JOURNAL OF HEALTH & LIFE SCIENCES LAW

VOLUME 4, NUMBER 2 FEBRUARY 2011

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NOTES AND COMMENTS

PRACTICE RESOURCE

AMERICAN HEALTH LAWYERS ASSOCIATION

Medical Control of Emergency Medical Services

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ABSTRACT: Effective medical control by medical directors and other medical oversight professionals is an essential element in providing appropriate emergency medical services (EMS). Within an EMS system, EMS medical directors have a supervisory rather than agency relationship with the emergency medical technicians (EMTs). Contrary to some commentary on the legal framework of this relationship, EMTs do not practice "under the license" of the medical director, but instead practice pursuant to their own state or county licenses, which generally require physician supervision. This article provides an overview of the legal issues that may arise in the relationship between EMS medical directors and the EMTs providing care under their supervision, the legal structure of medical direction within EMS systems, and the qualifications and responsibilities of EMS medical directors.

KEYWORDS: Medical Direction, Medical Director, Medical Control, Medical Oversight, Medical Supervision, Ambulance, Emergency Medical Services, Emergency Medical Technician, Interfacility Transport, EMTALA, Off-line, On-line, Concurrent, Medical Command, Delegated Practice, Standing Order, Protocol

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CITATION: Rick L. Hindmand and W. Ann Maggiore, *Medical Control of Emergency Medical Services,* J. Health & Life Sci. L., February 2011, at 65.

Hindmand and Maggiore: Medical Control of EMS

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Introduction

This article discusses the general structure of medical direction within emergency medical services (EMS) systems, the qualifications and responsibilities of EMS medical directors and other medical control physicians, and medical direction responsibilities in connection with interfacility transports. This medical direction function also is referred to as medical control, medical oversight, and medical supervision. These terms are used interchangeably in this article, although the terms may be distinguishable in some contexts.

Emergency medical technicians (EMTs), first responders, and other professionals typically perform EMS with no direct supervision at the scene. Behind the scenes, however, physicians and other professionals perform direct and indirect medical control activities that are crucial in ensuring the delivery of appropriate, quality medical care. Attorneys representing these services, physicians, hospitals, and patients must understand the legal framework of EMS and how the concept of medical direction works to counsel their clients on various aspects of EMS.

Background and Terminology

A federally-sponsored report evaluating EMS roles and recommending objectives for future development identified medical direction as one of the integral elements of an EMS system.[1] The National Association of EMS Physicians (NAEMSP), a leading professional association for physicians involved in EMS, defines "medical director" as follows:

> A physician who is responsible for the clinical oversight and patient care aspects of the EMS system. This position may include one individual with multiple

1 Nat'l Highway Traffic Safety Admin., Emergency Medical Services Agenda for the Future (Aug. 1996), *available at* www.nhtsa.gov/people/injury/ems/agenda/emsman.pdf [hereinafter Emergency Medical Services Agenda for the Future].

> tasks or several with divided tasks; such as training director, dispatch medical director or quality management director.[2]

The same text goes on to define the term "medical oversight" as follows:

> 1. Supervision by a physician of the medical aspects of an EMS system or agency and its providers; the process of performing actions to ensure that care taken on behalf of ill or injured patients by EMS personnel is appropriate. This includes the prospective, concurrent and retrospective aspects of EMS, and extends to various tasks such as quality management, hiring and education. 2. The ultimate responsible authority for the medical actions taken by providers functioning within an EMS system.[3]

The NAEMSP published a position paper, *Physician Medical Direction in EMS,* in July 1997[4] and reaffirmed it in December 2003. It identifies the qualifications and type of formal training for an EMS medical director candidate. It also defines an EMS medical director's areas of responsibility within the EMS system, such as communications, field clinical practice, education, system evaluation, EMS research, liaison activities, finance, public health and education, injury prevention, integration of health services and legislation. The NAEMSP published two other position papers on medical direction: *Medical Direction of Interfacility Transports* (March 2002)[5] and *Medical Director for Air Medical Transport Programs* (May 2002).[6]

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2 Nat'l Ass'n of EMS Physicians, Prehospital Systems and Medical Oversight (David Cone et al. ed., Kendall Hunt Professional 4th ed. 2009) [hereinafter Prehospital Systems and Medical Oversight].

3 *Id.*

4 Nat'l Ass'n of EMS Physicians, Physician Medical Direction in EMS (Hector Alonso-Serra et al. ed., reaffirmed Dec. 2003) (July 1997) [hereinafter Physician Medical Direction in EMS].

5 Steve L. Shelton et al., Nat'l Ass'n of EMS Physicians, Position Paper: Medical Direction of Interfacility Transports (Mar. 2000), *available at* www.naemsp.org/pdf/meddirinterfacility.pdf [hereinafter Medical Direction of Interfacility Transports].

6 Steven H. Thomas et al., Nat'l Ass'n of EMS Physicians, Position Paper: Medical Director for Air Medical Transport Programs (May 2002), *available at* www.naemsp.org/pdf/meddirforairmed.pdf.

On September 23, 2010, the American Board of Medical Specialties approved the subspecialty of EMS at its recent General Assembly. EMS has now become the sixth subspecialty available to emergency physicians, joining toxicology, pediatric emergency medicine, sports medicine, undersea and hyperbaric medicine, and hospital/palliative medicine. It is anticipated that the first board examinations will be given in the fall of 2013. This important recognition of the subspecialty of EMS was a goal of the NAEMSP and the American College of Emergency Physicians (ACEP) for many years. Mark T. Steele, MD, the president of the American Board of Emergency Medicine Board of Directors, stated:

> The purpose of the subspecialty certification is to standardize physician training and qualifications in EMS practice, to improve patient safety and enhance the quality of emergency medical care provided to patients in the prehospital environment, and to facilitate further integration of prehospital patient treatment into the continuum of patient care.[7]

There is no one single federal authority governing the provision of EMS, although certain aspects of the EMS system may be governed by federal authorities such as the Occupational Health and Safety Administration. The National Registry of Emergency Medical Technicians is a professional agency that provides a national certification to EMS personnel; some states recognize reciprocity with this certification. This certification also may be useful in times of national disaster, when large numbers of a state's EMS personnel may need to be activated to other states.

