

## Fend-Boehm, Valerie A. - EMS

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**From:** David Kim [boisedave@hotmail.com]  
**Sent:** Tuesday, October 31, 2006 5:24 PM  
**To:** sivertsk@slwrmc.org; kaniksu@alumni.ucsd.edu; dtk6@cornell.edu; scottfr@earthlink.net; KBRAMWELL@emidaho.com; msturkie@emidaho.com; ccsandymd@gmail.com; a\_deutchman@hotmail.com; dmckinnon50@hotmail.com; emartine@house.idaho.gov; EMS Physician Commission; Fend-Boehm, Valerie A. - EMS; Cay.Berg@inl.gov; ktsiv@juno.com; bat@my180.net  
**Cc:** Gainor, Dia - EMS; Nudell, Nick G. - EMS  
**Subject:** RE: EMSPC Meeting Monday

Are you asking a rhetorical question, Keith?

In fact, I believe that intubation can be done safely in the prehospital arena and can positively impact patient outcome if it is done with the right tools and extremely diligent medical oversight. I am totally committed to maximizing the first attempt success rate of Life Flight staff while avoiding hypoxia, hyperventilation, aspiration and other complications of intubation. I am proud to list (in random order) the major elements of Life Flight's advanced airway management program:

1. 100% medical director chart review with careful attention to advanced airway management. Since 10/2003, I have maintained a database on every intubation attempted by Life Flight, which includes stats on individual crew members.
2. Annual intubation "bean count" requirements.
3. Annual clinical rotation in the OR.
4. Intubation of airway manikins every morning by the on-duty crew.
5. Development of intubation documentation standards with regular chart audits to monitor compliance. These standards include documentation of tube depth, end-tidal CO<sub>2</sub>, etc. We just added a preoxygenation documentation standard in response to the data coming out of San Diego (preoxygenation was already part of our RSI protocol).
6. Availability of etomidate and succinylcholine for RSI.
7. Availability of flexguides and combitubes for difficult airways and failed airways.
8. Formal initial orientation program which includes an RSI didactic lecture and required OR intubations.
9. Formal, written airway management/RSI protocol.
10. Annual scenario-based competency assessment with emphasis on patient assessment, advanced airway management and critical decision-making.
11. Availability of qualitative ETCO<sub>2</sub> detection and quantitative ETCO<sub>2</sub> (waveform) measurement.
12. Medical director ride alongs for direct observation of crew members.
13. Availability of both Miller and Macintosh laryngoscope blades.
14. Monthly chart review meeting and lecture.

The question is whether this level of oversight can be effected by the average EMS agency, although one might argue that we've gone a bit overboard. Regardless, I submit that if you cannot assure a reasonable level of medical oversight and cannot maintain a reasonable level of intubation proficiency, you should only be carrying combitubes, LMAs or King LTs.

In case you were wondering, Life Flight's intubation overall intubation

success rate is 96% (since 10/03). Our first attempt success rate is 73%.

DTK

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>CC: boisedave@hotmail.com,GainorD@idhw.state.id.us,NudellN@idhw.state.id.us

>Subject: RE: EMSPC Meeting Monday

>Date: Tue, 31 Oct 2006 11:48:33 -0700

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>Have you prohibited endotracheal intubation by the flight crew for

>these indications at SA LifeFlight? K

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> >>> "David & Susan Kim" <dtk6@cornell.edu> 10/30/2006 7:45:09 PM >>>

>Hello All!

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>As promised, here are the articles I cite in my intubation lectures. If

>you would like a brief description of the articles, you'll have to

>listen to the

>whole presentation! Thank you for another very productive meeting

>today.

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>DTK

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>—Original Message—

>From: Fend-Boehm, Valerie A. - EMS [mailto:FendV@idhw.state.id.us]

>Sent: Thursday, October 26, 2006 11:33 AM

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