INTRODUCTION

EMS medical oversight provides unique opportunities for physicians to impact the health of a community. This privilege can produce significant satisfaction for the physician and benefit to the citizens. Inherent in this opportunity for the physician is entry into a very different environment with professionals engaged in a different discipline and outside of the usual hospital environment. The challenge for medical directors of EMS services is to learn the specifics of the “new” profession they join so they can effectively help lead the service to provide the highest quality medical care. An integral part of working toward the goals of delivering the best care for patients is the medical director’s participation in the overall management activities of the EMS organization.

The variety of services that provide EMS demonstrates the variety in how EMS organizations can be organized and funded: public, private, fire service, volunteer, career, third service, and public utility models are some of the more prevalent models. Similarly, there is a variety of ways in which the relationship between the medical director and the service can be structured and funded. The medical director may volunteer his or her time, may be employed by the agency or jurisdiction, or may be employed by the private EMS service or public agency. The document that defines the medical director’s responsibilities to the service is the contract between the two parties. A wise medical director knows his obligations vis-à-vis the contract and also knows the best way to accomplish an outcome based upon this relationship. This chapter describes the unique opportunities and challenges that exist at the interface between the management of EMS organizations and the role of the medical directors. It provides some strategies focused on helping the medical director succeed in his or her contribution in this important area.

STATE LAWS AND LOCAL REGULATIONS

An EMS medical director must understand and fulfill the specifications of his or her job description. One may find descriptions of the job in more than one place and may need to serve more than one “master,” based upon the regulation of EMS in the state and local jurisdiction. Some states provide clear, and sometimes detailed, enabling and regulatory legislation regarding medical direction. In the absence of state legislation, the medical director should find a job description and possibly regulation in the jurisdiction in which he or she has been hired as a medical director. If no job description or legislation/regulation exists, then job descriptions can be found and modified from various sources (NAEMSP and ACEP) or from other systems. It is in the best interests of both the medical director and the service to define the relationship specifically.

Maryland is one state that has described the role of the medical director through regulation at the state level. Maryland Title 30 describes the criteria for approval of a jurisdictional EMS operational program (Table 40.1), the roles and responsibilities of the medical directors of such programs (Table 40.2), and the means by which the program and the medical director credential providers (Table 40.3).
**TABLE 40.1**

**Maryland Institute for Emergency Medical Services Systems (MIEMSS)**

**EMS Operational Programs**

.02 Criteria for Approval as a Jurisdictional EMS Operational Program.

A. To be eligible for approval an applicant:
   1. May not be subject to licensure as a commercial service under Education Article, §13-515, Annotated Code of Maryland;
   2. Shall retain an EMS operational program medical director whose qualifications and duties are consistent with the requirements of COMAR 30.03.03;
   3. Shall have a written agreement with the EMS operational program medical director addressing:
      a. The medical director’s:
         i. Duties,
         ii. Authority, and
         iii. Responsibilities; and
      b. The jurisdictional EMS operational program’s:
         i. Duties,
         ii. Authority, and
         iii. Responsibilities; and
      c. Other terms as the parties may agree upon;
   4. Shall maintain a comprehensive quality assurance program consistent with the requirements of COMAR 30.03.04;

**TABLE 40.2**

**Maryland Institute for Emergency Medical Services Systems (MIEMSS)**

**EMS Operational Programs**

.03 EMS Operational Program Medical Directors.

A. An EMS operational program shall have an EMS operational program medical director appointed by the EMS operational program.

B. Qualifications of an EMS Operational Program Medical Director. An EMS operational program medical director shall:
   1. Be licensed to practice medicine in Maryland;
   2. Be familiar with the design and operation of EMS operational programs and systems including medical dispatch and communications;
   3. Have experience in and current knowledge of emergency care of patients who are acutely ill or injured; and
   4. Possess current knowledge of the Maryland EMS System including:
      a. Applicable laws and regulations,
      b. The Maryland Medical Protocols for Emergency Medical Services Providers,
      c. Applicable EMD protocols,
      d. Disaster and mass casualty plans,
      e. Organization and structure, and
      f. Medical quality assurance process.

C. Duties of an EMS Operational Program Medical Director.
   1. The EMS operational program medical director shall:
      a. Be responsible for providing medical oversight of patient care, including emergency medical dispatch, in the EMS operational program;
      b. Approve, participate in, and provide medical expertise for the EMS operational program in:
         i. A comprehensive quality assurance plan covering all aspects of EMS patient care, including emergency medical dispatch under COMAR 30.03.04,
## TABLE 40.3

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<tr>
<th>Maryland Institute for Emergency Medical Services Systems (MIEMSS)—cont’d</th>
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<td><strong>EMS Operational Programs</strong></td>
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<td><strong>.06 Credentialing of EMS Providers</strong></td>
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A. The EMS operational program medical director and EMS operational program shall determine, through clinical evaluation and other means as necessary, the capabilities and skills level of each affiliated EMS provider including the ability of the provider to function independently within that EMS operational program.

