Making Med Control Work For You

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Disclosure

No relevant disclosures

Learning Goals

-Review how to make an effective and efficient Med Control presentation

-Discuss the difference between A&Ox4 and Decisional Capacity

-Review NM state law regarding forced transport

What is Medical Control?

NM: Medical Control Emergency Physician

Why do crews call Med Control?

Complicated Refusals

Termination of Resuscitation

Psych Diversion

Medication orders beyond written protocol

Prisoner Clearance

I don’t have a protocol for this

The Goal

What happens

Hallmarks of a great Med Control presentation

1). Introduce yourself

2). Start with the question

3). Organize your thoughts

4). At least one full set of vitals

5). Closed loop communication

Introduce yourself

“Hi this is Chris Root, I’m a paramedic calling from UNM Rapid Response”

Start with the question.

“I’m calling for termination of a cardiac arrest.”

“I’m calling for a high risk refusal.”

“I’m calling for additional midazolam for an agitated patient.”

“I’m calling because I have a weird situation and I don’t know what to do.”

Organize your thoughts

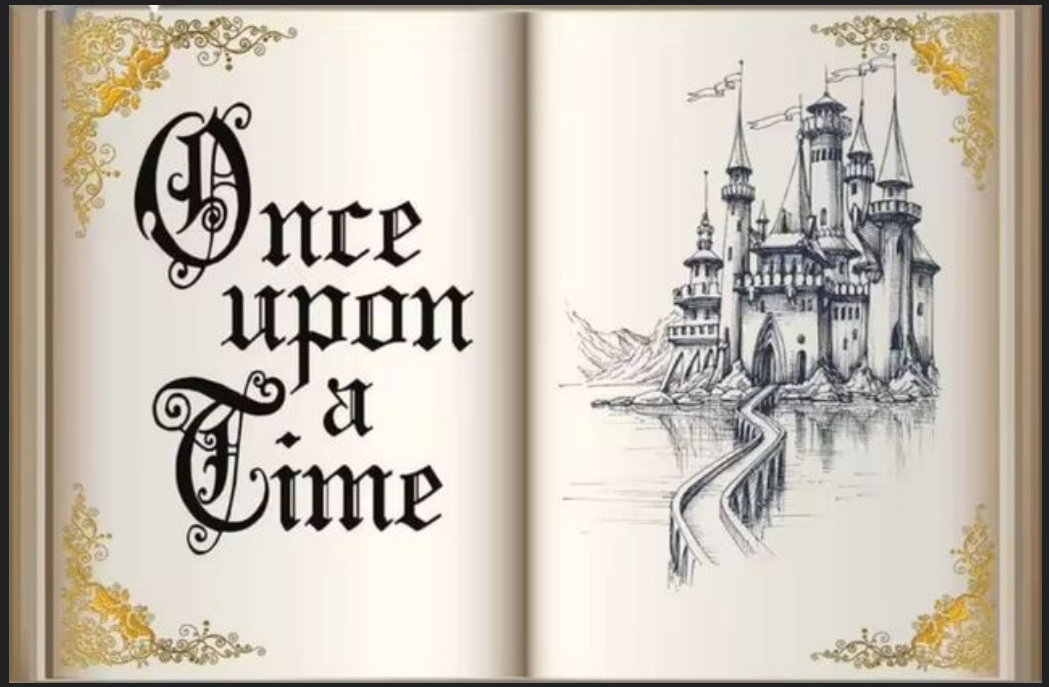
Dispatch

Chief complaint

History

Assessment

Rx/Treatment so far



Don’t say “stable”

At least one full set of vitals

Closed loop communication

Repeat back the doc's orders to confirm you're on the same page.

"Copy that, I will administer 5mg midazolam IV."

"Understood. Termination of resuscitation at 2021 hrs."

Complicated Refusals

Complicated refusals and forced transport

Universal Citation: NM Stat § 24-10B-9.1 (2021)

Any person may be transported to an appropriate health care facility by an emergency medical technician, under medical direction, when the emergency medical technician makes a **good faith judgment** that the person is **incapable of making an informed decision** about his own safety or need for medical attention and is **reasonably likely to suffer disability or death without the medical intervention** available at such a facility.

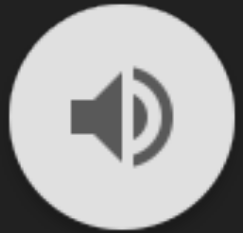
“A&O x 4” ≠ Capacity

Patient must demonstrate insight into their decisions

Does she have to go?

