**For all paramedics: important REMAC CME and exam changes below**

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**From the Editor**

To ensure the highest-possible quality of patient care in NYC, REMAC has raised CME and exam requirements for all re-certification and new candidates.

**All candidates must now meet CME requirements**

- **All REMAC paramedics and candidates** should review Certification & CME Information on page 3 journal and plan accordingly.
- **All upcoming exam candidates**, see registration instructions at the bottom of the last page of this journal.
- **Candidates who will not have a CME letter** at the time of their REMAC exam must email Christopher.Swanson@fdny.nyc.gov ASAP.

**The exam format has changed for all candidates**

- **Study Tips – to pass the exam, candidates MUST**:  
  - memorize the REMAC GOP, BLS and ALS protocols, and appendices  
  - interpret 3 and 12-lead ECGs  
  - calculate drug doses based on patient weight  

- **120 question multiple-choice exam** with a 3-hour time limit  
  - **20 Scenario questions: two new intensive patient-care scenarios**  
    - one adult medical and one pediatric, 10 questions each  
    - similar to past REMAC Orals and Scenario exams  
    - testing the candidate’s ability to integrate:  
      medical history, physical examination, ECG interpretation, diagnosis, treatment using the NYC REMAC protocols  
  - **100 General questions**: the same format and content as past REMAC exams, on protocol content and patient care  

- **Passing score** is 80%. Exam failure permits a retest the same month.

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**Inside this issue:**

From the Editor 1  
Protocol Outline 2  
Cert & CME info 3  
FDNY contacts 4  
OLMC physicians 4  
CME Article/Quiz 5  
Citywide CME  
Exam Calendar  

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Outline of May 2014 NYC REMAC protocol changes
see REMAC Advisories 2014-01 & 2014-02 at nycremsco.org

General Operating Procedures
- Medical Control at the Scene
  o deletes AED note
  o clarifies non-solicited intervention
- Prehospital Sedation
  o increases Etomidate dose
  o adds 0₂ via nasal cannula
- Transport Procedures
  o deletes stroke center distance
  o deletes LBBB to PCI facility
  o adds LVAD as specialty care
- CPR
  o adds medical criteria
  o clarifies CPR for pediatrics
- Pediatric Patients
  o clarifies age of patients
- IO Administration
  o adds shock indication
  o limits attempts
  o adds Lidocaine
- IN Administration
  o adds Glucagon & Fentanyl
- Drug Guidelines
  o adds Ondansetron caution
- Pediatric Protocols
  o adds Broselow tape

BLS Protocols
- 400 – WMD
  o updates table
- 411 – AMS, 413 – Seizures, 415 – Shock
  o removes note on immobilization
- 414 – Poison/Drug Overdose
  o removes obtaining sample
  o updates venomous bite
- 426 – Soft Tissue Injuries
  o adds tourniquet

ALS Protocols
- 503A, 503-B – Cardiac Arrests
  o changes vasopressin to if available
- 507, 554 – Adult & Pediatric Asthma
  o clarifies MCO epinephrine
- 510 – Allergic/Anaphylactic Reaction
  o changes name of protocol
- 515-B – Septic Shock
  o new protocol

Appendices
- Appendix H – Specialty Care
  o updates specialties
- Appendix I – Hospital Listings
  o adds available services
- Appendix U – Septic Shock
  o new appendix
REMAC Exam Study Tips

REMAC candidates have difficulty with: REMAC Written exams are approximately:
* 12-lead EKG interpretation 10% BLS 15% Adult Trauma
* ventilation rates for peds & neonates 10% Adult Arrest 15% Pediatrics

Certification & CME Information

- By the day of their exam, all REMAC paramedics and candidates must present a letter from their Medical Director verifying fulfillment of CME requirements.

- Upcoming candidates without a CME letter must ASAP email Christopher.Swanson@fdny.nyc.gov

- FDNY paramedics, see your ALS coordinator or Division Medical Director for CME letters.

- CME letters must indicate the proper number of hours, per REMAC Advisory # 2007-11:
  - 36 hours - Physician Directed Call Review
    - ACR Review
    - QA/I Session
    - Emergency Department Teaching Rounds - Maximum of 18 hours
  - 36 hours - Alternative Source CME - Maximum of 12 hours per venue
    - Online CME (see examples below) - Clinical rotations
    - Lectures / Symposia / Conferences - Associated Certifications – 4 hours each:
    - Journal CME

- Failure to maintain a valid NYS EMT-P card will suspend your NYC REMAC certification until NYS is recertified.