B. The EMS operational program medical director and the EMS operational program are responsible for monitoring all EMS providers through a comprehensive quality assurance program under COMAR 30.03.04.

C. The medical director of a specialty care transport program may delegate aspects of credentialing to an associate medical director or Maryland licensed critical care transport nurse.

D. The EMS operational program medical director may delegate any of the duties listed in §C(1) of this regulation to an assistant medical director.

E. If the EMS operational program medical director suspends or limits the privileges of an EMS provider under §C of this regulation, the EMS operational program medical director and the EMS operational program shall immediately notify the State EMS Medical Director of:
   1. The circumstances and grounds for the action;
   2. Specific plans for remedial education; and
   3. The process, including reevaluation, by which the EMS provider may be able to regain privileges.

F. The EMS operational program’s policies and procedures, which shall include procedures for due process as the EMS operational program may require, shall govern suspensions and limitations of EMS provider privileges.

G. This regulation does not otherwise affect the rights of parties under an employer-employee relationship or other contractual relationship including the rights of discipline and termination.
MEDICAL DIRECTOR AND EMS ORGANIZATION RELATIONSHIP

Although working conditions for medical directors may not affect the daily conditions for EMS personnel, any discussion of the various effects of medical oversight on the latter cannot be viewed in a vacuum. EMS personnel and organizations are best able to function when aware of the relationship between the physician and their provider or regulatory organizations.

Mode of Engagement of Medical Director Services

Most medical directors are involved in the systems they oversee on a part-time basis. A much smaller minority operate within a complex arrangement commensurate with the responsibilities or protections of formal employment for services. Such relationships lend themselves to a different place for the medical director within any existing organizational framework than is occupied by the rank-and-file EMS provider. Specifically, one would expect a very different relationship between an EMS provider whose medical director is a battalion chief in the system, as opposed to a volunteer in a fire or rescue company whose medical director sits on a committee that has representation from companies throughout the jurisdiction.

The mode of engaging the services of medical directors can be diverse but generally take on a few major types. In rural systems, multiple volunteer ambulance services may need to pool their resources to find a single physician able to guide them all via a regional committee or otherwise. Pennsylvania, for example, is divided into several major EMS regions for protocol purposes, but some individual rescue squads have their own medical directors. In hospital-based systems, it is common for one of the local emergency physicians from the local practice group to take on EMS duties. In populous metropolitan jurisdictions, physicians may compete for well-defined positions, most as civilians, some within public health, and some within the uniformed services.

Once the position is established within an organizational framework, the degree to which the medical director mission may affect the long-term functioning of the organization can be better understood.

Contractual Issues

The interface between the EMS physician and the provider can and should be defined in a written contract that spells out the details of the physician roles within the system. Depending on any of the above variables, tradition may dictate the functioning of the doctor without formal arrangements at the local level. Although the latter instances have been decreasing as the vocation of EMS oversight has been maturing, the absence versus presence of a contract has an effect on both the standing of the doctor in the agency and the perceived authority of the physician amongst the providers, notwithstanding their other supervisors.

A contract can improve the likelihood that the appropriate authority is granted to the physician so he or she can fulfill the role in protecting the public, the providers, and the integrity of the system. Each physician should have the agency’s mandate in nurturing medical accountability.

In the absence of a contract, it should be noted that some authority and responsibility of the physician may default to the state, county, or regional authority that has purview over licensure of the providers. In such cases, a provider retains some minimum accountability to the physician who may be partially estranged to some of the sponsoring agency’s powers in the absence of a local contract, but under the hierarchy of written regulations of a higher authority.

When one is present, the content of a contract should bestow upon the medical director a set of both responsibilities to the field staff and agency with a scope of practice, an appropriate flexible schedule commensurate with the size of the system, a set of benefits to the physician that may include financial reimbursement for time and/or expenses, as well as a defined authority. The contract must always comply with greater enabling laws and regulations, but when drafted it should address local differences in establishing the appropriate role of the EMS medical director in the system.

FIELD STAFF AND ORGANIZATIONAL RELATIONSHIPS

Because EMS personnel’s arrangements with their agencies are as diverse as those of physicians, any discussion of the various effects of putting EMS providers to work in a medical capacity cannot be
viewed in a vacuum by the physicians. In fact, medical directors and EMS personnel are best able to function when mutually aware of each others’ relationship with the sponsoring organization. It is vital that the EMS physician understand the type of governance of each EMS service in order to foster cooperation in oversight.

