ANSWERING PREHOSPITAL CALLS AS A NON-EMS PHYSICIAN

BEST PRACTICES IN COMMUNICATION AND TELEMEDICAL SUPPORT FOR PREHOSPITAL PROVIDERS

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LEARNING OBJECTIVES

- Review different methods of communication and telemedicine used in the prehospital setting
- Review the setup of “base hospital” systems and medical oversight in the prehospital setting
- Review of medicolegal issues surrounding scope of practice in the prehospital setting
- Review interpersonal and communication skills that can be used to improve patient care and teamwork
- Review and discuss common concerns surrounding consent and capacity
- Review and discuss the principles of scene safety
- Review and discuss the challenges presented by prolonged transport times in austere medical settings
- Demonstrate understanding of how cultural, racial, religious, political, language, and ethnic barriers can impact care in the prehospital setting

I HAVE NO DISCLOSURES.

BASE HOSPITAL CALLS

- MICNs answering a literal radio
- Doctors answering a literal radio
- Doctors answering a phone
- VOIP phone carried by doctor with calls patched in

CALL #1: PRONOUNCEMENT & ETCO2

CASE SUMMARY: 98 YO F IN CARDIAC ARREST

- 5 minutes of downtime before EMS arrival
- Initial rhythm asystole -> PEA -> transient Vtach (shock delivered)
  - PEA rate ranging from 20 – 120 beats per minute
- Interventions:
  - ET tube and IO in place
  - 7 x epinephrine
  - 1 x Bicarbonate
- “At one point we thought we got ROSC”
- EtCO2 ranging between 17 and 35
- Total downtime 50 mins

WOULD YOU PRONOUNCE THIS PATIENT DECEASED?

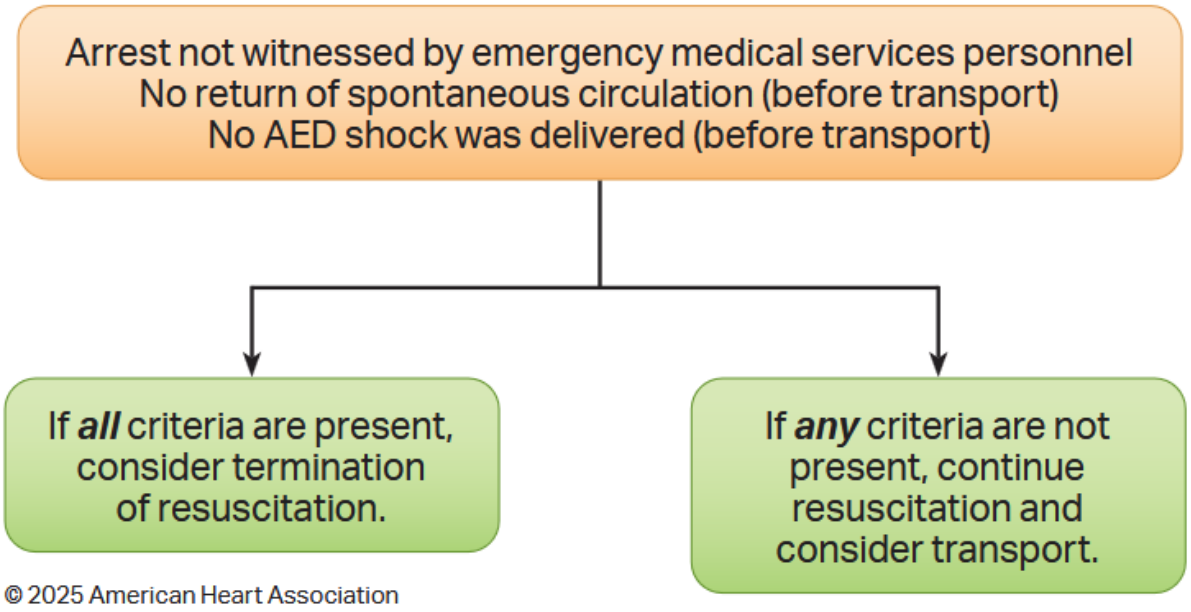
"The pooled incidence of return of spontaneous circulation (ROSC) was 29.7% (95% CI 27.6–31.7%) … and the 1-year survival rate was 7.7% (95% CI 5.8–9.5%)"

Yan S, Gan Y, Jiang N, et al. 2020

"The survival rate declines rapidly when the duration of CPR surpasses 10 minutes and even more rapidly if it exceeds 30 minutes"

Goto Y, Funada A, Goto Y. 2016

BLS/Universal Termination of Resuscitation Rules



"Patients transported without a ROSC who met the Universal TOR Guideline for transport had a survival of 3.0% (95% CI 2.5%–3.4%) compared to 0.7% (95% CI 0.4%–0.9%) in patients who met the Universal TOR Guideline for termination" -- Drennan IR, Case E, Verbeek PR, et al. 2017.

