2015 ASRC Retreat Medical Breakout

1/5/2015

Comments to: Keith Conover, kconover@pitt.edu

1) Purpose

a) The ASRC's 2015 Retreat will feature a number of plenary sessions (for everyone) and breakout sessions (people have to choose one or the other).

b) One of the breakout sessions is entitled "Medical." Keith Conover has been asked to moderate this session, and to provide an agenda. This is a proposed agenda and set of discussion points.

2) Schedule and Scope

a) The starting and ending times have not yet been determined.

b) A recommendation: once the duration has been determined, we assign half of the time to structural issues (organization and duties of the Medical Committee and Medical Advisory Committee) and principles and half the time to substantive issues.

3) Ancient History

a) A summary of medical issues discussed at ASRC BOD meetings over the years may be found at (not attached to printed or PDF version): http://archive.asrc.net/ASRC-Medical/2014-03-10-ASRC-BOD-Minutes-Medical-Excerpts.pdf

b) The ASRC from the very first believed that first aid and emergency medical care were central to its purpose. The emphasis was on medical care; thus, the Star of Life (the national Emergency Medical Services symbol, which was new when the ASRC was also new) became central in the ASRC logo and patch.

c) One the Conference's shared goals is to do search and rescue the best we can. One of the Conference's main roles to provide recommendations to the Groups on best practices.

d) Some "SAR" teams provide only search, and specifically exclude rescue. However, the current ASRC structure requires ASRC Groups to provide both search and rescue.

e) The ASRC used to have the following medical structure:

i) A **Conference Medical Officer**, who chaired a **Conference Medical Committee.**

(1) Over the years, this Committee was sometimes active, sometimes not.

(2) In recent years, it has not been active.

ii) For each state, a physician serving as **Conference State Medical Director**.

(1) We did this on a state-by-state basis, as medical care and EMS and first aid are regulated by the states, not the Federal government, and there are significant differences in the states' laws and regulations.

(2) The Medical Director was charged with providing a set of first aid and EMS protocols for the Conference's medical care within a state. No other duties or charges were given to our state medical directors.

(3) For some states, we had no Medical Director

4) Recent History

a) In June 2014, the ASRC BOD eliminated the positions of the Conference State Medical Directors.

b) In June 2014, the ASRC Board of Directors also accepted a new Conference medical structure, slightly revised at the October 2014 BOD meeting. This is attached to the printed and PDF versions of this document and available online at: http://archive.asrc.net/ASRC-Admin/ASRC-BOD-Membership-Minutes/2014-10-05-ASRC-Medical-Resolution-KC.pdf

c) A draft of a new Operations Manual (entitled Operational Guidance Manual) was circulated after the October 2014 BOD meeting. The medical section of this, if accepted, would dissolve the Medical Direction Committee. This is attached to the printed and PDF versions of this document and available online at: http://archive.asrc.net/ASRC-Medical/2014-10-00-DRAFT-OGM-Medical-Section.pdf

d) A proposal rewriting this was submitted to the BOD November 13, 2014, with the suggestion that this could be approved by the BOD as an interim update of the current medical policy. This is attached to the printed and PDF versions of this document and available online at: http://www.conovers.org/ftp/2014-11-13-ASRC-OGM-Medical-Section-KC.pdf

5) Structural Issues

a) Should we have a separate Medical Advisory

Committee and Medical Committee, or just one Medical Committee?

b) To whom should the Committees report?

c) Who should we recommend be the Chair of the Medical Committee (ASRC Medical Officer) since there seems to be none at present?

d) Should there be a designated Assistant Medical Officer to be vice-chair of the Medical Committee and act as understudy, with a general expectation that at some point, the Medical Officer will resign and the Assistant Medical Officer will become the Medical Officer?

e) Upon review of Keith Conover's November 2014 recommended replacement for the medical section of the Operations and Admin manuals, what changes do we wish to make? Do we want to submit this to the Board of Directors for a vote?

6) Principles for Discussion

If there is a consensus on some of these, an edited version could be submitted to the BOD to guide future medical and operational planning.

a) Search and Rescue

i) The name on the logo and patch: "Appalachian Search and RESCUE" argues that rescue is part of what we do.

ii) First aid, EMS or medical care are central to rescue, and thus, central to the Conference's mission.

iii) Our patch and logo depict a star of life, which is the symbol of the US Emergency Medical Services program developed by the US Department of Transportation. One can therefore argue that every ASRC group should do its best to provide First Responder level care to its patients. This does not mean that all members need to be trained as First Responders any more than all the members of a fire department that is also an EMS agency be trained as First Responders.

b) **Wilderness Patient Care, Legal Issues**:

i) Wilderness first aid, Wilderness EMS and wilderness medical care are different than "street" first aid, EMS and medical care. For example, the standard "street" care for a shoulder dislocation, is to immobilize and transport to the nearest Emergency Department. However, the standard of care in the backcountry, at all levels of care provider (wilderness first aid, Wilderness EMS and medical care), the standard of care is to attempt reduction in the field. However, this is not accepted by all authorities having jurisdiction over first aid, EMS or medical care.