Volunteer Organizations

The majority of EMS systems in the United States are still served by volunteer EMS and fire/rescue personnel. The governance of each EMS organization may be centered as locally as each department or submit itself to a more regional body of leadership. A classic example of governance includes the local squad or fire company in an area where township government is emphasized, and state or county government is less dominant. In such models, the fire chief, ambulance officers, or squad president may be analogous to the workplace supervisor at the volunteer level. The way in which providers are put to work and trained in EMS may include a membership committee voting in new persons and sponsoring their participation in EMT-B or ALS classes. It would be very challenging in this common model for physicians to help recruit, promote, or reject any individuals based upon a competitive process or previous knowledge of qualifications. Instead, the physician must learn to work with the organization to enlist its assistance in crafting and/or cooperating with the established quality assurance mechanisms applied to all individuals. This may highlight the need for a company or squad-level physician medical director.

Another volunteer model may exist in locales where many different EMS services accept the unifying governance of a single jurisdictional agency, such as a county, parish, or regional body. In Pennsylvania, regional “federations” unify several counties or agencies under certain operational processes, but each may have a medical group of its own services with local representation to the greater federation. Local leaders then may plan for physicians to sit on higher committees to carry out their oversight roles. In such instances, the physician may still have little influence over daily operations but may be able to have more authority with the weight of a larger agency of governance, because under that framework a jurisdictional medical director may have responsibility for multiple services within the jurisdiction.

One unique challenge and opportunity for physicians within management of providers in this arena is fostering retention of volunteers via medical mentorship, while holding providers responsible for a similar standard of care when pay status is not a criterion for accountability.

A more detailed discussion of volunteer issues is presented in Volume 2, Chapters 20 and 37.

Career Municipal Third Service

In some locales, both rural ones with large areas to cover and suburban/urban ones, the municipality has been compelled over its history to sponsor the EMS service, particularly at an advanced life-support level. These are often referred to as “third service” systems, with EMS as a third entity along with law enforcement and fire departments in a public safety agency triad. In such models, either the towns or counties employ providers, with all rights, responsibilities, and protections of other service employees. The personnel may or may not have the added representation of labor unions.

In this third-service career model, employment procedures govern the recruitment, retention, firing, and rejection of potential and actual employees. Although not universal, some areas present the physician opportunities to have a positive effect on the future of the system by involving them in the interview processes. Otherwise, the physician’s involvement in quality assurance starts after providers begin their work, and the employment relationship compels them to work within all regulations or policies—medical and otherwise.

A challenge often mentioned is a limited pathway for promotion up the ranks. Neither physician nor provider may have the tasks of hospital-based or fire service obligations that are added to other providers. This represents an opportunity for the physician to foster employee advancement and self-motivation using prehospital medicine, by encouraging leadership to create various roles as the pathway to leadership, such as quality, training, EMS technology, and research officers.

Career Fire-Based

Many cities and towns with either rich fire-based histories or with evolution have chosen a career fire department–based EMS model of delivery. Field staff are more commonly represented by organized labor in career fire-based organizations.

Career fire services deliver care in various ways that may include more than just the arrival of care via
a transportation resource. These include first response at all levels using all types of fire apparatus. A major advantage claimed by proponents of this cross-training model is the continuity of care involved when rescue is needed and the patient can stay with the same service throughout the public safety encounter. Others stress the fact providers are cross-trained and, by implication, have less specialization and focus on EMS.

A unique aspect of this relationship is the frequent presence of a paramilitary structure and culture, with some leaders and rank and file potentially less expert than many others in their emphasis on EMS. The medical director must recognize the chain of command and unique firefighter culture in order to work diplomatically with many stakeholders, develop a reputation for knowing his or her appropriate place in the organization, and stress the medical area of expertise and interventions. Many newer personnel seek out these models, eyeing the potential for promotion through the ranks during a full career, and this provides an opportunity for the physician to encourage promotion through medical education as well as knowledge in suppression. Entities such as real time quality through EMS supervisors, or Section Chiefs of EMS, provide positions for officers and incentives for rank and file to achieve goals.

Separate note should be made of the fact that the actual place on the organization chart given to the EMS medical director may vary and might truly influence the relationship of the medical director to the organization. Although most fire departments still place the medical director in a civilian role with hybrid responsibilities, some have actually placed medical directors at an officer or assistant chief’s rank, creating a situation closer to a workplace supervisor or military commander. This might have unintended consequences, such as perceptions by the field staff that employee discipline is part of the physician’s purview, when it usually is not.

**Private Industry**

In many areas of the country, in all demographics and settings, the private industry model of EMS is in place. The market rights for EMS in a given community are usually awarded through competitive bidding. Private industry models are often chosen in an effort to get the most efficient deployment of resources for a set amount of funding and known call volume. Private enterprise services can deliver all levels of care and sometimes operate in areas that have one model for ALS and another for BLS or transportation. It is less common for field staff to have labor representation. However, these field clinicians have chosen to emphasize EMS rather than fire suppression or other cross-trained roles.