REMAC certification exams are held monthly for new and expired candidates, and for currently certified paramedics who may attend up to 6 months before their expiration date.

REMAC CME and Protocol information is available and suggestions or questions about the newsletter are welcome. Call 718-999-2671 or email Christopher.Swanson@fdny.nyc.gov

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Alexandrou, Nikolaos  80282  Jacobowitz, Susan  80297
Asaeda, Glenn  80276  Kaufman, Bradley  80289
Barbara, Paul  80306  Lai, Pamela  80311
Bayley, Ryan  80314  Munjal, Kevin  80308
Ben-Eli, David  80298  Redlener, Michael  80312
Freese, John  80293  Rotkowitz, Louis  80317
Friedman, Matt  80313  Schenker, Josef  80296
Giordano, Lorraine  80243  Schneitzer, Leila  80241
Gonzalez, Dario  80256  Silverman, Lewis  80249
Hansard, Paul  80226  Soloff, Lewis  80302
Hegde, Hradaya  80262  Van Voorhees, Jessica  80310
Hew, Phillip  80267  Williams, Alan  80316
Huie, Frederick  80300  Zabar, Benjamin  80323
Isaacs, Doug  80299  Zimmerman, Jason  80824
REFUSING MEDICAL CARE

Introduction

The rates of patient non-transport have been reported in some EMS systems between 25 and 70 percent. Of these ambulance dispatches, as many as one-third are the result of patient-initiated refusal of medical assistance (RMA) and/or transport.

Patient non-transport pose significant quality of care and medical liability issues to both patients and EMS systems. Patients who refuse medical aid may suffer otherwise preventable morbidity and mortality. Clipped from the headlines is one story:

An elderly South Carolina man who refused to be checked by paramedics after crashing his car died a day later from a head injury. Investigators say he lost control of his van while trying to swerve to miss another car and hit a utility pole. He refused medical attention at the scene, but became confused with headaches several hours later. Family disputes the claim that the patient refused care at the scene.

Inadequate assessment or documentation of patient care or decisional capacity may provide a basis for future lawsuits/legal actions. Patients who RMA have been shown to be at risk for adverse medical consequences, as a function of both their presenting complaints and physical findings at the time of initial evaluation.

Many of these patients have cardiovascular complaints, abnormal vital signs and/or altered levels of consciousness. A significant incidence of disorientation, abnormal speech, inappropriate behavior, or possible intoxication has also been demonstrated in this population.

A Patient’s Right

Emergency Medical Technicians and paramedics are frequently posed with dilemmas when faced with the patient refusing care. The law and medical ethics require that we strike a balance between respecting the autonomy of patients who are capable of making informed decisions and protecting those with mental impairment. Where the greater risk arises both for the patient and provider is when the patient lacks decisional capacity. In the following article, a discussion of the elements and considerations for refusal of care is presented.
The right to refuse treatment is granted by the law which acknowledges personal freedom, autonomy and the belief in self-determination as a basic human right. Making decisions concerning one’s own health care has expanded over the years to include the right to withhold future care in the form of Advance Directives. We respect this patient right when we honor their request to withhold resuscitation in the form of a Medical Orders for Life-Sustaining Treatment (MOLST) or a prehospital DNR order. Along with the right to refuse care is the right to receive information to assist one in reaching a decision about what medical care may be provided or withheld and the resulting consequences of making those choices. More and more the process involves a partnership between the patient and the health care provider in making an informed decision based on a shared understanding of the risks and consequences of refusing care.