ii) **Standard of Care**: This different standard for backcountry care is established in textbooks, medical journal articles and even ASTM standards. These (sometimes conflicting) texts give those providing wilderness first aid, Wilderness EMS or wilderness medical care a certain level of legal protection from:

(1) civil suits (tort claims for monetary damages)

(2) criminal actions ("practicing medicine without a license"), and

(3) regulatory actions (removing an EMS or medical certificate or license based on violating "street" protocols).

iii) **Medical Directors:** A Group physician medical director may provide additional legal protection, in the form of Group protocols and standing orders for wilderness first aid, Wilderness EMS or wilderness medical care. A Group Medical Director may also serve to supervise the Group's first aid, EMS and medical training, and to provide quality review patient care cases. A Group Medical Director may also serve to provide online medical direction by radio or cellphone, providing medical advice directly to those in the field.

iv) **Medical Advisory Committee**: The Conference Medical Direction Committee (likely to be renamed the Medical Advisory Committee) provides Conference Groups legal protection for backcountry patient care through two means:

(1) "ex cathedra" white papers on medical topics that are, or should be, of particular interest to members of ASRC Groups, and

(2) general protocols for the wilderness first aid, Wilderness EMS, or wilderness medical care of SAR patients in our mid-Appalachian region, which may be referenced by Groups without a medical director.

c) **Medical Committee**:

i) Keeping up with the latest in first aid, EMS and medical issues, and separating the wheat from the chaff, are hard, even for full-time academic physicians. One of the

roles of the Medical Committee, in concert with the Medical Advisory Committee, is to continually assess the need for new recommendations for wilderness first aid, Wilderness EMS or wilderness medical care training or practice. Most such discussions would occur within the Medical Committee, with final White Papers on a topic occasionally emerging from the Medical Advisory Committee.

ii) The Conference as a whole will be served by better data about the first aid, EMS and medical care we render. This will allow us to better prepare for future needs. The Medical Committee will be the primary focus for gathering such information, drawing conclusions from it, and making recommendations.

7) Substantive Issue #1: Field Medical Record

a) A practical field medical record that is standardized across the Conference is a goal worth striving for, even if it never takes place.

b) Within AMRG we discussed the alternatives, including a smartphone app, but it only will work when you have connectivity (e.g., a cave rescue) and doesn't leave you with a copy to hand off to the ambulance crew. We also discussed using the Rite-in-the-Rain binder that is commonly used for cave surveying that holds 4x6" paper, but it was a bit too bulky to fit in a cargo or parka pocket easily, and the home-brew version (see below) won overwhelming support from the AMRG membership compared with the survey notebook.

c) Michael Lipay, one of AMRG's more tech-savvy members, suggested using a homunculus for charting. While this might have benefits for a smartphone app, I was not in favor of it for paper charting. I will paste in my email response here:

> I have a lot of experience with medical charting software, indeed have a website devoted to the usability of medical software which features charting software: http://ed-informatics.org
>
> I've used and analyzed a lot of medical charting software, some using the homunculus approach you suggest. While it's visually attractive, the vast majority of users find it doesn't help. Narrative text with an occasional drawing seems to work much better, and ends up being the user's choice.
>
> For example, I am at MedExpress right now, and in front of me I have a computer with DocuTAP on it, the charting system that is used here.
>
> One of the screens offers a homunculus to click to select a template (sore throat, ankle injury, etc.), and then a simple multicolumn list of templates to click as an alternative method to choose.
>
> I have yet to find a single person who uses the homunculus, and that's about 40 people I've surveyed.
>
> In DocuTAP, mall anatomic diagrams on which you can draw with the mouse are available, and about 5-10% of the people use this. But most just use text, using standard anatomic terminology ("5x3 inch partial thickness burn R anterior shin") as it's faster and easier. Maybe on a phone, using your finger, we could get more efficient drawing, and it might be more attractive, as I would think that people can draw better with a finger than a mouse. On the other hand, phone screens are small, and your finger covers up what you're drawing.
>
> So in practice, homunculi seem to take up space on the screen but not offer much if any advantage to text. But it looks great on your webpage when you're trying to sell a charting product.

d) AMRG developed what it believes is a both practical and usable field medical record. A prototype will be shown at the Retreat. It consists of a plastic one-ring binder sized to fit in a cargo pocket (pages 4x6", NCR two-part "carbon-paper" Rite-in-the-Rain water-resistant forms). This is attached to the printed and PDF versions of this document and available online at: http://www.conovers.org/ftp/AMRG-Patient-Record.pdf

e) The PDF shows a cover that can be created from two pieces of plastic "hinged" with some duct tape. Ben McCandless of AMRG is working on a more elegant solution, using laser etching and a number of other tech-y techniques. A prototype will be shown at the Retreat.