In private enterprise models, it is fair to say that a major concern, as emphasized in any operational issue, is the maintenance of a viable business model. Therefore, the field staff must be willing to participate in the leadership’s practices needed to sustain the business in addition to the daily high standard in quality of care. Such concepts include tenets such as daily variability in utilization of units, thorough billing practices, and the documentation habits to support the latter. Proponents often point to the fact that absent the company’s expertise in making such models work, municipalities may not be able to afford to support EMS alone. Although billing may be used by many of the other models mentioned to sustain their budgets, the very survival of the contract, and thus the service presence in an area, depends upon it. For this reason, it is impossible for the EMS medical director not to be sensitive to this issue on a daily basis, even as he or she has a divergent mission. Perhaps this emphasis provides an opportunity for the physician to use good medical practice as a springboard for excellent documentation, which enhances risk management as it supports reimbursement and funding.

The private ambulance industry is the favorite of many locales to provide the ideal deployment model for their needs. Within that model exist many possibilities, which include central or decentralized deployment, within or without hospital-based service. In this arena, providers may find themselves doing many down-time administrative duties, such as station support, billing, educational or quality control duties, or even assisting emergency department staff as nursing extenders in the latter example. Such may provide an opportunity for the physician to encourage academic practice using the continuity of the ED as a basis for comprehensive EMS didactic and procedural education at the bedside. In another hybrid model, private industry may partner with a municipal regulatory agency to create a public utility model of EMS delivery. In these systems, the employees function under a private umbrella solely to provide EMS, and the regulatory body emphasizes efficient utilization of resources under a renewable contract on behalf of citizens. The medical director may have the opportunity to use a high performance contract model to support quality of care through
process improvement and feedback loops. Public utility and other EMS system models are discussed in more detail in Volume 2, Chapter 11.

Perhaps there is not so much a unique aspect of medical supervision in a private sector model as, rather, a great degree of variability in the practice environment within a given system. Subject to the mandates and standards of medical practice, the individual daily practice environment within an ambulance company may be unique. However, a medical director must be assigned a place of leadership within the organizational structure. That detail may govern the perception by the rank and file of how the physician relates to management.

UNIFYING ROLES OF MEDICAL DIRECTION

It is significantly important to the discussion about the relationships between field staff and their systems or agencies to introduce the topic of the interfacing of physicians with operations. However, the interface has several unifying features that transcend the specific model of EMS delivery. Both the veteran and the aspiring EMS physician are best able to operate and foster credibility within very different models by understanding unifying features and emphasizing accepted tasks in medical oversight, which then elevate their involvement beyond smaller operational disputes or consequences that might otherwise burden the decisions.

Quality Systems

It is generally agreed in the physician community and in the enabling legislation by states that the ultimate path of physician authority rests in the oversight of the quality of medical care delivered. Therefore, it is important for physicians to identify and segregate the subsystems of EMS that do in fact have a medical impact, versus those that do not. Once this is done, all involvement in which the physician plans, creates, modifies, or implements the processes aimed at maintaining such quality is appropriate for his or her consultancy. These include the areas of quality improvement feedback mechanisms or retrospective reviews of individual or system behaviors.

The biggest area of interface will rest on the side effects of any medical director’s quality mandate on the status of field staff employment or membership in a service. Often, perceptions as well as reality about the decision-making authority will be felt in the rank and file with some trepidation. The best way to approach this is to stress the physician role in quality improvement and involvement in training, identifying pitfalls in practice, system evaluation, and feedback. A quality assurance inquiry and its just disposition might have repercussions that impact a field clinician’s operational status in a temporary or permanent way. It is important for field staff to understand the retrospective review process and know that the system is set up to be fair and quality focused.

Education

It is also widely agreed that an area of involvement for physicians is EMS education. The provision of out-of-hospital care is a unique extension of medical practice in community environments whose founding was driven by pioneer EMS physicians. Despite the autonomy of systems since their early history, physicians have the education level and opportunity to disseminate the science behind the medical care needed, keep abreast of the latest care advances, oversee the educational process, and mentor the educators when helpful in transmitting didactic and practical skills to new and veteran providers.

Because most providers and supervisors might agree that they and their peers should exceed the minimum in educational knowledge and skill standards, both for patients and their own working conditions, this duty is another key example of a universally accepted and rewarding role for the physician at the prospective input stage. Once didactic knowledge and skills are taught, proficiency can be tested and the provider evaluated by criteria for credentialing, as discussed below. The process is a marker for quality and less often controversial. In the rare instance of academic failure, the medical director may again have to make rulings that affect management and personal statuses of the EMS personnel involved, based on failure to meet requirements. A deeper exploration of medical director involvement in education is presented in Volume 2, Chapter 28.

Credentialing

It is also generally agreed is most areas that field staff, especially in ALS, must demonstrate the initial and continuing proficiency in their practice demanded by the system. As such, a separate but key path of physician authority rests in the power to credential providers at their level of care. Much like the mechanisms
of physicians, who keep state licensure but need local institution credentials to practice, each medical director reserves the right to plan and implement, along with the service leadership, a mechanism to ensure ongoing qualifications.

