8

Legislation

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Excellence in prehospital emergency medical management requires careful attention to EMS system structure and design at state and local levels. EMS is the provision of physician evaluation and management of prehospital emergency medicine through the employment of prehospital providers. In some systems, on-scene physician attention is a dynamic portion of patient care. However, for the most part, field personnel provide patient assessment and management in the absence of physicians. Modern parlance, especially as expressed in the mission statement of the National Association of EMS Physicians, suggests that providers' skills are generally considered extensions of the medical oversight physician's license.

EMS providers are rarely independent practitioners. They are trained in specific skills and have quite rigid descriptions of clinical conditions for which they may render patient care. EMS providers are permitted to complete their various medical duties and responsibilities as "dependent practitioners." Though they possess skills and are allowed by law to perform procedures, they can apply certain skills only through authorization by physicians either by prearranged protocol (indirect medical control) or real-time physician order (direct medical control).

All EMS providers have a specific "scope of practice." This means that they may perform only those skills delineated either in statute (written in the law) or in regulation (outlined by the department responsible under the statute for regulating these matters). Therefore, independence to "practice medicine and surgery" is not a privilege of prehospital providers who are limited to the skills mentioned.

This chapter describes how EMS providers become authorized to perform skills in the prehospital and interhospital environment. Mention is also made as to how legislation provides a legal framework for the development of EMS systems. Sample legislation that may be examined as a model for the design and implementation of EMS systems is also offered.

General Concepts

The fundamental element of an EMS system is medicine; the basic purpose is to offer relief for public cries of distress caused by acute medical conditions. The functional parameters required to operate a system such as hiring trained personnel, providing equipment, managing finances, maintaining supervision, solving problems, and being mired down in paperwork can easily relegate the "medicine" of EMS as secondary to "operations." System design and structure must revolve around the quality management of medicine.

EMS systems, like all medical provider systems, provide most hands-on medical care through technical support. EMS medical care is generally practiced in the physical absence of the physician. However, enabling legislation provides for physician assessment and treatment skills to be performed by EMS personnel. This concept has been popular in medical oversight circles for at least a decade; but as EMS providers acquire greater responsibility, it is arguably true that many physician skills are becoming field provider skills.

Some EMS legislation places other individuals between the physician and the patient. For example, in California the mobile intensive care nurse (MICN) provides prehospital care and instructs EMS personnel. The MICN is a registered nurse who is functioning pursuant to Section 2725 of the Business and Professions Code and who has been

authorized by the medical director of the local EMS agency as qualified to provide prehospital advanced life support or to issue instructions to prehospital emergency medical care personnel within an EMS system according to standardized procedures developed by the local EMS agency consistent with statewide guidelines established by the authority.

In the emergency department a physician can maintain a one-on-one relationship with a patient; there is no distance between them. If the physician gives an order to the nurse some distance develops between the physician and the patient as the nurse performs the duty. It is the physician's responsibility to guard the relationship with the patient. In the field the EMS personnel work as a direct extension of the physician and in accordance with the contract established between the physician and the patient. When the physician's role in the patient care scenario falls to zero the physician's relationship with the patient is breached.

History and Development

Independent physician practice acts have been predominant in the United States for generations. Encounters including the diagnosis, disposition, treatment, and release of patients are limited to physician authority, except in states where independent practitioners such as nursing practitioners and physician assistants are authorized. In many of these excepted situations the non-physicians practice under some form of blanket authority extended to them by a licensed physician. It should be emphasized that this discussion is essentially limited to the United States and "westernized" nations in general. Many countries, especially Russia and China, utilize physicians as part of routine care in the field. Some countries require field "rotation" as a part of a physician's routine duties under a national or local medicine provision program. Such practice extension generally describes the subordinate practitioner as a dependent practitioner.

EMS is somewhat new in the long history of medical practice. The lack of physicians to respond to the scene of accidents and illnesses, the growing sophistication of extrication and transport techniques, the general lack of familiarity by physicians of field conditions, and the growing need for secondary transport to alternative levels of care are some of the reasons that lead to the increased demand for and subsequent provision of prehospital providers who were not independent practitioners.