f) There are several principles that should apply to such a medical record. We in AMRG have tried to develop something that meets them all, though with necessary compromises. Here are the design principles, in no particular order:

i) Employ the principle espoused by information-design experts such as Robert Barnett and Edward Tufte. See, for example: http://ed-informatics.org/2010/02/11/medical-computing-9/ and http://ed-informatics.org/2010/04/12/tracking-systems-part-6

ii) Lots of room for writing, unconstrained by boxes; very flexible, given there isn't much room on a small page.

iii) Reminders for important stuff, including "Page # of #" (requires a little training; you fill in the "page" number as you start a new page, and the "of" number once it's all done).

iv) Patient ID information.

v) The more detailed elements of a history that may be appropriate in the backcountry.
vi) The elements of clearing the cervical spine in the field by protocol (though, remember, you might be able clear the cervical spine even if a patient doesn't meet all the criteria, with medical direction from a physician).
vii) A checklist for clearing the cervical spine to make charting it easier.
viii) Small; 8.5x11 is too big to use in the field. 4"x6" seems about right.
ix) Ability to use additional pages for generic timed entries (especially important for many-hour cave rescues).
x) No rigid blocks for vital signs and physical exam reassessment. Instead, there should room for time and whatever you want to write. For example, if you wrote: **1230 hrs 140-22-110/70-93%RA** anyone could probably figure out which vital signs are which.
xi) Reminders for common and important things right on the form. We also discussed having a single page with lots more reminders and mnemonics for the back of the notebook, and all I can say is that it's a good idea and it's on the to-do list.

8) **Substantive Issues #2: White Papers**
a) Medical Advisory Committee white papers will present and review the available literature on a medical/first aid topic of particular interest for SAR teams in general, and ASRC Groups in the mid-Appalachian region in particular. If the literature is persuasive enough, the paper will also make a recommendations for best practices. In some cases there will *not* be good enough information to make a recommendation. Nonetheless, having a group of SAR team physicians present and review the evidence might still help Groups make a decision as to what their protocols should be.
b) Some such topics have already been covered in the Guidelines produced by the Wilderness Medical Society, in a small book and in a series of articles in the journal Wilderness & Environmental Medicine, but some have not, or there may be practical issues with implementing the recommendations of the Wilderness Medical Society in our setting. Too, practical considerations are generally skimpy in the WMS guidelines and may be very important for our members.
c) Topics would generally be chosen based on the following criteria:
i) New treatments, drugs or devices: do they work? What is the ratio of benefits to harms? What are the practical constraints on our use in the field? How strong is the evidence? Here are some examples: full-body vacuum mattresses, pelvic binders, King LT airways, tranexamic acid.
ii) Old treatments, drugs or devices: do they work? What is the ratio of benefits to harms? What are the practical constraints on our use in the field? How strong is the evidence? Here are some examples: MAST trousers, Critical Incident Stress Debriefing (specifically: group debriefing), backboards, and using a log roll to put people on backboards or other stretchers.
iii) How do we adapt accepted treatments, drugs or devices to our SAR context? For example, if we want to use intraosseous infusion as an alternative for IVs, which system is best for our particular use? Does it require adaptations to work properly? Or, we know that tranexamic acid works to save lives after major trauma if given IV; do we want to generalize this to recommend that oral tranexamic acid pills be a reasonable addition to first aid or medical kits that include prescription medications?
d) What other examples can we come up with?
e) What are the best methods for discussing these issues before referring to the Medical Advisory Committee for an official White Paper?

9) **Substantive Issues #3: From the Floor**
a) What are other substantive issues we should discuss?

Attachments:

http://archive.asrc.net/ASRC-Admin/ASRC-BOD-Membership-Minutes/2014-10-05-ASRC-Medical-Resolution-KC.pdf

http://archive.asrc.net/ASRC-Medical/2014-10-00-DRAFT-OGM-Medical-Section.pdf

http://www.conovers.org/ftp/2014-11-13-ASRC-OGM-Medical-Section-KC.pdf

http://www.conovers.org/ftp/AMRG-Patient-Record.pdf

From: **Keith Conover, M.D., FACEP, ASRC Medical Director for Pennsylvania**

To: **ASRC Board of Directors**

Date: **10/5/14~~5/5/14~~**

Subject: **Medical Direction**

I would like to suggest that the Board of Directors consider the following motion. As is standard, the "Whereas" preamble is informational, not part of the motion, and not to be voted on; only the "Resolved" is to be voted on, provided the BOD is willing to vote at this.