The task of credentialing may represent in many systems an area most recognized as being solidly under medical oversight, yet having the largest potential effect on operational status, which is otherwise not controlled by physicians. The processes of hiring, firing, new membership, promotion, and progressive discipline, as noted above, are predominantly governed by certain nonmedical tenets. Yet in many systems, new providers cannot even make it past certain stages in those processes without first proving themselves medically qualified for credentialing. Veteran providers are subject to the personal responsibilities of recertification and recredentialing in order to maintain or advance their status in an organization. The ramifications of the above become self-evident when the physician in good faith approves appropriate standards for education and patient care, yet the provider for whatever reason does not meet them. In such cases, the aforementioned history of the physician remaining focused in those unifying medical tasks may provide that credibility and barrier of protection against arguments mainly centered on the employment repercussions experienced by a substandard provider.

Many examples of scenarios that stress the above interface have occurred and can be hypothesized, depending upon all the variables about medical directors and providers already described. An analogy may be drawn in the educational arena, where academic institutions enjoy traditionally and legally a degree of deference when making decisions about standards and holding students to them. We do not hear frequently about students or advocates successfully “suing to get a better grade.” Similarly, the good faith EMS medical director, in consultation with the system academic faculty, has unique recognition as an arbitrator of good medicine, and those removed from public health and medical roles should hesitate to challenge credentialing.

**De-Credentialing or Medical Suspension for Cause**

We mentioned above that decisions regarding modification of credentialing should rest primarily in the purview of the physician. The mode of engaging services of the provider stands outside this purview. Yet ironically, because of the high stakes of employment and the requirement of minimal medical qualifications to remain employed, the most frequent reasons for litigation involving medical directors are indeed rooted in administrative tasks including denial of medical credentialing. Legal issues are addressed in more detail in Volume 2, Chapter 5.

The act of modification of medical credentials may be made on a temporary basis such as medical suspension, or be more long-standing or even definitive and permanent. What is universally recognized is that system leaders and medical directors have discretion to protect the public or the integrity of the system when making suspension decisions for cause.

Examples of scenarios may be helpful to put into perspective the criteria used to modify credential parameters. A classic example is the receipt via public, coworker, or supervisor of a quality of care concern which may have merit and did or could have resulted in an adverse outcome. In the early stages, even with the tenets of quality improvement in mind, the medical director may be faced with the uncertainty that without remediation, the provider may have a knowledge deficit that might drive a future shortcoming. In such cases, suspension pending resolution may protect the provider as well as the system and future patients, though of course the provider is unlikely to take this view. Less common is an allegation, initially yet to be sustained, that a crime took place in the medical encounter, or news that a provider is arrested for crimes of moral turpitude. Any medical director who acts in good faith on the allegation should be protected for removing credentials as a potential risk to the public during a criminal investigation.

In a quality assurance inquiry, an initial step should be to determine the level of shortcoming and whether it rises to probable or potential future adverse patient care. It may be counterproductive for the criteria that led to suspension to be either too hasty or not compulsive enough to address shortcomings. Some set of guidelines that rank deficits in care, coupled with local physician judgment on individual cases, may be a solid foundation. The physician must have a best practice for minor acts worthy of some intervention, but in a purely educational manner. Those may mostly fall shy of the need to modify or suspend in the first place. After classifying a medical error that requires some time to investigate, for high-impact or high-profile cases or sentinel events worthy of root-cause analysis, the need to modify or suspend may be more commonplace. The next steps of disposition include fielding information
and drafting a remediation plan that addresses the specific infraction and its roots within a system or individual failure. The medical director’s involvement in investigating facts may have pitfalls, and a risk/benefit analysis needs to be made on its return before giving the physician such a role. Figure 40.1 shows the quality management inquiry process flow diagram of a jurisdiction, known as an EMS Operational Program, within Maryland’s structured state and regional system.\(^1\)

**Other Tasks**

Although the above areas classically unify most medical directors, it would be appropriate to include many more task areas as those under physician purview in many places. Specifically, any best practice debated within an EMS subsystem having a medical repercussion or thought to be affected by medical delivery is often presented to the medical director for consideration. Depending upon the system, these include strategic planning, educational curricula, local protocol variations, public health, and disaster planning, which may all have an effect on EMS operations or the status of a provider in the organization. There may also be a need for a local physician to separately advocate for local providers in compliance with state regulations, and to encourage or resist state changes based upon that advocacy. NAEMSP published a position paper in 1997 outlining such recommended tasks.\(^4\)
LIABILITY ISSUES

Liability as an EMS medical director may not come from traditional malpractice events as experienced in the clinical practice of medicine. It is important to understand the operational areas that generate the most risk for medical directors of EMS services. Only through adequate knowledge of the potential sources of liability and insurance products that cover the medical director for his or her actions can a medical director comfortably practice the specialty without undue influence from liability fears.

