Wilderness EMS Institute http://www.wemsi.org/
Frequently Asked Questions (FAQ) -- Legal Issues
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1. I have just taken a [wilderness first aid][Wilderness First Responder][Wilderness Emergency Medical Technician] course, and they taught me to [use an Epi-Pen][reduce shoulder dislocations][give oral antibiotics][perform field appendectomies]. Is it legal for me to now do these things?

It depends. If you are already a physician licensed in your state, and you're operating in your state, the answer is yes.

If you are a first aider, and are think you are just performing first aid, the answer is yes. (You may have to persuade a judge and or jury of this later on. If it's just splinting a broken leg, no problem. If it's using an Epi-Pen on someone who just got stung by a bee and who swelled up and turned blue and almost died, or even did die, you're probably in good shape. If you are a first aider and botch a field appendectomy, I wouldn't bet on you – most judges and juries would see that as practicing medicine without a license, or perhaps a reason to award damages against you for exceeding your ability. Other medical procedures fall in between. Sorry for the fuzzy answer, but that's the way the law works.

If you are a Wilderness First Responder, and have not been trained to the level of a non-wilderness First Responder, nor received state Emergency Care—First Responder certification, you're just another first-aider and the above applies.

If you are indeed certified as an Emergency Care—First Responder, you may or may not be regulated by the state EMS act – it depends on the state. If you are regulated by the state, then you're supposed to do only what the state says you can do. (Same for EMT-Basics, EMT-Paramedics and in between, and for nurses, PAs, CRNPs, etc.) If, as part of your regular job as a [First Responder][EMT][paramedic], do something well outside of your "scope of practice" your supervisor will not like it. The state will not like it. Bad things may or may not happen to you. You're unlikely to face criminal charges of "practicing medicine without a license" but you may receive a reprimand, get fired, have your license as an [First Responder][EMT][paramedic] suspended, or be assigned to care for only demented nursing home patients with diarrhea for the next month. However, if you did a good job of what you did, and it really helped the patient, and you didn't act like an a**hole about it, you

may even get a commendation. Many EMS systems have provisions for personnel occasionally exceeding the scope of practice. Ideally this occurs with online consultation with a medical direction physician who will back you up.

If you expect to only occasionally do things “outside your scope of practice” on a rare, emergency basis, see below for more.

If you expect to perform advanced medical procedures above your “scope of practice” on a regular basis with your SAR team or EMS agency, and there’s no state law permitting it, you better coordinate with your state EMS people and see about changing the laws or regulations.

2. What is a Medical Practice Act and why should I care?

In the U.S., 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.

3. What is Delegated Practice and how does it apply to Wilderness EMTs?

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. Delegated practice provisions vary widely from state to state.

4. How do nurses fit into Delegated Practice, then?

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 RNs 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.

5. What is the role of the physician in Emergency Medical Services and Wilderness EMS?

Some prehospital personnel (e.g., many SAR team members) just provide first aid. Most states don't see first aid as the practice of medicine and don't regulate it. The Wilderness First Responder sometimes falls into this “first aid” category, sometimes not – depends on who you ask (even state health department lawyers and judges).

Some (let's use the new term "out of hospital" from now on) out-of-hospital personnel clearly practice medicine: **paramedics**. In the U.S., paramedics can generally 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" (see 3., above) paramedic and physician "parts," state laws provide specific authorization for paramedic's delegated practice.

In England, though, paramedics have a distinct independent right to practice a subset of medicine independent of physician medical direction. And there is a growing tendency in a few U.S. states to recognize, in legislation, some independent right to practice by paramedics. Most states, however, emphasize the dependence of the paramedic's right to practice on a physician's license.

Do **EMTs** practice medicine? With the new EMT-Basic Curriculum, which includes medication administration (epinephrine, nitroglycerin, and albuterol), the answer is

clearly yes. Under the old Curriculum, some states, deliberately or by 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." And there is a new emphasis on the need for medical direction for EMT-Basics.

6. What happens when a paramedic or an EMT goes across state lines?

Well, basically, the EMT or paramedic has no right to practice medicine in the other state unless specifically granted by that state. And, indeed, many states have established "reciprocity" (but see below) arrangements for both EMTs and Paramedics. The Atlantic EMS Council consists of PA, NJ, RI, DE, DC, MD, VA, and WV. It has arrangements for "granting reciprocity" between EMT and paramedic levels between all members. Specifically, this agreement allows providers of **equivalent levels** to apply for certification and licensure in another state. Providers have to apply for this, it's not automatic. But among these states, it's generally easy to get EMT or paramedic licensure in another state.

Your state EMT certificate is good in another state only if your state and the other state has a special agreement, **and** you have previously applied for EMT certification in that state. In general, granting EMT certificates is a state responsibility, and they can't automatically offer "reciprocity" for other states' EMTs. But, states can and often do make arrangements to make it easier for EMTs to get a license in another state (e.g., maybe all you have to do is submit paperwork rather than take the state test).