Provision of initial patient care by technicians, especially when advanced skills such as endotracheal intubation and intravenous medications are used, generally requires the enactment of a state law enabling non-physicians to assume certain medical skills with physician oversight. Laws enacted for this purpose are deemed "enabling legislation." Other aspects of such laws enable the state, region, or locality to develop regulations to fulfill legislative goals and intent.

Enabling legislation allows non-physicians to provide specific diagnostic and treatment skills. Although all states provide some sort of EMS enabling legislation, many do not view their statutes as providing specific extension of physician licenses to the prehospital arena. This is due in part to the development of extensive EMS medical oversight long after most initial EMS statutes were set in place. Only later did EMS physicians realize that field providers were practicing skills requiring physician authorization, skill, time, and judgment and the subsequent medicolegal risk extended to the physician's themselves. In the 1980s, revised EMS statutes began to reflect that the medical oversight physician was extending his medical license and authority to the non-physician technician.

One reason for the recent formal licensure extension was the need to assure the quality of medical care through physician review and direction. Whether by clear and concise mandate or inferential statutory construction, the role of the physician is generally acknowledged as the central element of medical oversight.

Another reason for licensure extension is the merger of traditional terms advanced life support (ALS) and basic life support (BLS); differences in ALS and BLS skills have essentially disappeared. Initially, any invasive procedure requiring medical oversight was considered ALS. However, determining whether a skill is BLS or ALS depending on the risk to the patient blurs the distinction. Suctioning an airway, traditionally a BLS skill, incurs great risk to the patient if inappropriately performed. Direct and indirect medical control physicians bear the responsibility for all prehospital skills. Therefore the medical oversight is responsible for all assessment and management skills practiced by all levels of prehospital providers.

Rule-making

Newcomers to the legislative process may not be familiar with the concepts of legislative mandate and departmental rule-making. The state legislature is the collective voice of the citizens. Federal issue

generally supersedes state legislative issue. The legislative voice of the state, through discussions and votes, provides laws or statutes. After the generation or modification of the statute, further definition and explanation are often required. State executive departments promulgate regulations in fulfillment of their operational roles and provide further definition and explanation. The formation of rules and regulations is an important method by which a state shapes policy to address the general instructions given under a statute.

Not uncommonly the statute may contain only a few sentences, but the rules and regulations addressing the statute may run to reams. For example, the Georgia EMS statute states that "to enhance the provision of emergency medical care, each ambulance service shall be required to have a medical adviser [and] the duties of the medical adviser shall be to provide medical direction and training for the ambulance service personnel in conformance with acceptable emergency medical practices and procedures." The Georgia Department of Human Resources rules and regulations list many headings by which the medical adviser is to perform these duties including formulation of policy and procedures affecting patient care; formulation, development, and evaluation of training objectives; establishment of quality control; and performance of liaison roles with the greater medical community.*

It is critical that the EMS physician be informed concerning state regulations relative to EMS. Meaningful input of the appropriate departments when rules and regulations are being created or changed is essential. Approaches to EMS statutes differ from state to state. What is actually written law and what is left to rules and regulations also varies significantly. For all practical purposes the statute and subsequent regulation carry the same authority. Although penalties exist for violations of either, it is far easier to modify a regulation than to amend a statute.

Sample Components of EMS Law

EMS statutes contain many elements. This section discusses in some detail concepts of selected elements that may be found in a state EMS statute.

Title

Each EMS statute has a title indicative of the content that will follow. Typical titles include Emergency Medical Services and Emergency Medical Care Personnel.

EMS is a service provided to the public similar to fire and police protection. The titles of EMS statutes make it clear that medicine is the service. There may be a medical act separate from the legislative act establishing the state medical board. The public can demand that a service be provided and the state will provide that service irrespective of existing physician medical acts. EMS legislation often emphasizes the incompleteness of existing physician practice acts. The entirety of the EMS statute could be covered under the rules established by the state medical board; however, the complexity of EMS, including personnel, management, certification, and ambulance licensure, necessitates detail that cannot be included solely in the state medical board purview. Thus the EMS statute often provides direction to a department that can manage such administrative details.

The provision of EMS is rooted in many different resources such as fire departments, other public safety agencies, and hospitals. There are private providers in the business of providing EMS. In addition, public providers were established by many counties, fire districts, rescue agencies, and municipalities. Ideally, EMS statutes create the framework for prehospital medicine to be provided by well-trained personnel, staffing carefully maintained vehicles, dispatching through controlled communications systems, ultimately providing an equitable distribution of patient calls.

