Council Member Jim Cooper

Olympia City Council,

PO Box 1967,

Olympia, WA 98507-1967

Email: [jcooper@ci.olympia.wa.us](mailto:jcooper@ci.olympia.wa.us)

Phone: 360.753.8447

Dear Councilman Cooper,

First of all, congratulations on your new position on the multi-county Western Regional EMS & Trauma Care Council. I am writing to express my concerns about the Thurston County EMS protocol on chemical restraint and hope you will take my concern to the Council. Chemical restraint by EMTs in non-clinical settings with agitated, unfamiliar patients is inherently more dangerous than chemical restraint in nursing homes, psychiatric wards, hospitals or oral surgery clinics.  I believe we can eliminate chemical restraint by EMTs entirely by adopting methods such as wrapping agitated patients prior to transport, which has been used successfully in Japan. But if we do allow chemical restraint, we must ensure protocols are safe and EMTs are highly trained and not overly influenced by law enforcement officers.

I am concerned Thurston County’s EMS protocol is both out of date and in conflict with drug manufacturer’s warnings and instructions. The TC EMS protocol specifies one dosage of one drug – midazolam 10 mg IV or IM – and gives very little guidance on its use. Midazalom is a potent sedative agent that is used in clinical settings as a pre-anesthesia. Drug manufacturer specifies “continuous monitoring of cardiac and pulmonary function” in a clinical setting and use by “personnel skilled in early detection of hypoventilation, maintaining a patent airway and supporting ventilation.” This is not a drug to take lightly. Drug warnings are very clear. For example, see <https://www.rxlist.com/midazolam-injection-drug.htm#W>.

At a time when we have an opioid epidemic, why are EMTs applying this particular drug on patients they suspect of being under the influence of drugs, as in Vaneesa Hopson’s case and others, when midazalom carries this warning**: *“Using midazolam with opioid medications (such as codeine, hydrocodone) may increase your risk of very serious side effects, including death.”?* We need to review the medications used in chemical restraint carefully, given the fact that EMTs will not have the benefit of drug screening of the patient.**

The National Association of State EMS Officials (NASEMSO) released new draft national model EMS guidelines in September 2017. Refer to pages 53 to 58 of <https://www.ems.gov/pdf/advancing-ems-systems/Provider-Resources/National-Model-EMS-Clinical-Guidelines-September-2017.pdf>

In comparison, TC EMS protocol falls short in many ways. Here are a few I noticed:

* The dosage of midazalom in the TC EMS protocol at 10 mg is twice the level of midazalom specified in NASEMSO guidelines!
* NASEMSO guidelines give several drug alternatives and guidance for adjusting the dosage considering the patient’s condition.
* NASEMSO guidelines give guidance for first establishing patient rapport with verbal reassurance and engaging family members and loved ones. Step number 1 is to attempt to avoid the need for chemical restraint in the first place.
* The TC EMS protocol allows the “assistance/direction of law enforcement” to substitute for physician’s orders for chemical restraint. NASEMSO does not include such a pathway for interference by law enforcement officers in a serious medical issue.
* NASEMSO defines treatment goals, requires patient assessment and continuous monitoring of the patient, and includes exclusion criteria.

I learned talking with Vaneesa Hopson’s family that chemical restraint was applied to her when she was in a prone position, handcuffed with ankles bound and with a spit hood over her face. She had been quiet for 20 minutes prior to the injection. The EMT injected her and then walked away leaving her unattended. When he returned and rolled her over and unhooded her, he discovered she was blue. In light of this case, it is worth quoting the NASEMSO guideline directly:

***The following restraint techniques should be expressly prohibited by EMS providers: restraint or transport in a prone position with or without hands and feet behind the back (hobbling or “hogtying”), “sandwiching” patients between backboards, techniques that constrict the neck or compromise the airway, or EMS provider use of weapons as adjuncts in the restraint of a patient.***

**I understand it is “common knowledge” among medical practitioners that patients should never be sedated in a prone position and left unattended. This causes me to question the training level of our EMTs. In addition to revising the EMS protocols, I hope you will consider training and other methods to ensure EMTs comply with the protocol and best practices and also are not unduly influenced by law enforcement officers in making medical decisions.**

**Thank you for your attention to my concerns.**

**Sincerely,**