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7 Am. Bd. of Emergency Med., EMS Approved as an Emergency Medicine Subspecialty (Sept. 28, 2010), www.abem.org/PUBLIC/portal/alias__Rainbow/lang__en-US/tabID__4128/DesktopDefault.aspx (last visited Oct. 14, 2010).

The legislative and regulatory schemes governing EMS are generally functions of the states as part of each state's responsibility for its citizens' health and public safety. In some states, notably California, counties regulate EMS. EMS may be provided through municipal and county fire departments or by privately owned ambulance services. In most rural areas of the United States, the vast majority of EMS is provided by volunteers who function as part of either governmental or private services. Volunteers, however, fall under the same regulatory schemes as their paid counterparts.

Although medical directors have not been named in litigation often, there are a few published appellate opinions helpful in defining the role of the EMS medical director.[8] The majority of these opinions have declined to hold EMS medical directors liable for civil rights violations based on employment actions taken against EMS personnel, such as where an EMS medical director exercised supervisory authority to limit or suspend medical supervision to a particular EMS provider.

General Structure of Medical Control

Medical control encompasses a wide range of responsibilities including prospective activities prior to the patient encounter, contemporaneous direction and supervision of care, and retrospective activities that occur after the patient encounter. Prospective and retrospective activities are generally administrative or managerial and also are referred to as "off-line" or "indirect." Contemporaneous activities typically involve interactions with EMS personnel and also are referred to as "direct," "concurrent," "on-line," or "medical command." This article generally uses the terms "off-line" and "on-line " to describe these categories of medical direction.

8 County of Hennepin v. Hennepin Co. Ass'n of Paramedics, 464 N.W.2d 578 (1990); Weigand v. Spadt, 317 F. Supp. 2d 1129 (D. Neb. 2004); Miracle v. Bell County EMS et al., 237 S.W.3d 555 (2007).

The structure of medical direction varies based on state law and on the EMS system's characteristics. Some states provide detailed statutory or regulatory medical direction requirements[9] while other states' statutes and regulations provide little or no specific guidance on medical direction.[10] In light of variations in the statutory and regulatory approaches of the states and the lack of any uniform act for EMS, medical direction requirements need to be reviewed on a state-by-state and system-by-system basis.[11]

State law classifies EMS at various levels. Categories of first response, basic life support (BLS), advanced life support (ALS), and air ambulance are common. Some states also recognize a category for intermediate life support (ILS). The National Registry of Emergency Medical Technicians provides five levels of certification, namely:

1. First Responder,
2. EMT-Basic,
3. Intermediate/85,
4. Intermediate/99, and
5. Paramedic.[12]

First response services are typically defined as a preliminary level of prehospital emergency care including cardiopulmonary resuscitation, monitoring of vital signs, and control of bleeding. BLS services involve care that is principally noninvasive and requires more extensive training than first response services. Some states, such as New Mexico, recognize a category for ILS services[13] that includes BLS and other techniques

9 *See, e.g.*, Ill. Admin. Code tit. 77, § 515.330(g), Fla. Admin. Code r. 64E-2.004(4); N.M. Code R. § 27.7.27.3.
10 *See, e.g.*, N.D. Cent. Code § 23-27-04.1.
11 Gerald C. Wydroa et al., *Legislative and Regulatory Description of EMS Medical Direction: A Survey of States*, 1 Prehospital Emergency Care 233–37 (1997).
12 *See* NREMT—Nat'l Registry of Emergency Med. Technicians, www.nremt.org (last visited Oct. 18, 2010).
13 N.M. Code R. § 27.7.27.3.

and procedures that vary from state to state. In New Hampshire, an intermediate practitioner can administer epinephrine 1:1,000 and 1:10,000 as well as Narcan®, Atropine, Thiamine, nebulized Albuterol and Atrovent®, and a host of other medications.[14] New Hampshire calls its paramedic level I/99. Other states, such as Alaska, call the intermediate level an EMT-II and also have an EMT-III level similar to the I/99 or paramedic level.[15] ALS includes invasive procedures such as needle thoracic decompression, cricothyrotomy, and an extensive list of medications. In New Mexico, the scope of practice can be broadened by approval of a special skills program by the state EMS office.[16]

The differences among the scopes of practice of the various EMS levels began to diverge so widely that recently, as a continuation of the commitment of the National Highway Traffic Safety Administration to implement the *Emergency Medical Services Agenda for the Future*,[17] there has been an attempt at coordinating the definitions of the different levels of practice. The National Scope of Practice Model endorsed by the National Association of State EMS Officials supports a system of EMS personnel licensure that is common in other allied health professions and is a guide for states in developing their own EMS legislation.[18] The model defines and describes four levels of EMS licensure: emergency medical responder, emergency medical technician (EMT), advanced EMT, and paramedic. Each level represents a unique role, set of skills, and knowledge base. National EMS educational standards for each level are in the development stage. The objective is to create a

14 New Hampshire Department of Safety, Division of Fire Standards and Training and Emergency Medical Services, www.nh.gov/safety/divisions/fstems/ (last visited Oct. 18, 2010).

15 State of Alaska Health & Social Services, EMS Levels in Alaska, www.chems.alaska.gov/EMS/Levels.htm (last visited Oct. 18, 2010).