Rationale

In the rationale section of an EMS statute a statement is made as to why the state legislature approved the statute. Typically it states that the legislature finds it in the public interest to assure that emergency medical services are readily available and coordinated. Occasionally the need for quality in the provision of these services is included. The complex nature of EMS makes coordination essential; it is not a given that such services are in fact highly coordinated. In general, if something that cannot take care of itself is important to the public the government will step in and ascertain the need for a law that provides regulation. This is an important justification for EMS laws. It is equally important, of course, to allow extension of physician practice to non-physician providers in the prehospital environment. However, the fact that EMS is important to the public is most commonly the actual driving force behind legislation.

The state is responsible for protecting the public interest and has broad power through the legisla-

*Georgia EMS Code Chapter 11 and Department of Human Resources Rules and Regulations Chapter 290-05-30.

tive process to carry out this duty. In general, a state may regulate anything considered in the public interest or presenting a risk to citizens. EMS is viewed by many legislatures as just such an entity that should be broadly regulated. Matters relative to EMS that may be regulated include the distribution of calls, the number of providers established in the interest of economy and efficiency, the regulation of the flow of patients to trauma centers, the provision of immunity from civil liability, and the description of who is allowed to carry out EMS duties.*

State and Local Administration

Typically, EMS statutes address the various official positions required for administration of the system.

State EMS director. Statewide professional direction of the EMS system is under the guidance of a state EMS director. There is a national organization of these directors.† The state EMS director is usually not a physician, though this varies from state to state.‡ The state EMS director functions both as the manager of the office that generates state EMS policy and as the enforcer of that policy. Other duties include directing licensure, certification, recertification, and disciplinary processes. Typically the appointment is made by the governor or the director of the state health or public safety agency. Responsibilities include management of the system and medical matters. In the absence of medical training the state EMS director should not give medical opinions. It is not the purpose of the state EMS director to make quality assurance judgments regarding medical care. The need for a person with a medical background to make such judgments cannot be overemphasized; medical oversight is extremely important to EMS.

State EMS committee, council, or commission. Many state EMS statutes provide for the appointment of a state EMS governing or advising committee, council, or commission. The responsibilities, compositions, and appointments of these groups vary significantly. Progressive statutes provide for appointment of a representative group from the EMS community including physicians, fire chiefs, administrators, county commissioners, and laypersons. In California the law provides for appointment of the EMS Commission, which has direct authority to establish rules regulating the state EMS system.§ Although the EMS Board of Tennessee is similarly structured, this centralization of power is uncommon.¶ Alabama has a state EMS medical control board consisting of physician representatives from the state's six EMS regions. Advisory in nature, this board makes recommendations directly to the Alabama Board of Health. In New York recommendations of the state medical board are made to the state EMS council for final approval.

The direct authority of the California EMS Commission should be contrasted with states such as Georgia, where only a passing reference to an "Emergency Medical Services Advisory Council" is made in the law.** The Georgia Council is appointed by the state EMS director and has no direct authority. As in many other states, recommendations are made to the regulatory agency (in this case the Georgia Department of Human Resources), which

*Georgia EMS Code Chapter 11 and Department of Human Resources Rules and Regulations Chapter 290-05-30.

†National Association of State EMS Directors.

‡The State of California mandates, "The Emergency Medical Services Authority shall be headed by the Director of the Emergency Medical Services Authority who shall be appointed by the Governor upon nomination by the Secretary of the Health and Welfare Agency. The director shall be a physician and surgeon licensed in California pursuant to the Provisions of Chapter 5 of Division 2 of the Business and Professions Code, and who has substantial experience in the practice of emergency medicine." (1979.101) The Texas statute states that the bureau shall be under the direction of a bureau chief with proven ability as an administrator and organizer and with direct experience in emergency medical services. In filling the position of bureau chief, a preference shall be given to any applicant for the position who is a physician.

