ISSUE PAPER

Prepared for: Rocky Mountain Area Coordinating Group

Submitted: November 3, 2008

Title: Lack of medical oversight and legal authority for fire line and base camp medical personnel

Issue: Emergency Medical Technicians (EMT's), EMT-Intermediates (EMT-I's) and Paramedics (collectively "EMT's") can provide valuable care at fire incidents, but in most or all states they must operate under medical oversight of a licensed physician – a medical director. If that is not available, they cannot legally operate at their level of certification, and are only legally authorized to provide first-aid level care like any layperson. Yet EMT's are routinely expected to operate at their level of certification, without medical control on incidents.

Background: It is common practice to order EMT's to fire and all-risk incidents to provide health and emergency medical service to personnel involved in the incident. There are limited regulations and standards in place, including that EMT's must be state certified, and that Medical Unit Leaders (MEDL's) or Incident Medical Specialist Managers (IMSM's) should seek local medical control on incidents with over 250 people. However, while state laws governing medical practice vary from state to state, it is generally true that EMT's of all levels must have medical oversight from a licensed physician in order to provide any care beyond the first aid that could be provided by a layperson. The physician's oversight may be via direct orders (calling during patient contact for patient care orders) or via written protocols/standing orders. These are the only two means by which an EMT can be authorized to provide care beyond first aid level. Also necessary is after-care review and quality assurance by the medical director (physician) to ensure standards of care are met. State or national certification indicates the holder is qualified to be employed, but does not confer any authority whatsoever to actually provide medical care. Only a physician medical director can do that.

Yet, on fire after fire, EMT's are ordered up, in some cases with the orders specifying that they are to bring advanced life support equipment with them, and are expected to provide care to their level of certification without having any form of physician oversight or medical direction available to them. This opens the individual provider, as well as the host agency to significant liability, and potentially even criminal action or license revocation for practicing outside of their medical authority. My efforts to obtain further information and direction on this have been unsuccessful. The IEMTG website references US Forest Service medical protocols, but I have yet to see any, or talk to anyone who can direct me to them. I have heard there is a USFS medical director, but have no means of contacting him/her for medical orders or quality review, or even verifying their existence. EMT's and paramedics continue to be ordered to fires, showing up with controlled substances, surgical equipment, and other advanced medical equipment they have no legal authority to use, yet they are expected to save lives with it if the need arises.

NWCG Medical Unit Standards, (NWCG#011-2208 Interim NWCG Minimum Standards for Incident Emergency Medical Services) also indicate that an incident with over 250 personnel should establish local medical control. However, having worked with countless physicians through the years, I cannot imagine most local medical directors being willing to extend their medical authority to provide advance level care to providers they know absolutely nothing about. Advance procedures are typically authorized only to those with whom the physician has established a relationship of trust. This is usually based on personal familiarity with the provider, or involvement with their particular EMS system, such that the physician has a degree of confidence that care will be rendered in a competent manner, that training is appropriate for the care authorized, and that they have a means of recourse if sub-standard care were to occur. None of these would apply to a local medical director when an MEDL or IMSM calls to report they are in town for a couple of weeks and want advanced medical protocols for their staff.

Some firefighters are dispatched as official representatives of fire departments or similar organizations that in fact have a medical director, and may bring their equipment and protocols with them. However, a significant question remains if that medical director's authority can extend outside their state of licensure.

Alternatives:

1. One of the most basic initial steps would be to establish a set of national-level medical protocols/standing orders for fire and all risk incidents managed by NWCG member agencies, with medical direction established. This will only work if the orders are readily available to all who need to access them. The protocols need not be as comprehensive as a typical EMS agency would provide, because pediatric, geriatric, and other issues would not be relevant. Only basic medical and trauma emergencies would need to be addressed. They should incorporate the flexibility/recognition that care may be provided under less-than-ideal conditions, with limited equipment and personnel at times. Along with this should be a system for patient reports to be submitted to the medical director upon the provision of any care beyond basic first aid, and the ability for the medical director to provide for re-training, correction, or discipline in the event of inappropriate

care. This protocol document could then be provided to a local physician as "the standard protocols" for their approval. At the same time, a specific medical director should be identified for each region, GACC or state, who is willing to provide their oversight in the case a local medical director is not readily available, or cannot or will not accept responsibility for the "outside" resources he or she is unfamiliar with. With these protocols should also be written purchasing authority for the prescription pharmaceutical items and restricted medical equipment addressed within the protocols, so that agencies and IMT's would have the authority to purchase the required items for fire incident or for pre-incident preparedness, since many items require physician authority to purchase. Only those items included within the protocols/standing orders would be authorized items to possess, use, or carry while on a fire assignment.

2. A system could be established for identifying and recognizing those individuals who do in fact respond as an agent of a locally licensed and authorized EMS provider (fire department or ambulance service typically), who in fact have a medical director in place who can authorize care outside of their local jurisdiction. If this applies, they could then provide a copy of their home-unit protocols upon checking in. Upon doing so, they could be authorized to perform activities and levels of care that may exceed the basic national protocols, but which they are specifically trained, authorized, equipped, and provided quality assurance for by their local agency and medical director. It would then be up to their home system to provide for any equipment or pharmaceuticals beyond the basic authorized list. A standardized authorization form could be established to be signed by their medical director and home agency representative indicating that this would apply to that specific individual.

Recommendation: Prior to the 2009 fire season, this issue should be addressed at the national level, in order to provide legal authority for EMT's to perform the skills routinely asked of them on fire assignments. The alternatives above are recommended, although it is also recognized that there may be other viable options available. Inaction will, sooner or later, result in legal action against individual providers and/or their hosting agencies due to providing medical care without medical authority to do so, and should not be considered as an acceptable alternative.

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APPROVED / APPROVED AS MODIFIED BELOW / REJECTED / DEFERRED UNTIL:

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