On the surface this appears very basic. But in practice, it can become very complicated as we attempt to inform and also assess the patient’s ability to understand and use reasoning. From the doorway, we begin assessing the environment for safety. A safe home setting will have adequate food, warmth, and access to clean water for the near future. An unsafe environment may give the appearance of self-neglect or suspicion of abuse (whether it be child, spousal or elder). Starting with the information obtained from dispatch data, we look and listen to identify any discrepancies between what the caller stated and the scene. Try to locate the caller, if possible, and get a first-hand account of the problem. At this point, asking a simple question, “Do you want to go to the hospital?” before assessing the presenting medical problem or physical findings throws out the whole process of informed consent and the dialogue that must be part of this process. This dialogue requires mindful attention to the patient’s story, our first glimpse at the patient’s mental ability to make a decision regarding their health choices. Asking this question implies that the patient knows the source and severity of the problem, which is not always the case. It also may push a patient more quickly to say “No” before they have had a chance to hear our concerns. It shuts down all discussion from the outset and gives the impression that the crew is not really trained to provide much more than transport (not the right image of EMS).

The three essential elements of informed consent, and likewise informed refusal, are legal capacity, decisional capacity and consent based on information. Legal capacity involves the ability of the patient to legally consent for their own care. Minors cannot consent for their own care and thereby cannot refuse. This of course excludes mature minors and emancipated minors. A grandparent, school official or a legal guardian can consent for a minor’s care. Refusal of care by any of these three follows the same process as a refusal by a competent adult. Decisional capacity requires that the patient must be fully able to understand the extent and severity of their condition, the nature of the treatment being proposed, the risks and consequences of accepting or refusing the treatment and any available alternatives. Merely being alert and oriented to person, place and time is not enough. In rare cases, decisional capacity may exist without being A&O x3. The last but certainty not least of these three is information. In civil actions, this is often where the plaintiff can make a strong case. The EMT or paramedic will need to discuss the specific condition in detail and any associated conditions that may arise. The discussion should use plain language. In the prehospital setting, we do this by explaining our treatment as we proceed with care. For example, a patient having severe pain from a fracture is told why we use the splinting device and encouraged to speak up if the pain changes. When administering pain medication, we ask about any allergies describing the risks and benefits of the drug. You may ask,
“How can we possibly explain all of the risks?” In reality, only the major risks that commonly occur, or that would produce serious harm or death need to be discussed. When administering nitroglycerin, the patient should be informed of the likelihood of a headache or flushing, which would commonly occur. Your explanations can be short and simple when time is at stake. For example, when starting an IV for a patient with internal bleeding, you may explain the process as you are collecting your equipment and mention the benefit of additional fluid in preventing shock. Then ask, “Is that all right with you?” Keep in mind, a patient can withdraw their consent at any time, even after accepting transport to the hospital, provided they meet all of the three elements. However, refusing one treatment does not mean the patient refuses all care. If the patient refuses the oxygen mask but will accept a nasal cannula that should be offered, and then documented.

**Decisional Capacity**

Capacity, which reflects the patient’s decision-making capabilities, is decision-specific and determined on a case-by-case basis. Patients are considered impaired who have diminished ability to exercise appropriate judgment regarding their health care, either because of a lack of knowledge or understanding or ability to recognize the need for medical care, or the use of poor judgment or reasoning regarding their current healthcare situation. An individual’s decision-making capacity may fluctuate over time as a result of temporary changes in their ability to comprehend or communicate. A variety of conditions may impair the patient’s cognitive abilities, including drugs, alcohol, head injury, hypoxia, shock, infection, metabolic abnormalities, psychiatric problems, or mental deficiency.

Severe emotional stress may also play a role. In observing the patient, does their attention appear to drift away or wander? If a patient cannot focus for one minute then decisional capacity is in doubt.

The following questions can help establish if your patient has capacity:

- Does the patient have the ability to express a choice?
- Is the patient able to understand his problem or situation?
- Is the patient able to appreciate the seriousness of his condition and the consequences of accepting or rejecting treatment or hospital transport?
- Is the patient able to explain his reason for rejecting care?

