

POSITION PAPERS

INDUCED THERAPEUTIC HYPOTHERMIA IN RESUSCITATED CARDIAC ARREST PATIENTS

APPROVED BY THE NAEMSP BOARD OF DIRECTORS

PREHOSPITAL EMERGENCY CARE 2008;12:393-394

POSITION STATEMENT

The National Association of EMS Physicians believes that:

1. Induced hypothermia in the postresuscitative period has been shown to benefit select survivors of cardiac arrest. Whether the benefits of induced hypothermia extend to all cardiac arrest patients, and what the most effective means and best time of initiation of this modality are, remain unknown. A lack of evidence on induced hypothermia in the prehospital setting currently precludes recommending this treatment modality as standard of care for all emergency medical services (EMS) patients resuscitated from cardiac arrest.
 2. At present, it is more important to focus efforts on proper resuscitation techniques, including high-quality cardiopulmonary resuscitation and appropriate defibrillation, and attentive postresuscitation monitoring and support.
 3. Further research is needed to examine the ideal time of initiation of induced hypothermia, types of patients likely to benefit, and most practical and effective means of cooling.
 4. Any implementation of prehospital cooling must be done in conjunction with a hospital program that will continue the treatment.
1. Early defibrillation, as part of an emergency response including high-quality bystander cardiopulmonary resuscitation (CPR), is essential to maximizing survival from cardiac arrest.
 2. While there has been increasing attention on the importance of the quality of CPR, early defibrillation is still important. Defibrillation should be preceded by good-quality chest compressions unless the cardiac arrest is witnessed by providers with immediate access to a defibrillator.
 3. All emergency medical services (EMS) responders (including police, fire/rescue, and other types of rescuers when serving in a designated first responder role) should be equipped with a defibrillator.
 4. Public-access defibrillation programs in which non-traditional first responders provide CPR and defibrillation in the first few minutes of cardiac arrest appear to improve survival. Such programs should be integrated with local EMS systems.
 5. Good Samaritan laws or similar legislation should hold harmless any person who uses an automated external defibrillator in good faith.

EARLY DEFIBRILLATION

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POSITION STATEMENT

The National Association of EMS Physicians believes that:

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ROLE OF EMERGENCY MEDICAL SERVICES IN DISASTER RESPONSE

APPROVED BY THE NAEMSP BOARD OF DIRECTORS

POSITION STATEMENT

The National Association of EMS Physicians believes that:

1. Within a defined community, the local emergency medical services (EMS) authority should have a lead role in disaster response and collaborate with other appropriate agencies in a unified command structure as determined by the specific disaster.

2. EMS physicians and administrators should participate in the four phases of disaster management for a defined community (mitigation, planning, response, and recovery).
3. EMS providers are uniquely positioned to respond to disasters and work within an incident command system (ICS). Therefore, EMS providers should be utilized in disaster response at a local level and encouraged to work together and/or participate with support teams such as CERT/MRC/DMAT.
4. EMS physicians and administrators should plan to address the following issues in anticipation of EMS providers' participating in disaster response: licensure, worker protection, liability protection, surge capacity, documentation, and stress management.

PREHOSPITAL MANAGEMENT OF ACUTE MYOCARDIAL INFARCTION

APPROVED BY THE NAEMSP BOARD OF DIRECTORS MAY 14, 2007

A resource document for this position statement appears on page 395.

POSITION STATEMENT

Emergency medical services (EMS) providers care for patients with acute ST-segment-elevation myocardial

infarction (STEMI). The National Association of EMS Physicians recommends that:

- Advanced life support EMS providers and units should have the appropriate training, equipment, and protocols to facilitate early identification and initial care of patients with STEMI.
- Prehospital 12-lead electrocardiograms should be used, whether interpreted by paramedics, direct medical oversight physicians, or other methods, as they facilitate early STEMI diagnosis.
- EMS systems should be integrated with community and regional cardiac care programs to optimize the organization of STEMI care. This may include the transport of selected patients to centers capable of primary percutaneous coronary intervention (PCI) and, in individual systems and circumstances with appropriate training and medical oversight, the prehospital administration of fibrinolytic agents and adjunctive therapy.
- Prehospital EMS communications should be integrated with community and regional cardiac care programs (including early receiving facility notification) to expedite the delivery of STEMI care.
- EMS systems, in cooperation with community and regional cardiac care programs, should undertake quality assurance and improvement measures in the care of STEMI patients.