16 N.M. Code R. § 7.27.2 AAA.

17 Emergency Medical Services Agenda for the Future.

18 Nat'l Highway Traffic Safety Admin., National EMS Scope of Practice Model (Sept. 2006), *available at* www.nasemsd.org/Projects/ScopeOfPractice/FINALEMSSept2006_PMS314.pdf.pdf.pdf.

strong and interdependent system to ensure competency of EMS personnel nationwide. However, these efforts to achieve uniformity have provoked opposition in some states, including Texas and Virginia.[19]

The EMS system must satisfy state requirements, including medical control, for the level of services to be provided. States typically require some level of medical direction for all EMS at or above the BLS level,[20] although some states require medical direction for ALS services but not for noninvasive services. For example, New York law requires medical direction for agencies and ambulance services providing ALS and defibrillation services, but not for other BLS services.[21]

Ongoing medical direction may be required even if a statute may appear to be more permissive. For example, in 1996 the Court of Appeals of Oklahoma held that an ambulance company was required to retain a medical director to monitor and supervise the performance of medical services in addition to establishing protocols.[22] The court rejected the argument of an ambulance service that an Oklahoma statute, which required the performance of medical procedures under the direction of a medical director or in accordance with written protocols, was satisfied by contracting with a physician for the sole purpose of establishing protocols, then providing ambulance services under the protocols without medical control.[23] The court interpreted the statute to require that medical procedures be performed under the direction and supervision of a medical director unless the medical director is temporarily unavailable, in which case the medical procedures may be performed under approved protocols.[24]

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19 Emergency Medical Services Association of Texas (EMSEAT), Scope of Practice Position Statement, www.emseat.com/documents/EMS_SoP_Position_Statement.pdf.

20 *See, e.g.*, Cal. Health & Safety Code § 1798; 210 Ill. Comp. Stat. 50/3.35; Fla. Admin. Code r. 64E-2.004(1); Mich. Comp. Laws Ann. § 333.20918(3); 28 Pa. Code § 117.25.

21 N.Y. State Dep't of Health, Providing Medical Direction (2003), *available at* www.health.state.ny.us/nysdoh/ems/policy/03-07.htm [hereinafter Providing Medical Direction].

22 Big Elk Ambulance EMS v. State of Okla., 920 P.2d 1083 (Okla. Ct. App. 1996).

23 *Id.* at 1084.

24 *Id.*

The NAEMSP position paper on EMS medical direction notes that "EMS systems require knowledgeable physician participation and supervision at every level."[25] The final influence, authority, and responsibilities of a medical director will depend on the specific system's structure, the needs of the community and its resources, and a number of other variables. The standard of care in modern EMS systems requires physician supervision.[26] Even if not specifically mandated by law, some level of medical direction is highly important to further the credibility and development of the EMS system.[27] The voluntary accreditation standards of the Commission on Accreditation of Medical Transport Systems include medical direction requirements.[28] Moreover, quality medical direction should help to reduce liability exposure by providing physician oversight and supervision of the EMS system.

EMS Medical Directors

The medical director for an EMS system is the physician assigned with the principal responsibility for medical direction. The *Emergency Medical Services Agenda for the Future* summarizes the role of the medical director as follows:

> The medical director's role is to provide medical leadership for EMS. Those who serve as medical directors are charged with ultimate responsibility for the quality of care delivered by EMS, must have the authority to effect changes that positively affect quality, and champion the value of EMS within the remainder of the health care system. The medical

25 Physician Medical Direction in EMS.
26 Nat'l Ass'n of EMS Physicians, Prehospital Systems and Medical Oversight (Kendall Hunt Prof'l, 4th ed. 2009, vol. 2: Medical Oversight of EMS).
27 *See* Providing Medical Direction (recommending that every agency providing pre-hospital emergency medical care have a physician medical director, even though this is not required for some agencies).
28 Comm'n for Accreditation of Med. Transp. Sys., General Standards, §§ 02.01.00, 02.02.00, 02.03.00.

> director has authority over EMS medical care regardless of providers' credentials. He or she is responsible for coordinating with other community physicians to ensure that their patients' issues and needs are understood and adequately addressed by the system.[29]

The qualifications for EMS medical directors vary widely among states. In rural areas of the country, sometimes the only physician willing to provide medical direction is given the job, which may not carry any monetary stipend at all. In urban and more sophisticated EMS systems, medical directors are expected to be well qualified, well compensated, and very involved in system oversight. The following discussion outlines the qualifications and characteristics of EMS medical direction.

Qualifications

The qualifications for medical directors vary among states. Within a state, the qualifications may vary depending on the level of the EMS system. The NAEMSP position paper outlines the EMS medical director qualifications by breaking them down into "essential," "desirable," and "acceptable" qualifications.[30] Essential qualifications include a license to practice medicine or osteopathy and familiarity with local and regional EMS activity. Desirable qualifications include board certification or at least preparedness in emergency medicine from the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine, active clinical practice of emergency medicine, and completion of an EMS fellowship. Acceptable qualifications include board certification or preparedness in a clinical specialty approved by the American Board of Medical Specialties or the American Osteopathic Association. The same position paper outlines the required formal training or demonstrated continuing activity for an EMS medical director.[31]

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29 Emergency Medical Services Agenda for the Future, at 31.
30 Physician Medical Direction in EMS.
31 *Id.*

Medical director qualifications also are addressed in some state EMS legislation. Essential qualifications include a license to practice medicine and EMS experience or board certification.[32] In some states, board certification in emergency medicine is required for a medical director of an ILS or ALS system, whereas the qualifications for a BLS level system may be less demanding.[33] Air ambulance medical directors may be required to satisfy additional statutory or regulatory requirements, such as experience with or knowledge of air medical services.[34] States often require EMS medical directors to attend EMS medical direction courses.[35] The NAEMSP offers a course at least annually at its conferences.[36]

The legal relationship between medical directors and EMTs

The legal relationship between medical directors and EMTs is a supervisory one and not one of agency.[37] An "agent" is a person who is authorized by another to act for him or her.[38] Although the EMT is an agent of the employer, he or she is not an agent of the physician who acts in a medical supervisory role. This distinction is particularly important in litigation, as the EMS medical director typically cannot be held vicariously liable for the actions of the EMT any more than a physician can be held vicariously liable for the actions of nurses or other allied healthcare providers. In essence, although not identical, the relationship is similar to that of the supervising physician for a physician's assistant. There may not be vicarious liability, but there may be liability exposure for negligent supervision or training, as well as for negligence in preparing or implementing EMS protocols.[39]

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32 *See, e.g.*, Fla. Admin. Code r. 64E-2.004(3); 210 Ill. Comp. Stat. 50/3.20(c)(6) (Illinois); Mich. Comp. Laws Ann. § 333.20918(3); 22 Tex. Admin. Code § 197l.3(a).
33 *See, e.g.*, 210 Ill. Comp. Stat. 50/3.20(c)(6).
34 *See, e.g.*, Fla. Admin. Code r. 64E-2.004(3)(b); 22 Tex. Admin. Code § 157.12(d).
35 *See, e.g.*, Ill. Admin. Code tit. 77, § 515.340.
36 Nat'l Ass'n of EMS Physicians, National EMS Medical Director's Course, www.naemsp.org.
37 Prehospital Systems and Medical Oversight, ch. 5.
38 Black's Law Dictionary (6th ed.).
39 Prehospital Systems and Medical Oversight, ch. 5.

