ASRC BOARD OF DIRECTORS MEETING
25 FEB 95
MINUTES

Meeting was called to order at 1035 by Dave Carter.

BUSINESS MEETING

Attendance: (People in bold were present)

AMRG - Keith Conover
AMRG - Charles Kollar
MSAR - Peter McCabe
MSAR - Darrel Hale
SMRG - Gary Mechtal
SMRG -
TSAR - Dave Carter
TSAR - Candi Capozzi

BRMRG - Audrey Wilson
BRMRG - Bob Koester → Proxy given to Jean Avery
RSAR - Mark Pennington
RSAR -
SWVaMRG - Brian Ferguson
SWVaMRG - Tony Bordeaux
***PVRG - Michael Vatalaro**
*PVRG - Karen Vandersall

*Probationary Group

OTHERS: **Mark Jones-TSAR, Rob Christie-SMRG, Patrick Turner-BRMRG, Rita Krenz-BRMRG (ops meeting only)**

Minutes (Candi Capozzi) - The minutes for 17 DEC 94, were distributed, reviewed and accepted with no corrections. ***Motion to accept*** ***(Yes 4 No 0 Abs 0)***

Officer and Committee Reports

Treasure's Report: (Read by Dave Carter for Patrick Turner):
Since the last meeting, we have had an income of $345.00. Thank you to BRMRG, TSAR, SWVaMRG, and SMRG for paying their 1995 dues. AMRG, PVRG, MSAR and RSAR still owe their 1995 dues. RSAR still owe their 1994 dues.
Since the last meeting, we had a debit of $228.72. $8.00 went to postage for the Alert Dispatch Officer; $20.36 went to office supplies for maintaining mission files, and $200.36 went to pay for our pager expenses. I am sorry for any trouble that the pagers going off on Monday 20 February. This was my fault and it will not happen again. Our pager account has now been prepaid through our May bill.
I have opened a personal banking account with Crestar Bank and have moved all of our money into this account. As long as we keep over $500 in the account, there will be no finance charges. I have closed the account with Nations Bank. I need to have Dave Carter and Camille Birmingham sign the account card so that they can write checks until the next election. As of 24 February 1995, our account stood at $1202.77.
Two more items: The first is that a while ago, there was interest in the ASRC as unit starting to purchase ASRC materials (patches, stickers, magnetic car tags) which could then be resold t the individual groups or to members at a slight mark up. Is this something that the BOD wants me to start looking in to?
Finally, the 1995 budget: listed below are the unavoidable costs and projected income. This does not include any funds for the officers. We need to alter our financial structure so that: (1) Our officers do not have to take financial burdens upon themselves; (2) the ASRC can pay for our radio license renewal when it comes up; and (3) we are not constantly budgeting a deficit.

Projected Income	
Individual Dues	$275.00
Group Dues	$390.00
Total	$665.00

Known Unavoidable Debits	
Pager Cost	$400.72
State Corporation Fee	$ 25.00
Already Spent	$ 28.36
Total	$454.08

Chairman's Report (Dave Carter):
- The SAR Coordinator's position is scheduled to be posted on Monday 27 Feb. Please pass the word along to the folks that might be interested. It will require a State Personnel Application. I am crossing my fingers that the selection process will be fair and in the best interest of the SAR community. I am also hoping that pre-selection has not already taken place.
- The GSAR Institute coming up is small in comparison to past institutes. This is due to a shortage of funds. SARTA will schedule a full blown institute with Camp Virginia JAYCEES for Nov/Dec of this year. If DES, the new coordinator and other players can get their act together and find funds then SARTA will relinquish the dates to the Commonwealth. However, if it doesn't happen an institute will still be held.
- I attended a meeting during January in Maryland where Peter McCabe was attempting to begin the process to start a SAR council type of organization. I was pleased at the number of people who showed up representing eight different SAR groups. This group has great potential to overcome the many jurisdictional and other such issues in Maryland. I wish them good luck in their efforts.
- Keith Conover recently expressed in letters to a variety of folks and myself his concerns over ASRC turning away from it's roots in the "wilderness". He is deeply concerned that the MRA will wrest this role away from the ASRC. What was not clear was how we would be physically able to respond to New York, Vermont, Maine, New Jersey, PA, etc., when such incidents occur when we can barely field enough people to run a mission in Virginia.
- Steve Houck will not be able to attend this meeting, but sends his regards. All is quiet on the radio front, except our aircraft license will expire in September. He is working the paper work and will need a check for about $125.00 at the right time.

Training Report (Candi Capozzi): I have been working on the simulation set for September and asked for input at the last meeting for what you want to train in. I received no inputs. I am again asking for input. Also the park personnel would like to know if we want them to run the staff portion, half and half, or do we do it all.