Whereas, the ASRC previously determined that its medical direction function should be managed on a state rather than a Group level;

Whereas, the ASRC ~~is~~ was recognized as an EMS Agency in Virginia;

Whereas, the ASRC has had statewide medical protocols for Virginia and Pennsylvania, as well as a Pennsylvania Medical Policy to support the protocols for Pennsylvania;

Whereas, at the last BOD meeting, a proposed update (and significant expansion) of the Pennsylvania Medical Policy was rejected by the Board of Directors, with a suggestion that in the future such policies should be carried out at the Group level and not at the ASRC state level;

Whereas, some ASRC Groups wish to provide an advanced level of medical care whereas others prefer to stay at the first aid or Basic Life Support (BLS) level;

Whereas, state EMS agencies are used to dealing with advanced medical providers at an individual agency level than at a statewide conference level; be it

Resolved, that the ASRC:

1. discontinues the practice of having state medical directors, and thanks the current state medical directors for their service in this position;
2. rescinds the prior Virginia and Pennsylvania medical protocols;
3. will no longer be licensed as an EMS agency in any state (though Groups certainly may do so if they wish);
4. establishes a Medical Direction Committee, details of which shall be incorporated in the ASRC Administrative Manual, as follows:
    a. Members of the Medical Direction Committee shall be appointed by the Board of Directors, using the following criteria, and shall serve at the pleasure of the Board of Directors without terms or term limits:

i. candidates for the Medical Direction Committee must be licensed by at least one US state or territory as a physician or osteopathic physician;

ii. candidates for the Medical Direction Committee must be ~~Active~~ Certified Members of the Appalachian Search and Rescue Conference;

iii. the Board of Directors shall show preference for candidates who have achieved Field Team Member or higher ASRC certification;

iv. the Board of Directors shall show preference to physicians or osteopathic physicians who serve as Medical Director of an ASRC Group.

b. The Board of Directors shall select a member of the Medical Direction Committee to serve as chair, who shall serve at the pleasure of the Board of Directors, without terms or term limits. For any external relations requiring the signature or assent of a single ASRC "Medical Director," the Chair of the Medical Direction Committee shall serve this function.

c. The Medical Direction Committee shall be charged to:

i. develop and maintain a set of wilderness protocols, at both first aid and BLS levels, that apply to ASRC members' care on all operations, unless superseded by specific state wilderness EMS protocols for that state. When possible, this should be evidence-based, and if that is not possible, in line with accepted standards care, such as those promulgated by the Wilderness Medical Society;

ii. work with state EMS offices, and in particular with state EMS Medical Directors, for the states in which the ASRC operates, to harmonize state wilderness EMS protocols across the states in which the ASRC operates;

iii. work with Group Medical Directors and the ASRC Medical Committee[1] to harmonize advanced medical care provided by those Groups that provide such care;

iv. work with Group Medical Directors and the ASRC Medical Committee to develop and harmonize credentialing across the ASRC for members who provide advanced medical care, for Groups that provide such care;

v. review all medical and first aid care provided by the ASRC, with an eye to improvement in the quality of care;

vi. work with the ASRC Medical Committee to develop, maintain and improve a system of medical and first aid reporting that is suitable for the field yet provides adequate information for quality improvement efforts;

[1] Note this is the ASRC *Medical* Committee, which is under the Operations Committee, not the ASRC *Medical Direction* Committee, which reports directly to the Board of Directors.

vii. as appropriate, make formal written recommendations for improving first aid or medical care to the Medical Directors of ASRC Groups, or to the entire ASRC membership, via the Group Medical Directors; and

viii. complete other tasks assigned by the ASRC Board of Directors.

d. Meetings of the Medical Direction Committee shall be at the discretion of the Committee. Committee business may be conducted by email or other electronic means at the discretion of the Committee. Records of all votes, with relevant prior discussion, and all formal meetings, shall be filed with the conference Secretary and placed in the ASRC Archive.

e. The ASRC Medical Committee shall be charged with developing a system for obtaining and compiling all Group medical reports and forwarding them to the Medical Direction Committee for review.

5. ~~requires~~ strongly recommends that all ASRC Groups appoint a Group Medical Director, the method for which shall be incorporated in the ASRC Administrative Manual, as follows:

a. Group Medical Directors shall be licensed by at least one US state or territory as a physician or osteopathic physician, but this need not be the state in which the majority of the Group's members live, or the state in which the Group's official address lies;

b. Group Medical Directors shall be Active Members of the ASRC; while CQ certification or higher is strongly recommended, it is not required;

c. A Group Medical Director may serve as the Medical Director of more than one Group;

d. Group Medical Directors shall become a non-voting ex-officio members of the ASRC Medical Direction Committee, and may be appointed to a voting membership in the Committee by the Board of Directors, and serve in this capacity at the pleasure of the Board of Directors;

e. Group Medical Directors shall:

i. represent the first aid and medical interests of the Group to the ASRC Medical Direction Committee;

ii. monitor and oversee any first aid and medical care provided by members of the Group, and work to ensure that such care is of the highest quality possible, and whenever possible, in accordance with the ASRC Medical Committee's first aid and BLS protocols and other written recommendations; and

iii. provide other services as required by the Group or state licensing bodies.

