

BOARD OF MEDICAL EXAMINERS

1500 SW 1st Ave, Suite 620
Portland, Oregon 97201

EMERGENCY MEDICAL TECHNICIAN ADVISORY COMMITTEE

Friday, March 11, 2005, 9:00 AM

1500 SW 1st Ave, Suite 620
Portland, Oregon 97201

MEMBERS PRESENT

Gregory Lorts, MD, Chair
John J. Herbold, EMT-I
Dave Lapof, EMT-B
Paul S. Rostykus, MD
Jon Tardiff, EMT-P

STAFF PRESENT:

Kathleen Haley, Executive Director
Diana Dolstra, Licensing Administrator

GUESTS

Peggy Andrews, Chemeketa Community College
Chris Benson, OFMAA, Lane County Fire District #1
Justin Dillinger, OHSU-OIT, Paramedic Education
Tina Greiner, Jefferson RFPD/OVFA
Toni Grimes, Woodburn Ambulance
Cindi Halaas, AMR
Cameron Helikson, EMT-I, Newberg Fire District
Tim Hennigan, Department of Human Services-EMS
Randy Jackson, Keizer Fire District
Gregg Lander, Chemeketa Community College
Mark Liepold, Boring Fire
Gary McLean, EMT-P, OSPA
Shane Moore, Portland Community College/Hooper Detox
John Praggastis, OSPA
Suzann Schmele, EMT-P, OSHU-OIT
Scott Shepard, Jefferson FD
Donna Wilson, Department of Human Services-EMS
Paula Wilson, Portland Community College
Joseph Worley, Tualatin Valley Fire & Rescue

AGENDA

Approve minutes of the December 10, 2004 EMT Advisory Committee meeting.

Senate Bill 698 – Allows a supervising practitioner, defined as a physician assistant approved by the Board, to provide written authorization and standing orders for EMTs

Update to the EMT-Intermediate curriculum development – Peggy Andrews, Chemeketa Community College

Discuss need to poll supervising physicians on the changes in the EMT-Intermediate curriculum – Jon Tardiff, EMT-P

Presentation by Paul Rostykus, MD on the Supervising Physician forum that was part of the Oregon College of Emergency Physicians annual educational conference in Sunriver in February 2005.

Consistent terminology for airway devices in the First Responder and EMT scope of practice – Jon Tardiff, EMT-P

Discuss impact of potential changes to the American Heart Association’s Guidelines for ACLS certification on the EMT-Intermediate scope of practice – Jon Tardiff, EMT-P

Use of cervical collar by fire rescue personnel – Todd Carpenter, Fire and EMS Chief, City of Dallas & SW Polk

Discuss EMT-B scope of practice on obtaining a peripheral blood specimen – Chris Benson, EMT I, Lane Co., Fire District #1

Final Review of OAR 847-035-0030 – Changing terminology of airway device; changing EMT-Intermediate scope of practice to reflect new EMT-I curriculum

Announcement of EMT-P position on the Committee ending on June 30, 2005

Other business

Future meeting

Gregory Lorts, MD, Chair, called the meeting to order at 9:00 AM.

APPROVE MINUTES OF THE DECEMBER 10, 2004 EMT ADVISORY COMMITTEE MEETING

It was moved and seconded that

THE MINUTES OF THE DECEMBER 10, 2004 EMT ADVISORY COMMITTEE MEETING BE ACCEPTED.

Motion passed unanimously.

SENATE BILL 698

SB 698 (*Exhibit A*) allows a supervising practitioner, who is defined as a physician assistant, to provide orders to EMTs. Ms Haley requested input because this bill will be heard in Salem next week.

Dave Lapof said that the legislative committee of the ambulance association is meeting this morning and that the State EMS Committee looked at the bill a week ago.