Safety Report (Gary Mechtal): Not Present

Operations Report (Gary Mechtal): Not Present

Communications Report (Steve Houck): Not Present

Medical Report (Rob Christie):
- Hope to get automated here soon. There is a potential problem some people are expired or about to expire. I am trying to make a new PCR (run sheet) for the ASRC that will more fit what we do and the information we need.
- The VA state protocols for First Responder through CT through Paramedic are being reviewed and will be updated appropriately.
- I am still trying to update our list of personnel who are medically qualified please send in any updates and information as soon as possible. I still have not received the information needed since Amy's request.

ADA Committee (Peter McCabe): I have nothing to report

<u>Old Business</u>

Status of 501 (C)(3): (Dave Carter) Bob Koester was supposed to have sent out a letter to each group advising of what was needed to send in for this date this has not been done. We need this status so that we can raise funds. ***Patrick Turner has volunteered to take this project over.***

Appointment of Medical Chair (Dave Carter): Rob Christie has agreed to take the Medical Chair and we need to vote on this at this time. ***Motion Candi Capozzi, Second Keith Conover Yes 6 No 0 Abs 0.***

Annual Meeting (Cindie Lambert) - Not Present

What to do about Affiliate Groups (Gary Mechtal): Gary is not here yet we will hold this until he shows up.

Committee Report on Physically Disadvantaged (Peter McCabe): Nothing to report, The excuse for not doing anything is the ASRC as an organization has to address the policy of whether or not we will allow people with disabilities to act as IS's. As the policy stands now everyone must go through the same training FTM, FTL and so on. Do we want to say that a communications officer and/or plans officer does not have to be field trained.

(DC) You should get with your committee and discuss this. What are the aspects of this? Where we legally medically etc... Should we have a policy that you must be able to do this to be at base
(RC) Take a look at disabilities on a one by one basis.
(KC) Make physical standards that you must meet to be able to take this class and perform that function. The EMT classes all have that type of criteria.
Consensus of the board that we should examine this issue and Peter was given the charge of this.

Simulation (Dave Carter and Candi Capozzi) Let's help Candi get this off the ground. As she said there has been no responses to any of the request for ideas or aid. The questions were asked in her report. The park personnel would like to know if we want them to run the staff portion, half and half, or do we do it all. From the discussion that went around the room it was decided that a half ASRC and half park personnel staff would be good and that a full blown field exercise is what is wanted. Dave Carter will help to set up the scenario.

Medical Legal (Keith Conover)
-Will review with lawyer Andy Appel, he will keep working on this as his load decreases. He is putting together a detailed wilderness EMS legal briefing that he will send to Kenneth Brody, the assistant legal counsel for the PA Department of Health, for review.
-Atlantic Council - Medical command is illegal to cross state lines according to Harry Teter of the Atlantic EMS council.
-We are in the process of redoing the reciprocal agreement for reciprocity for wilderness.
-Would also like to get ASRC classified as DMAT teams federalized for small disasters, such as a search.
-A handout was given with more information (Handout included in minutes)
-Trying to set up Wilderness EMT course set to WEMSI standards at Allegheny Community College in Cumberland.
-Protocols and policies confused - any motion made regarding medical protocols is invalid, the board cannot decide on protocols.
Motion, Keith Conover - Resolve that the motion accepted by the board at the last meeting, regarding the ASRC medical protocols for PA is null and void, as only physicians may establish medical protocols, which is the practice of medicine.
Second Candi Capozzi ***Yes 7 No 0 Abs 1***

Motion, Keith Conover - Table the proposed ASRC policies to next meeting.
Second Jean Avery ***Yes 8 No 0 Abs 0***

New Business

New Staff/IC proposals (Dave Carter): We are going to do new staff proposals first at the request of Deming Herbert.
For IC, Jean Avery
Motion Bob Koester (by Proxy)
Letters of Recommendation read from William Dixon, Bob Koester, and Dave Carter
Letters of Support read from Deming Herbert, Mark Buursink
Second Audrey Wilson (by Proxy) ***Yes 7 No 0 Abs 1***

For IC, Ruth Carter
Motion Candi Capozzi
Letter of Recommendation read from Dave Carter (letter serving as all three required)
Second Peter McCabe ***Yes 6 No 0 Abs 2***

For IC, Mark Eggman
Motion Dave Carter
Letters of Recommendation read from Dave Carter and Bob Koester
Second Gary Mechtal ***Yes 7 No 0 Abs 1***

Lisa Hannon's induction to SAR Hall of Fame (Deming Herbert): Call Deming if interested in attending.

SAR Coordinator's Job Announcement (Dave Carter): The SAR Coordinator's job is approved as a critical job to be filled. If anyone is interested fill out a state application and get it turned in. You can do a resume, but it still must have a state application with it.

