SAGINAW VALLEY
MEDICAL CONTROL AUTHORITY

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MEMO

#2009-2

TO: All EMS Providers and Agencies

FROM: Noel Wagner, M.D.
Medical Director

DATE: February 25, 2009

RE: Cardiac Arrest

This is a follow up to the Cardiac Arrest Memo of February 9, 2009. Most of you have read it and many have offered insight as well as asked some excellent questions. This memo is intended to clarify the original and answer some of these questions. **Everything that was stated in the original memo is accurate and still in effect.**

1. Movement. The directive not to move does not preclude proper positioning. Moving from the bed to the floor or the bathroom to the hall is a 5 second move and is necessary for proper working space. We are trying to discourage long moves that do exceed 5 seconds (or so).
2. The only reason to move quickly to the hospital is if they have something you do not. A perfect example is known blood loss. A blood loss patient (AAA, varicies, GI bleed, etc.) is more like a trauma patient than a medical patient and rapid transport is indicated. For most sudden cardiac death patients, **CPR**, **defibrillation**, O_2, vasopressin, epinephrine, atropine, amiodarone, lidocaine, magnesium, calcium, and bicarb are what is usually needed and is at every patient's side.
3. Environment. An acceptable reason to move a patient is that you are physically incapable of caring for the patient. Snow covering you and the equipment, a downpour, or a wind chill that prohibits you from properly using your hands all qualify as reasons to move. Likewise bonafide risks such as fire, gunfire, and traffic all qualify. Survival is affected by CPR lapses, but you must weigh this against your own safety during resuscitation.
4. Time. The resuscitation time recommendation is a time to reassess. An elderly person who was found down has a different prognosis than a young, previously healthy person who received CPR starting in the first half minute of their arrest. On one you should stop and the other you should continue. Every case is different and must be treated as such. 25 minutes is a guide for stopping, moving, or continuing.
5. Termination. This directive for aggressive resuscitation does not affect the ultimate decision to transport or terminate. It only affects how we will resuscitate a medical cardiac arrest. In the future, we will examine the endpoint of our arrests, but for now this part has not changed.

6. Physician on scene. This is always difficult, and is even more so in a cardiac arrest. Our new policies will address the difference between a stranger physician (one who wanders onto the scene) and a known physician (the patient's own doctor). You are under no obligation to follow the directives of a stranger physician if they cannot produce identification, if you feel they are inappropriate, or if they will not accompany you to the hospital. The patient's own doctor is a different situation. He or she has a pre-existing relationship with the patient. We will attempt to accommodate this type of physician/patient relationship. You may take orders from them. They do not need to accompany their patient to the hospital. You should still attempt to do what is right keeping in mind that they are probably not versed in the most current state of cardiac resuscitation. It is a difficult situation. Try and do what is right, but this must be tempered with the interaction with the patient's pre-existing doctor. There will never be any negative consequences from my office for any one who tries to do the right thing, but is directed differently by the patient's established physician.
7. Out in the middle of nowhere. If you are in an isolated area and a second unit is not coming, it still is appropriate to aggressively resuscitate. The purpose of resuscitation is to get a return of circulation. A two person move and transport to the hospital is not as desirable as it would be with more providers. It makes sense to maximize the procedures and techniques that will give you the best chance of survival before the suboptimal movement. This also applies to BLS on scene and a long ALS response time. With CPR and defibrillation being the hallmarks of good resuscitation, it makes no sense to attempt a suboptimal movement early in the process.
8. Family/public concerns. All of the first responder organizations have been instructed on how we will proceed. Additionally, all of the law enforcement agencies are aware and should be prepared to help us. We will all benefit from being on the same page. If someone questions what we have done medically after the call, it is my job to handle it. If we have resuscitated the patient as we should, I have no problem helping the family to understand what we did and why.
9. Modesty. After the pads are applied, you can appropriately cover the patient. CPR can be done with a towel, a sheet, a pillow case, etc. on the chest.
10. Pediatrics. You need to use your best judgment on these patients. No one ever met you at the ambulance with patient during an adult cardiac arrest. I do understand that you can probably do good compressions in a moving ambulance on an infant or child. You should understand that you will not be able to properly start an IV or IO while the ambulance is moving. All that is expected is that you can continue to provide continuous CPR and be in a situation where you can accomplish your critical procedures.

This list is extensive, but not all inclusive. We are not trying to eliminate "common sense." Remember, you must keep in mind what is known about resuscitation medicine and make every effort to adhere to those principals. It is not "sense" when you lose sight of the underlying concepts. When you deviate from the desired plan, there needs to be a legitimate reason other than tradition, habit, or being uncomfortable with the situation.

If you have any additional concerns please feel free to contact me. I can still be reached at nwagner@synergymedical.org.