As mentioned earlier, some patients, who at baseline have chronic mental status changes (e.g., mild dementia), may still be able to give informed consent if they demonstrate they understand the risks and benefits of refusing care for an acute medical problem. However, if decisional capacity is lacking and the patient has no acute medical condition, the OLMC physician may grant the RMA as a 10-93A. For illustration, a group of autistic students are on a school trip and a bystander believes that one of the students is having a seizure and calls 911. The OLMC physician may talk to the school agent and assure that the student is at their baseline and honor the RMA.
The following steps will guide you when dealing with a patient who is refusing medical aid:

√ **Explain.**

The EMT or Paramedic has a duty to reasonably inform the patient, given the available information, about his presenting problem. Without information, the patient cannot make an informed decision. A limited discussion or incomplete disclosure of information by the EMT or Paramedic may constitute negligence (breach of duty), if found to be the cause of injury to a patient. A patient cannot weigh all the facts unless they are clearly explained. **If the patient is non-English speaking, the use of a reliable translator (family, friends, crew members, police, etc.) is an acceptable option. The staff at Telemetry can also link with an AT&T Language Line translator when necessary.**

√ **Discuss.**

Begin a discussion that allows the patient to voice their reasons for refusing. This will allow you to assess how the patient is able to think and process the information. Is he debating the facts, or listening carefully and thoughtfully weighing them? In exploring the patient’s reasons for refusing care, the EMT or Paramedic must listen carefully to how the patient makes his decision. In cases where the patient’s wishes are nonsensical or illogical, this can show a lack of capacity to refuse care.

In some cases, after discussing the patient’s objections it may become obvious more information is needed to help him or her understand the nature of the problem and the need for medical care. **Ultimately, when refusing care, the patient must accept the risks described and make a choice that is rational.**

√ **Confirm Understanding.**

The patient must have a reasonable understanding of the problem, including all the risks and consequences that may result from refusing treatment (or transport to a recommended facility). To confirm that the patient has an understanding of the situation and the risks involved with refusing care they need to express their understanding in their own words. Simply, a nod is not enough. The EMT or Paramedic must ask the patient about any questions he or she may have and clarify any misunderstanding, using language the patient can understand. **This discussion should be documented in the patient care report using the patient's own words and should include the reason for refusal, your offers of alternatives, witnesses present, and the necessary signatures.**

√ **Offer All Available Options.**

EMTs and Paramedics can be very resourceful people. With the help of family members, the provider often can come up with remedies that address the patient’s concerns or objections. Family or friends will have a better understanding of the person’s fears or reasons for their resistance to seek medical care. Keep in mind that, when there is a patient request for a particular hospital destination, EMS Officers can approve transport decisions beyond the “10-Minute Rule” for an additional 10 minutes.
The Decision Must Be Voluntary.

If the patient is coerced into making a decision by the use of threats then the decision is not of his will. A patient may later claim that his decision was made under duress. Detainees at local police precincts, or at Central Booking locations, have the right to refuse medical aid, or seek medical care. Some may feel pressured to complete the processing of their case for a hearing, and refuse medical aid. These patients should be handled like all other refusals, including assessment and clearance through an OLMC Physician if indicated.

Consider the Message Behind the Message.

Fear and denial will influence how the patient may frame their situation. Many patients will try to shield themselves from facing a life-changing diagnosis by telling themselves it does not exist, or latching on to a less serious condition. Often we hear, "It must have been something I ate," or "It's probably my nerves." They may even lead their health care team down the wrong path in so doing. Despite how the patient sees their condition, the EMT or Paramedic needs to stay focused on the greatest risk and not go off course.

Take the High Road.

By maintaining a professional rapport, the EMT or Paramedic will achieve a higher level of respect and trust. This includes admitting your limitations openly and without embarrassment. The test of a true professional is being able to approach all patients the same, despite others bad behavior. How you deal with people acting badly is the true test of a professional. Think about the last time you felt really sick or were faced with dealing with a sick family member. The combination of pain and fear are a volatile mix. It can quickly lead to increasing anger toward crews and assaults on unsuspecting EMTs and paramedics.

Involve Telemetry.

Involving the On-Line Medical Control (OLMC) physician at any point in this process has often influenced the patient toward accepting treatment. Speaking with the OLMC physician often gives the patient more time to think through his or her choices. The patient also will have the chance to again express his concerns and be assured that his feelings are valid. Because not all medical conditions are part of the EMT or Paramedic training, consultation with the OLMC physician may be necessary to provide the patient with necessary information to understand all of the risks. The physician will also test the patient’s decisional capacity. This test involves comprehension of the medical condition, ability to weigh all the options, express a clear and reasonable choice, and recall the important facts. The following situations require contact with OLMC when a patient is refusing care:

- Patient is age 5 or under.
- Patient lacks decisional capacity.
- Crew feels there is a High Index of Suspicion that the patient's condition could result in a serious threat to life or produce a bad outcome (i.e. permanent disability).
• All patients having a syncopal or near-syncopal episode (even of brief duration), trouble breathing, neurological deficits, high impact mechanism of injury, or abnormal vital signs, should be considered a High Index of Suspicion case.