§The California statue provides for a Commission on Emergency Medical Services consisting of 16 members: one physician and surgeon whose primary practice is emergency medicine, one trauma surgeon, one physician representative from the California Medical Association, a county health officer, a registered nurse, a full-time paramedic, a private provider, a representative of fire protection, an emergency physician who is knowledgeable in state emergency medical services programs and issues, a hospital administrator of a base hospital, a peace officer, two public members who have experience in local EMS policy issues, a local agency, and an active member of one of the firefighting associations. This commission has direct authority to review and approve regulations, standards, and guidelines to be developed by the EMS Authority, to advise the authority on the development of an emergency medical data collection system, to advise state health facilities, and make recommendations for further developments. The Commission may use technical advisory panels. (1799.2)

¶The Tennessee statute provides for a Board of 13 members of similar appointments to 10 above though with fewer mandated physician members. This Board approves EMS schools and curricula, promulgates regulations for the issuance of licenses and certificates of personnel, services, and vehicles, provides for hearings, and establishes standards for the amounts and types of insurance coverage required for ambulance services. It also regulates the development and operation of EMS telecommunication systems and regulates fees. The Board's rulings are advisory to the Tennessee Board of Health.

**State of Georgia EMS Statute, Code Chapter 11.

can act either positively or negatively on those recommendations. In practice the opinions of this body are accepted as authoritative, although they require review and final approval by the Department of Human Resources, the Composite Board of Medical Examiners, or both.

Formation of rules and regulations. Many statutes provide for an element of state government to make rules and regulations that "carry out the purposes and intent of this part and to enable the authority to exercise the powers and perform the duties conferred upon it by this part not inconsistent with any of the provisions of any statute of this state."* It is not practical or logical for the statute to contain all necessary policy and procedure for the provision of EMS.

One area of great variability among EMS statutes is the amount of detail. In the California statute the specific duties of EMS personnel are enumerated, but the certification and recertification standards are left to the regulatory agency approved by the EMS Commission. However, in the Georgia law the requirements for EMT-B recertification are delineated.

Rules and regulations become the living organ of the provision and administration of EMS; and the law is the guiding force for formation of the rules. Therefore if the law states that the regulatory agency should determine certification requirements, then the rules should provide for these requirements, generally after consultation with experts and the public.

Less astute statutes provide significant operational detail in the language of the law; modifications in the scope of practice then require changes in the law through the legislative process. In Georgia, for example, all duties of EMS personnel are spelled out in the statute. Therefore the provision of defibrillation by EMT-Bs required a change in the law. The wording and detail in the writing of EMS law is critical to the progress and growth of EMS systems. Changes in regulation are much easier than changes in statute. A well-thought-out statute will need very little modification.

Regional EMS councils or coordinating entities. The impact of the 1973 EMS System Act may be traced across the country by the development of regional EMS councils.† These councils considerably influenced the training of personnel, purchasing of equipment, and the initial design and direction of EMS systems.

Fiery politics raged when state legislators addressed the issue of regional EMS councils. Many private and public providers had a stake in the channeling of patients within the EMS systems. Regional councils in many states were authorized to make such determinations of need and award response zones to various providers.

The Georgia EMS law delineates a bureaucratic process for patient routing through a "local coordinating entity." This entity operates at the regional level in the stead of the controlling board of the state regulatory agency or its designee, the Director of Public Health.‡ Therefore the regional level has guidance and policy mandates from the state. The membership of these local coordinating entities is not spelled out in Georgia law.

On the other hand, the Pennsylvania EMS law details the membership, terms, quorums, and duties. Carrying out "the emergency medical services plans" of the state and region is included in the duties. The Texas statute provides for regional EMS councils, but also allows local providers to make their cases with the county commission or local municipalities; an appeal to the state is also available. A distinct flavor of the initial organization of a state's EMS structure can be gained from analyzing the establishment of regional EMS councils.

Local EMS planning. Many EMS statutes address the need for comprehensive planning by local EMS systems. The complex and sophisticated nature of EMS is exemplified in the delineations of how local-level issues should be handled. Such issues include awarding calls and response zones to various providers, handling complaints, managing the communications system, coordinating with state emergency preparedness agencies, approving new EMS providers, initiating contracts, providing for hearings, appointing EMS medical directors, developing mechanisms for quality improvement, and assigning responsibilities to a local EMS office.