Unfortunately, however, this 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 who is licensed in the "foreign" state.

The Atlantic EMS Council is now working on a new cooperative agreement that will cover many different problems with EMS between its member states, including helicopter transports between one state and another. (Note that the standard practice for cross-state emergency medical flights – that the sending facility provides medical direction until the aircraft arrives at the receiving facility – has no basis whatsoever in law.

Once upon a time, some Wilderness EMS Institute staff attended one of the Atlantic EMS Council meetings and spoke about the need for making out-of-state providers able to

provide advanced care, even beyond the paramedic level. We gave as example a rescue at Crossroads Cave in Bath Co., Virginia several years ago. By the time the entire NCRC Eastern Region cave rescue class (about 100 students and instructors) learned of the incident and drove to the site (and just after the final exercise, we might add), the local cave-rescue trained people were exhausted and had to come out of the cave.

As we continued the rescue over the next 12 hours or so, we used a North Carolina orthopedic surgeon, a Pennsylvania emergency physician, and out of state paramedics to care for the patient. We used all sorts of “EMS-unapproved” medications (e.g., ketorolac IM) and procedures (e.g., shoulder dislocation reduction, clearing the cervical spine in the field, medical direction by an orthopedic surgeon for orthopedic problems).

When we explained to the assembled lawyers and state EMS directors that we wanted to figure out a way to make this all have some semblance of lawfulness, they said “OK, we’ll add that to the list of other unlawful things we have to do all the time. Let’s see, that’s #11 on the list.”

We hope this makes you feel more sanguine (or at least less fearful) when you decide to do something that’s unlawful but in the patient’s best interest. Remember that helicopter and fixed-wing crews are doing similar unlawful things all the time and nobody’s suing them or taking away their certification.

7. So if I'm an First Responder, EMT or paramedic, what is my legal status in the *backcountry* in another state, both for unexpected emergencies and if I respond to the other state regularly as part of a search and rescue team?

At present, the only state that we know of with **officially state-certified** Wilderness EMTs is Maryland. So at present there is no way for these Wilderness EMTs to get "reciprocal" WEMT certification by another state. Several other states “recognize” WEMT certificates from various providers, but there are no reciprocity arrangements of which we are aware.

(A) Unexpected Emergencies: Assume you find yourself in an "exceptional" circumstance, such as this. You are an EMT from Virginia. You are hiking along a trail in Pennsylvania's Potter County, a mile from the nearest road. You run across a hunter who was shot in the leg and has an open fracture. In such a case, you have no **legal** authority to provide medical care. But Pennsylvania has a Good Samaritan law, specifically designed to encourage people

like you to render care. This suggests that, despite the letter of the law that requires you to have a Pennsylvania EMT to provide care, that you should go ahead and provide care for the patient.

In the unlikely situation where you end up in court or in a hearing, what standard of care would you be held to? If your training is EMT-Basic, you would be expected to control bleeding and dress and splint. If you are trained as a Wilderness EMT, you would also be expected to, if possible, irrigate the wound before dressing it.

(B) Routine Backcountry Care: What if you are part of a SAR team, and your team responds regularly into another state? Well, since there isn't yet any Wilderness EMT "reciprocity," so you can't do that. (Maryland ***may*** decide to make it easy for EMTs with WEMSI Wilderness EMT certificates to get Maryland WEMTs, but that's still only a remote possibility at this point). It certainly would be a good idea to get a certificate at the EMT or paramedic level even if, as in Pennsylvania or Maryland, this doesn't extend to the wilderness setting. (If you get into court or into a hearing, it would be evidence of a good-faith intent to abide by the states' laws as much as possible.)

WEMSI doesn't provide on-line medical direction except to Wilderness Medics in its own special pilot program. However, you ***can*** certainly use the WEMSI protocols as a good guide to the "standard of care" for backcountry medical care in Pennsylvania. Which means if you have WEMT training plus an EMT or paramedic certificate from another state, you will be well-off legally if you follow a set of recognized wilderness protocols such as the WEMSI protocols (posted on the WEMSI Web page at http://www.wemsi.org).

8. But what about aeromedical transports across state lines? We all know that the sending facility's physician provides medical direction until the craft lands, and that the paramedics and nurses continue to follow the standing orders from their original medical director until the land.

"Legally," medical direction for helicopter crews must stop at state lines. Though it has no grounding in law, only in common sense, there is an informal agreement pretty much nationwide to allow the helicopter's (or plane's) medical direction to continue until it arrives at the receiving facility. A few helicopter services' medical direction facilities are registered in more than one state, but overall most long-distance medical air transports have little legal backing for physicians or others providing medical care en route.

For those with questions about the "legality" of certain wilderness EMS issues, this should be reassuring -- states have many bigger "legal" EMS problems than wilderness EMS. Indeed, when WEMSI approached the Atlantic EMS Council with a request to add interstate medical direction for wilderness EMS to their agenda for the new interstate agreement, it was #11 on the list of "unlawful EMS things we are already doing but need to put into the law."

