EMS Physician-Performed Clinical Interventions in the Field
Position Statement

Approved by the NAEMSP® Board of Directors: October 10, 2017

POSITION STATEMENT:
The practice environment of EMS medicine differs greatly from other medical specialties. One aspect of this environment is that, though rare, there exists a set of high-risk, low frequency clinical interventions that may benefit a patient but that are outside the scope of practice of local EMS personnel. Part of the practice of EMS medicine by EMS physicians can and should include the performance of clinical interventions in the field. The scope of such interventions must be determined at a local level, though examples could include central vascular access, invasive airway management, thoracostomy tube placement, thoracotomy, field amputation of an entrapped limb, perimortem C-section, and others. While these interventions vary in complexity and may not be distinctly unique to the practice of EMS medicine, it must be recognized that the environment in which such interventions are performed is distinct to the practice of EMS medicine. Furthermore, performance of such interventions should be conducted within operational practices designed to improve patient care and mitigate risk for prehospital providers including but not limited to: triage, regionalization of care, and the provision of care as part of an integrated prehospital system.

Despite the unique clinical environment, the core elements that are critical to the safe performance of any clinical intervention by any specialist in any environment must be adhered to when EMS physicians perform clinical interventions in the field.

NAEMSP® believes:

- The need and scope of EMS physician-level clinical interventions may be determined at the local level, depending on the scope of practice of the local EMS responders, the existing standard and special responding EMS assets (USAR, WSAR, HAZMAT, etc.), and the potential clinical needs of the operational jurisdiction.
- The practice environment of EMS medicine requires EMS-specific cognitive, psychomotor, and operational aptitudes that physicians should have achieved before they perform patient care in
the field. Such aptitudes are also desirable for, but are not required of, physicians who were not dispatched to an incident but voluntarily render aid while awaiting formal EMS response assets.

- Physicians functioning as a responding/deployable asset and performing clinical interventions in the EMS environment must have appropriate training and education in those clinical intervention(s) prior to attempting to perform such intervention(s) in the field. Responding physicians should also have appropriate training and education to perform cognitive tasks unique to the prehospital environment including assessment of patients for capacity of informed refusal. Such training and education should be based on locally defined standards or on regional or national benchmarks from EMS specialty organizations.

- EMS agencies that include physician responders as part of their deployable assets should consider developing policies that address the methods and frequency of cognitive and psychomotor skills education necessary to maintain and/or periodically assess the competency of physician responders in their ability to perform specific EMS-based clinical interventions. Such assessment may be based upon standards that are locally determined or are defined by national professional organizations.

- Clinical interventions performed by physicians in the field should be subject to at least the same rigor of quality assurance review as exists for performance of EMS clinical interventions by non-physician clinicians within the EMS physician’s agency or system.

- Ideally, a system of oversight should be established for clinical intervention(s) a physician intends to perform in the field. Such oversight should be protected by peer review standards and statutes and should be performed by (other) EMS physicians, emergency physicians, or surgical specialists at facilities that the EMS physician has a pre-established relationship with. Oversight processes and peer-review/oversight panel members are likely to differ based on the individual intervention performed and, at times paucity of local resource experts may obligate the inclusion of experts from outside the local practice area. The oversight/peer review panel should include at least one member who is board certified in EMS Medicine or has EMS-based operational and clinical experience at the physician level.

- Ideally, physician field response should occur as part of a pre-established, deployable asset that is an integrated part of the local/regional EMS system.
• An ad hoc physician response to the field may sometimes be necessary, though the principles outlined in this position paper should be considered when such a response is requested.

• Regardless of the type of EMS service, the operational and logistic needs of physician clinical practice must be addressed. This should be determined locally, but at a minimum should consider appropriate training, transportation, communications, medical and/or surgical equipment, consumable supplies, medications, fitness to respond/medical screening, personal protective equipment, documentation/billing practices, and professional liability protection.

• Physicians who act as a deployable asset for a given EMS system but who function independently of any specific EMS agency should seek intellectual support from other EMS physicians who perform field response, and consider seeking institutional support for their field response from a local or regional clinical entity.

• A physician intending to respond to the field to perform direct patient care, including specific clinical interventions, should be protected by adequate malpractice and liability protection, as well as death and disability coverage. Hazardous duty benefits may also be appropriate in some circumstances. Such protections should ideally be provided by the supporting or employing agency, institution, or government body, not the physician him/herself.

• Physicians who are considering performing clinical interventions in the field should proactively build relationships with the facility(ies) that will primarily receive the patients who underwent the field intervention. The purpose of these relationships should be to establish awareness and understanding at the receiving facility of the capabilities of the physician field response asset(s), and to coordinate patient care.

• Final authority over the scope of practice of a physician EMS responder lies with the EMS-based entity under which the physician is partnering with or otherwise employed by to provide physician-level response assets to the field.

A note on non-EMS clinicians performing field response:

NAEMSP® believes that the points made above can address the needs and expectations of any physician, physician assistant, nurse practitioner, or advanced practice registered nurse who might provide patient care in an EMS setting. While this position is written with the focus on EMS physicians, NAEMSP® believes that the same concepts should apply to physicians and non-physician providers of other specialties
who may find themselves participating in clinical care in the field, either as a structured clinician response asset, or as part of an ad hoc response team. While it is likely that these non-EMS physician specialists are clinically competent in the in-hospital environment, such a hospital-based clinician may require more intensive accommodations to function in the unique environments outside the hospital. Deployment of such hospital-based non-EMS clinicians to the prehospital environment can carry significant risk to the clinician, the patient, and other EMS personnel, and should be undertaken with extreme caution, and only with proper personal protective equipment and situational awareness of the prehospital scene. Furthermore, any clinicians who were not dispatched to an incident but voluntarily render aid while awaiting formal EMS response should adhere to the principles outlined in the NAEMSP® and American College of Emergency Physicians (ACEP) joint position statement: Unsolicited Medical Personnel Volunteering at Disaster Scenes. *Prehospital Emergency Care* 2003;7(1):147-148.