This section of EMS law is vitally important in areas where EMS personnel cannot carry out med-

*California EMS Code 1797.107: Rules and regulations. Note that the EMS Commission in California must approve all regulations promulgated by the EMS Authority.

†Public Law 93-154, Emergency Medical Services Systems Act of 1973, Title XII of the Public Health Service Act.

‡"The Board of Human Resources shall have the authority on behalf of the state to designate and contract with a public or nonprofit local entity to coordinate and administer the EMSC Program for each health district designated by the Department of Human Resources. The local coordinating entity thus designated shall be responsible for recommending to the board or its designee the manner in which the EMSC Program is to be conducted." Georgia EMS Code 31-11-3.

ical acts unless employed. Since local-level certification is provided in such areas, EMS personnel are allowed to perform their duties only when employed by an approved EMS service in the geographical area. Lack of employment means inability to carry out prehospital skills professionally. Local-level medical oversight and system design therefore become prominent parts of the provision of EMS.

Ambulance Services

EMS statutes often focus on developing methods to approve vehicles and services. The extent to which methods are covered varies. Some statutes go as far as establishing local certificate of need (CON) procedures similar to those required for hospitals and other health facilities. Others, like the California EMS statute, leave the determination of approval to the state agency or local EMS systems.

The Georgia statute includes specifics on the application for licensure, the description and location of ambulances, the duties of the license officer, the requirements for insurance coverage, the ambulance standards specifications, and the procedures for renewal, suspension, and revocation.* The Tennessee law strikes a middle ground; it requires a state EMS board to form standards for ambulance vehicles and equipment, but the licensure, permit, and certification criteria are in another section of the law.†

In general, EMS statutes provide for the licensure of ground, air, and water vehicles and the systems that operate them. Performance standards are often defined either in law or rules. Inspections must be conducted by a state or local government entity. A logical inclusion is a provision for the revocation of system or vehicle licenses including allowable reasons for revocation and the method for appeal. Whether ambulance regulation is directly in the law or indirectly assigned to some portion of the system varies.

Medical Oversight

Authorization of EMS personnel to carry out medical activities also varies in EMS law. Typically the need for EMS and its coordinated provision is stated in the opening rationale statement. However, statutory descriptions of EMS as the provision of medical care through others are unusual. EMS laws often do not address this concept; consequently, EMS physicians in many states lack statutory authority for medical oversight.

The Georgia statute is a good example of the medical oversight problem. Although EMS systems are required to have a medical director to "enhance the provision of emergency medical care," this physician must simply be licensed to practice medicine in the state. If a medical director cannot be obtained, the district health director should fill the role. The enumerated duties of the medical director include providing medical oversight and training for the ambulance service personnel "in comformance with acceptable emergency medical practices and procedures." Notably and commendably, the rules and regulations use that statement to layout "acceptable emergency medical practices and procedures" of the medical director.‡

Since EMS law often does not instruct the responsible agency to draw up medical oversight regulations, it has been argued that the agency does not have the authority to address and expand the medical oversight portion of the statute by issuing rules and regulations. However, broad interpretation of the state EMS agency's responsibilities allows for such authority. In Georgia rules and regulations have been established for trauma systems despite the absence of specific authorization.§ Statutory modification over the years has provided for greater specificity in medical oversight.

A striking contrast is the California law, which provides for medical oversight of EMS systems through prospective creation of policy and procedure, concurrent review, direct management, and retrospective audit.‖ It further states that these are minimum standards for any system implemented in the state.

An EMS law should provide direct physician authority for medicine practiced in the field. Any

*Georgia EMS code 31-11-30 through 31-11-36.

†"Standards for the design, construction, equipment, sanitation, operation, and maintenance of ambulances, invalid vehicles, and for the operations and minimum emergency care equipment for emergency response vehicles shall be promulgated by the EMS board. The EMS Board may authorize standards for the licensure of air ambulance services to provide for such special personnel equipment operation and activities as may be necessary. Permits shall not be required for individual aircraft." Tennessee EMS Statutes 68-140-506.

‡Georgia EMS Code Chapter 11 and Department of Human Resources Rules and Regulations Chapter 290-05-30.

§Senate Bill 320, 1989, now Code Chapter 31-11-60.1 provided for a name change from EMS medical "adviser" to "director" and provided for the first time sufficient authority for the medical director to perform quality assurance duties. Interestingly, this bill, though passed into law, did not go into effect for 2 years until 1991.