The conference is not an operational entity and the member teams are responsible for creating the documentation for the topics listed above. At request, the COO will provide a review of any member team's Operations Manual.

5.3 Rendition of Medical Care Guidelines

Personnel of member teams learn first aid, CPR, and AED skills primarily to provide medical care to fellow teammates and secondarily to provide medical care to a subject, if required. Member teams shall have policies which allow for rendering medical care to the extent which law permits and to the level of training, but not beyond. When available, care for a subject shall be relinquished to the highest trained individual on-scene and/or professional medical care provider.

A Medical Care Guidance Committee (MCGC, or committee) may be established by the conference to provide support to the member teams. Each state that is covered by the Conference shall be represented on the committee. Members of the committee need not be professional medical care providers, but shall demonstrate in the form of submitting a resume to the BOD of their qualifications. Each member of the committee and member periods of service shall be approved by the BOD. The committee may put forth:

- updates to certification standards, used by member teams;
- updates to best practices when those updates are permitted by the certifications used by member teams;
- updates when laws, rules, and regulations change within each state covered by the conference;
- recommendations to the member teams for best practices to train and learn the skills and techniques required by the certifications used by the member teams; and
- responses to requests made by the COO or BOD.

The MCGC will produce deliverables in the form of memorandums or white papers for delivery to the BOD for acceptance. The MCGC shall establish peer review policies for any deliverable they produce. Deliverables shall be marked "Draft – for internal review only" until approved by the BOD, when the markings can be removed. Information and recommendations contained in deliverables are for the benefit of the member teams to use to the extent they desire, but are not enforceable by the conference.

5.4 Membership

Member teams should have membership policies for the recruitment and maintenance of personnel. Member teams should provide for a background check for each member on a routine basis and procedure for confidential review of the background checks and acceptance or rejection of a member based on the results of the background check. Member teams should have an on-boarding process for new members to orient them to SAR operations, certification requirements, and general SAR culture. Member teams may consider the need ~~to~~ for multiple levels of membership including: (i) provisional, probationary, or candidate member, (ii) operational or active members, (iii) support, associate, or not operational members, (iv) lifetime or founder, and (v) inactive, dismissed, terminated or removed.

Member teams should have a process to terminate the membership of personnel for cause and exit procedures for all personnel regardless of reason for leaving. The BOD should be notified once a member has been dismissed but need not be notified if a member leaves voluntarily.

5.5 Radio Communications

Comment [KC11]: I don't think this is true for AMRG. Our members for the most part take these courses, and wilderness first aid, Wilderness First Responder, EMT and Wilderness Emergency Medical Technician classes, primarily to care for our patients. We are indeed a Pennsylvania-licensed EMS agency.

Comment [KC12]: Duh. Is it necessary to spell this out in the Operational Guidance Manual? The law can take care of itself, I think. I don't see the ASRC Operations Officer trying to determine the law about what level of medical care can be provided by each individual Group. State laws are quite different on this point.

Comment [KC13]: This is a thorny point; in the backcountry, who is "higher" trained, a Wilderness Emergency Medical Technician-Basic or a "street" EMT-Advanced? Wee the AMRG Medical Policy Manual for our take on this. I'm not sure that we should be specifying something like this in the ASRC Operational Guidance Manual, as it is a matter for the Group's internal medical protocols.

Comment [KC14]: See separate proposed revision of this entire section.

From: **Keith Conover, M.D., FACEP**

To: **ASRC Board of Directors via AMRG Operations Officer**

Date: **11/13/2014**

Subject: **Medical Section, Draft Operations Manual**

I suggest that the Board of Directors consider replacing the Medical section of the draft Operations Manual (section 5.3) with the following. Note that this is based on the current Articles of Incorporation and Bylaws; if these change then the wording of this section will necessarily change as well. A set of corresponding inserts for the Administration Manual appear at the end.

5.3: Medical

1. **Background**:
    a. ASRC member teams generally provide both search *and* rescue.
    b. Rescue generally involves evacuating the victim from the backcountry to a ground or air ambulance, as well as providing first aid or medical care at the scene and en route to the ambulance.
    c. When needed, member teams may also provide first aid or medical care for team members, members of other member teams, members of other organizations or spontaneous volunteers.
2. **Level of Care**: To avoid criminal or civil liability, individuals in ASRC Groups shall provide care to members and patients in accordance with Group policies, applicable state legislative and regulatory law, and common law principles. Member Groups may provide care at whatever level they wish, and may change this at any time**.** However, member Groups shall inform the other member Groups of the level of care they provide, and shall share their patient care policies and protocols with other Groups, through the Conference Medical Officer, who shall place such information in the ASRC Archive and ensure it is updated as appropriate. Generally such care will fit into one or more of the following categories:
    a. No first aid or medical care
    b. First aid level care
    c. Emergency Medical Services (EMS): Basic Life Support (BLS) level care
    d. Emergency Medical Services (EMS): Advanced Life Support (ALS) level care
    e. Wilderness Medical Care outside the state EMS system