In the past, a great deal of confusion resulted from a description of a legal concept of "delegated practice" in the Department of Transportation's early EMS curriculum. In reality, very few states—most notably, Texas—actually have legislation permitting a physician to delegate procedures to EMTs. Further confusion resulted from the description of EMS providers in early texts as the "eyes, ears, and hands of the physician." Other early EMS texts described EMTs as practicing "under the license" of the physician, although in most states there has never been legal justification for this.[40]

Generally, EMS personnel are licensed by the states, but licensure requires medical supervision for EMS personnel to perform invasive procedures. Many states still call licensure "certification," creating even more confusion. "License" is defined as "the permission by a competent authority to do an act which, without such permission, would be illegal, a trespass or a tort."[41]

In essence, EMS personnel are subject to three lines of authority. The medical director provides medical supervision and may withdraw that supervision from a particular EMS provider, even in the context of collective bargaining agreements.[42] When a medical director withdraws medical supervision, the EMTs may no longer practice, even if they are still employed by an EMS provider. The withdrawal of medical supervision and subsequent employment consequences have resulted in most of the litigation against EMS medical directors.[43] The second line of authority involves the government agency that licenses the EMT and can rescind that licensure after the requirements of due process are

40 James O. Page, *Whose License Is It, Anyway*, J. Emergency Med. Services (May 1999).
41 Black's Law Dictionary (5th ed.).
42 Hennepin Co. v. Hennepin Co. Ass'n of Paramedics, 464 N.W.2d 578 (Minn. Ct. App. 1990).
43 County of Hennepin v. Hennepin Co. Ass'n of Paramedics, 464 N.W. 2d 578 (1990); Baxter v. Fulton-DeKalb Hosp. Auth. et al., 764 F. Supp. 1510 (1991); Weigand v. Spadt, 317 F. Supp. 2d 1129 (D. Nebraska 2004); Rhinehart v. City of Greenfield, No. 1:06-cv-00688-DFH-TAB (S.D. Ind. May 11, 2007) (unpublished), *available at* http://www.insd.uscourts.gov/Opinions/AP6880O2.pdf.

satisfied. Finally, the third line of authority is the employer. EMTs who work for a service must provide care in accordance with the policies and procedures of their employer or risk termination. These lines of authority occasionally become blurred, such as when a medical director's withdrawal of medical supervision results in employment and/or licensure consequences for the EMT. The typical scenario is that the medical director withdraws supervision, the EMT suffers either a demotion or a termination, and ultimately sues for employment civil rights violations.

Responsibilities and authority

The medical director's responsibilities and authority depend on a number of factors, including state law and the structure of the EMS system, the needs and resources of the community, and the scope of the administrative directors' management authority. The EMS medical director has a responsibility to supervise the practice of EMS personnel. The director also may have responsibilities to ensure that the EMS agency functions appropriately.[44] The NAEMSP position paper states that "depending upon the state of evolution of an EMS system and its current level of sophistication, the medical director's role may range from solely offering medical direction to being responsible for operations and fiscal management."[45] The responsibilities and authority of the medical director may be mandated by state statute or regulation, contract, or policies and procedures established by the EMS system. Voluntary accreditation, such as that offered by the Commission on Accreditation of Ambulance Services (CAAS) or the Commission on Accreditation of Medical Transport Systems (CAMTS), is a "gold standard" that can be helpful for services that want to promote excellence in providing EMS.

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44 *See* Off-line Medical Control.
45 Physician Medical Direction in EMS.

A physician may serve as medical director of the entire EMS system or of a particular component such as a hospital, air medical service, or medical command facility. Various states have state EMS system medical directors who provide leadership and guidance. In some states, a medical direction committee made up of physicians may share medical direction responsibility.[46] An EMS system also may have an alternative or assistant medical director who serves in the absence of the medical director under protocols established by the EMS medical director.[47]

Some states have established medical director committees[48] or EMS councils[49] within each region. Responsibilities of the regional committee or medical director may include the development of protocols, standing medical orders, disaster preparedness plans for the region, standard continuing education requirements, and do-not-resuscitate policies.[50] Commonly, the medical director delegates various aspects of medical direction to physicians and other professional or administrative personnel within the EMS system. The medical director, however, retains ultimate responsibility for medical direction for the EMS system. In a few states, the medical command physician provides the authority for EMS care, and the actions of the EMS professionals are deemed delegated medical practice.[51] Texas regulations define "delegated practice" as "permission given by a physician licensed by the board, either in person or by treatment protocols or standing orders, to a specific prehospital provider to provide medical care."[52] In Texas, a physician who provides or delegates on-line medical direction assumes responsibility for the care provided under his or her direction[53] and may be subject to disciplinary action for failure to provide adequate supervision.[54]

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46 *See* 28 Pa. Code § 117.25(b).
47 *See* 210 Ill. Comp. Stat. 50/3.35(b).
48 *See, e.g.*, 210 Ill. Comp. Stat. 50/3.30(a).
49 *See, e.g.*, 35 Pa. Stat. Ann. § 6923 (definition of "emergency medical services council").
50 *See, e.g.*, 210 Ill. Comp. Stat. 50/3.30(a).
51 *See, e.g.*, N.J. Admin. Code §§ 8:41-10.6, -11.6.
52 22 Tex. Admin. Code § 197.2(4).
53 *Id.* § 197.4(e).
54 *Id.* § 197.1.