‖"The medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency." California EMS Act, 1798.(a). In 1990, the California EMS statute was changed to require that each local EMS agency have a medical director. This medical director must be a physician who has substantial experience in the practice of emergency medicine. (1797.202)

medical system that may hold a physician liable for the practice of medicine should provide authority for design, implementation, maintenance, and quality improvement with the statute as the final arbiter. EMS physicians must determine how prehospital medicine will be practiced. Otherwise, the medicine practiced may not be under the final control of physicians. Difficulty establishing medical oversight at the state level is caused in part by the absence of national standards on EMS medical director education and responsibility.

Prehospital Care Reports

The requirement for recordkeeping is highly variable in EMS statutes. The Georgia law states, "Records of each ambulance trip shall be made by the ambulance service in a manner and on such forms as may be prescribed by the Department through regulations. Such records shall be available for inspection by the Department at any time, and a summary of ambulance service activities shall be prepared on specific cases and furnished to the Department upon request." The rules and regulations of Georgia detail what should be included on the prehospital care reports and the summary that must be submitted to the Department on request. The need for medical record confidentiality is mentioned in many statutes.*

Communications

The federal effort to bolster EMS through the EMS System Act concentrated on providing communication equipment. Consequently the authors of state statutes usually included methods of system design and regulation for such equipment, including the regulation of frequencies and occasionally the licensing of users. The term "communications" usually includes handling public calls, such as through 9-1-1 systems, and operating radio and telephone response equipment. Advancing communications technology has caused a gradual metamorphosis of EMS statutes. Cellular equipment and satellite communication are logical targets for EMS legislation and regulation.

An important part of communications addressed in state statutes is the provision of care in the absence of radio communication with direct medical control. The California statute addresses this point extensively.† Some states require completion of a special report, similar to a hospital incident report, if direct medical control contact cannot be made. Georgia, in its new allowance for standing orders, requires such a report.

Providers

Another fundamental area of EMS law is the provision for EMS personnel. Some state laws mention provider levels but assign state or local authorities to define these levels.‡ On the other hand the Georgia statute meticulously defines all levels of EMS personnel. Such statutory delineation is trying in modern EMS. Changing duties of EMS personnel may be difficult if specifics are written into statute. Defibrillation could not be added as an EMT-B skill in Georgia until the law was changed. In New York, emergency medical technician-defibrillation (EMT-D) was implemented across the state, but only under the guise of an experimental trial.

The Texas Code of 1983 progressively provides minimum skill levels for EMS technicians, but allows the state agency to determine precisely what skills EMS personnel can perform. Other states allow localities to define the care provided at a given level.

Standards found in EMS statutes include certification, recertification, continuing education, active practice requirements, services by providers working in hospitals, methods for obtaining medications, disciplinary procedures, and standards for use of standing orders.

*The subject of medical records is not mentioned in either the Tennessee statute or the rules and regulations. Medical records are not mentioned in the California statute or in the Texas statute. In Tennessee, there exists a general requirement for record-keeping in a policy statement issued under authority of regulation. In California, there is regulation providing for record-keeping under statutory authority given to the rules-making process from 1791.107.

†"When an EMT-P who, at the scene of an emergency, reasonably determines that voice contact or a telemetered electrocardiogram for monitoring by a physician or authorized registered nurse cannot be established or maintained and that delaying treatment may jeopardize the life of a patient, and when authorized by policies and procedures approved by the local EMS authority, the EMT-P may initiate any paramedic procedure specified in this section in which such EMT-P has received training until such direct communication may be established and maintained or until the patient is brought to a general acute care hospital ..." California Code of Regulations Title 22, Social Security, Division 9, Pre-Hospital Emergency Medical Services, Chapter 4, EMT-Paramedic, Section 100144, Scope of Practice.

‡The State of California allows for modification of the basic state scope of practice for paramedics by EMS medical directors at the local level. Under 1797.172, the authority and commission adopt minimum state standards for training and scope of practice. Local level medical directors may petition a committee of local EMS medical directors named by the Emergency Medical Directors Association of California for additions to a "local optional scope of practice for EMT-P's ... prior to the implementation of the addition in the local system."

