Designation: F 1149 – 93 (Reapproved 1998)

Standard Practice for Qualifications, Responsibilities, and Authority of Individuals and Institutions Providing Medical Direction of Emergency Medical Services[1]

This standard is issued under the fixed designation F 1149; the number immediately following the designation indicates the year of original adoption or, in the case of revision, the year of last revision. A number in parentheses indicates the year of last reapproval. A superscript epsilon (ε) indicates an editorial change since the last revision or reapproval.

1. Scope

1.1 This practice covers the qualifications, responsibilities, and authority of individuals and institutions providing medical direction of emergency medical services.

1.2 This practice addresses the qualifications, authority, and responsibility of a Medical Director (off-line) and the relationship of the EMS (Emergency Medical Services) provider to this individual.

1.3 This practice also addresses components of on-line medical direction (direct medical control) including the qualifications and responsibilities of on-line medical physicians and the relationship of the prehospital provider to on-line medical direction.

1.4 This practice addresses the relationship of the on-line medical physician to the off-line Medical Director.

1.5 The authority for control of medical services at the scene of a medical emergency is addressed in this practice.

1.6 The requirements for a Communication Resource are also addressed within this practice.

2. Referenced Documents

2.1 *ASTM Standards:*

F 1031 Practice for Training the Emergency Medical Technician (Basic)[2]

F 1086 Guide for Structures and Responsibilities of Emergency Medical Services Systems Organizations[2]

3. Terminology

3.1 *Description of Terms Specific to This Practice*

3.2 *communication resource*—an entity responsible for implementation of direct medical control. (Also known as medical control resource.)

3.3 *delegated practice*—only physicians are licensed to practice medicine; prehospital providers must act only under the medical direction of a physician.

3.4 *direct medical control*—when a physician or authorized communication resource personnel, under the direction of a physician, provides immediate medical direction to prehospital providers in remote locations. (Also known as on-line medical direction.)

3.5 *emergency medical services system (EMSS)*—all components needed to provide comprehensive prehospital and hospital emergency care including, but not limited to; Medical Director, transport vehicles, trained personnel, access and dispatch, communications, and receiving medical facilities.

3.6 *intervener physicians*—a licensed M.D. or D.O., having not previously established a doctor/patient relationship with the emergency patient and willing to accept responsibility for a medical emergency scene, and can provide proof of a current Medical License.

3.7 *medical direction*—when a physician is identified to develop, implement, and evaluate all medical aspects of an EMS system. (*syn.* medical accountability.)

3.8 *medical director off-line*—a physician responsible for all aspects of an EMS system dealing with provision of medical care. (Also known as System Medical Director.)

3.9 *on-line medical physician*—a physician immediately available, when medically appropriate, for communication of medical direction to non-physician prehospital providers in remote locations.

3.10 *prehospital provider*—all personnel providing emergency medical care in a location remote from facilities capable of providing definitive medical care.

3.11 *protocols*—standards for EMS practice in a variety of situations within the EMS system.

3.12 *standing orders*—strictly defined written orders for actions, techniques, or drug administration when communication has not been established with an on-line physician.

---

[1] This practice is under the jurisdiction of ASTM Committee F30 on Emergency Medical Services and is the direct responsibility of Subcommittee F30.03 on Organization/Management.

Current edition approved August 15, 1993. Published October 1993. Originally published as F 1149 – 88. Last previous edition F 1149 – 88.

[2] *Annual Book of ASTM Standards*, Vol 13.02.

4. Significance and Use

4.1 Implementation of this practice will ensure that the EMS system has the authority, commensurate with the responsibility, to ensure adequate medical direction of all prehospital providers, as well as personnel and facilities that meet minimum criteria to implement medical direction of prehospital services.

4.1.1 The state will develop, recommend, and encourage use of a plan that would assure the standards outlined in this document can be implemented as appropriate at the local, regional, or state level (see Guide F 1086).

4.1.2 This practice is intended to describe and define responsibility for medical directions during transfers. It is not intended to determine the medical or legal, or both, appropriateness of transfers under the Consolidated Omnibus Budget Reconciliation Act and other similar federal and/or state laws.

5. Medical Director

5.1 *Position*—System Medical Director (Off-line Medical Director).

5.1.1 Each EMS system shall have an identifiable Medical Director who, after consultation with others involved and interested in the system, is responsible for the development, implementation, and evaluation of standards for provision of medical care within the system.

5.1.1.1 All prehospital providers (including EMT (Emergency Medical Technician) basics) shall be medically accountable for their actions and are responsible to the Medical Director of the EMS agency (local, regional, or state) that approves their continued participation.

5.1.1.2 All prehospital providers, with levels of certification above EMT basic, shall be responsible to an identifiable physician who directs their medical care activity.