3. **Committee Structure**: The ASRC has two committees dealing with medical issues. The *Medical Advisory Committee* consists solely of team member-physicians. The *Medical Committee* has a broader membership, including all members of the Medical Advisory Committee, all member Group Medical Officers for member Groups that have such an officer, and any other interested members of ASRC member Groups. Details of these structure and duties of these committees may be found in the ASRC Administration Manual.
4. **Group Medical Directors**: The Conference strongly recommends that all member Groups appoint a Group Medical Director. Details are provided in the ASRC Administration Manual.

Corresponding inserts for the ASRC Administration Manual

1. **Group Medical Directors:** The Conference strongly recommends that all member Groups appoint a Group Medical Director.
    a. If a Group appoints a Medical Director, said Medical Director should be:
        i. licensed by at least one US state or territory as a physician or osteopathic physician, but this need not be the state in which the majority of the Group's members live, or the state in which the Group's official address lies;
        ii. an Active Member of the ASRC, and a member of the Group for which the physician provides medical direction; CQ certification or higher is strongly recommended, but is not required;
    b. A Group Medical Director may serve as the Medical Director of more than one Group.
    c. Medical Directors shall become non-voting ex-officio members of the ASRC Medical Advisory Committee, and may be appointed to a voting membership in the Committee by the Board of Directors, and serve in this capacity at the pleasure of the Board of Directors.
    d. Group Medical Directors shall:
        i. represent the first aid and medical interests of the Group to the ASRC Medical Advisory Committee;
        ii. monitor and oversee any first aid and medical care provided by members of the Group, and work to ensure that such care is of the highest quality possible, and whenever possible, in accordance with the ASRC Medical Committee's first aid and BLS protocols and other written recommendations; and
        iii. provide other services as required by the Group or state licensing bodies.
2. **Medical Advisory Committee**:
    a. Background:

i. Best practices for first aid, EMS and medical care during search and rescue operations differs significantly from that on the street. Although the underlying principles are the same, the search and rescue context requires different decision-making and sometimes different treatment.

ii. For both Groups and individual members, having formal expert advice on best practices for modification of "street" protocols protects against malpractice claims, criminal charges, and revocation of a state license or certification. Although the likelihood of such legal complications is low, it is prudent to protect against the as best we can. An example would be a recommended best practice of attempting to reduce shoulder dislocations in the field at the wilderness first aid level and above.

iii. For example, assume a member "violates" street protocols by attempting to reduce a shoulder dislocation in the field, but is unsuccessful.

1. The patient might file a malpractice action against both member and Group for the member causing additional pain and suffering while violating standard "street" first aid and EMS protocols.

2. The state might press criminal charges for the member practicing medicine without a license while violating standard "street" first aid and EMS protocols.

3. If the member holds a First Responder or EMT certification, the state EMS agency might threaten to revoke the member's certification for violating standard "street" first aid and EMS protocols.

iv. Expert advice on such best practices will carry the most weight in court if it comes from a committee of search and rescue physicians, as opposed to a group that is mostly non-physician. Thus, the ASRC has established a Medical Advisory Committee as well as a Medical Committee.

a. Membership: Members of the Medical Advisory Committee shall be appointed by the Board of Directors, using the following criteria, and shall serve at the pleasure of the Board of Directors without terms or term limits:

i. candidates for the Medical Advisory Committee must be licensed by at least one US state or territory as a physician or osteopathic physician;

ii. candidates for the Medical Advisory Committee must be Certified Members of the Appalachian Search and Rescue Conference;

iii. the Board of Directors shall show preference for candidates who have achieved Field Team Member or higher ASRC certification;

iv. the Board of Directors shall show preference to physicians or osteopathic physicians who serve as Medical Director of an ASRC Group.

b. Chair: The Board of Directors shall select a member of the Medical Advisory Committee to serve as chair, who shall serve at the pleasure of the Board of Directors, without terms or term limits. For any external relations requiring the signature or assent of a single ASRC "Medical Director," the Chair of the Medical Advisory Committee shall serve this function.

c. Meetings: Meetings of the Medical Advisory Committee shall be at the discretion of the Committee. Committee business may be conducted by email or other electronic means at the discretion of the Committee. Records of all votes, with relevant prior discussion, and all formal meetings, shall be filed with the conference Secretary and placed in the ASRC Archive.

d. Duties:

i. With the advice of the Medical Committee, develop and maintain a set of wilderness protocols, at both first aid and BLS levels, that apply to ASRC members' care on all operations, unless superseded by specific state wilderness EMS protocols for that state, or by member Group protocols established by a Group Medical Director. When possible, these protocols should be evidence-based, and if that is not possible, protocols should in line with accepted standards of care, such as those promulgated by the Wilderness Medical Society.

ii. In concert with the Medical Committee, work with state EMS offices, and in particular with state EMS Medical Directors, for the states in which the ASRC operates, to harmonize state wilderness EMS protocols across the states in which the ASRC operates.

iii. Work with Group Medical Directors and the ASRC Medical Committee[1] to harmonize advanced medical care provided by those Groups that provide such care.

iv. Work with Group Medical Directors and the ASRC Medical Committee to develop and harmonize credentialing across the ASRC for Groups that provide advanced care.

v. Work with the ASRC Medical Committee to develop, maintain and improve a system of medical and first aid reporting that is suitable for the field yet provides adequate information for quality improvement efforts.

