gave an excellent presentation of the project. However, after the Committee's review of the drug manufacturer's evaluation, they determined that there are alternative methods of administration which would not require a delay of transport.

The last item on the agenda is new procedures and trends in prehospital advanced life support. Dr. Deschamps explained that there had been no action by the subcommittee, other than to ask that a letter be sent out to prehospital providers asking them to report new procedures or trends in advanced life support for which additional training should be provided. He said that it had been suggested that videotapes related to individual procedures could be circulated and used as continuing

education. Mr. Smith said that the letter had been sent out, but no responses had been received. He agreed to send the letter again. Dr. Deschamps said that the Committee may want to consider the interfacility drug list and determine what's going to be on the list and how long it should be.

Mr. Futrell asked if 0.9 is the normal solution for saline because some providers have asked if they could run half normal solution. Does normal saline mean up to 0.9 or only 0.9? The Committee agreed that this means solutions up to D5 and up to normal, or 0.9, saline can be used. This will be corrected in the drug list.

Dr. Perina stated that the new procedures subcommittee might also want to consider, in light of health care reform, the settings in which paramedics practice. In New Mexico, paramedics are performing as physician extenders performing assessments and in New Mexico and Utah paramedics are immunizing children in rural areas. Mr. Warren stated that the Long Range Planning Committee had asked a task force to look at ways in which health care reform will affect paramedics.

The next Medical Control Committee will be held sometime prior to November 10th, probably the first week of November. Division of EMS will poll the members for appropriate meeting dates. With no further discussion, the meeting was adjourned.

MEDICAL CONTROL COMMITTEE

Minutes

November 2, 1994

<u>Members Present:</u>	<u>Others present:</u>
Debra Perina, M.D. Chairman	Michael Stein, M.D.
Doug Norcross, M.D.	Albert M. Futrell
Ed DesChamps, M.D.	Alonzo W. Smith
Bob Malanuk, M.D.	Doug Warren
John Sorrell, M.D.	Joe Fanning
Richard Bell, M.D.	Phyllis A. Beasley
Carol Baker, M.D.	Don Whitely
William C. Gerard, M.D.	Thomy Windham
Marni Bonnin, M.D.	Judy Jones, R.N.

Dr. Perina opened the meeting by asking for a motion to accept the minutes of the September 16, Medical Control Committee meeting. The minutes were approved by the consensus of the committee members.

Dr. Perina welcomed the newest member of the Committee, Dr. Marni Bonnin, who is now the Medical Director for the Midlands EMS Region.

Regulation 7

The first item on the agenda was the review of Regulation 7 with the changes necessary to require medical control for the basic EMT as well as the intermediate and advanced EMT's.

Dr. Norcross asked if this direction was going to make it impossible for any of the licensed services to continue in the business. Al Smith said that only a few ambulance services presently functioned without a medical control physician. He said that requiring medical control on these should not present a problem.

The first change in the regulations is found under Section 302 C. This would now read "The Medical Control Physician may have disciplinary authority sufficient to oversee the quality of patient care for all EMS personnel and retain other responsibilities as may be negotiated by agreement with the service." This was approved at the last Committee meeting and later approved by the State EMS Advisory Council.

The change in this portion of the regulations also required changes elsewhere in the regulations. The first of these is the definition of the On-Line Medical Control Physician: (found on page 3). It would now read "The physician who directly communicates with EMT's regarding appropriate patient care procedures en-route." "An on line medical control physician must be available for all units performing procedures designated as such by DHEC."

The next area that was changed was the first two paragraphs in section 302 entitled, MEDICAL CONTROL PHYSICIAN. It would now read, "Each licensed provider that provides patient care shall retain a medical control physician to maintain quality control of the care provided, who's functions include the following: A. Quality assurance of patient care including development of protocols, standing orders, training, policies, and procedures: and approval of medications and techniques permitted for field use by direct observation, field instruction, in-service training or other means including, but not limited to:"

The last area needing change was Section 802 C. It would now be titled "Guidance for EMT's" This section would now read "All emergency medical technicians may only 'engage in those practices for which they have been trained' in a state approved curriculum and for which the supervising physician will assume responsibility." "In all cases, an EMT will perform procedures under the supervision of a physician licensed in the State of South Carolina." "Means of supervision should be direct, by standing orders or by radio and telephone communications."