To perform medical direction properly, an EMS medical director needs to have the authority to suspend EMS providers who do not satisfy appropriate criteria or who provide inappropriate or substandard care. Statutes or regulations, as well as contractual provisions, may authorize the medical director to suspend EMS providers subject to due process requirements and the right to appeal.[55] Some statutes or regulations also provide procedures allowing the medical director to immediately suspend an EMS professional, pending hearing or review, in the event of an imminent danger to the public[56] or for due cause.[57]

Off-Line Medical Control

Medical control functions are divided between on-line and off-line activities. Off-line medical control involves administrative and management activities relating to the design, operation, evaluation, and refinement of the EMS system. The medical director's off-line medical control responsibilities typically include:

- establishing and reviewing protocols and standing orders governing the performance of medical services as well as related operational aspects of the EMS system;
- credentialing EMS providers and taking corrective action when providers fail to satisfy applicable qualifications or standards of conduct;
- coordinating and supervising education and training programs for EMS personnel;
- developing and supervising programs to monitor, evaluate, and improve the quality of medical care;
- actively participating in administrative decisions relating to medical care within the EMS system;

55 *See, e.g.*, 210 Ill. Comp. Stat. 50/3.40; 28 Pa. Code § 1003.28.
56 *See, e.g.*, 210 Ill. Comp. Stat. 50/3.40(c).
57 *See, e.g.*, 22 Tex. Admin. Code § 197.3(b)(10).

- ensuring that transportation is safe and appropriate;
- acting as liaison between the EMS system and the medical community, the general public, and governmental authorities; and
- serving as patient advocate within the EMS system.

Protocols and standing orders are written instructions, algorithms, or other guidelines relating to the performance of EMS. The terms may have different meanings depending on the particular state, EMS system, or other context and are sometimes used interchangeably.

Protocols, although they do not cover all situations, are intended to cover all anticipated clinical care issues,[58] and judgment is important in any EMS practice. The NAEMSP defines "protocols" as:

> Written procedures providing prehospital personnel with a standardized approach to commonly encountered patient problems, thus providing a pathway to the rendering of consistent care. Protocols may include standing orders to be carried out prior to establishing communication with direct medical oversight. These procedures usually relate to the assessment, diagnosis, triage, treatment, transfer and destination of patients. Protocols commonly have indications as to when direct medical oversight must be contacted during the patient encounter for further medical input and assistance.[59]

Standing orders generally provide instructions to be followed without on-line medical direction. The NAEMSP defines "standing orders" as "instructions approved by indirect medical oversight for prehospital care personnel, directing them to perform certain emergency medi-

58 Nat'l Ass'n of EMS Physicians & Am. Coll. of Emergency Physicians, Guide for Preparing Medical Directors 30 (2000), *available at* www.ncttrac.org/LinkClick.aspx?fileticket=jgrtx_3ixw%3D&tabid=79&mid=558 [hereinafter Guide for Preparing Medical Directors].

59 Prehospital Systems and Medical Oversight, Glossary.

cal care procedures in the absence of any communication with direct medical oversight."[60] Standing orders are often for simple procedures such as oxygen administration and initiation of intravenous access; protocols actually may define a step-by-step process to be followed in specified situations.

The establishment and implementation of protocols and standing orders are generally the responsibility of the medical director, with input from other healthcare professionals and providers. A state may establish statewide protocols[61] or require that protocols satisfy standards established at a state level.[62]

Protocols address various other issues relating to the operation of the EMS system, including the establishment of procedures for:

- bypassing or diverting to a hospital or other physician;
- communications with EMS personnel under the authority of the EMS medical director;
- interfacility transfers;
- do-not-resuscitate orders;
- designation of circumstances requiring direct medical oversight by a physician;
- approval requirements for deviations from protocols;
- authority of EMS professionals to provide services in the event of communications failures, and the establishment of standing orders governing such situations;
- patient assessment; and
- interaction among EMS personnel and physicians on the scene.

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60 *Id.*

61 N.Y. Pub. Health Law § 3001(15); 28 Pa. Code § 1001.2 (definition of "Statewide BLS medical treatment protocols").

62 *See, e.g.*, Okla. Stat. Ann. tit. 63 § 1-2506 (written protocols must be authorized by the medical director, approved by the Department of Health, and not conflict with state standards).

Education of EMS personnel is an important medical control function. The *Emergency Medical Services Agenda for the Future* recommended EMS medical director involvement in education program planning, presentation, and evaluation, and also recommended the frequent updating of education core content objectives to reflect healthcare needs.[63] The NAEMSP and ACEP also recommend active medical director involvement in EMS education and outline related responsibilities and authority.[64] It is unknown how many states actually have complied with these recommendations.

On-Line (Direct) Medical Control

In addition to off-line medical direction activities, the medical director is responsible for supervising on-line medical direction, which some state statutes refer to as "medical command."[65] On-line medical direction consists of monitoring telecommunications with EMTs and other professional personnel in the field and providing EMS instructions.