There is still a question of whether outsiders can be on the board. Big concerns however are pre-selection. There are several rumors that William Dixon has already been selected for this job. Also several of Winnie Pennington and a couple rumors that state an outsider to the SAR world, but insider to the politics has gotten the job. All we can hope for is that the process will be fair.

ASRC Logo Being used Commercially (Michael Vatalaro): Someone brought to our attention that our patch was used in a commercial retail magazine. Halfway thru the magazine on a full page add. A letter from an individual - stating that they loved their boots. Using the ASRC patch. Concerned about what to do.
Gary Mechtal was asked to look into this and report back to the BOD.

Medical Mutual Aid Agreement (Mark Jones): As a favor to the departing Amy Rue I have written letters to Pennsylvania and West Virginia telling them who we are and what we do and what we would like, as of today we have not heard anything back from either state. There are copies of the letter here for anyone to review and to bring our new medical chair up to date.
(DC) Please pursue this.

Appalachian Alert out (Peter McCabe): Please make corrections to officers and return and will be out in a week.

Maryland SAR Council (Peter McCabe and Gary Mechtal): Maryland is developing a SAR council. (MSARCo) is unofficial name. Meet in Frederick, Maryland on January 28, 1995. Quite a few SAR organizations attended. Another meeting was held in Rockville, Maryland, the name of MASARO (Maryland Association of Search and Rescue Organizations) came out of this meeting along with some objectives.

Closed Business Meeting 1235

Operations Meeting

Overview of Operations Goals

• Approve next version of Operations Manual	Open
• Initiate data collection process	Complete
• Initial operation analysis program	Open
• Statistical report per meeting	None to date
• MOU with MDF	Postponed
• Improve RA to ASRC alert mechanisms	Open
• FTL performance/training	Passed to Training
• On-scene management	Complete (needs follow-up work)
• Rapid Response	Working
• Safety Officer Authority	W. Dixon new S.O.
• IC Meeting	Complete
• Ops Officer Manual	Working

Ops Manual Update

Had one review
Split up manual
Initial portion is out
Final portion by General membership meeting

Rapid Response Issue

Concerns
- AMRG response to Mass Casualty Incident
- Issue over immediate response - what happens if get called direct or what happens if an accident happens and your right there
- Estimate ASRC approval cycle
  - if call comes in to non-AO
  - 10 min to 1 hr (source: Mechtel)
    Take data
    contact AO
    AO call back

AO checks with RA
RA available?
AO messages to initial caller

- Other possible issues:
  - Vertical rescue??
  - Stopping by roadside/while on training??
  - Medical Standbys??
  - Another SAR group requests aid??

Rapid Response History
AMRG: A mass casualty incident
ESAR (MSAR): Mass casualty incident
AMRG: Training session(s) vertical rescue
SMRG: Broken leg @ PATC event (while in uniform)
SMRG: Direct calls from Mid-Atlantic Dogs
Others??

Here's the Problem our present process is good for: Customers who call us via DES and the Standard lost person search. However our goal is to help the lost and injured. What of indirect contact procedures? Police calling an individual that they know does this kind of work, While you are at another activity, Another SAR team calls you direct, or Fire/Rescue calls direct.

So what do we do? Here are some possible solutions. Ignore the problem, because the incident rate is too low. Train a lot more AO's. Develop SOP's for unusual cases. Allow ad hoc response to unusual cases. Or Provide the authority, but review cases with teeth. Any other suggestions will be welcome.
What happens if we ignore the problem. Sure this is the simple answer and it does not make much of an impact and we said the incident rate is low. But this would not solve the problem and would make AMRG unhappy. Plus there are a wide variety of cases, what about our image in the community, what of our liability. This could lead to others running open looped and give us the appearance of the "Good old boy" attitude.
We could train many more AO's, what would that do. This is simple answer, but could be a difficult approach because of the training involved, but it would certainly help if there were more AO's around.
However, Will an AO always be contacted? A wide variety of cases are still not covered, we still have the community image issue and what of liability.
Developing SOP's for unusual cases, this could be easy and could provide a complete solution. But how to we police this?, what about our liability if a decision made in error. This also will be more work to develop, more work to train people. How do we capture the broad nature of the problem and what about documentation.
Using an ad hoc response to unusual cases, this is easy and can provide a complete solution. But what of the liability if in error?? and this would take more work to develop.
Authorize, but reviewing with teeth can provide a complete solution to this problem also. Again, we wonder of the liability if in error. It will take more work to develop this and the ASRC does not have a good history of developing plans with teeth.
Recommendations:
1. Ignoring the problem, incident rate too low - this is not an option
2. Training more AO's, this is a maybe
3. Develop SOP's for unusual cases - again a maybe
4. Allow ad hoc response to unusual cases - this is not an option
5. Provide authority, but review with teeth - again a maybe

We could use a combination of 2, 3, and 5.
Use AO's to initiate whenever possible, encourage more AO's, authorize AO's for direct decision without RA (under certain circumstances) i.e. a call another well-established SAR group, a call from Fire/Rescue. Identify who can initiate under what circumstances. Senior on-scene person. Is it an immediate life/death situation. Provide an escape clause with teeth, something to cover unknown cases. There will be a need to review the process. What should the penalties be. Demotion, Expulsion.
(DC) We seem to be barking up the right tree but there are several branches. Pursue the idea, one of the things we do not do well is document, just capture the details.
GM told to pursue 2, 3, and 5 and report back.