WHAT ABOUT THE ETCO2?

"Initial $ETCO_2$ or 20-min $ETCO_2$>20mmHg appears to be a better predictor of ROSC than the 10mmHg cut off value. A $ETCO_2$<10mmHg after 20min of CPR is associated with a 0.5% likelihood of ROSC."

--Paiva EF, Paxton JH, O'Neil BJ. 2018

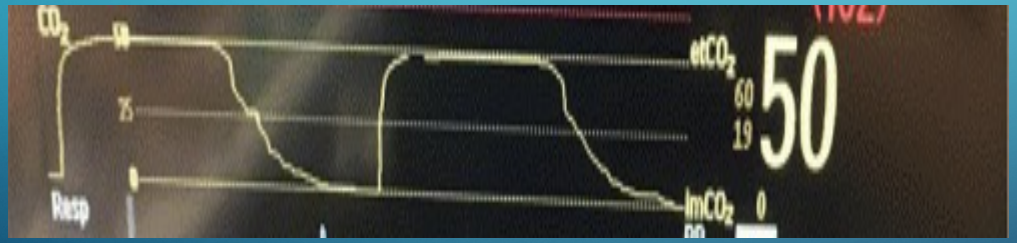


Image credits: Farkas J. Waveform capnography in the intubated patient. EMCrit. Published 5 Aug 2021. Accessed 11 Apr 2026. https://emcrit.org/ibcc/co2

CALL #2: CAPACITY/AMA

Paranoid Delusions.mp3

CASE SUMMARY: ? YO M HIKING THE PACIFIC CREST TRAIL

- Is doing so because he was told to by spirits
- Currently 15 mi into Yosemite National Park backcountry in November
  - Wearing nike sneakers
  - Has “adequate food” but no ice gear
- Reports history of people trying to kill him
- AAOx4/4
- Does **not** desire medical care
- EMS personnel request pt be placed on involuntary psych hold*

*A 5150 is an involuntary psychiatric hold placed by a qualified physician, social worker, or sometimes police that allows for 72 hours of involuntary confinement in a healthcare facility of people who pose a danger to themselves or others due to a psychiatric condition

Image credits: Landes-Michelli C. Weather forecasts. Pacific Crest Trail Association. Accessed 7 Apr 2026. https://www.pcta.org/discover-the-trail/backcountry-basics/weather-forecasts

WOULD YOU APPROVE THIS AMA?

CALL #3: CAPACITY/AMA (AGAIN)

CASE SUMMARY: 30 YO F WITH CHIEF COMPLAINT OF ABDOMINAL PAIN

- Patient would like to AMA
  - plans to have a family member transport her to another ED
  - has an IV in place
- VS notable for bradycardia
- Pt is s/p 50 mcg of fentanyl given approx. 20 min prior
- Pt is on hospital grounds but not yet registered
- Per medic, patient “does have capacity”

WOULD YOU APPROVE THIS AMA?

WHAT DOES EMTALA HAVE TO SAY ABOUT THIS SITUATION?

WHAT HAVE YOU SEEN GO WRONG WITH AMA CONVERSATIONS?

Understand what risks are involved in the situation

Speak to the patient

Understand what the *patient* knows about the risks of non-transport

Explain the situation and the risks of non-transport to the patient

Confirm understanding

Approve the AMA (or not)

WHAT WENT WELL IN THIS CONVERSATION? WHAT COULD HAVE GONE BETTER?

WHAT DUTY DOES THIS DOCTOR HAVE WITH REGARD TO THE PATIENT?
…TO THE EMS CREW?
…TO THE PATIENTS IN THE ER?

TAKEAWAY POINTS

Capacity means “understanding the risks associated with refusal”

Base hospital physicians have a duty to:

a) the patient on the other end of the line

b) the crew on the other end of the line …but also

c) the patient(s) currently in the ER

SOURCES

Drennan IR, Case E, Verbeek PR, et al. A comparison of the universal TOR Guideline to the absence of prehospital ROSC and duration of resuscitation in predicting futility from out-of-hospital cardiac arrest. *Resuscitation*. 2017;111:96-102. doi:10.1016/j.resuscitation.2016.11.021

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QUESTIONS?

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