• Low Risk may include a motor vehicle collision with no physical damage to passenger compartment, with damage limited to scratches, mirrors or fenders. Similarly, when fumes are released in the general vicinity of a person but without direct exposure and the patient is asymptomatic, this could also be a low risk scenario.

• Someone on-scene known to the patient expresses concern for their health.

• 911 caller reports suicidal or homicidal behavior.

• 911 caller is a physician or other health care provider with cause for concern.

• Administration of medication by crew or prior to arrival (excluding oxygen for low-index patients, such as for chronic use with no respiratory complaint).

• Surrogate (health care proxy) wants to refuse for the patient.

• Patient seeks a hospital outside the Ten-minute Rule.

When calling OLMC, be prepared to answer the following questions:

• Who called EMS?

• Did the crew speak directly to the calling party?

• Why was EMS called?

• Why does the patient not want to go to the hospital?

• Would anything change the patient’s mind?

• Are there any obvious signs or symptoms of physical or mental illness?

If a crew is unable to establish contact with OLMC, an EMS Officer should be dispatched to the scene to assist with transport. If the crew, in conjunction with the EMS Officer, is still unable to convince the patient to go to the hospital, then the assistance of the NYPD should be requested.

🧟 OLMC may accept the RMA of a minor patient if no guardian is on-scene, or of a patient without decisional capacity, if **ALL** of the following criteria are met:

• There is a low index of suspicion for life-altering or life-threatening conditions.

• No medications have been administered.

• The environment is safe.

• A responsible adult is taking responsibility for the patient.
√ Remember, It’s Not Personal.

Reasons for refusing care may include fear, humiliation, mistrust, cost concerns, or obligations to others (or pets), to name just a few. For whatever reason, it is important that the providers not perceive this as a negative reflection on them and take this as a personal rejection of their attempts to provide care. Whether we realize it or not, our feelings about a patient may influence our willingness to extend ourselves or be the patient’s advocate, when necessary. *Caring for patients is never about us.* We need to park our ego at the door oftentimes to allow the patient to feel they are the center of our focus. When we transmit this, it builds the necessary trust required to elicit the necessary information about the chief complaint, as well as relevant medical history that may involve social stigma, such as alcohol use, drug use or history of mental illness.

√ Take your Time

Beware the last call of the tour. A rushed approach may lead to missteps or omissions. Consider that special populations like the elderly, non-English speakers, or mentally challenged patients may need more time to process information. Adapt your approach to these patients and you may get more cooperation and agreement. Some helpful suggestions:

- Maintain a calm and relaxed attitude.
- Gain knowledge of the patient prior to assessment, when possible (family/caregivers).
- Explain EVERYTHING (even the small stuff) to the patient prior to doing it.
- Questions should be simple and clear. Avoid slang or medical jargon.
• Rephrase questions in a manner the patient might better understand.

Taking more time may allow the patient to change their mind and accept treatment once they are able to consider the facts. Always let the patient know that should they change their mind they can make another call through 911 and we will return.

Consider the following examples:

Example #1: A 65 year-old female is informed that she requires spinal immobilization. The patient refuses because she states she feels that this would be very uncomfortable. Is this patient making an informed decision?

Consider: This patient may need more information about the forces that caused the accident and its likely medical consequences.

Example #2: A 50 year-old male is complaining of chest pain. You have administered oxygen and informed the patient that he requires an intravenous line. He refuses because he states he believes the pain will go away with oxygen, since the cause is the result of toxic fumes introduced into his apartment by his landlord in an attempt to kill him. Does this patient have the capacity to refuse medical care?

Consider: This patient’s reasoning appears to be impaired, possibly by mental illness or mental deficiency (as in CNS, metabolic, etc.).

Example #3: A 25 year-old male, who was thrown from his motorcycle after losing control, has sustained a four-inch laceration to the forehead and is covered in blood. He has a strong smell of alcohol on his breath. He adamantly refuses to go to the hospital because he wants to make sure that his bike is properly removed to a repair shop. Does this patient have the capacity to refuse medical care?

