Letter to the Editor: Letter in Response to "Receiving Patients with Vital Signs Absent from Paramedics"

Dear Editor,

We thank Dr. Nolan for highlighting the need to protect frontline health care workers when managing patients without vital signs during the coronavirus disease 2019 (COVID-19) pandemic.[1] The authors correctly point out health care workers are at greatest risk of infection, particularly where aerosol generating medical procedures occur. However, in choosing the emergency department (ED) as their focus, they do not balance patient outcomes with the risks paramedics face with these patients.

Hospitals mitigate risk during a cardiac arrest using the "protected code blue" approach in a controlled setting. Paramedics resuscitate these patients in uncontrolled and unpredictable settings. The authors do not consider these differences in risk. During the severe acute respiratory syndrome (SARS) outbreaks, up to one-third of Toronto's paramedics were on home- or work-quarantine at any one time. Given COVID-19, we must examine everything we do to provide greatest benefit to the population we serve while protecting paramedics from unnecessary risk.

The percentage of survivors to hospital discharge after prehospital cardiac arrest remains in low- to mid-single digits, despite our participation in multiple trials. We were also involved in developing termination of resuscitation guidelines. Medical directives now include decision points for paramedics to contact medical control for termination of resuscitation and field pronouncement. Most paramedic services have experienced "near misses" with high-speed crashes when running lights-and-siren to hospital. Evidence shows these transports pose a safety risk to both paramedics and public at large. Appropriate use of termination of resuscitation reduces unnecessarily long resuscitations and the number of such transports.

The authors correctly point out patients with prolonged resuscitations or nonshockable rhythms or asystole have poor outcomes. We observe that medical control physicians advise further resuscitation and transport for patients meeting termination of resuscitation criteria. We take issue with termination of resuscitation in the back of an ambulance *after* ED arrival. We view the reluctance for termination of resuscitation as an unnecessary safety risk to paramedics without tangible patient benefit.

The authors' approach starts with "prior to patient arrival." We believe it should start with "resuscitation in the field," and include decision points where transport occurs only if return of spontaneous circulation is achieved within a reasonable timeframe. Otherwise, termination of resuscitation should be advocated. If the authors' intent to mitigate risk to *all* health care workers, they must consider workplace safety risks unique to the prehospital setting and evidence on patient management *before* considering transport. We welcome an open dialogue to ensure all benefits and risks are considered and weighed appropriately before any action is taken based on the authors' work.

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REFERENCE

1. Nolan B, Chartier LB, Verbeek PR, Huyer D, Lazurik L. Recommendations for emergency departments receiving patients with vital signs absent from paramedics during COVID-19. *CJEM* 2020;epub, doi: 10.1017/cem.2020.389.

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