Sources of Liability

The first and most obvious source of liability is the clinical practice of EMS. The potential for liability for clinical practice occurs in two ways. If the medical director rides on EMS units or responds to scenes, then there is a possibility for the medical director to provide care which is alleged to be substandard. Certainly it would be important to have malpractice insurance coverage for the possibility of these acts or claims. Another liability from clinical practice exists from the supervisory relationship between the medical director and the EMS personnel providing direct patient care. In this situation, the medical director may find himself or herself named in a lawsuit for alleged negligence by EMS personnel. Despite this type of malpractice liability being the most well known to physicians, it does not entail the most risk.5

Another source of liability, increasing in recent years, involves employment practices. This liability occurs when a medical director limits, modifies, or suspends the ability of a provider to function clinically. This commonly can occur when either an EMT or an ALS provider’s care is assessed to be substandard and in need of remediation. If the physician withdraws the provider’s ability to function during remediation, this can have economic consequences for the provider. Medical directors can be named in legal actions where the provider alleges that it was the
physician’s limitation of the provider’s prehospital authority that was the basis for the employment action.\textsuperscript{9} It is important to understand this separate source of liability and that traditional malpractice policies do not cover employment practices liability.

Yet another source of liability for the medical director includes allegations of discrimination against a protected class of individual, or harassment. Similar to employment practices liability, the medical director is implicated when quality improvement reviews raise the possibility that the provider’s patient care actions did not meet the standard set by protocol or practice. When the provider challenges the employment action or sues for damages, the medical director may be included in the lawsuit.

**Coverage for Medical Director Actions**

There are many possible sources of employment for medical directors. Some physicians provide their medical direction services as faculty in an academic medical center. Their malpractice may be covered by the university’s self-insurance trust. It would be important for the physician to secure, in writing, a statement from the trust outlining what activities are covered. The academic physician should also enquire whether employment practices and discrimination actions are included in the coverage.

Emergency physicians frequently serve as medical directors of EMS services. Some emergency medicine groups value EMS medical oversight and provide reimbursement for EMS activities. These groups may include the EMS physician’s activities in their malpractice coverage. Similarly, the medical director should ask how coverage will be provided for employment practices and civil rights or discrimination actions. At times, the physician providing medical direction has a specialty other than emergency medicine. Medical directors can come from many different specialties; the questions regarding the method of insurance coverage for malpractice, employment actions, and discrimination are the same.

The medical director may be employed either part-time or full-time by the EMS service. The negotiations regarding the position may include who will provide the insurance coverage and what it will cover. In the best circumstance, if the medical director is hired by the jurisdiction as an employee, the insurance need may be fully covered by the city’s, county’s, or other jurisdiction’s insurance coverage. In this circumstance it would be important to evaluate whether employment practice and discrimination coverage is included. Another potential employment relationship is that of hiring the medical director as an independent contractor. In this case the agency, as a condition of employment, requires the medical director to provide proof of malpractice insurance coverage.

An additional method of employment includes the medical director providing services for volunteer EMS organizations. Despite the fact that the providers are volunteering their time, the medical director should have insurance coverage for his oversight functions. If the volunteer agency effectively fundraises or if it bills for EMS services, it is possible that the organization can provide a stipend for the medical director, and it may be possible for the medical director to negotiate some contribution to help defray the costs of malpractice insurance. It may also be possible for the medical director to be added on to the officers’ and directors’ insurance policy that exists to cover the volunteer officers for the decisions they make in the management of the organization. This would provide legal defense for the physician in the areas of employment practices and discrimination allegations.

Over approximately the past decade, the National Association of EMS Physicians has explored with different malpractice carriers the feasibility of providing coverage for the actions of physicians engaged in medical direction activities. Early in the period, multiple carriers’ analyses reached similar conclusions: it was not economically feasible to provide a policy specific to medical direction of EMS services. Fortunately, in the past year at least two insurers have developed and offered for general purchase policies developed specifically for EMS physicians. For one, EPIC, a company established to provide malpractice coverage for emergency physicians, the medical direction coverage grew out of a need that their covered physicians identified from their EMS activities. Over time, EPIC learned that a market existed and began offering coverage for purchase by non-EPIC physicians. As this coverage was specific to medical oversight, an added benefit was that it included coverage for employment practices and discrimination. Another insurer, Raymond James, has developed and offers a competitive product for EMS medical direction that also includes components that cover employment practices and discrimination claims.
Liability Originating from Direct Medical Oversight

Direct medical oversight is the provision of real-time medical consultation to a provider in the process of caring for a patient. Most commonly, this is performed by an emergency physician while on duty in the emergency department. In this case, providing direct medical oversight is part of the job function, and the physician should be covered by the malpractice insurance available for his clinical role.