5.1.2 The Medical Director shall be appointed by, and accountable to, the appropriate EMS agency in accordance with Guide F 1086.

5.2 *Requirements of a Medical Director*:

5.2.1 The medical aspects (see 5.3) of an emergency medical service system shall be managed by physicians who meet the following requirements:

5.2.1.1 Licensed physician, M.D. or D.O.

5.2.1.2 Experience in, and current knowledge of, emergency care of patients who are acutely ill or traumatized.

5.2.1.3 Knowledge of, and access to, local mass casualty plans.

5.2.1.4 Familiarity with Communication Resource operations where applicable, including communication with, and direction of, prehospital emergency units.

5.2.1.5 Active involvement in the training of prehospital personnel.

5.2.1.6 Active involvement in the medical audit, review, and critique of medical care provided by prehospital personnel.

5.2.1.7 Knowledge of the administrative and legislative process affecting the local, regional, and/or state prehospital EMS system.

5.2.1.8 Knowledge of laws and regulations affecting local, regional, and state EMS.

5.3 *Authority of a Medical Director Includes but is not Limited to*:

5.3.1 Establishing system-wide medical protocols (including standing orders) in consultation with appropriate specialists.

5.3.2 Recommending certification or decertification of non-physician prehospital personnel to the appropriate certifying agencies.

5.3.2.1 Every system shall have an appropriate review and appeals mechanism, when decertification is recommended, to assure due process in accordance with law and established local policies. The Director shall promptly refer the case to the appeals mechanism for review, if requested.

5.3.3 Requiring education to the level of approved proficiency for personnel within the EMS system. This includes all prehospital personnel, EMTs at all levels, prehospital emergency care nurses, dispatchers, educational coordinators, and physician providers of on-line direction (see Practice F 1031).

5.3.4 Suspending a provider from medical care duties for due cause pending review and evaluation.

5.3.4.1 Because the prehospital provider operates under the license (delegated practice) or direction of the Medical Director, the director shall have ultimate authority to allow the prehospital provider to provide medical care within the prehospital phase of the EMS system.

5.3.4.2 Whenever a Medical Director makes a decision to suspend a provider from medical care duties, the process shall be prescribed by previously established criteria.

5.3.5 Establishing medical standards for dispatch procedures to assure that the appropriate EMS response unit(s) are dispatched to the medical emergency scene when requested, and the duty to evaluate the patient is fulfilled.

5.3.6 Establishing under what circumstances non-transport might occur.

5.3.6.1 All decisions by prehospital providers regarding non-transport shall be based on defined protocol or on-line communications.

5.3.6.2 Develop a procedure for record keeping when the reason for non-transport was the result of a patient's refusal, including the appropriate forms and review process.

5.3.7 Establishing under which circumstances a patient may be transported against his or her will; in accordance with state law including, procedure, appropriate forms, and review process.

5.3.8 Establishing criteria for level of care and type of transportation to be used in prehospital emergency care (that is, advanced life support versus basic life support, ground, air, or specialty unit transportation).

5.3.9 Establishing criteria for selection of patient destination.

5.3.10 Establishing educational and performance standards for Communication Resource personnel.

5.3.11 Establishing operational standards for Communication Resource.

5.3.12 Conducting effective system audit and quality assurance.

5.3.12.1 The Medical Director shall have access to all relevant EMS records needed to accomplish this task. These documents shall be considered quality assurance documents and shall be privileged and confidential information.

5.3.13 Insuring the availability of educational programs within the system and that they are consistent with accepted local medical practice.

5.3.14 May delegate portions of his or her duties to other qualified individuals.

6. Direct Medical Control (On-Line Medical Direction)

6.1 *The Practice of Direct Medical Control*:

6.1.1 On-line medical direction capabilities shall exist and be available within the EMS system, unless impossible due to distance or geographic considerations.

6.1.1.1 All prehospital providers, above the certification of EMT basic, shall be assigned to a specific on-line communication resource by a predetermined policy.

6.1.2 Specific local protocols shall exist which define those circumstances under which on-line medical direction is required.

6.1.3 On-line medical direction is the practice of medicine and all orders to the prehospital provider shall originate from or be under the direct supervision and responsibility of a physician.

6.1.4 The receiving hospital shall be notified prior to the arrival of each patient transported by the EMS system unless directed otherwise by local protocol.

6.2 *The On-Line Medical Physician*:

6.2.1 This physician shall be approved to serve in this capacity by the system Medical Director (off-line).

6.2.1.1 This physician shall have received education to the level of proficiency approved by the off-line Medical Director for proper provision of on-line medical direction, including communications equipment, operation, and techniques.

6.2.1.2 This physician shall be appropriately trained in prehospital protocols, familiar with the capabilities of the prehospital providers, as well as local EMS operational policies and regional critical care referral protocols.