9. What is the legal status of Wilderness EMS in Pennsylvania?

Pennsylvania's 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. This does not permit the Pennsylvania Department 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 Council, and have provided testimony on the subject to the Pennsylvania legislature, to see if we can incorporate wilderness EMS within the state EMS system. Probably this will be by modification of the state EMS law to specifically include wilderness and backcountry patients in the definition of EMS. Two facts are encouraging along those lines: for the past several years, WEMSI’s Medical Director (Keith Conover) has had a seat on the Medical Advisory Committee of Pennsylvania Emergency Health Services Council, and that the new (2000) State EMS Director (Doug Kupas) has run WEMSI Wilderness EMT classes on a regular basis.

Again, from Dr. Conover's notes from discussions with Pennsylvania Department of Health and Board of Medicine:

"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, 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, limited as it is. 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."

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. In exceptional circumstances (such as when you're backpacking along the Laurel Highlands Trail and run across someone with an open leg fracture) you as a Pennsylvania EMT or paramedic might be able to stretch your scope of practice to cover care in the backcountry. And, certainly the Good Samaritan law would provide some protection for you when rendering care in such an exceptional situation.

But what if an EMT or paramedic plans to regularly operate in the backcountry (e.g., by joining a SAR team, or by taking a Wilderness EMT course to prepare for such cases)? In a court, what standard of care would the EMT or paramedic be held to? Very likely, the standard of care the court would apply is that for backcountry EMS, not "street" EMS.

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. However, when considering a potential disciplinary action, the Board of Medicine and state EMS are expected to exercise broad discretion, particularly when the situation is one not foreseen by the EMS law. This is not ideal, but should suffice for many wilderness EMS situations.

However, 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.

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 (available on the WEMSI Web Page at http://www.wemsi.org). 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) if dragged into court or into an EMS hearing, the EMT can point to the WEMSI protocols as a state-level backcountry EMS standard of care.

10. What about Wilderness EMS in Maryland?

The Maryland Institute for Emergency Medical Services Systems (MIEMSS) is currently establishing a state wilderness EMS system, headquartered in MIEMSS Region I (the western part of the state). This program will use the WEMSI curriculum to provide Wilderness EMT classes through the Maryland Community College system. This will allow reciprocity with other WEMSI Wilderness EMTs when needed for mutual aid in Maryland. A Pilot Class has been held, and final approval of the protocols by the state is anticipated in the early spring of 1997.

11. What about the legal status of Wilderness EMS in other states?

The status of EMTs and paramedics in the backcountry of other states is not known to us. Probably, we need a legal opinion from each state. We are working to compile such data as can be found, and it will be posted at http://www.wemsi.org/ as it becomes available.

12. Are there national "standards of care" for wilderness EMS?

There are national and regional clinical standards for the treatment of patients in the backcountry. These standards are in part reflected in the Practice Guidelines of the Wilderness Medical Society, and the Clinical Guidelines for Delayed/Prolonged Transport of the National Association of EMS Physicians.

The Web URL for the Wilderness Medical Society is:

http://www.wms.org/

That for the National Association of EMS Physicians is:

http://www.naemsp.org/

13. If I am faced with a patient in the backcountry, and I don't know what it's legal for me to do, what should I do?

The very bottom line 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 doctors 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, the doctor can't treat a minor without the parent's permission. However, if the doctor delays Emergency Department care pending the parent's permission, he or she is taking a big medical and legal risk. Dr. Conover (WEMSI's Medical Director) says he doesn't even ask about parental permission until after he sees the child and figures out if the child needs treatment. Unless the medical treatment the doctor is contemplating is clearly elective, or can wait without any detriment to the child at all, lawyers advise doctors to just go ahead and "do it": suturing a wound, giving an antibiotic, whatever. Only later should the doctor worry about parental permission. Since what the lawyers tell doctors to do what they 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."

Here are some quotes from noted medical ethicist, Dr. Ken Iserson:

"Rather than concern about scope of practice, the ethical bottom line is always the patient. When physicians (or probably other licensed health care providers) are involved, there should be no problems, since they are legally covered as Good Samaritans. With others, someone has to bite the legal bullet to guarantee the best patient care. In our

case, I simply use off-line control to extend the scope of practice. In many of our calls, on-line medical control is impractical or unavailable.

"Think of it this way: no EMS protocol takes wilderness medical scenarios into consideration; our patients need help; the law should not prevent this help if it can be safely delivered by wilderness personnel whether trained or not; it is our responsibility to make sure our personnel are as well trained as possible in safe practices for themselves and the patients.

"While we can squabble over minutiae involved with first-aiders, EMTs, etc. performing certain tasks in the field, there is no ethical squabble that if they can and do not help the patient, they violate the ethical principles associated with medicine (at all levels), the ethical principles associated with wilderness search and rescue, and the ethical principles associated with being a member of our society."

[end]