Roles of Affiliate Vs Certified Groups
Roles are currently poorly defined at a high level, therefore derived requirements are poorly defined for example. What uniform do they wear, How do they respond to incidents, What other activities can they participate in, What

is the authority of the ASRC over affiliates? Here is our history on this issue: Circa 1985-1986 - Mechtal and Shea led effort to define. The intent was to open up conference to more SAR providers - 4-wheel drive groups, dog groups, horse groups and/or logistics groups. The issues are; loss of control by the "core groups", reduces level of effort needed by affiliates, process definitions. ESARs was the first group, they moved on to become Certified (now MSAR).
(DC) How do we make a clear distinction.
At present there is no real issue at low level. There is no reason affiliates cannot use our uniform or our licenses (radio, medical, etc..) ASRC does not police our assets, however this is true of certified groups too! All ASRC incident response is dictated by policy: ASRC response, Non-ASRC response. The policy is transparent to affiliate vs certified. Only difference between affiliate and certified are the number of people at training levels and equipment requirements.
The real issue is the high level description is flawed. Do we want to make it wide open? Do we want to separate classifications. Should provide voice at BOD level (suggest one vote). Requirements should be tailored for type of affiliate. I.E. why FTM level for 4 wheel drive or communications group?, why hand-helds radios for 4-wheel drive groups?
We should make it easy to attract and acquire affiliate groups, ASRC administrative overhead is high! Review of new group's established MOU's et al. Never done!
Suggested approach, continue culture change, be receptive to new groups. Change bylaws: Offer vote!! Adjust ops manual as needed on a case by case basis, place responsibility on new group prior to end probationary period. Need to update our training standards as necessary, get new group to initiate effort. Require complete operational review prior to accepting new groups with emphasis on their existing agreements, their performance, and their standards.

Gary handed out OPS manuals: These are not the finals. Is it a consensus that group equipment changes do not effect PVRG for their certification next BOD. *YES*
(DC) Is this the Operations Manual for the ASRC (GM) *YES*

A couple of new issues
-New Rosterss
-Minors joining - how do you operate. Gary to do Paper of what issues

Safety officer report (Gary Mechtal): Got a verbal from William Dixon. There is a virus throughout Shenandoah valley and Shenandoah National Park called Hampta. Nothing on On-Scene safety office.

1995-1996 Tentative Operation Goals (Gary Mechtal):
1. Develop organization and process to do operations properly.
2. Initiate round-table discussions on common practices for incident management.
3. Initiate review of mission documentation.
4. Initiate Operations Analysis process.
5. Develop baseline Vertical Rescue standards.
6. Study operational growth options.

General comments:
Ops officers from groups should be helpers.
Maybe put more effort into training non-ASRC people.

The Top Down Review (Dave Carter): Is still not done and I propose that we take 3 of the next 6 meetings to be working meetings instead of BOD meetings.
- What does ASRC mean
- What are we trying to accomplish
- Where are we going

Most groups are already redefining the way they do business.

Mission Files (Patrick Turner): The mission files are somewhat a mess, some are named and some had mission numbers from the state. For filing and reference purposes we would like to assign ASRC mission numbers. Starting with 1 and going on. This will make it a little easier to track. ***It was the consensus of the BOD that this be done and the go ahead was given.***

Bike SAR (Tony Bordeaux): A paper was handed out up dating Bike SAR. This paper defined bike SAR's uses and set into Ops manual format the equipment, training, operating procedures and types of tasks. Any question, comments or additions need to be directed to SWVaMRG.

Next BOD (Dave Carter): Will be held at VPI, Blacksburg, VA. Elections and General Membership Meeting will be held. Activities are planned including a night orienteering course. The only changes to the By-laws are what we discussed in this meeting.

Announcements for the good of the order:

Mar 11-12 - Center for Emergency Medicine/Wildemess EMT part I, Camp Soles, SW PA
April 8-9 - WEMSI-Recognized WEMT Part 1: Muncy Terraces, 15 miles east of Williamsport.*
April 22-23-24 - WEMSI -Recognized WEMT Part 2: Crystal Lake, 30 NE of Williamsport, off Rt 220.*
* Register through Bloomsburg State University, 717-389-4323 - Cost $300 - 325 for both weekends.

SMRG FTM course being held 11-12 and 25-26 March and 8-9 April contact Todd L'Herrou.