Consider: This patient’s reasoning appears to be impaired by a combination of emotional distress, alcohol, head injury and possible internal bleeding.

Example #4: A 45 year-old female, with a history of diabetes is complaining of pain in her stomach. She states her son died in an accident last week.

Consider: This patient’s reasoning may be impaired by emotional distress.

Example #5: A 55 year-old male is found lying in bed. His family is concerned because he has had blood in his stool for the past three days and he fell in the bathroom just prior to your arrival. The patient is agitated and refusing evaluation and hospital transport.

Consider: Advise dispatcher that NYPD and an EMS Officer are needed ASAP for removal of a patient with a high index of suspicion that is refusing medical aid.

Tragically, there have been cases in the past with negative patient outcomes and long-term disability and/or death subsequent to the refusal of medical aid. Recently, a case involving a single mother who lost both distal arms and legs and sight in her left eye brought on by sepsis due to a kidney stone, resulting in shock and gangrene. This case was settled for 17.9 million dollars, with the penalty split...
between the hospital and City of New York. While mental capacity was not a major issue in this case, the real problem that makes cases like this one difficult to defend is the belief by patients that their medical providers did not share a sense of urgency or significant risk that would warrant seeking immediate medical care. In the last two years, there have been other financial settlements of lesser amounts where the patients, young and old, have subsequently died following refusal of medical aid. In the realm of emergency care, delay to ultimate medical care, even for a condition that is not immediately life-threatening, will be traced back to the first patient contact, who may be the EMTs or paramedics who were called initially through 911.

The “art” and “practice” of medicine requires continuous learning through trial and error. We all need to acknowledge our errors, but not let them hold us back from moving forward. Once we own our mistakes we can learn from them. This approach toward professional development will build our knowledge base and critical thinking skills, making it part of our future practice. Our future patients will thank us for it.

References:

EMS OGP 106-04 – *Refusal of Medical Aid*


Moore, Randall F. “A Guide to the Assessment and Care of the Patient Whose Medical Decision-Making Capacity is in Question” Medscape 1999:1(3)


Written by: Lt. Joan Hillgardner, EMT-P  
FDNY Office Of Medical Affairs

All 10 questions for ALS and BLS Providers

1. Decisional capacity implies:

   a. The ability to understand the consequences of refusing care
   b. The ability to choose between different treatment options
   c. The ability to communicate a logical reason for refusing care
   d. All of the above
2. You arrive at an office where a co-worker states, “I called 911 because my friend has been really sad recently after breaking up with her boyfriend. She got more upset when she found out I called. She is doing much better now. Thanks anyway, but we need to cancel.” You should:

   a. Close the assignment with a 10-87
   b. Close the assignment with a 10-90
   c. Close the assignment with a 10-93
   d. Insist on seeing the patient

3. You are called to an apartment, and a 42 year-old man answers the door. He says his wife called because he had been coughing a lot. Before you arrived, his doctor finally returned his call, and now he doesn’t want your help. He refuses to let you in, and eventually shuts the door because he says “I’m in the middle of watching a football game!” You are unable to get him to return to the door or answer any further questions. Does a PCR need to be completed for this call?

   a. Yes
   b. No

4. You are called to a police precinct for a 26 year-old having a mild asthma exacerbation. After one treatment the patient’s symptoms have resolved. A police officer is demanding that you transport the patient to a hospital but the patient wishes to RMA. Does the patient have the right to RMA?

   a. Yes
   b. No

5. You are called to a house where an 89 year-old woman had slid to the floor as the home health aide (HHA) was trying to assist her back into bed. The patient has advanced Alzheimer’s disease. The patient has no complaint and you do not find any evidence of injury during your assessment. You contact OLMC and the physician agrees that there is no acute medical condition requiring transport. You should assign this call a disposition code of:

   a. 10-87
   b. 10-93A
   c. 10-93
   d. 10-95A

6. A BLS crew arrives at a house to find a 56 year-old woman who was concerned because her home blood pressure monitor recorded a BP of 145/72 and she thought it was too high. Her BP is now “normal.” She refuses any treatment or transport. You do not have a high index of suspicion for this patient. Do you need to contact OLMC to accept the RMA?