In discussion of these changes a motion was made, but withdrawn that page 40, Section 802 A, line 9 be changed to read EMT's so certified, may perform those functions taught in the approved basic EMT curriculum if they are employed and functioning under the auspices of the licensed provider.

The withdrawn motion was introduced during a discussion questioning the authority of the EMT to provide service anywhere outside his/her service. Discussion also included the problem of physicians who have no emergency medical capability giving medical directions on the scene. Dr. Sorrell suggested that the state supply all EMTs with the cards that state that if the physician is to give medical direction then he has responsibility for the patient and must accompany the patient to the hospital. The committee agreed that every EMT in the state should have such a card. Dr. DesChamps made the motion which was seconded and passed that no changes be made in this area of the regulations at this time.

These revisions were then presented as a group for approval. Dr. Baker made the motion, seconded by Dr. Sorrell that all revisions as listed be approved. The motion passed.

Role/function of paramedics in situations outside the prehospital setting.

Dr. Baker then asked for discussion of using paramedics outside the pre-hospital EMS system. She felt that we need to address the need for utilizing the paramedics outside the ambulance service

itself. The jail in Greenville wishes to use paramedics to screen and provide services as an extender to the physician. It was suggested that if the county EMS contracts for EMTs to work at the jail it might be OK.

Dr. Sorrell said he would like to see an EMT perform services only when working with a licensed service. Dr. Perina said that legally the paramedic cannot function as a paramedic outside his service's area unless he has special permission by medical control to perform these services.

Dr. Perina said that EMS regulations do not prohibit paramedics from providing services for which they are trained, provided it is done as a recognized skill within a hospital or like setting. However neither do the regulations enable the paramedic to perform the skills.

Dr. Malanuk asked if a paramedic, who is outside his area/service, can practice his skills as a paramedic. Mr. Futrell said that he could provide service provided that he does so under direct medical control. Discussion ensued how different scenarios of hospital settings vs. jail or other settings affected the ability of the paramedic to perform his skills. Mr. Futrell said the paramedic cannot work in an emergency room or other situation as a paramedic, but this person can perform these services under a different job description in the setting outside the prehospital setting if he is under the direct control of a physician. Mr. Futrell said that if we are to allow the paramedic to function as a "paramedic" it would require a different ruling by the legal department or a change in the law.

Dr. Sorrell suggested that we need to look at options with the nursing practice act. Dr. DesChamps requested that staff study the subject, asking the opinion of the Board of Medicine and the Board of Nursing regarding the EMTs of all levels being able to perform their skills in setting other than the ambulance/EMS. Also ask if the nursing practice act or any other act either enables the EMT to perform or prevents him from performing his functions in the hospital or other setting outside the ambulance/EMS. These two organizations should also be invited to the next medical control meeting. Staff was also asked to check with the states of Florida and New Mexico to determine under what circumstances paramedics function in the hospital setting in their respective states. Among those questions to be answered are can a paramedic work in the hospital setting as (1) a separate job, or (2) as a part of an ambulance service which is separate from the hospital, or (3) as a part of the hospital's ambulance service.

Dr. Perina suggested that this discussion might be premature and that staff should develop research in this area. This subject is to be placed on the agenda of the next meeting.

Dispatch Training

Doug Warren was then asked to give a report/update on what was happening with dispatcher training within the Criminal Justice Academy. Doug said the curriculum is ultimately determined by the advisory council of the criminal justice academy. They have recently hired the person who will run

the dispatching program at the academy (Gene Wicker). Gene has stated that he has some concerns/reservations regarding the use of prearrival instructions as part of the dispatch protocol. Now that he is on board he is rewriting the curriculum to include the EMS portion. Mr. Warren expressed concern that the part of the EMS portion of the curriculum could be deleted. Doug requested that both Mr. Futrell and Dr. Perina write letters expressing the necessity of leaving all EMS portions as they are. He will provide them with an outline to cover the concerns. The letters should be written to Billy Gibson, Dir. Criminal Justice Academy.