The inclusion of certain items in law may make later educational change cumbersome. In Georgia, for example, state-level recertification materials are minutely delineated, including the requirement that five "different and discrete" modules be covered over five years. It is difficult to cover skills such as patient assessment and endotracheal intubation that must be reviewed annually without conflicting with the statute.*

The Indiana EMS law is extremely progressive and should be read by anyone contemplating a change in law. A state agency is responsible for drawing up recertification requirements; the result is an excellent model for EMS providers.†

In 1992, 17 states "licensed" paramedics. The meaning of this licensure varies from state to state. The usual interpretation is that the licensed paramedic may carry out certain skills and procedures without the approval of direct medical control. This "dependent licensure" requires various system components such as physician medical oversight to allow the use of standing orders. However, many states that allow paramedics to use standing orders simply call the process "certification." No state licenses prehospital providers as independent practitioners.

Specifics to Individual States

The flavor of various statutes is reflected in the details included. For example, "invalid cars," vehicles used for convalescent calls, are often mentioned. In the New York and Georgia laws, these vehicles are specifically not regulated by the EMS statutes.‡

Small counties are often excluded from law and regulation for financial reasons. The Georgia law excuses counties with populations less than 12,000.§ The Tennessee statute excludes counties with populations less than 50,000.‖

Good Samaritan laws and other liability limitations are included in many EMS statutes; however, in states such as Colorado the limitations are elsewhere in law.¶ Liability for simple negligence is usually excused; however, Good Samaritan laws generally do not provide immunity from liability for gross negligence or willful and wanton misconduct.

An immunity statute in no way protects the provider from litigation, rather, it excuses the provider from liability if the individual was not guilty of gross negligence or willful and wanton misconduct. Therefore liability is generally absent if the provider acts competently within the standard of care. Occasionally, similar provisions are made for EMS medical directors or council members who serve for no remuneration.# The standard of care for medical oversight is far more complex than it was a few years ago. To avoid being guilty of willful and wanton negligence, EMS physicians must demonstrate the provision of reasonable medical oversight, including direct and indirect medical control, depending on the level of participation.

Regional trauma systems and other programs that divert patients to appropriate facilities are allowed in many statutes. The Georgia law was amended recently to allow EMS agencies to route prehospital patients to trauma centers. The California law includes a section entitled Regional Trauma Systems. Statutory expansion of the "regionalization" of patients with specific medical conditions is likely in the future.

Indemnification is a new concept in some statutes; providers of public services may be offered a death or disability settlement for injuries or death resulting from their jobs. It is debatable whether private providers and EMS medical directors should be included in such indemnification.

*"The continuing education requirements shall be met by annually completing one-fifth of the following five-year requirements for hours of continuing education: 50 hours for emergency medical technicians; 75 hours for cardiac technicians; and 100 hours for advanced emergency medical technicians. These five-year continuing education requirements shall be divided into five different and discrete segments or modules of equal length." Georgia EMS Code 31-11-58 (d). In 1992, an attempt was made to allow for flexibility in establishing recertification requirements for EMTs. This required a law change that would give the authority to the Department of Human Resources. The bill giving this flexibility was defeated in committee, and hence even with the recommendation of the state EMS Advisory Council, minimal annual requirements cannot be established due to the wording of the law.

†State of Indiana Official Rules and Regulations for the Operation and Administration of Advanced Life Support, revised September 1984, 836 IAC 2-6-4 Continuing Education Reporting Requirements.

Advanced Life Support Continuing Education Manual from the Indiana EMS Commission: "The purpose of this manual is to outline the specific continuing education requirements for the Paramedic and the Advanced EMT, and to provide the mechanism for reporting continuing education to the commission."

‡"This chapter shall not apply to an invalid car or the operator thereof." Georgia EMS Code 31-11-11(4).

§"This Code section shall not apply to any county having a population under 12,000." Georgia EMS Code 31-11-50(c).

‖"The provisions of this part shall not apply to counties having a population of not less than 49,400 nor more than 50,000 according to the 1980 Federal Census or any subsequent Federal Census." Tennessee EMS Statutes 68-140-516(c).