Patients are allowed to make decisions we might not agree with.

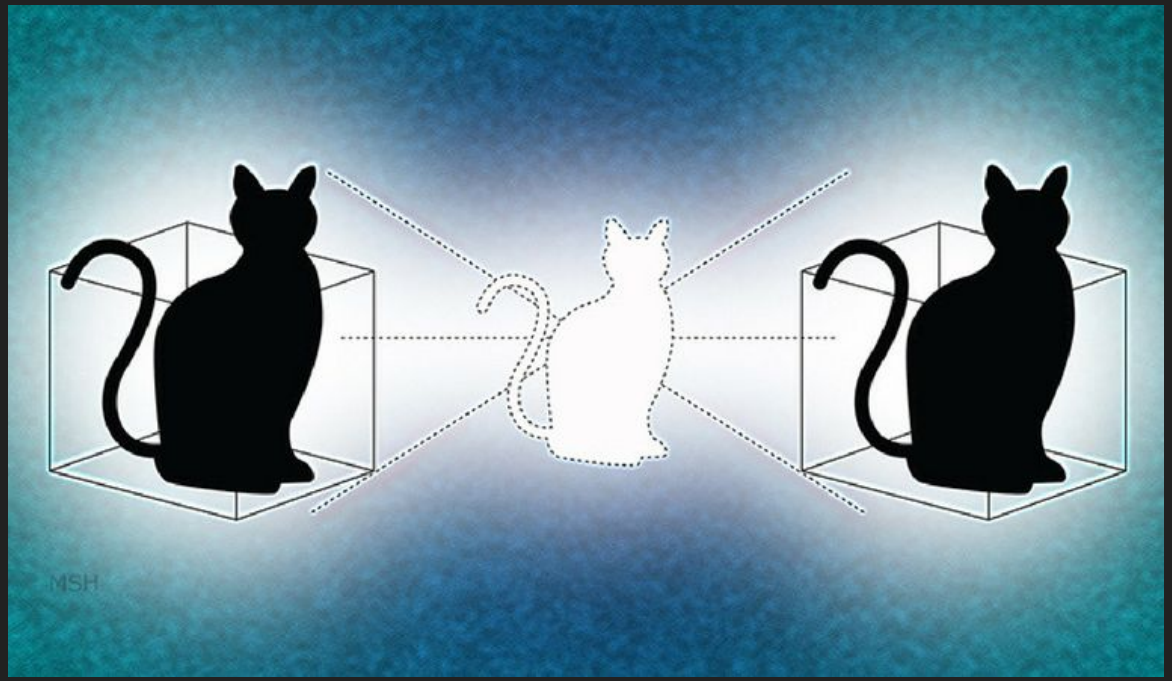
Does she have to go?



Terminating Cardiac Arrest

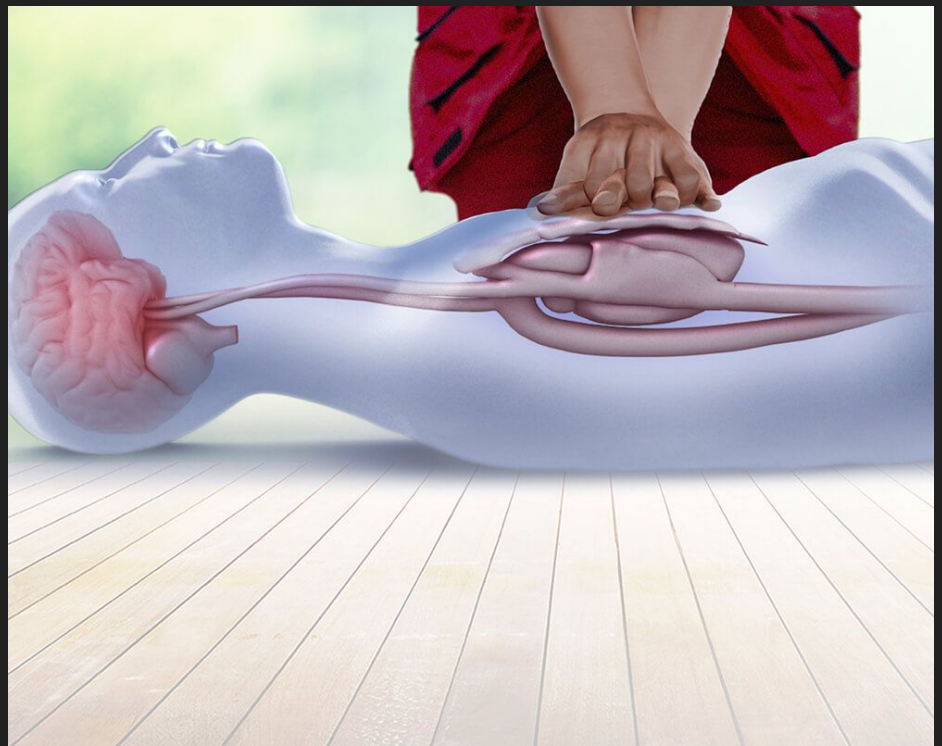
What factors matter to you? When do you call? Do you have protocolized criteria?