(Rob Christie) Jeff Mitchell (CISD) will be speaking at the Baltimore Sheredan March
-In Stanton, VA 25-26 March

(Dave Carter) TSAR simulation at SeaShore State Park 25-26 March at 0800.

Appalachian Trail Club will hold it's annual meeting 1 - 8 July. There will be 1500 hikers per day.

Motion to close meeting Gary Mechtal
Second Dave Carter

Adjourn at 1535

Candi-
Overall, the February ASRC Board minutes look great. I have just a few minor clarifications to suggest for the next meeting, as I won't be there. These all have to do with the Medical Legal section on page three.

1. Andy Appel is Legal Advisor for the ASRC/CEM Wilderness EMS Institute, and an active member of the WEST team in Lancaster, PA.

2. "Medical command is illegal across state lines . . ." unless specifically authorized, and in our area there is only one situation in which an interstate agreement allows this: transport from one state to a medical facility in another state, which is authorized by the current Atlantic EMS Council (PA, NJ, RI, DE, DC, MD, VA, and WV).

3. "We are in the process of redoing. . . ": actually, it's the Atlantic EMS Council that's redoing the reciprocity agreement to include other kinds of cross-state medical command, and will consider wilderness rescue as one of the eleven situations they will try to deal with in the new agreement.

4. Jack Grandey of AMRG/ER-NCRC (WEMSI Operations Director) is also _investigating_ having ASRC and NCRC teams, or maybe just the medical personnel on them, declared special-function federal Disaster Medical Assistance Teams, which would mean we wouldn't have to worry about state EMS regulations and state Medical Practice Acts.

Thanks!

William--

Thanks for your email question about medical direction for ASRC EMTs in various states. Your question is about which procedures and treatment protocols EMTs should follow: protocols for the state in which they are certified as EMTs, or protocols in the state in which they are operating. This is actually a complicated question without a simple answer.

I'll take a few paragraphs to lay out some background; please share with others as you wish. I'll also cross-post this to the other ASRC Groups. To check on the accuracy of this summary, I'll send it to lawyers Harry Teter of the Atlantic EMS Council, Andy Appel of the Wilderness EMS Institute, and Kenneth Brody of the Pennsylvania Department of Health. I'll post any corrections or additions they have, and will at some point develop this discussion into a more detailed description of regional wilderness scope of practice, but in the interests of timeliness, here is my understanding:

MEDICAL PRACTICE ACTS

First, consider the practice of medicine. Each state has a Medical Practice Act that restricts the practice of medicine to those who are licensed by the state. There are two primary reasons for licensing physicians from the state's view: 1) it provides money for the state in the form of licensing fees (a form of tax), and 2) it provides the state's citizens some protection from quacks by establishing criteria for licensing. From the physicians' viewpoint, it both elevates the profession to a higher level and restricts entry to those who meet the criteria, allowing more prestige, higher fees, and some protection against incompetents in their midst. Again, controlling the practice of medicine is entirely a state prerogative, and the federal government basically isn't involved at all. This means that the privilege to practice medicine ends at the state line.

DELEGATED PRACTICE

From the earliest time, physicians didn't want to do everything themselves. They wanted to delegate certain tasks (applying leeches, drawing blood, administering medications) to others. States have universally allowed this "delegated practice" in their Medical Practice Acts. So, a physician could tell an office medical technician to give a vaccination, or tell an office orthopedic technician to apply a cast, and it was OK (not a violation of the Medical Practice Act). However, the physician has to directly order the "technician" (the generic term used in most Medical Practice Acts), and accept responsibility for the technician's work quality.

NURSING AND EMS

After a while, nursing became a profession, with standardized training. Nurses, too demanded licensure, for the same reasons as physicians. Physicians agreed, too, because it gave them a big benefit. Just like the industrial revolution allowed us to build things with uniformly manufactured interchangeable parts, registered nurses became (somewhat) interchangeable. This meant the physician didn't have to take total responsibility for the nurse's training; a R.N. could be assumed to meet certain minimum standards. As part of this process, state laws laid out what R.N.s could and couldn't do. Similar state laws for Physician's Assistants, Nurse Practitioners, and other "technicians" also evolved.

As EMS developed, paramedics and later EMTs were placed in a similar "interchangeable parts" category by state laws. However, as with nursing and to a lesser extent medicine, the state laws vary.

MEDICAL CONTROL

Some prehospital personnel just provide first aid. Most states don't see first aid as the practice of medicine and don't regulate it.

Some (let's use the new term "out of hospital" from now on) out-of-hospital personnel clearly practice medicine: paramedics. Paramedics can only practice medicine at the direction of a physician. This can be "on-line command"/"direct medical control" where this paramedic and physician are talking over the radio, or "off-line command"/"indirect medical control" where a physician medical director provides protocols and standing orders, and reviews the performance of paramedics. To provide the interchangeable paramedic and physician parts, state laws provide specific authorization for this kind of delegated practice.

