(AMRG Letterhead)

Reply to:
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David A. Carter, ASRC Chairman
803 Townsend Court
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Dear David:

SUBJECT: **Can't get you by phone**

Sorry to keep this correspondence up, but your and my schedules seem totally incompatible, and I haven't been able to reach you by phone.

a. From the way Mike Kuga related it to me, he didn't actively offer an ASRC response but merely asked if the county wanted a mountain rescue team at the scene. I, too, think he should have called and alerted an ASRC AO right away; I agree. I've always been insistent that AMRG members "play it by the book" when AMRG receives a call directly. Members' compliance with this has been poor to fair, and I keep yelling at people at meetings. The credibility of AMRG within the ASRC depends on its following the rules and not acting like a loose cannon, as some see AMRG.

However, the ASRC needs a rapid response policy for situations like this, so that members can get on the road without even waiting the fifteen minutes or so to contact an AO. I've asked Mike Kuga to draft such a policy for presentation to the ASRC as a whole, to eventually become a component of the Ops Manual. Such a plan should have a limitation on who (what level of training) can be started en route (or on the helicopter for helicopter rescue responses) immediately, and under what specific conditions such a response can occur. As Camille suggested, one solution is to run an AO class here in Pittsburgh, and Camille

has volunteered to do so. I've been bugging Mike Yee to set this up, and by copy of this letter will encourage him once more to set up an AO class here.

b. I'll ask Don Scelza to include information on reaching an AO via the pager system to the top of the next AMRG Callout Roster.

c. This particular operation was complicated by the fact that it was almost literally in some AMRG members' back yards, and their response time to the scene was in minutes. I'm not sure how many decades it will be until we have another rescue response so close.

d. Mike used to be an IS and to be truthful I though he still was. He tells me he was downgraded to FTL by the ASRC Board of Directors, but I'm not sure of the details.

e. Sorry; didn't want this to be seen as a cheap shot. When at the scene, and unable to reach an AO to play by the rules, our only options were (1) to tell them we couldn't go into the field because we couldn't reach an AO, or (2) to offer our on-scene personnel for a field response even though we couldn't reach an AO. Option (1) would have made us a laughingstock; I hope with this clarification, that on reflection you'd agree.

f. Records: we spent the whole time on-scene trying to find the sign-in, as Beaver County was running operations and we were only a resource. When we found there **was** no signin, we and Rescue 40 suggested they start one. Rescue 40 started PSARC base operations after we left, so there are no signin sheets; I documented in my narrative who responded.

Item Two: AMRG has indeed been involved in a number of rescues during training sessions, and has been on standby several times for rescues. I've sent NASAR mission report forms to those involved and asked them to submit reports to the ASRC records. I wasn't involved except for dispatching on one of the rescue standbys, and participating in one rescue call, records for both of which (including slides from the rescue) have been submitted to the ASRC files. I can't provide records for the other incidents, though I've requested that Mike Kuga, Warren Shaulis, and others involved with these submit reports.

Item Three (ASRC Medical Policy for PA Draft): I've got two conflicting pressures on this. First, I should have established written policies a long time ago, which is why I chose the December 1 date. We shouldn't be without a written medical policy. On the other hand, once I wrote out the draft, it was oxbvious that the policy interfaced with many other areas and brought up issues that need to be discussed. I had originally intended to go ahead and get something into place (better a flawed policy than none at all, I thought). It is best that we delay implementation until January 1, and discuss the issues at the December Board of Directors meeting. By the way, I still

can't find out when the December meeting is going to be. Maybe you and I can discuss this next week; I hear there is a remote chance our schedules will allow us to talk by phone then.

I realize that the draft policy places a burden on the entire ASRC, as far as training. I hadn't expected that when I started writing, but it is a logical consequence of having a different medical policy and different medical director for each state. And, directing how personnel are trained to provide medical care is the practice of medicine, and part of the duty of a medical director. If we didn't cross state lines so much, this would be a lot easier. Unfortunately, medical practice is a state and not Federal issue.