New Trends

Dr. Perina suggested that the topic of new trends in EMS be postponed until the next meeting, to be placed first on the agenda.

Process for re-certification of paramedics

Dr. Sorrell explained the request to change the process for the certification/recertification of paramedics. His case is a nurse who is eligible to sit for the test. She can sit for the test but cannot get her license "paramedic certification" until a medical control physician signs her off. She has six months to find a position with medical control. Dr. Sorrell said that the license should be given by DHEC without medical control sign off. He said that once they had that license or "certificate of competence" he/she could not practice as a paramedic until he/she becomes a part of an EMS organization. Dr. Baker said she had had a similar position, where a person wanted to be licensed but did not want to work for a service. Nurses may want to become a paramedic to teach, without practicing in the street. Mr. Futrell said that the paramedic can only perform those procedures for which they have been trained and have a physician to sign off for them.

The committee agreed that they all feel that the system puts the medical control physician in a precarious position of having to sign for the person before they are certified. After much discussion in defining the problem as well as determining possible solutions, the chairman suggested that this item be tabled until the next meeting.

The question was asked as to where is it written that a paramedic must be hired by a service and signed off by a medical control physician before they get their certification. Is there anything in the regulations that before a basic EMT can take a paramedic course he must be part of a service? Mr. Futrell said that he sees nothing specific in the regulations, but it is in the policy.

Staff report on trauma and EMS for Children

Phyllis Beasley gave a brief report on the progress of the trauma and EMS for Children grants. She stated that both grants have been funded and that work has begun in each of the areas, though there has been no approval yet to hire the staff. She expressed concern that staff will have the time necessary to carry out the schedule to provide the logistics and review of all trauma centers every

two years. If we are to stay on schedule the level III trauma centers should be reviewed again next year. She reported that a number of meetings have been completed for the purpose of developing regional trauma plans. These are near completion and hearings should be scheduled to publicize these plans. Other hospitals have also expressed interest in becoming trauma centers. The federal grant for trauma specified that we should give special emphasis should be placed on trauma legislation to continue the support for the trauma system development and maintenance. Also, on Nov. 10 the organizational meeting of EMS for Children will be held to develop membership and some early planning issues.

There was some discussion regarding the agenda and the dates for the next meetings. It was decided that the committee would not meet at the Symposium in February. Instead it would be best to have a regular meeting in Columbia in January and a meeting to review the "Drug List" in March.

Staff was requested to poll the membership before November 15 to allow physicians to have time to work up their January schedule around the meeting date. Staff agreed to poll the members for appropriate meeting dates. With no further discussion, the meeting was adjourned.

The first change in the regulations is found under Section 302 C. This would read "The Medical Control Physician may have disciplinary authority sufficient to oversee the quality of patient care for all EMS personnel and retain other responsibilities as may be negotiated by agreement with the service. This was approved at the last Committee meeting and later approved by the State EMS Advisory Council.

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The change in this portion of the regulations also required changes elsewhere in the regulations. The first of these is the definition of the On-Line Medical Control Physician: (found on page 3) It would read "The physician who directly communicates with EMTs regarding appropriate patient care procedures en-route." "An on line medical control physician must be available for all units performing procedures designated as such by DHEC."

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A. Quality assurance of patient care including development of protocols, standing orders, training, policies, and procedures: and approval of medications and techniques permitted for field use by direct observation, field instruction, in-service training or other means including, but not limited to:"

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The last area needing change was Section 802 C. It is now titled "Guidance for EMTs -" This section has been changed that it would read "All emergency medical technicians may only 'engage in those practices for which they have been trained' in a state approved curriculum and for which the supervising physician will assume responsibility." "In all cases, an EMT will perform procedures under the supervision of a physician licensed in the State of South Carolina." "Means of supervision should be direct, by standing orders or by radio and telephone communications."

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