Do EMTs practice medicine? With the new EMT-Basic Curriculum, which includes medication administration (epinephrine, nitroglycerine, and albuterol), the answer is clearly yes. Under the old Curriculum, some states, deliberately or be ignoring the issue, classed EMT-Basics with first aiders and let them practice without medical direction. However, the trend is clearly away from EMTs as "first aiders."

MUTUAL AID

What happens when a paramedic or an EMT goes across state lines? Well, basically, the EMT or paramedic has no right to practice medicine at all in the other state unless specifically granted by that state. And, indeed, many states have established reciprocity arrangements for both EMTs and Paramedics. The Atlantic EMS Council consists of PA, NJ, RI, DE, DC, MD, VA, and WV. It has reciprocity for EMT and paramedic between all members. However, unfortunately this reciprocity doesn't apply to the physicians who are providing medical control. This means you, as an EMT or paramedic, can practice your limited kind of medicine in a "foreign" state only under the medical direction of a medical control physician from the "foreign" state.

The Atlantic EMS Council is now working on a new cooperative agreement that will cover medical direction between the states, and at the February meeting, Wilderness EMS Institute staff will present the needs of the wilderness community and see if the new agreement can provide for wilderness EMS mutual aid between various states.

EMS LIMITATIONS

Pennsylvania's Act 45 (Emergency Medical Services act) can only be definitively construed to apply to emergency care given on or near ambulances or other EMS vehicles, per discussions with the Pennsylvania Department of Health's lawyers. This does not permit the Pennsylvania Dept. of Health to manage or regulate what we think of as wilderness EMS.

Therefore, the Wilderness EMS Institute (WEMSI) has instituted a pilot program of "delegated practice" wherein out-of-hospital providers act as generic Pennsylvania Medical Practice Act "technicians" rather than as EMTs or paramedics. These providers are called "Wilderness Medics" to differentiate them from EMTs and paramedics (though all the pilot Wilderness Medics are trained as and function as paramedics when on the street). This is, we hope, a temporary measure, and we are working with the Pennsylvania Emergency Health Services to see if we can incorporate wilderness EMS within the state EMS system, probably by modification of the state EMS law to specifically include wilderness and backcountry patients in the definition of EMS.

Surprisingly, this limitation of Pennsylvania EMS can be interpreted to mean that an EMT or paramedic in the Pennsylvania backcountry is outside the EMS scope of practice. Certainly, the existing EMS protocols and medication limitations prevent "street" EMTs and paramedics from administering care meeting national wilderness EMS standards when in the backcountry.

Luckily, WEMSI has established a set of clinical standards for how backcountry medical care at the EMT-Basic level should be performed: the WEMSI WEMS Protocols. These specifically state that they may be taken as orders from the WEMSI Medical Director. Thus, someone with EMT-Basic training in the Pennsylvania backcountry, while being outside the scope of practice of a "street" EMT, could follow the WEMSI Protocols and be assured that (1) the patient is getting appropriate care, and (2) the EMT is functioning as a generic "technician" of the WEMSI Medical Director, and thus not practicing medicine without a license.

The status of EMTs and paramedics in the backcountry of other states is not known to me. Probably, we need a legal opinion from each state. Andy Appel, the Legal Advisor for WEMSI, plans to complile such data, and I'll forward it as it becomes available. However, there are national and regional clinical standards for the treatment of patients in the backcountry. These standards are in part reflected in the Position Statements of the Wilderness Medical Society, and the Rural Affairs Committee NAEMSP. Clinical guidelines for delayed/prolonged transport:

BOTTOM LINE

At present, your EMT or paramedic from any Atlantic EMS Council state is good in any other state. However, you need to follow the protocols of that state when you're in it.

The very bottom line, though, is that when in doubt, do the very best for your patient that you can. Providing bad care because you're afraid of the legal consequences is an almost sure way to get in both medical and legal trouble. Providing good care even if you're not sure it's "legal" is the best way to care for your patient and keep yourself clear of the court system.

Just about any lawyer will tell you the same; lawyers are always giving me this advice in medical-legal seminars. A good example is a child who comes to the Emergency Department with a significant injury. In some legal sense, I can't treat a minor without the parent's permission. However, if I delay Emergency Department care pending the parent's permission, I'm taking a big medical and legal risk. I don't even ask if we have parental permission until after I see the child and figure out if the child needs treatment. Unless the medical treatment I'm contemplating is clearly elective or can wait without any detriment to the child at all, I go ahead and do it: suturing a wound, giving an antibiotic, whatever. Only later do I worry about parental permission. Since what the lawyers tell me to do what I want to do anyway, it's very satisfying.

