



GUEST COMMENTARY

Adios, Rampart: *Give medical control the boot*

By Bryan E. Bledsoe, DO, FACEP, EMT-P

I MUST CONFESS THAT I'M AN EMS DINOSAUR. I TOOK ONE OF THE first paramedic classes in north Texas and worked the mean streets of Fort Worth for several years during the 1970s. EMS of that era was both different from and the same as the practice of today. The patients and their problems were the same, but the way we approached them was a little different. EMS was a little less scientific and a lot more anecdotal. We used to lug nearly 100 lbs of medical equipment to virtually every call: a 50-lb defibrillator, a 20-lb biophone and 30 lbs of bulky Plano 747 tackle boxes stuffed with everything imaginable.

Medical control in the 1970s was a “Mother-may-I” proposition. No ALS skills could be applied until Medical Command received a patient report and issued orders. Often, the orders were simply, “Administer 2 L oxygen per minute and transport.” *Another common activity:* We would frequently telemeter an ECG to Medical Command so the online physician could confirm our dysrhythmia interpretation. Rarely were we wrong—and they knew it.

A large city 30 miles to the east required telemetry on virtually every call. The system had just eight available Biomed channels and the constant telemetry made it difficult to contact Medical Command. In that city to the east, internal medicine residents worked with nurses in the county hospital emergency department (ED) to manage medical control. The orders we heard via the Biomed channels often included, “Give the patient two red boxes and one blue box,” referring to the era’s standard two amps of sodium bicarbonate and one amp of epinephrine. Defibrillation was allowed when the medical residents felt confident the erratic waveform on their telemetry screens was ventricular fibrillation instead of the more common dysrhythmia—patient artifact.

Even then, we were well-trained. We generally knew what the patient’s problem was and the preferred prehospital treatment. We soon learned the online practice patterns of Medical Command physicians and started to “dial-a-doc” to reach the physician who commonly gave the orders we felt were most appropriate for our patient. We always strove to administer the best possible care to our patients, despite online medical control orders.

Today, paramedic education is more comprehensive and sophisticated than ever. In focused areas, paramedic skills rival those of physicians. Then why do we still have online or direct medical control? I’ve ridden on many calls with Australian paramedics and have never seen them call online medical control.

For more than 14 years I’ve been on the other side of the EMS radio. I’m the doctor who has to take off his sterile gloves when suturing an eight-month-old child’s forehead to walk to the EMS radio in

order to take a report from a paramedic who knows as well as I do what the patient needs. In fact, my delay in getting to the radio may adversely impact patient care.

This ritual has no basis for continued existence. Was there ever really a need for online medical control? Probably not, but the practice was necessary to obtain and establish the blessing and respect of the medical community. So why don’t we completely discard this whole, silly notion of online medical control?

One possible reason: Many emergency physicians are reluctant to give up the concept because it provides them an avenue to divert ambulances to other facilities when their ED patient census is high. This indicates the patients already in the ED are more important than those in an ambulance. I don’t like this conundrum at all, but it’s really a problem for the medical ethicists to sort out.

Don’t get me wrong, I feel medical oversight of EMS is an absolute necessity. But the concept of *medical control* should be changed to *medical consultation*. The vast majority of prehospital cases can be managed by aggressive, medically sound standing orders. In most cases, a receiving hospital should be contacted only to advise them of the care administered to an arriving patient. We’re only fooling ourselves if we think online medical control provides any added benefit or medical-legal protection.

That said, every EMS provider should be able to contact a physician to discuss a problem case or a case for which pre-approved standing orders don’t apply. Also, every paramedic should be able to transmit a 12-lead ECG for confirmation, if needed. Today, the technology to accomplish this costs virtually nothing.

In this day of decreasing reimbursement, evidence-based medicine and the drive for EMS research, why do we still practice this archaic ritual? By eliminating online medical control, EMS could recognize significant cost savings, decreased scene times and increased paramedic satisfaction.

Of course, constant monitoring of medical practices and procedures should continue via a comprehensive, continuous quality improvement program. This is a fascinating time to be involved in EMS because the medical community is examining every practice and principle and a new breed of EMS physicians isn’t afraid to challenge the status quo. Now is the time to examine online medical control and give it the boot it deserves. ■

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Above: The author, in 1976, working the first ALS call in Fort Worth, Texas. Note the bulky EMS equipment of the day. The child did not survive.