EMS services generally must be performed under protocols, standing orders, or other written or verbal direction by the medical director or other authorized professionals. Some states permit EMTs or other providers to practice only under the written or verbal direction of the medical director.[66]

Physicians and other designated professionals are responsible for monitoring telecommunications from EMS personnel and giving voice orders to EMS personnel under the authority of the medical director. Statutes or regulations may specify qualifications that medical command physicians must satisfy.[67] Some states allow emergency

63 Emergency Medical Services Agenda for the Future, at 35–36.
64 Daniel L. Storer et al., Physician Medical Direction of EMS Education Programs: Policy Resource and Education Paper (1997), *available at* www.naemsp.org/pdf/physicianmedicaledu.pdf.
65 *See, e.g.,* Pa. Stat. Ann. tit. 35, § 6923; N.J. Admin. Code § 8:41-1.3.
66 *See, e.g.,* 210 Ill. Comp. Stat. 50/3.55(b).
67 *See, e.g.,* 28 Pa. Code § 1003.4; 22 Tex. Admin. Code § 197.4(c).

communications registered nurses to monitor communications and give voice orders to EMS system personnel under the authority of the medical director.[68] EMS medical direction continues until appropriate medical personnel in the hospital or other facility assume the responsibility for patient care.[69]

EMS systems vary with regard to the degree of on-line medical direction required. Most EMS systems rely principally on standing orders requiring direct medical direction for conditions outside the scope of the standing orders.[70] Other systems or states require direct medical direction in connection with all ALS care.[71] The advisability of the routine use of on-line medical direction has been the subject of debate within the EMS community.[72] The benefit of on-line medical direction is tighter supervision of highly invasive procedures; the disadvantage is the time it may take to secure an order to perform a procedure, particularly when seconds matter.

Interfacility Transport

EMS also has a role in the transportation of patients between medical facilities. The reason for interfacility transports varies. Some patients are transported for testing, while others are critical care transports to tertiary care facilities. "Interfacility transport" is defined as the movement of a patient from one healthcare facility to another in a licensed ground or air ambulance.[73] Typically, medical direction of interfacility transport is shared by the transferring physician, the medical director of the EMS

68 *See* 210 Ill. Comp. Stat. 50/3.80.
69 *See, e.g.,* 210 Ill. Comp. Stat. 50/3.35(n); Cal. Health & Safety Code § 1797.52.
70 McIntosh & Schwartz, *Direct Medical Oversight*, in Prehospital Systems and Medical Oversight 320 (3rd ed. 2002) [hereinafter *Direct Medical Oversight*].
71 *See, e.g.,* Cal. Health & Safety Code § 1797.52 (direct supervision of a base hospital); N.Y. Pub. Health Law § 3030 (ALS services provided by an advanced EMT shall be provided under direction of qualified personnel utilizing patient information and data transmitted by voice or telemetry).
72 *See Direct Medical Oversight*, at 320–23; Emergency Medical Services Agenda for the Future, at 30.
73 Medical Direction of Interfacility Transports.

system, and a physician at the accepting hospital. These responsibilities vary from state to state[74] and often are not defined clearly.[75]

In a 1997 policy statement, ACEP described the responsibilities as follows:

> Medical direction of the transferred patient is a shared responsibility. The transferring physician is responsible under federal laws for ensuring that the patient is transferred by qualified personnel and appropriate equipment. Off-line medical control for the interfacility transfer of patients is the responsibility of the EMS system and its medical director, unless another responsible physician is identified, such as exists in hospital-based or private ambulance critical care transport or air medical services.[76]

The Emergency Medical Treatment and Labor Act (EMTALA) does not directly regulate EMS, although EMS can (literally and figuratively) provide the vehicle for EMTALA violations.[77] Under EMTALA, if a patient has not been stabilized, the transferring physician is responsible for certifying that the medical benefits reasonably expected from medical treatment at the other facility outweigh the risks of transfer to the patient (and unborn child, if any).[78] The transport must satisfy the EMTALA standards for "appropriate transfer," including requirements that:

- the transferring hospital provides medical treatment within its capacity to minimize health risks;
- the receiving facility has available space and qualified personnel and agrees to provide appropriate treatment;

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74 Guide for Preparing Medical Directors, at 34.
75 Medical Direction of Interfacility Transports.
76 Included in David P. Keseg, Medical Direction of Emergency Medical Services, app. C (2001).
77 42 C.F.R. § 489.24(b) definition of "comes to the emergency department."
78 42 U.S.C. §§ 1395dd(c)(1)(A)(ii)–(iii); 42 C.F.R. § 489.24(e).

- medical records are transferred; and
- the transport is performed by qualified personnel and transportation equipment, including the use of necessary and medically appropriate life support measures during the transfer.[79]

In some cases, an EMS crew or equipment may not be able to provide the level of care required under EMTALA for interfacility transfers. For example, in 1991 the Fifth Circuit held the transfer of a pregnant patient inappropriate under EMTALA because a physician and fetal heart monitor were not present during the transfer.[80] In that case, the court determined that the use of an ambulance and personnel satisfying state licensing requirements did not satisfy EMTALA requirements for appropriate transfer.

Although the transferring physician and the transferring hospital have responsibilities under EMTALA relating to interfacility transport, the medical director typically has responsibility under state law to provide medical direction of all medical services performed within the EMS system. Some states may impose specific obligations relating to interfacility transport. For example, Florida requires air ambulance medical directors to evaluate each patient in person or by written protocol prior to each interfacility transfer flight to determine that the aircraft, flight, medical crew, and equipment meet the patient's needs.[81] Moreover, under the accreditation standards of the Commission on Accreditation of Medical Transport Systems, the medical director's duties include ensuring that transport is appropriate and safe for the patient and implementing policies ensuring compliance with EMTALA.[82]

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79 42 U.S.C. § 1395dd(c)(2); 42 C.F.R. § 489.24(e)(2).
80 Burditt v. U.S. Dep't. of Health & Human Servs., 934 F.2d 1362, 1372–3 (5th Cir. 1991).
81 Fla. Admin. Code r. 64E-2.004(3)(b).
82 Comm'n on Accreditation of Med. Transport Systems., 8th Edition Accreditation Standards, §§ 02.01.11; 02.01.12, *available at* http://www.camts.org/.

The EMTALA regulations provide that a patient who is transported in a ground or air ambulance owned and operated by a hospital for treatment at the hospital's emergency room is generally deemed to have come to the hospital's emergency department for purposes of EMTALA, subject to exceptions relating to community-wide protocols and ambulances operated under medical direction by physicians not affiliated with the hospital.[83] Therefore, an accepting hospital that owns and operates the ambulance performing the interfacility transport would be required to comply with EMTALA during the transport. In addition, the medical director of the accepting hospital's EMS system would bear responsibility for medical direction.