I'm surprised that some feel that the WEMT training program is not needed; after all, it was the ASRC's early experience with inadequacy of existing EMT training that led us to set up Wilderness EMS Institute in the first place. Certainly the training has been used for multiple patients in Pennsylvania, Virginia, and West Virginia, by ASRC and NCRC Wilderness EMTs, who all found it invaluable. Speaking as a physician with expertise in the area, and having reviewed the relevant statistics, I think there's good justification for having ASRC Wilderness EMTs. We don't need zillions of them; we just need enough in each Group to ensure that when we have patients a Wilderness EMT can be there relatively soon to supervise on-scene medical care.

Limitations? Not sure what you mean. If you mean following WEMSI protocols in Pennsylvania, that's what medical direction is all about: controlling how medical care is provided in the field. This is a physician function, carried out by the agency's medical director. If someone deviates from the "proper" way to care for patients, as established by the agency medical director, then there is medicolegal liability, and the agency's CQI (continuous quality improvement) process should investigate and take corrective action.

"Threat"? Not sure what you're referring to. If you mean my comment that the Board of Directors can replace a state medical director, I'm not suggesting that you replace me, threatening to resign, or anything like that. Perhaps I was misunderstood.

The practice of medicine is a state monopoly, with licenses granted only to those meeting state standards and paying a fee to the state. Medical care in the field is the practice of medicine. By state law EMTs and others can practice medicine within certain bounds, but only under the control of a physician with a state license. The ASRC, or any EMS agency, can't practice medicine, as it's not a physician. Giving medical orders, such as in standing orders or protocols, is practicing medicine. So the ASRC and other EMS agencies can hire or appoint

a physician to provide standing orders or protocols, but can't override or revise those standing orders or protocols, or tell the physician how providers have to be ordered or trained to perform specific medical procedures, because that would be practicing medicine. The ASRC or another EMS agency can, in one way or another, get rid of an unsuitable medical director. That's about the only way to change the protocols or standing orders, unless you can persuade the physician medical director that it's proper to change them (not all that hard, most of the time, if it's a reasonable change). In the case of "street" EMS agencies, medical director are often tied to specific medical control facilities, and thus there are limits to who you can choose as a medical director. However, EMS agencies sometimes change their medical control facilities and also medical directors because they're dissatisfied; some Pittsburgh area EMS agencies are doing just that right now.

My comments were designed to explain the above limitations on what we as the ASRC can do regarding medical directors. We can't overrule their medical decisions, whether on-line or off-line, we can only replace the medical director if dissatisfied. At least for the ASRC, getting a new medical director is easier than it is for EMS agencies that are tied to a particular command facility. I just wanted everyone to understand this limitation, not just as it applies to me, or to the Virginia medical director, but as a general medico-legal reality. I thought that even writing something to this effect into our Operations Manual would be useful to prevent misunderstandings in the future.

Item Four: As far as I know, Equi-SAR is still interested in joining the ASRC. Mike Yee has been working with them. They have all the information on ASRC Group membership they need, and as I understand it are working with AMRG on training enough individuals to meet the ASRC standards to join. I don't know of any action that you or the ASRC Board are supposed to take until they apply for membership.

I think the problem with Irv Lichtenstein's ant-ASRC comments is being adequately handled by members of his own group, based on their phone calls to me and their comments at the last meeting. I personally don't think the Board of Directors needs to consider any action unless something new crops up.

Hope this clears up a few things. Too much stuff in one letter, but with us being two physicians short right now, "I've written a long letter because I lack the time to write a shorter one." Hope to talk with you on the phone next week, and see you at the next Board of Directors meeting, whenever that is. Press on.

Yours truly,

Keith Conover, M.D.
AMRG ASRC Delegate
ASRC Medical Director for Pennsylvania
cc: Candi Partlow, SecretaryGary Mechtel, OperationsCamille Birmingham, Dispatch CoordinatorMike Kuga, AMRG Operations OfficerRich Worst, AMRG ChairMike Yee, AMRG Training OfficerDon Scelza, AMRG Alert Systems OfficerJack Grandey, WEMSI Director of OperationsPeter McCabe, PSARC President

P.S. Pardon me if I seem to be writing you as much as Irv Lichenstein seems to write me. Just trying to do my best to improve SAR, the ASRC, and wilderness medical care.