[1] Note this is the ASRC *Medical* Committee, which is under the Operations Committee, not the ASRC *Medical Advisory Committee*, which reports directly to the Board of Directors.

vi. Review all first aid and medical care provided by the ASRC, with an eye to improvement in the quality of care.

vii. As appropriate, make formal written recommendations for improving first aid or medical care to the Medical Directors of ASRC Groups, or to the entire ASRC membership, via the Group Medical Directors.

viii. Complete other tasks assigned by the ASRC Board of Directors.

3. Medical Committee:

a. Membership:

i. Members of the ASRC Medical Advisory Committee shall be ex-officio voting members of the Medical Committee.

ii. For Groups who identify a Group Medical Officer or similar position, such Group officers shall be ex-officio voting members of the Medical Committee.

iii. The Chair/CMO may appoint additional interested ASRC members to the Medical Committee with the advice and consent of the current Medical Committee membership.

iv. The Chair/CMO may remove members from Medical Committee with the advice and consent of the current Medical Committee membership.

b. Chair/Conference Medical Officer:

i. The Chair of the ASRC Medical Committee shall also be known as the Conference Medical Officer (CMO).

ii. The Chair/CMO shall be appointed by the Conference Operations Officer with the advice and consent of the ASRC Board of Directors.

iii. The Chair/CMO shall be supervised by, and report to, the Conference Operations Officer.

iv. The Chair/CMO serves at the pleasure of the ASRC Board of Directors.

c. Vice-Chair/Assistant Conference Medical Officer:

i. The Vice-Chair of the ASRC Medical Committee shall also be known as the Assistant Conference Medical Officer (Assistant CMO).

ii. The Vice-Chair/Assistant CMO shall be appointed by the Conference Operations Officer with the advice and consent of the ASRC Board of Directors.

iii. The Vice-Chair/Assistant CMO serves at the pleasure of the ASRC Board of Directors.

iv. The Vice-Chair/Assistant CMO shall carry out duties as assigned by the Chair/CMO.

v. The Vice-Chair/Assistant CMO shall serve as understudy for the Chair/CMO; the Chair/CMO shall mentor the Vice-Chair/Assistant CMO with the expectation that, at some point, the Vice-Chair/Assistant CMO shall become Chair/CMO.

d. Meetings: Meetings of the Medical Committee shall be at the discretion of the Committee. Committee business may be conducted by email or other electronic means at the discretion of the Committee. Records of all votes, with relevant prior discussion, and all formal meetings, shall be filed with the conference Secretary and placed in the ASRC Archive.

e. Duties:

i. Assist the Medical Advisory Committee to develop and maintain a set of wilderness protocols, at both first aid and BLS levels, that apply to ASRC members' care on all operations, unless superseded by specific state wilderness EMS protocols for that state, or by member Group protocols established by a Group Medical Director.

ii. In concert with the Medical Advisory Committee, work with state EMS offices, and in particular with state EMS Medical Directors, for the states in which the ASRC operates, to harmonize state wilderness EMS protocols across the states in which the ASRC operates.

iii. Work with Group Medical Directors and the ASRC Medical Advisory Committee to harmonize advanced medical care provided by those Groups that provide such care.

iv. Work with Group Medical Directors and the ASRC Medical Advisory Committee to develop and harmonize credentialing across the ASRC for Groups that provide advanced care.

v. Develop, monitor and maintain a system for obtaining, compiling and securely archiving Group medical reports, analyzing them for patterns, and forwarding them to the Medical Advisory Committee for expert review.

vi. Develop, maintain and disseminate to the Groups a comprehensive reference to laws, regulations and other considerations relevant to the practice of wilderness first aid, wilderness EMS and wilderness medicine in the states in which ASRC Groups operation.

vii. Assist the Conference Operations Officer by making recommendations as to recommended team medical equipment, and lists of medical equipment required of ASRC Groups for certification.

viii. Monitor developments in wilderness first aid, EMS and wilderness medicine, provide relevant information on such developments to the Groups as appropriate, and make recommendations to the Medical Advisory Committee for new formal recommendations as appropriate.

ix. Perform other duties as assigned by the Conference Operations Officer.