In light of the shared responsibility for medical direction and the lack of clear standards distinguishing the authority of the transferring physician, the EMS medical director, and the accepting physician, it is important for these physicians to understand and coordinate responsibilities and authority prior to the transfer. The NAEMSP position paper on interfacility transports directly addresses physician coordination.[84] EMTALA views a hospital-owned ambulance service as an extension of the hospital. Therefore, the patient transfer to the accepting facility occurs when the patient is moved from the transferring facility's bed to the transport service's stretcher. At that point, EMTALA views the accepting hospital as the responsible party. The medical direction for the transport would then be the responsibility of the hospital-owned ambulance medical director or the accepting physician. The medical director should establish protocols for interfacility transport and should ensure that the EMS crew obtains appropriate training and is adequately equipped.

83 42 C.F.R. § 489.24(b)(3).
84 Medical Direction of Interfacility Transports.

Liability Issues

Although EMS medical directors are not often named in EMS litigation, such litigation is on the rise. In many states, the "gross negligence" standard governs the litigation of EMS clinical issues and that high evidentiary standard has limited the number of lawsuits. EMS is still not well understood by plaintiffs' attorneys, who may not recognize physician supervision of the EMTs. Litigation against EMS providers results in unwanted media attention, fosters a lack of trust in the community relying on 911 services for emergency care, and could discourage qualified EMS providers, physicians, and other professionals from providing EMS care. On the other hand, in some cases litigation could increase accountability.

Medical direction activities may create liability exposure for medical directors and other medical command physicians, as well as for hospitals, ambulance companies, municipalities, and other institutional EMS providers. Potential theories of liability include failure to properly supervise, train, or instruct EMS personnel, or failure to comply with applicable law. Some liability issues of particular relevance to medical direction are discussed below.

There has been little reported case law addressing the liability of medical directors or institutional providers arising out of medical direction activities. Liability could arise from instructing EMS professionals to act outside their scope of practice or in a manner inconsistent with their training, deviating from the applicable standard of care in providing on-line medical oversight activities, or violating applicable laws, rules, or regulations. However, the vast majority of legal cases in which medical directors have been sued involve employment issues.[85] The typical scenario arises when an EMS medical director withdraws medical supervision from an EMT, and the EMT subsequently suffers employment consequences. This type of litigation creates particular

85 Prehospital Systems and Medical Oversight, ch. 5.

concern because, in the past, most EMS medical directors were not covered by insurance for liability resulting from employment practices. EMS medical directors who work for public institutions usually have insurance coverage through their employment. For private EMS medical directors, there are now insurance products on the market that will cover the EMS medical directors for employment practices liability.[86]

For example, a medical director withdrew medical supervision from a Nebraska paramedic for clinical issues, including protocol deviations. As a result of the paramedic's inability to function as a paramedic, the fire chief reduced her rank. She ultimately sued the fire department, the fire chief, and the medical director for violating her civil rights and conspiring to do so. The court ultimately found no gender discrimination and no violations of the First Amendment or due process standards.[87]

The courts will look with disfavor on EMS medical directors who do not fulfill their responsibility to ensure quality patient care. For example, a court upheld a jury verdict against a medical director in a wrongful death case in which the plaintiff cited a lack of protocols not generally required by the standard of care. In a wrongful death action in Florida in 1989, the court upheld a verdict against a medical center for failure to properly supervise, train, and instruct paramedics who left without transporting a child who they determined did not need emergency medical care.[88] The court found substantial evidence that the medical center's EMS medical director deviated from the standard of care by failing to establish written procedures on how to take a patient history, how to distinguish between emergency and nonemergency situations, and how to distinguish between taking a child's vital signs and an adult's vital signs.

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86 *See, e.g.,* Lapre Scali & Company Insurance Services, EMS Medical Directors Insurance, www.emsmdinsurance.com/ (last visited Oct. 21, 2010).

87 Weigand v. Spadt, 317 F. Supp. 2d 1129 (D. Neb. 2004).

88 Tallahassee Mem'l Reg'l Med. Ctr. v. Meeks, 543 So. 2d 770 (Fla. Ct. App. 1989), *aff'd in part, rev'd in part*, 560 So. 2d 778 (Fla. 1990), *rehearing denied*, No. 74,408 (Fla. 1990). The Florida Supreme Court affirmed the liability determination and quashed the determination of the amount of damages.

A medical command physician will be responsible for the instructions he or she provides. In 1993, a Louisiana court held that an EMT who follows a protocol upon direction by the on-line medical command physician will be deemed to be following the instructions of the physician for purposes of a statute that provided immunity to EMTs for following the instructions of physicians.[89]

Some states provide statutory immunity for EMS personnel, medical directors, and other persons or entities involved in providing, supervising, or supporting EMS. Protection may be available under Good Samaritan, governmental immunity, and sovereign immunity statutes.[90] Some statutes protect good faith conduct or establish a heightened standard, such as gross negligence or willful and wanton misconduct.[91] Other states apply a standard of ordinary care.[92] The practical impact of these immunities and heightened evidentiary standards is to provide some protection for EMS personnel working under dangerous and uncontrolled conditions for low wages, and may serve to make the profession more attractive. Motions to dismiss and motions for summary judgment are common, based on immunity considerations, particularly in states applying the gross negligence standard and challenging the court to decide whether a particular alleged act or omission falls into the category of gross negligence.