If in the field and you have a choice between what is right and what you think is legal, choose what's right and you'll probably do better in court, if it ever comes to that, than if you did what's "legal."

I hope this is of some help. I'm sure the lawyers will have corrections and amplifications, and I'll make sure you get them. Thank you.

Wilderness EMS Institute
Internet email memo
February 3, 1995

To: William Dixon
From: Keith Conover, M.D., Medical Director
cc: WEMSI email mailing list recipients, Mr. Appel, Mr. Brody, Ms. McClain, Mr. Teter
Subj: Wilderness EMS Legal Aspects

I just got off the phone with Kenneth Brody, the assistant legal counsel for the Pennsylvania Department of Health. He reviewed my prior memo to you, and generally agreed, with one exception, and had a few more thoughts to offer. He will review the detailed wilderness EMS legal briefing that Andrew H. Appel, Esq., the WEMSI Legal Advisor, will send him for review; I will post it when available. However, it'll be another month or so until that's available, so I wanted to get this information to you now.

STREET EMTs IN THE WILDERNESS

As regards "street" EMTs and paramedics in the wilderness:

Mr. Brody said the scope of practice of "street" EMTs and paramedics _can_ be thought of as extending into the wilderness. For example:

Assume a "street" EMT or paramedic is in exceptional circumstances that are not a part of his or her "regular" or "street" EMS job, (e.g., in a wilderness rescue with life or limb potentially at risk). Assume the patient needs something that's _not_ acceptable for "street" EMS, at least in Pennsylvania. E.g., the patient needs a shoulder dislocation reduction to facilitate evacuation, or needs a medicine such as phenytoin=Dilantin(r). Assume there is contact with a Medical Command Physician. Assume the Medical Command Physician has some understanding of wilderness EMS. In such a case, "Medical Command Physicians are expected to exercise broad discretion in what they direct the EMT or paramedic to do, consistent with their ability to practice medicine." If the physician ordered the EMT to reduce a shoulder dislocation (and the EMT had previous training in this), or ordered the paramedic to give PO phenytoin, there might be the potential for disciplinary action by the Board of Medicine or state EMS, but such boards are expected to exercise broad discretion, particularly when the situation is one not foreseen by the EMS law, when considering a potential disciplinary action. This is not ideal, but should suffice for many wilderness EMS situations.

However, as Mr. Brody and I discussed, note that the above applies to those who find themselves in exceptional circumstances outside their normal EMS practice. For medically-trained members of search and rescue teams, whose main EMS practice is taking care of wilderness patients, a wilderness patient would not be an exceptional case but the norm, and the non-EMS delegated medical practice option discussed below would be a better legal route to providing wilderness medical care.

NON-EMS WILDERNESS DELEGATED PRACTICE IN PENNSYLVANIA

Mr. Brody agreed that Pennsylvania's legal provisions for delegated practice by physicians are broad, and can include the kind of delegated practice that WEMSI uses: "Delegated practice isn't limited to just the office, or just the hospital." The Medical Practice Act places no restrictions on when or where a physician may delegate practice.

However, he did note that there may be liability concerns for both physician and delegatee– this kind of delegated practice doesn't have the same liability protection as afforded under the EMS Act. We of WEMSI know this, but our physicians are covered for their Wilderness EMS activity by their existing malpractice insurance, and while our field providers would like the same legislative protection as their "street" counterparts, don't plan to let this stop them from giving care to those in need.

INTER-STATE ISSUES

Mr. Brody noted that Pennsylvania state law has already has a provision for ambulances coming into Pennsylvania from outside Pennsylvania in exceptional circumstances. In such circumstances, for example disasters, they can operate under their own out-of-state medical control.

I didn't get the exact reference for this from him, but on reviewing the EMS law I found the following in the Pennsylvania Emergency Medical Services Act (1985), Section 12, Minimum Standards for Ambulance Service: "(t) Exemption.–The following are exempted from the licensing provisions of this act: (1) privately owned vehicles not ordinarily used to transport patients. (2) A vehicle rendering temporary service as an ambulance in an emergency when ambulances based in the locality of the emergency are insufficient to render services required."

However, this doesn't say anything about the EMS _personnel_ not needing a license/certification to practice in Pennsylvania, nor does it cover cases where the EMS personnel are working without an ambulance, as is the case for Wilderness EMS. It also doesn't say who gives these ambulances medical command, nor which protocols or standing orders they follow, their home ones or Pennsylvania's. I'll have to get back to him on these points.

