

2016 ASRC Retreat Medical Session Information

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Wilderness First Aid and Medical/EMS Topics

The ASRC's 2015 Retreat will feature a number of plenary sessions. The Medical and First Aid session is scheduled for one hour.

The Medical Committee and Medical Advisory Committee recommend that we discuss the following topics during this hour. We want to briefly present information on several topics but concentrate on the final one, wilderness first aid integration into FTM.

Protocols and White Papers

History

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>

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.

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

The ASRC used to have the following medical structure:

- For each state, a physician serving as Conference State Medical Director.
- 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.
- 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.
- For some states, we had no Medical Director.

In 2004, Don Scelza authored a proposal about conference-wide medical protocols, recommending:

- *The ASRC adopt the WEMSI protocols as a starting point for a set of Conference wide protocols.*
- *That the WEMSI protocols be updated and modified to better meet the needs of the ASRC.*
- *The State OMD's approve the new protocols for use in their specific states.*
- *That each group in the ASRC functions under the updated protocols when providing care in the wilderness environment.*

In June 2014, the ASRC BOD

- eliminated the positions of the Conference State Medical Directors.
- accepted a new Conference medical structure, slightly revised at the October 2014 BOD meeting. This is available online at:
<http://archive.asrc.net/ASRC-Admin/ASRC-BOD-Membership-Minutes/2014-10-05-ASRC-Medical-Resolution-KC.pdf>

Last year, we established a *Medical Advisory Committee* and a *Medical Committee*.

The Medical Advisory Committee is charged with providing both Protocols and a series of White Papers. A draft set of **Protocols** and a draft **White Paper on Critical Incident Stress Debriefing** are attached. Additional White Papers on Spinal Immobilization, Pelvic Binders, Primary Surveys, and Bleeding Control (including tranexamic acid) are being considered.

Specific wording from the motion passed at the June 2014 ASRC BOD meeting, and corrected slightly at the October 2014 ASRC BOD meeting says the Medical Advisory Committee¹ shall:

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...

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 [which we have decided to call White Papers consistent with the UAV White Paper terminology]

We see the Protocols and White Papers evolving together.

White Papers

White papers are to address controversial issues, or issues where there has been a recent change in how we deal with something. They will have a detailed literature review and lots of references.

White papers may also deal with issues beyond the Protocols. For example, the **CISD White Paper** (currently in draft and attached) will address the question of whether after-action group CISD sessions are appropriate or not. This is far outside the scope of Protocols. The spinal immobilization protocol will also fall outside of the Protocols in part. There will probably be a recommendation that each Group get rid of all their backboards and purchase vacuum mattresses, which is an operational issue and not a first aid or BLS issue. Here is what was said about White Papers at last year's retreat:

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 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.

¹ Originally we called it the Medical Direction Committee but then we changed it to Medical Advisory Committee.

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.

Topics would generally be chosen based on the following criteria:

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.

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.

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?

Protocols

Protocols are wide-ranging; most of them are non-controversial and represent standard practice. Not all of the standard practice has solid evidence behind it, but is still fairly well established. For example:

Smith, G. C. and J. P. Pell (2003). "Parachute use to prevent death and major trauma related to gravitational challenge: systematic review of randomised controlled trials." *Bmj* 327(7429): 1459-1461. OBJECTIVES: To determine whether parachutes are effective in preventing major trauma related to gravitational challenge. DESIGN: Systematic review of randomised controlled trials. DATA SOURCES: Medline, Web of Science, Embase, and the Cochrane Library databases; appropriate internet sites and citation lists. STUDY SELECTION: Studies showing the effects of using a parachute during free fall. MAIN OUTCOME MEASURE: Death or major trauma, defined as an injury severity score > 15. RESULTS: We were unable to identify any randomised controlled trials of parachute intervention. CONCLUSIONS: As with many interventions intended to prevent ill health, the effectiveness of parachutes has not been subjected to rigorous evaluation by using randomised controlled trials. Advocates of evidence based medicine have criticised the adoption of interventions evaluated by using only observational data. We think that everyone might benefit if the most radical protagonists of evidence based medicine organised and participated in a double blind, randomised, placebo controlled, crossover trial of the parachute.