In other arrangements, the physician may provide direct medical oversight without concomitant clinical obligations. This may be accomplished in a central location or remotely, by dispatch patch to a cell phone or radio. In either of these arrangements, the employing organization should provide coverage for the consulting physicians.

Indirect Medical Oversight

The system medical director has a significantly more comprehensive span of responsibilities than those of the direct medical oversight physician. Some functions include credentialing of providers, education, quality improvement review, protocol development, evaluation of field providers, and dispatch oversight, representing the service to the medical community and receiving hospitals. Some of these activities, such as performance evaluation and quality assurance review, provide liability exposure in the ways outlined above.

Administrative Oversight

In most roles as a system medical director, the responsibilities regarding administrative oversight are shared with operational administrative supervisors. Given this relationship, an important consideration for the medical director includes his or her employment and liability coverage. For example, if the medical director is an independent contractor, responsible for his own malpractice and employment practice coverage, he or she may want to plan a meeting with a provider regarding administrative consequences for quality improvement lapses to include the supervisor. In addition, allowing the supervisor to carry out the administrative action following medical director input may share the liability of the personnel action fairly and proportionately with the supervisor.

Other systems, some of which may include union representation, may emphasize an approach that provides maximal guarantees of due process throughout. In such a system it is not unusual for the provider to view a meeting with the medical director as punitive and request union representation. Similar to the example above, the medical director would benefit by ensuring the EMS supervisor is present at the meeting as well, to represent the administrative supervisory perspective on the incident. In this system, it may pay large dividends to “catch” providers doing things right and emphasize quality improvement as process improvement rather than affixing individual blame. Propagating QI tenets, then, may be a long-haul project, accomplished when the numbers of providers embracing process improvement outnumber the doubters.

FIELD STAFF HIRING AND ORIENTATION PROCESSES

The earlier in the field staff employment process that the medical director can become involved, the more the focus can be directed to selecting candidates primarily on the basis of the quality of medical care they provide. In this way, participation of the medical director in the hiring of providers can be viewed as quality control directed at the earliest possible point in the process, well in advance of actual patient care.

In many large systems, the hiring process is directed by a municipal human resources department, structured to provide uniformity in the evaluation process. This can exclude other inputs, including the medical director’s, from the process. Though one may enquire about inclusion of the medical director in the hiring process, practically, medical director involvement may have to wait until after the candidate has been hired. The next opportunity for medical director interaction with a newly hired provider may be credentialing or education.

Credentialing of new field staff is a process in which the medical director can and should be closely involved. If the medical director is new to the system, observing the steps of the credentialing process can provide significant insight into the values that have been woven into this important step in provider development. With more time, the medical director can begin to solicit input and include his or her values in the credentialing process and make them public in a document that clearly defines roles, responsibilities, and expectations of all involved in the process, from the candidate through the preceptor to the supervisor, including the medical director.
Many EMS field clinicians have more than one job; changes to their credentials on one job may have implications for the other job. This creates some challenges as the personnel actions taken by one job are treated as confidential information between the employee and employer. Release of information in the wrong way could have consequences (firing) and trigger the field clinician to file claims alleging breach of confidentiality. One approach that can protect the goals of medical quality and the roles of medical directors and supervisory personnel exists when the state EMS oversight agency requires reporting of serious quality lapses and then shares the information with other jurisdictions that the provider has listed as secondary affiliation sites. When the state agency acts to protect the quality of medical care across different jurisdictions, this can insulate the medical director from the liability of sharing confidential quality improvement information with another jurisdiction.

Not infrequently, following a quality improvement review of a field clinician’s care that identifies deficiencies in knowledge or action, there can be a “piling on” of other administrative “complaints” by others in supervisory positions. Each complaint should be considered on its own merit; if the complaints allege a pattern of problematic administrative behavior without documentation, then a sage medical director will avoid lumping the undocumented administrative complaints in with the QI action. In general, with similar organizational attributes, it would be a good rule of practice to include only administrative behaviors that are well documented and directly related to the patient care episode. Complaints not related to patient care should be referred to the field clinician’s administrative supervisor for evaluation through the organization’s process for administrative review.

An infrequent result of a quality improvement action is dismissal of a field clinician. This can occur for certain singular events that represent a true danger to patients, or be a result of a pattern of behavior that does not improve after a formal remediation plan. The medical director should be intimately involved in evaluation of the behavior and the remediation plan. Involvement of the medical director in the decision to terminate an employee versus actual participation in the meeting, delivering news of the termination, depends upon many factors. These include the employment relationship of the medical director, his or her position in the organizational chart of the service, the actual behaviors involved, the operational chain of command of the service, and many other factors. All of these factors can be considered by the medical director in the decisions regarding his or her participation and level of involvement in termination of an employee.