Cut5: 5″

Cut6: 1″

Cut 1: 7.5″

1	
Page	of
Date/time	

Name, age, sex, date of birth, weight:

ALLEGHENY MOUNTAIN RESCUE

Field Diagnoses

Physical: Deformities, Open inj., Tenderness, Swelling

Hx: Chief Compl., Hx of Present Illness, Past Medical Hx (allergies, meds), Family/Social Hx; SAMPLE: Signs and Symptoms, Allergies, Meds, Last meal, Events eading to problem.

VS: pulse, respirations, BP, temp, O_2 sat.

C-spine Clearing:

- Alert, no intoxication ☐
- No distracting injury ☐
- No neck pain ☐
- No neck tenderness ☐
- No numbness, tingling, weakness ☐
- Normal motor and sensory exam ☐
- Painless range of motion of neck ☐

reason for clearing?
time cleared?
who cleared?

Patient Record Form 0.7 8/27/14

Cut2: 6.5″

2	
Page	of

Name:

ALLEGHENY MOUNTAIN RESCUE

Time:

Notes:

Treatment: protocol? standing orders? medical direction/physician name? physician present?

Scene: weather, terrain, resources, distance, evac priority, evac time.

Common re-exams: level of consciousness, distress/pain, skin, lungs, abd, input, output.

Medics: names, times, cert levels.

Patient Record Form 0.7 8/27/14

Cut3: 10″

Cut4: 6″

Page	of	Name:

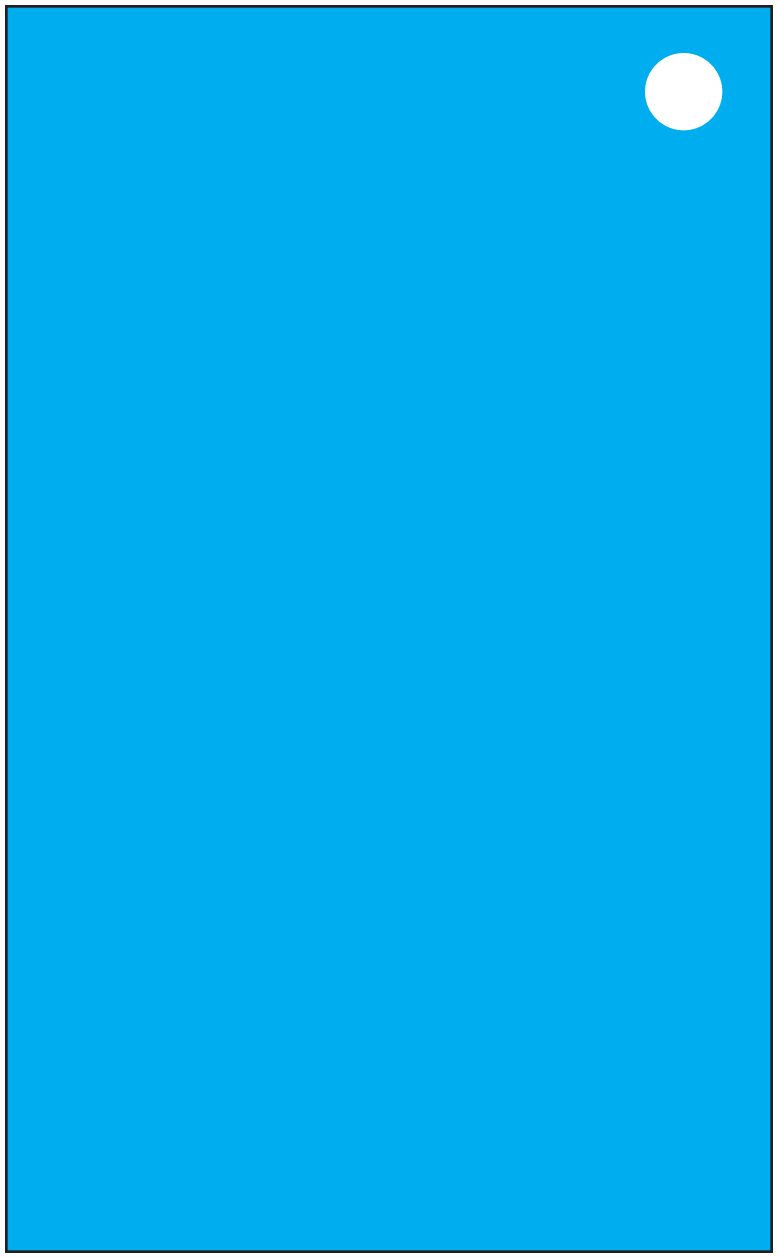
Time: | Notes:

Patient Record Form 0.7 8/27/14

Page	of	Name:

Time: | Notes:

Patient Record Form 0.7 8/27/14



Bottom, with hole for binder ring

Top, with cutout for binder ring and AMRG sticker. Top and bottom attached at lower edge with duct-tape hinge.