A possibility that I did not discuss with Mr. Brody, but occurred to me later, is to define a Wilderness Ambulance. This is suggested in the National Association of EMS Physicians' EMS textbook:

> "The goals of wilderness EMS equipment are the same as for ambulance equipment: high quality prehospital care. However, much of ambulance equipment is inappropriate for the wilderness. For instance, an ambulance cot is a poor choice for cliff or cave rescue. However, the underlying _reasons_ for ambulance equipment requirements may, after consideration, give clues about equipment for wilderness EMS.
>
> Consider a wilderness "ambulance." The litter team members' booted feet are its "tires." Blistered feet or slippery shoes on a rescue team may be just as hazardous as bald tires on an ambulance. Training in good foot care, and proper personal equipment, are essential parts of the wilderness

"ambulance." One might argue that the rescue team's equipment can be all team equipment, with no need for personal equipment, but a quick thought about boots will belie this. A five-mile hike in not-broken-in "team" boots would make any rescuer into a casualty.

The rescuers' headlamps are the wilderness ambulance's headlights. Night-time rescuers carrying a patient and using hand-held flashlights are probably worse off than providers in an ambulance with no headlights and no interior lighting.

These analogies can, of course, be carried to extremes, but are a useful starting place for examining the equipment needs of a wilderness rescue team."

(from: Conover K. Wilderness. In: Kuehl AE, ed. National Association of EMS Physicians' _Prehospital Systems and Medical Oversight_, 2E. St. Louis: Mosby, 1994.)

This "Wilderness Ambulance" idea is also reflected in the WEMSI proposal to modify Pennsylvania's EMS law to provide for wilderness "life support units":

" . . . As a rough guide only, we suggest the following additions to the Pennsylvania EMS law. . .

1. "Advanced wilderness life support unit." The assembled personnel and equipment to provide advanced life support in a wilderness/backcountry context."

2. "Basic wilderness life support unit." The assembled personnel and equipment to provide basic life support in a wilderness/backcountry context.

. . .

12. "Wilderness life support service." An entity which regularly engages in the business or service of providing emergency medical care and evacuation of patients in a wilderness/backcountry context within this Commonwealth. The term includes Advanced Life Support services that may or may not evacuate patients.

Next, a recommended addition to section 4 (4) on the emergency medical services system: "Include an adequate number of ambulances and other transportation _and evacuation_ means, _including teams to treat and evacuate persons from wilderness and backcountry sites,_ to meet the individual characteristics . . ."

Recommended addition to section 5 (9): "Establish minimum standards for, license and inspect ambulance _and wilderness life support_ services in accordance with section 12."

(from PROPOSED ADDITIONS TO THE PENNSYLVANIA EMERGENCY MEDICAL SERVICES LAW (Act of 1985, P.L. 164, No. 45), REGARDING WILDERNESS EMERGENCY MEDICAL SERVICES, from the Wilderness EMS Institute, submitted in 1994 as

testimony to the Pennsylvania House Health and Welfare Committee hearings on EMS)

If Pennsylvania were to enact legislative changes for Wilderness EMS, the Section (t) exception above could also be modified to include Wilderness Life Support Units.

I'm not sure if the existing section (t) exception can be extended to wilderness EMS personnel from out-of-state without an ambulance; I'll have to ask Mr. Brody about this.

Mr. Brody also pointed out that EMS agencies from other states that expect to run into Pennsylvania on a regular basis can apply to become recognized PA EMS medical command centers. There is no requirement that a command center be located in Pennsylvania; the physicians would have to get licenses for Pennsylvania, (there's no "EMS reciprocity" for command physicians) but otherwise the command center can become just like any other Pennsylvania command center as well as providing command for its home state.

I thought there was an existing reciprocity among all the participating states, which allowed EMT and paramedic reciprocity across state lines. I had thought that this meant that EMTs and paramedics from any Atlantic EMS Council state could go into another state without need for EMT or paramedic licensure/certification in that state. Mr. Brody said that isn't so; EMTs and paramedics still need Pennsylvania licensure to be able to operate here (except for the exceptional case of ambulances coming into the state, mentioned above). The copy of the PA EMS law I have here confirms this: (28 PA. CODE Chapter 2, section 2.5, "reciprocity") "(a) The Secretary may enter into a reciprocity agreement with the appropriate official of a state which has certification requirements which the Secretary finds to be equivalent to those of Pennsylvania. (b) Persons applying for Pennsylvania certification who hold current certification for which such an agreement is effective will be issued a Pennsylvania certification, if they can demonstrate a need for such certification." So, "reciprocity" means you don't have to retest, but you have to apply for a Pennsylvania EMT or paramedic (but note this won't apply to any levels in between, as Pennsylvania has only EMT and paramedic certification).

And, based on the above, Mr. Brody didn't think that for "street" EMS there is need in Pennsylvania for an interstate agreement on medical command reciprocity, as I believe the Atlantic EMS Council is considering: there are adequate means for both unexpected exceptional cases and routine cross-state ambulance EMS.

Well, I suspect this memo raises more questions than it answers. However, I hope that in the not-too-distant future we'll get all these questions answered and get wilderness EMS, including interstate issues, on a solid legal footing.

Thank you.