¶Personal communication from CJ Shanaberger, JD, July 1988. "

#A physician shall not be civilly liable for damages resulting from that physician's acting as medical adviser to an ambulance service if those damages are not a result of that physician's willful and wanton negligence." Georgia EMS Code 31-11-8(b).

Local Ordinances

One of the most vital areas of legal control and direction of EMS is the development of local ordinances. Municipalities and counties can establish local ordinances. These decrees set rationales and structures for the performance and regulation of various matters.

If a city declares that it is in the interest of the populace to forbid the sale of alcoholic beverages within certain distances of churches, then this issue is a "local law," with various penalties for infractions thereof. Likewise, if a county determines that standards must be met by road contractors building thoroughfares within the county boundaries, then such roadways can only be built according to such specifications. Local ordinance cannot conflict with state statute. Furthermore, local ordinance often requires a complex hearing process before adoption.

Similarly, local jurisdictions may issue ordinances concerning EMS. Such standards are powerful tools for EMS medical directors and should be carefully studied and pursued. Topics that can be addressed locally include the following:

1. Direct medical control training standards
2. Indirect medical control requirements and contractual arrangements
3. Specifications for vehicles
4. Minimum response times for EMS services
5. Minimum equipment standards for vehicles
6. Minimum training standards for providers
7. Quality management requirements

The EMS medical director must carefully review the existing local ordinances in the community. Perhaps the most significant impact of the medical director is the creation of a lasting, quality local EMS ordinance that provides for physician medical control of EMS activities.

A Model EMS State Legislation Outline

I. Title of the EMS Act and rationale for EMS provision
II. State administration
  A. State professional director of EMS
    1. Qualifications
    2. Powers
    3. Duties
  B. State medical director of EMS (if state director is a non-physician)
    1. Qualifications
    2. Powers
    3. Duties
  C. State EMS commission
    1. Appointments
    2. Responsibilities
    3. Authority
  D. EMS department
    1. Allowance for formation of rules and regulations
    2. EMS department duties
III. Regional administration
  A. Regional EMS councils
  B. Regional EMS medical director
  C. Regional EMS coordinator
  D. Provision for regional patient flow guidance
IV. Local administration
  A. Local EMS councils
  B. Local EMS system directors
  C. Local EMS medical directors
V. Ambulance services (specifics may be relegated to the Commission)
  A. Licensure of ground, air, and water vehicles
  B. Standards
  C. Inspections
  D. Revocation of licenses
  E. Penalties
VI. Medical control
  A. Authorization for physician authority and medical direction
  B. Provision for EMS technicians to provide practitioner assessment and management responsibilities
  C. General EMS physician qualifications and responsibilities to EMS systems
VII. Indemnification
VIII. Limitations on liability
IX. Medical records
X. Communications
  A. Rationale: The responsibility to respond to the public cry for distress
  B. Confidentiality
XI. EMS technician (specifics may be relegated to the Department or commission)
  A. Certification
  B. Recertification
  C. Services
  D. Continuing education
  E. Active practice requirements
  F. Hospital services
  G. Obtaining drugs for EMS services
  H. Revocation of certificates
  I. Penalties
  J. Standing orders
XII. Specifics to states
  A. "Invalid cars"
  B. Special provisions for small counties or large cities

Summary

The proper formation of EMS statutes, regulations, and ordinances is critical to the continued EMS system growth. However, many aspects of EMS practice are found outside the EMS enabling legislation, making the search for medical oversight authority confusing. In some states the specifics of medical oversight are not found in the statute but in the activities of a state medical board.

EMS laws should limit inclusion of matters such as personnel criteria, continuing education requirements, and specific skills and medications. Authoritative bodies of EMS physicians and other qualified personnel can then determine the responsibilities and skills of the various levels of EMS personnel.

An EMS commission including physicians practicing within the state EMS system is essential. The commission must have statutory authority relative to the EMS system. When regional systems were established the medical oversight necessary for the proper monitoring and functioning of EMS was absent. Medical oversight is necessary for all EMS providers as is statutory authority for direct and indirect medical control physicians to carry out their delegated duties.

All EMS physicians should take a dynamic role in the review of their EMS statutes to facilitate excellence in EMS practice and future growth. They must assume that liability limitation laws do not protect them unless they can demonstrate and document aggressive participation in their EMS systems.