Now that the Protocols may be real in the near future, we have been having a more detailed discussion about how the Protocols apply to Groups and individuals. The existing Medical Policy states: *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.*

Now might be the time to consider this in more detail.

Groups can have wilderness protocols outside the EMS system (AMRG is an example), or even Group EMS protocols in some states, so perhaps we should consider applying this Group by Group rather than state by state. If a state's Wilderness EMS protocols apply to a Group, such as with MSAR, that's well and good, but the Maryland WEMS protocols don't apply to a member from Virginia (or any other state) who is in Maryland for a search. While we can argue that someone from Virginia isn't authorized to provide EMS care in Maryland, if push comes to shove and they have to provide care to prevent charges of gross or wilful negligence, it would probably be better if they followed protocols from their home Group, as they'd be more familiar with them.

The existing statement about Protocols also makes them mandatory, which is not really consistent with the ASRC's current approach of supporting Groups rather than regulating them. If you read the attached draft Protocols, the statement in there makes them optional... Groups can adopt them or not as they choose. (They can also steal them, modify them, and make them Group protocols if they have a Medical Director who's willing to go along.)

We could also make them Guidelines instead of Protocols. This might be more in concert with the approach of the ASRC providing best practices for the Groups. On the other hand, that would mean that they could not be considered a physician's orders. Some members might feel better following physician's orders rather than following guidelines, especially if doing something like reducing a shoulder dislocation in the field where that is not permitted by state EMS protocols.

Field Medical Record

A practical field medical record is something we've been looking for. AMRG and then the ASRC Medical Committee have worked for over two years to develop this. A detailed **ASRC Patient Record Form and Notebook Proposal** is attached. We think it is ready for prime time. We do expect to update it once we get some real field experience with it.

Motion:

Resolved, that the ASRC

- 1. accepts this attached proposal as a Medical Committee White Paper;***
- 2. accepts the described ASRC Patient Record Form as the official ASRC Patient Record Form;***
- 3. encourages Groups, but does not require them, to adopt the official ASRC Patient Record Form for their own use; and***
- 4. requests that Groups forward a copy of all completed Patient Record Form to the ASRC Archivist via encrypted PDF for filing in a secure location.***

Wilderness First Aid Integration into FTM

The Medical and Medical Advisory Committees feel this is the most important issue that we are dealing with right now. We have a consensus proposal which enjoys strong and wide support among Committee members and wish the proposal to get wider discussion. **The detailed proposal** is attached. The key points are:

Get rid of the external first aid certification requirement for FTM; the required course is no longer available, and decreasing barriers to FTM is a good idea. The Wilderness Medical Society Wilderness First Aid Curriculum is authoritative. Based on this, only a few items would need to be added to FTM standards to meet the WMS WFA standard. The WMS WFA curriculum appears in the attached document.

Existing FTM standards already include much of what is covered in wilderness first aid.

These additional WFA items are basic and simple and can be covered in Group training as with the current FTM material.

Those studying for FTM could study a WFA book, do online WFA education, or take an optional WFA class if they wish, but this should not be a requirement for FTM.

By adding these few items to FTM, we can state on FTM certificates that the FTM meets the WMS WFA requirements, so that an ASRC FTM certificate also serves as a WFA certificate. This would be a competency-based and not hours-based certificate, and would be backed by the new ASRC credentialing system.

The ASRC should not be in the business of offering WFA certification except as part of FTM credentialing. The only way to get ASRC WFA certification would be to become an FTM. Renewal of FTM or FTL credentialing would also be renewal of ASRC WFA credentialing.

Attachments

<http://www.conovers.org/ftp/ASRC-First-Aid+BLS-Protocols-0.1.pdf>

<http://www.conovers.org/ftp/ASRC-MAC-Stress-Mgt-0.3.pdf>

<http://www.conovers.org/ftp/ASRC-Patient-Record-Proposal-02.pdf>

<http://www.conovers.org/ftp/ASRC-WFA-Integration-Proposal-0.5.pdf>