   a. Yes
   b. No
7. You arrive at the scene of a rollover MVA on a major highway. The car was being driven by a 48 year-old man who states he lost control and hit into the divider, causing the car to roll. He was wearing his seatbelt and was able to slide out the window. He denies any injury and doesn’t want any further assessment by EMS. You should:
   a. Assign the call a dispo of 10-87
   b. Assign the call a dispo of 10-90
   c. Complete an PCR and have the patient sign the RMA section
   d. Complete an PCR and call OLMC to accept the RMA

8. A BLS crew is caring for a 22 year-old woman who was having a mild asthma exacerbation. After you administer one nebulizer treatment, she feels completely well and has a normal exam. She refuses transport. Does the crew have to call OLMC to accept an RMA?
   a. Yes
   b. No

9. You have assessed a 5 year-old who tripped and fell for a superficial abrasion on the arm. The grandparent does not wish for the child to be transported. Does the crew have to contact OLMC?
   a. Yes
   b. No

10. You arrive at a store where the manager had called 911 after a 50 year-old patron had fallen down. He is sitting in a chair but gets up when he sees you approach. He says “I am fine. I told them not to call.” He refuses to give his name or any other information and leaves the store. You should assign this call a disposition code of:
   a. 10-87
   b. 10-90
   c. 10-93
   d. 10-93A
Based on the CME article, place your answers to the quiz on this answer sheet. Respondents with a minimum grade of 80% will receive 1 hour of Online/Journal CME.

Please submit this page only once, by one of the following methods:
- FAX to 718-999-0119 or
- MAIL to FDNY OMA, 9 MetroTech Center 4th flr, Brooklyn, NY 11201

Contact the Journal CME Coordinator at 718-999-2790:
- three months before REMAC expiration for a report of your CME hours.
- for all other inquiries.

Monthly receipts are not issued. You are strongly advised to keep a copy for your records.

Note: if your information is illegible, incorrect or omitted you will not receive CME credit.

check one:  EMT  Paramedic  _______________
other

Name

NY State / REMAC # or “n/a” (not applicable)

Work Location

Phone number

Email address

Submit answer sheet by the last day of February 2015

January – February 2015 CME Quiz

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  
9.  
10.  Questions 1-10 for all providers
### Regional CME

Sessions are subject to change without notice. Please confirm through the listed contact.