6.2.2 This physician shall have demonstrated knowledge and expertise in the prehospital care of critically ill and injured patients.

6.2.3 This physician assumes responsibility for appropriate actions of the prehospital provided to the extent that the on-line physician is involved in patient care direction.

6.2.4 The on-line physician is responsible to the system Medical Director (off-line) regarding proper implementation of medical and system protocols.

7. Authority for Control of Medical Services at the Scene of Medical Emergency

7.1 *General*:

7.1.1 Control of a medical emergency scene shall be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing prehospital emergency stabilization and transport.

7.1.2 When an advanced life support (ALS) squad, under medical direction, is requested and dispatched to the scene of an emergency, a doctor/patient relationship has been established between the patient and the physician providing medical direction.

7.1.3 The prehospital provider is responsible for the management of the patient and acts as the agent of medical direction.

7.2 *Patient's Private Physician Present*:

7.2.1 When the patient's private physician is present and assumes responsibility for the patient's care, the prehospital provider should defer to the orders of the private physician if they do not conflict with established system protocols and the private physician documents the orders in a manner acceptable to the EMS system.

7.2.2 The Communication Resource shall be contacted for recordkeeping purposes to notify the on-line medical physician.

7.2.3 When the medical orders of the private physician differ from system protocol, Communication Resource shall be contacted and the private physician placed in communication with the on-line physician. If the private physician and the on-line physician are unable to agree on treatment, the private physician must either continue to provide direct patient care and accompany the patient to the hospital, or defer all remaining care to the on-line physician.

7.2.4 The prehospital provider's responsibility reverts to the systems Medical Director or on-line medical direction any time the private physician is no longer in attendance.

7.3 *Intervener Physician Present and Non-Existent On-Line Medical Direction*:

7.3.1 When an intervener physician has been satisfactorily identified as a licensed physician and has expressed his or her willingness to assume responsibility and document his or her intervention in a manner acceptable to the local emergency medical services system (EMSS), the prehospital provider should defer to the orders of the physician on the scene if they do not conflict with system protocols.

7.3.2 If treatment by the intervener physician at the emergency scene differs from that outlined in a local protocol, the physician shall agree in advance to assume responsibility for care, including accompanying the patient to the hospital.

7.3.3 In the event of a mass casualty incident or disaster, patient care needs may require the intervener physician to remain at the scene.

7.4 *Intervener Physician Present and Existent On-Line Medical Direction*:

7.4.1 If an intervener physician is present and on-line medical direction does exist, the on-line physician should be contacted and the on-line physician is ultimately responsible.

7.4.2 The on-line physician has the option of managing the case entirely, working with the intervener physician, or allowing him or her to assume responsibility.

7.4.2.1 If there is any disagreement between the intervener physician and the on-line physician, the prehospital provider should take orders from the on-line physician and place the intervener physician in contact with the on-line physician.

7.4.3 In the event the intervener physician assumes responsibility, all orders to the prehospital provider shall be repeated to the Communication Resource for purposes of recordkeeping.

7.4.4 The intervener physician should document his or her intervention in a manner acceptable to the local EMS.

7.4.5 The decision of the intervener physician to accompany the patient to the hospital should be made in consultation with the on-line physician.

7.5 Nothing in this section implies that the prehospital provider can be required to deviate from system protocols.

7.6 Air Medical Emergency Medical Service (EMS) Assistance at the Scene of a Medical Emergency (non-mass casualty):

7.6.1 Dispatch of air medical EMS assistance should be according to a pre-established state/regional/local EMS plan. Dispatch according to this pre-established EMS plan should take into account, for example, the patient's condition, response time, proximity of the receiving facility, geographical ease of access by ground, flight safety, and mechanism of injury.

7.6.1.1 The decision to request air medical EMS assistance at the scene of a medical emergency shall be the responsibility of a qualified individual, identified to assume such authority by the pre-established state/regional/local EMS plan.

7.6.2 When the air medical EMS assistance has arrived on the scene, the following shall apply:

7.6.2.1 There will be an orderly transfer of responsibility from the local EMS unit to the air medical EMS unit and its medical control authority, according to local protocols. These protocols should include a method of determining when air transport is appropriate.

7.6.2.2 Medical direction (on-line/off-line) of the local EMS unit retains responsibility until formally relinquished to the medical direction (on-line/off-line) of the receiving air medical EMS unit.

7.6.2.3 If there is a physician on-board the air medical EMS unit, this physician shall be considered an intervenor physician, unless on-line medical direction transfers responsibility to the physician. (See 7.3 and 7.4.)

7.6.2.4 After responsibility has been transferred to the air medical EMS unit, the local EMS unit should cooperate with the air medical EMS unit, and/or assist the air medical EMS unit crew as long as they are not required to exceed the levels of intervention permitted by their certification.