Patient is either dead or in cardiac arrest



When in doubt, Start CPR

You don’t have to wait 20 min to call for termination



Terminating Cardiac Arrest

Resuscitation efforts may be terminated in the field after preferential EMS Consortium call and/or hospital MCEP secondary for approval if the following conditions apply:

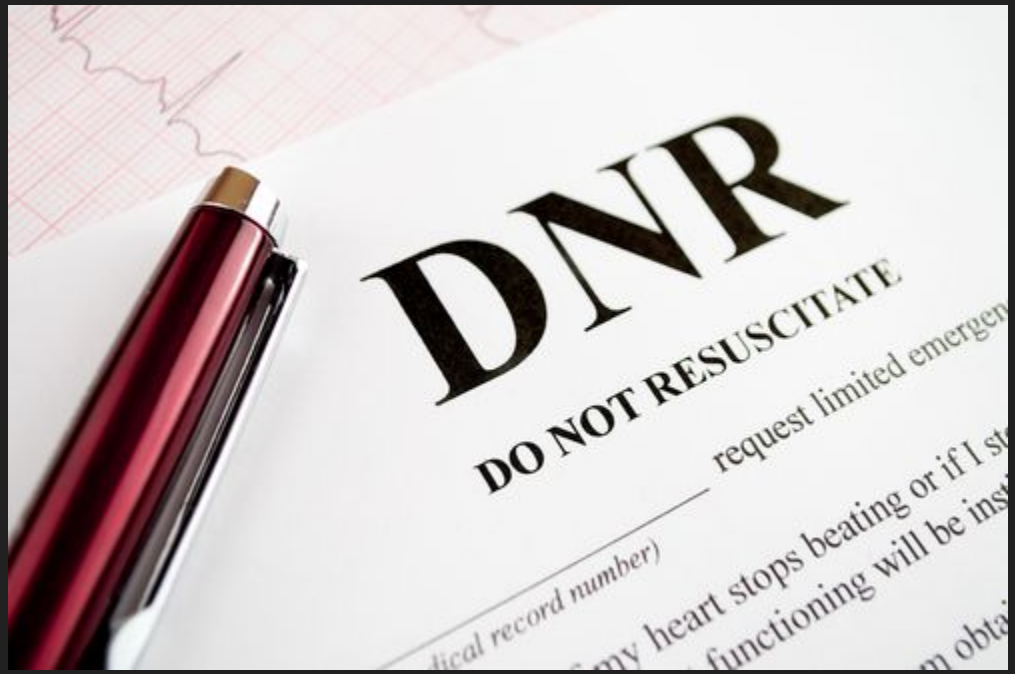
- ALS interventions have been implemented for at least 30 minutes, and
  - No return of spontaneous circulation (ROSC) occurred, and
  - The terminal rhythm is asystole
  - The arrest is not the result of hypothermia; if so consider early EMS Consortium consultation for possible EMCO cannulation.
- Any patient who presents in the following rhythm at any point during the resuscitation will be resuscitated on scene for a minimum of 40 minutes:
  - **Ventricular Fibrillation**
  - **Ventricular Tachycardia**
  - PEA >40 bpm

Terminate resuscitation efforts WITHOUT MCEP CALL if the following criteria met:

- Unwitnessed or unknown downtime with persistent, uninterrupted asystole for 20 minutes despite ACLS

Advanced directives

Family says stop but there’s no DNR



Terminating Arrest

Review

Introduce yourself and start with the question.

A&O x 4 does not equal decisional capacity

Forced transport: good faith judgement, lacks capacity, likely to come to harm.

When in doubt, start CPR.

It okay to call MCEP early if you feel like you should stop early.