<table>
<thead>
<tr>
<th>Boro</th>
<th>Facility</th>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
<th>Location</th>
<th>Host</th>
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<td>BK</td>
<td>Kingsbrook</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>ED Conference Room</td>
<td>Dr Hew</td>
<td>718-363-6644</td>
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<td>LICH</td>
<td>TBA</td>
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<td>TBA: contact to inquire →</td>
<td>Avram Conference Rooms</td>
<td>Dr Brandler</td>
<td>718-780-1859</td>
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<td>Lutheran</td>
<td>4th Wed</td>
<td>1730-1930</td>
<td>Call Review RSVP →</td>
<td>Contact for location →</td>
<td>Dr Chitnis</td>
<td>Dale Garcia 718-630-7230 <a href="mailto:dgarcia@lmcmc.com">dgarcia@lmcmc.com</a></td>
</tr>
<tr>
<td>MN</td>
<td>Lenox Hill</td>
<td>TBA</td>
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<td>TBA: contact to inquire →</td>
<td>Contact for location →</td>
<td>TBA</td>
<td>Brian Lynch <a href="mailto:bmlynch@nshs.edu">bmlynch@nshs.edu</a></td>
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<tr>
<td></td>
<td>Mt Sinai</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>Contact for location →</td>
<td>TBA</td>
<td><a href="mailto:eunice.wright@mountsinai.org">eunice.wright@mountsinai.org</a></td>
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<tr>
<td></td>
<td>NY Presbyterian</td>
<td>TBA</td>
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<td>TBA: RSVP →</td>
<td>Weill Cornell Campus TBA</td>
<td>Dr Williams</td>
<td><a href="mailto:ssamuels@nyp.org">ssamuels@nyp.org</a> Ana Doulis 212-746-0885 x2</td>
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<td></td>
<td>NYU School of Medicine</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>Schwartz Lecture Hall 401 E 30 Street</td>
<td>TBA</td>
<td>Jessica Kovac 212-263-3293</td>
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<td>QN</td>
<td>Elmhurst Hosp</td>
<td>1st Wed</td>
<td>1300-1400</td>
<td>Call Review: Trauma Rounds</td>
<td>A1-22 Auditorium</td>
<td>TBA</td>
<td>Anju Galer, RN 718-334-5724 <a href="mailto:galera@nychhc.org">galera@nychhc.org</a></td>
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<td>Flushing Hosp</td>
<td>TBA</td>
<td>TBA</td>
<td>Call Review RSVP →</td>
<td>Contact for location →</td>
<td>Dr Crupi</td>
<td><a href="mailto:kortiz@jhmcc.org">kortiz@jhmcc.org</a></td>
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<tr>
<td></td>
<td>Mt Sinai Qns</td>
<td>last Tues</td>
<td>1800-2100</td>
<td>Lecture or Call Review</td>
<td>25-10 30 Ave, conf room</td>
<td>Dr Dean</td>
<td>Donna Smith-Jordan 718-267-4390</td>
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<td>NYH Queens</td>
<td>TBA</td>
<td>TBA</td>
<td>TBA: contact to inquire →</td>
<td>East bldg, courtyard flr</td>
<td>Dr Sample</td>
<td>Mary Ellen Zimmermann RN 718-670-2929</td>
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<td>Queens Hosp</td>
<td>2nd Thurs</td>
<td>1615-1815</td>
<td>Call Review</td>
<td>Emergency Dept</td>
<td>TBA</td>
<td>718-883-3070</td>
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<td>TBA</td>
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<td>TBA: contact to inquire →</td>
<td>Board Room</td>
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<td>Judith Brown 718-869-7223 <a href="mailto:jbrown@ehs.org">jbrown@ehs.org</a></td>
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<td>175-05 Horace Harding Expr</td>
<td>Dr Politi</td>
<td><a href="http://www.StJohns.edu/EMS">www.StJohns.edu/EMS</a></td>
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<td>SI</td>
<td>RUMC</td>
<td>TBA</td>
<td>1400</td>
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<td>MLB conf room</td>
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<td>William Amaniera 718-818-1364</td>
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<td>SIUH North</td>
<td>Tues TBA</td>
<td>1900</td>
<td>TBA: RSVP →</td>
<td>Regina McGinn Center Room D/E, 475 Seaview Ave</td>
<td>TBA</td>
<td>Andrea Kleboe 718-226-7878 <a href="mailto:siemscme@gmail.com">siemscme@gmail.com</a></td>
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<td>Nassau</td>
<td>St Joseph Hosp</td>
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<td>TBA</td>
<td>TBA: RSVP →</td>
<td>TBA</td>
<td>Dr Zito</td>
<td>Liz Schwind <a href="mailto:elizabeth.schwind@chsli.org">elizabeth.schwind@chsli.org</a></td>
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## 2015 NYC REMAC Examination Schedule

<table>
<thead>
<tr>
<th>Month</th>
<th>Registration Deadline</th>
<th>Refresher exams(^1)</th>
<th>Basic exams(^2)</th>
<th>NYS/DOH Written(^3)</th>
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<td>January</td>
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<td>September</td>
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<td>9/21 @18:00</td>
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<td>12/16 @10:00</td>
<td>12/16 @18:00</td>
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\(^1\) REMAC Refresher examination is offered for paramedics who meet CME requirements and whose REMAC certifications are either current or expired less than 30 days. To enroll, go to the REGISTER link under “News & Announcements” at nycremsco.org before the registration deadline above. Candidates may attend an exam no more than 6 months prior to expiration.

\(^2\) REMAC Basic examination is for initial certification, or inadequate CME, or certifications expired more than 30 days. Seating is limited. Registrations must be postmarked by the deadline above. Exam fee by $100 money order to NYC REMSCO is required.

**All Basic candidates must meet new education requirements.** Email Christopher.Swanson@fdny.nyc.gov for instructions.

\(^3\) NYS/DOH exam dates are listed for information purposes only. Scheduling is through your paramedic program or contact NYS DOH for more information.