7.6.3 Air medical EMS should offer assistance only when invited or requested, or both, unless no ground unit is available.

7.6.4 The transport destination for the patient should be based upon a pre-established EMS plan that considers time and distance as well as the patient's medical condition and the capability of the receiving facility.

7.6.4.1 If no pre-established EMS plan for patient transport exists, the transport should follow the usual transport pattern of the requesting local EMS unit, unless otherwise indicated by medical considerations.

8. Requirements for Communication Resource (Medical Control Resource)

8.1 Communication Resource shall be designated to participate in the EMS system according to a plan developed by a state or regional authority.

8.2 The Communication Resource shall meet the following requirements:

8.2.1 The Communication Resource shall assure adequate staffing for the communication equipment at all times by health care personnel who have achieved a minimal level of competence and skill and are approved by the system Medical Director.

8.2.2 The Communication Resource shall assure that all requests for medical guidance, assistance, or advice by prehospital personnel will be promptly accommodated with an attitude of utmost participation, responsibility, and cooperation.

8.2.3 The Communication Resource shall provide assurance that they will cooperate with the EMS system in collecting and analyzing data necessary to evaluate the prehospital care program as long as patient confidentiality is not violated.

8.2.4 The Communication Resource will consider the prehospital provider to be the agent of the on-line physician when they are in communication, regardless of any other employee/employer relationship.

8.2.5 The Communication Resource shall assure that the on-line physician will issue transportation instructions and hospital assignments based on system protocols and objective analysis of patient's needs and facility capability and proximity.

8.2.5.1 No effort will be made to obtain institutional or commercial advantages through the use of such transportation instructions and hospital assignments.

8.2.6 When the Communication Resource is acting as an agent for another hospital, the information regarding patient treatment and expected time of arrival will be relayed to the receiving hospital in an accurate and timely fashion.

8.2.7 Communication Resource shall conduct regular case conferences involving the on-line physicians and prehospital personnel for purposes of problem identification and provide continuing education to correct any identified problems.

8.3 If the Communication Resource is located within a hospital facility, the hospital shall meet the requirements listed in 8.1 and 8.2 and the equipment used for on-line medical direction shall be located within the Emergency Department.

9. Medical Direction During Interfacility Transfers (Non-Mass Casualty):

9.1 *General Principles*:

9.1.1 When an emergency patient arrives for initial evaluation at a medical facility, that patient becomes the responsibility of that facility and its medical staff. This responsibility continues until the patient is appropriately discharged, or until the patient is transferred and the responsibility is assumed by the personnel of a facility with equal or greater capability.

9.1.2 All transferring personnel should have standing orders or protocols available for use as appropriate, in the event of inability to communicate with on-line medical direction.

9.1.3 Patient medical records for any interfacility transfer shall be the responsibility of the transferring facility.

9.1.4 A patient not receiving treatment, and expected to remain stable during interfacility transport may, with physician approval, be transferred by an appropriate medical transportation provider with personnel certified at the level of Emergency Medical Technician-Basic, or greater.

9.1.5 When the patient has a probability of experiencing complications which cannot be managed within the scope of

practice of non-physician personnel, the transfer shall be managed by an appropriately trained physician, either on-line or off-line.

9.2 *Interfacility Transfers Conducted by the Transferring Facility*:

9.2.1 When a patient is transferred to another facility, is receiving treatment, medically unstable, or potentially medically unstable, it is the responsibility of the transferring facility to assure that the medical transport agency has qualified personnel and transportation equipment to complete the transfer.

9.2.2 The transferring personnel shall act as the agents of the transferring facility and the physician approving the transfer, regardless of any other employer/employee relationship. Communication between the transferring physician, the prehospital on-line medical direction, and the transferring personnel is required, with agreement between physicians regarding medical care. (See 7.2.1 and 7.2.3.)

9.2.3 When a patient experiences complications beyond situations addressed in physician written orders, or beyond off-line protocols, the medical transport provider should, if possible, contact the transferring facility or the receiving facility for additional orders. Or, if deemed necessary, the EMS on-line medical direction should be contacted for consultation.

9.3 Interfacility transfers conducted by a receiving facility when the transferring personnel are agents of the receiving facility:

9.3.1 When the transferring personnel includes a physician, the patient becomes the responsibility of the receiving facility as soon as the patient leaves the transferring facility.

9.3.2 When the transferring team does not include a physician, the physician from the receiving facility who authorizes the transfer is responsible for the patient. The receiving facility must assure that the medical transport team has qualified personnel and transportation equipment to complete the transport.

10. Keywords

10.1 aeromedical; interfacility; medical control; medical direction; on-line/off-line