The qualified immunity statutes of some states apply to medical directors specifically. For example, Illinois and Michigan EMS statutes provide immunity for good faith actions by the medical director, except for willful and wanton misconduct,[93] gross negligence, or willful

89 Falkowski v. Maurus, 637 So. 2d 522 (La. Ct. App. 1993), *writ denied*, 629 So. 2d 1176 (La. 1993), *reconsideration denied*, 631 So. 2d 1168 (La. 1994).
90 Sadler v. New Castle County, 524 A.2d 18 (Del. Super. Ct. 1987).
91 *Liability for Negligence of Ambulance Attendants, Emergency Medical Technicians and the Like, Rendering Emergency Care Outside the Hospital*, 16 A.L.R. 5th 605 [hereinafter *Liability for Negligence of Ambulance Attendants*]; Malone v. City of Seattle, 600 P.2d 647 (Wash. Ct. App. 1979).
92 *See* Tex. Health & Safety Code § 773.009.
93 210 Ill. Comp. Stat. 50/3.150(g).

misconduct.[94] Pennsylvania law protects medical command physicians and medical command facilities for good faith instructions, except in cases of gross or willful negligence.[95] Pennsylvania law also immunizes ALS and regional medical directors for good faith instructional and training activities, excepting gross or willful negligence.[96] Washington State indemnifies medical program directors and hospitals for good faith conduct and for claims of negligent training of EMS personnel.[97] A comprehensive article provides further information on EMS liability and immunity.[98]

In some states, statutory immunity for individual providers does not protect their employers. A Kansas immunity statute protects physicians giving emergency instructions to EMTs, except for gross negligence, and protects the EMTs following the instructions, except for gross negligence or willful and wanton acts or omissions.[99] In 2005, the U.S. District Court for the District of Kansas held that even though this immunity statute protected the medical adviser of an air ambulance service, immunity did not extend to a claim against the ambulance service based on vicarious liability for the conduct of the immune employees.[100] Courts also have held that immunity for EMS under Massachusetts[101] and Pennsylvania[102] statutes did not extend to employers. Courts in other states, however, have held that immunity statutes extended to employers.[103]

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94 Mich. Comp. Laws § 333.20965.
95 35 Pa. Stat. Ann. § 6931(j).
96 *Id.*
97 Wash. Rev. Code § 18.71.215; Marthaller v. Kings County Hosp., No. 31288-4-1 (Wash. Ct. App. 1999).
98 *Liability for Negligence of Ambulance Attendants.*
99 Kan. Stat. Ann. § 65-6124.
100 Garcia v. Estate of Arribas, 363 F. Supp. 2d 1309 (D. Kansas 2005).
101 Taplin v. Chatham, 453 N.E.2d 421 (Mass. 1983).
102 Regester v. County of Chester, 797 A.2d 898 (Pa. 2002).
103 *See* Pavlov v. Community Emergency Medical Service, 491 N.W.2d 847, *appeal denied*, 442 Mich. 883 (Mich. App. 1992) (Michigan EMS statute was subsequently repealed and reenacted in different form); Wicker v. City of Ord, 447 N.W.2d 628 (Neb. 1989).

Some situations may create heightened levels of risk, and therefore warrant particular attention in developing protocols and in providing on-line supervision. These areas include interfacility transfers, patient refusals of transport, "no loads" or failures to transport, interventions by non-EMS professionals, incompetent patients, resuscitation, transition from ALS to BLS care, and transport of minors.[104] To manage these risks, medical directors must monitor documentation of these calls closely for protocol violations.[105] Further, they should focus training and quality assurance activities in these areas. For example, a retrospective review of all no load calls can be quite illuminating.

Medical malpractice insurance policies should be reviewed to determine whether they cover medical control activities; as a general rule, they do not. In particular, standard medical malpractice policies typically exclude indirect EMS medical oversight activities because they do not include protection for employment practices liability. It therefore may be necessary for medical directors to obtain malpractice coverage through the EMS agency, obtain a rider to the malpractice policy, or obtain a special policy designed for EMS medical directors. Some insurance companies that provide insurance for ambulance companies or EMS systems offer secondary policies that cover medical oversight activities of medical directors to the extent that primary malpractice insurance does not provide coverage.

Medical Director Contractual Issues

It is not uncommon for medical directors to perform their functions without a formal written agreement. Failure to enter into a written contract or establish formal guidelines, however, creates a significant risk of potential conflicts relating to the authority and responsibilities of the medical director, and may hamper the ability of the medical

104 *See* Guide for Preparing Medical Directors, at 33–34, for a discussion of activities creating high levels of risk.

105 Prehospital Systems and Medical Oversight, ch. 5.

director to provide appropriate medical direction. A written contract may be required to comply with fraud and abuse laws, particularly if a referral relationship exists between the medical director and the EMS system or any of its affiliates.

The *Emergency Medical Services Agenda for the Future* recommended that the relationships between EMS systems and their medical directors be formalized.[106] Although circumstances vary, it generally is advisable for the medical director and the EMS system to enter into a written contract setting forth the responsibilities and authority of the medical director, as well as the obligations of the EMS system to provide appropriate support in fulfilling medical oversight functions. Some states require the execution of a medical director agreement.[107] The parties to the agreement may be the governmental or private EMS agency, institution, or other entity responsible for operating the EMS system, on the one hand, and either the physician acting as medical director or the hospital, group practice, or other party responsible for providing services of the medical director, on the other hand.

The terms of the contract will vary depending on a number of factors, including the scope and nature of the EMS system, applicable state law, and business issues. The contract should provide the medical director with sufficient authority and independence to maintain appropriate standards of direction and care, including authority to establish protocols and standing orders, supervise training, and take appropriate corrective action—up to and including withdrawal of medical supervision. Issues of particular importance include:

- clarification of the authority of the medical director, particularly in light of the potentially overlapping authority of others within the EMS system, such as administrative directors;
- acknowledgment of the medical director's authority to limit, suspend, or revoke medical supervision of an EMT;

106 EMERGENCY MEDICAL SERVICES AGENDA FOR THE FUTURE, at 33.
107 *See, e.g.,* FLA. ADMIN. CODE 64E-2.004(1).

- identification of the person or body to whom the medical director reports;
- qualifications of the medical director;
- the EMS system's obligations to provide personnel and other resources necessary for medical direction;
- liability insurance; and
- indemnification of liabilities incurred by the medical director in performing his or her medical direction activities.

Conclusion

Effective medical direction is essential for the effective performance of EMS. The medical director and other medical direction physicians are responsible for medical direction of care provided within an EMS system. Medical control functions include a broad range of on-line and off-line responsibilities such as developing protocols and standing orders, credentialing EMS professionals, instructing EMS personnel, monitoring telecommunications, and implementing quality assurance programs.