INTERACTION OF MEDICAL OVERSIGHT MISSIONS IN OTHER ENVIRONMENTS

EMS Local or Regional Committees

Many circumstances already mentioned may land the EMS physician on a review committee with or without some combination of operational and medical duties. These may include local or regional protocol, CQI, or peer review groups, which may supplement or serve as the quality mechanism for the system. To the extent that the physician may be able, seeking out the medical aspects of each issue raised, accentuating the prospective input that enhances the unifying medical mission of all stakeholders, and deferring other issues to the expertise of the EMS leadership together all reduce controversy and maintain long-term credibility.

It is then also appropriate for the public good and productive for credibility of the physician to reserve the right of ultimate authority in retrospective review of quality of care when indicated. Even while using input from all leaders and staff in committee deliberation, the body will often need or turn to the expertise of the physician as the final arbitrator. The respect the physician has for the staff in deferring operational issues, and his or her confidence in commanding medical issues, are likely to be productive for the interface between medical oversight and the agency representatives on the committee.

Organized Labor Environment

It is well beyond the scope of this text to recall the history of or analyze the benefits of organized labor, but medical directors would agree that good working conditions, wellness, and safety are necessary and beneficial parts of a successful public safety mission. In that spirit, some of the most influential unions include those representing fire or EMS workers. They usually support workers in an employment arena, via a collective bargaining agreement with a hiring agency, and subject to other employment laws. In a rare exception, the Montgomery County Fire Rescue Service in
suburban Maryland introduced the country’s first collective bargaining agreement with the volunteer arm of their combination service, to ensure benefits outside of compensation and some of the agency support for volunteers given to municipal workers.

It is paramount that in a medical inquiry, the physician’s judgment is freestanding, not subject to debate by nonmedical forces. Such an assertion should be upheld whether or not organized labor is available to the provider. Since poor outcome is not necessarily a reflection of egregious care, and significant shortcomings in care do not necessarily result in adverse outcome, an additional challenge exists in a labor-protective atmosphere of not simply using ends to justify means but using guidelines that rank deficits in care and treating all cases similarly regardless of the patient.

In a unionized environment, the physician’s authority is often not defined within collective bargaining agreements and not subject to the tenets of progressive discipline. Still, the physician must ponder whether he or she wishes to be perceived as one jumping to suspension for minor acts. What may be a safe approach is to strive for the least adverse intervention for a field clinician that accomplishes the aim of the remediation and protects the public and system. Specifically, where the interface of medicine and operations dictates that a suspended field clinician will lose something significant, such as hours for overtime, an earlier chance for promotion, or an otherwise stellar reputation, it may be counterproductive to the medical mission for the criteria that lead to suspension to be weighted toward an intervention that has more rather than fewer side effects on worker conditions. The latter may make it more difficult to get openness from field clinicians in quality improvement affairs.

Although medical oversight often divorces itself from hiring, firing, or disciplinary processes, the individual rank and file or union may still see all interventions through the glasses of employment. The medical director must at least acknowledge these viewpoints. The existence of the concepts of progressive discipline, disparate treatment, documenting deficiencies, grievances, and seniority may be visible during the quality improvement processes, even if nonapplicable in a given case. Thus, the medical director may have to interact in a diplomatic way to point out those differences, and potentially not emphasize employment or membership consequences when medical quality supersedes. It may not be widely known that a field clinician who repeatedly errs medically or errs once seriously may not be entitled to analogous steps in medical review as are present for discipline. But transparency in medical interventions, such as allowing shop stewards to sit in on certain proceedings with medical information beyond their scope, may ease some concerns.

While interactions with unions are often in the context of retrospective quality assurance inquiries, efforts by medical directors to stress prospective input in the interest of quality as well may find themselves at odds with some interests of organized labor, usually in a manner unintended or unforeseen by physicians. For example, a training mission using veteran preceptors paired with novices may require a transfer or scheduling waiver that flies in the face of a seniority issue. Or an effort to promote veteran paramedics as an incentive to create EMS real-time supervision and career ALS retention may be felt as adverse to traditional promotional tenets by a majority of non-ALS providers seeking promotion. The injection of an evidence-based push for a change of practice habit or protocol, such as trauma triage or air evacuation, may be questioned by labor as adverse to tradition. Whatever the unintended path, the emphasis on the medical rationale for change, the stressing of a system fix, or the parallel intention to advocate for providers and public may achieve a buy-in from the union, and if not will at least be viewed as good faith even in disagreement with the physician. The latter may keep future dealings with labor harmonious on the whole.

CONCLUSION

This chapter has covered many aspects of the interface between medical direction and the management of EMS personnel. A consistent approach by a new medical director can yield slow but steady gains when applied patiently. First and foremost, the medical director should be a patient advocate. He or she should be one of the leading voices asking how any particular proposed change might impact patients. A close second, however, should be the medical director’s advocating for field personnel. This is especially effective when ensuring the field staff have the right training, the right experience, and the right tools to provide the best possible patient care. If the medical director consistently advocates for patients and field staff, this can have positive effects when working to secure gains in clinical care and performance.
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