Suzann Schmele said that last week the State EMS Committee looked at SB 698 and feels that it is not appropriate, that it is not necessary because any medical director can name someone to be their affiliate or associate to work along with them and do part of their duties, but that it is necessary for a physician to do the medical director/physician advisor portion of it. Physician assistants work under a physician's license already so it really needs to be the physician who is providing medical direction.

In response to the question of where did this bill come from, Ms Haley said that the physician assistant association brought the bill. She was told that the community was supporting it. The bill will be heard on Monday (March 14th) at 1:00 PM.

Dave Lapof said that he talked to people in eastern Oregon and no one seems to know where it is coming from. It does not seem like there is a lot of support for it and the supervising physicians he talked to deny that they need physician assistants to help them in their role with the EMTs.

Dr. Rostykus moved that and Dave Lapof seconded that

THE EMT ADVISORY COMMITTEE OPPOSES SB 698 AS THERE ARE PUBLIC SAFETY CONCERNS AND THE COMMITTEE WILL SEND A LETTER TO THE SENATE HEALTH POLICY COMMITTEE OPPOSING THE BILL.

Motion passed unanimously.

The Committee felt that a physician has a lot more training in looking at the big picture in emergency care and public health. They are trained in public safety and as physicians they are accountable for those they extend their license to, such as EMTs. What training do physician assistants have in EMS? With PAs providing direction to EMTs there would be a diffusion of accountability and responsibility where it is no longer the supervising physician providing medical direction, it is the PA, with an indirect track to a physician. Someone from the audience pointed out that a supervising physician is required to sign off on those EMTs who are National Registry certified. EMT-Ps are not required to maintain national certification, although they do initially take the National Registry examination.

Gregg Lander, Peggy Andrews and Dr. Jon Jui, representing the State EMS Committee, have been working on drafting a letter to the State Health Committee to oppose SB 698. Mr. Lander said that their letter points out that to have a physician assistant, who is under a physician, over EMTs, who are under a physician, makes no sense. He felt this bill is probably from a rural area, Halfway or Ontario. He said there is a way to deal with the issue because physician assistants can work under a physician; just as a paramedic or EMT can, as a contact point. The fact that PAs have a lower level of education than physicians may impact decision-making when paramedics and EMTs need

assistance. The State EMS Committee is willing to facilitate PAs working with EMTs and within the EMS system.

UPDATE TO THE EMT-INTERMEDIATE CURRICULUM DEVELOPMENT

Peggy Andrews said that the Education Modality Workgroup had continued work on developing the bulk of the curriculum, finishing out the course content and beginning work on lecture presentation to offer to instructors. At the next Committee meeting they will be able to identify sites for pilot classes and update training dates for existing instructors so they can start teaching the pilot classes in September.

In response to Dr. Rostykus voicing his concern with the drug Nubain, Peggy Andrews said that the curriculum will be reviewed again in about two years, and if some portion of the curriculum or a drug is not working, then that will be the time to make a change. Dr. Rostykus said that he would like a drug with fewer adverse side effects.

There was discussion again about the amount of time spent on pharmacology, with Jon Tardiff wanting more hours on teaching pharmacology and Peggy Andrews saying that with pharmacology being taught throughout the curriculum and with the lab hours there will be plenty of time in the curriculum for pharmacology. The Workgroup is developing case scenarios where students are making decisions about which drugs to use, the dosages, and are able to justify their decision in the classroom. With this training, when the Intermediate gets out to the scene, they can make their choices and will be aware of the complications.

Suzann Schmele said that the discussion is getting hung up on hours, whereas the instructors want to teach and evaluate competencies to make sure the students understand it in all the different modules throughout the curriculum. The evaluation of competency will be continuous.

In response to a question from the audience, the Committee said that EMT-Intermediates will be able to start administering the new medications as soon as the Board adopts the new EMT-I scope of practice and after they have adequate training. There are only a small number of drugs that are totally new to the Intermediate scope of practice.

Peggy Andrews said that a bridge course will be under development this summer for currently certified Intermediates and it will be important to not start administering the new medications without more background in pharmacology and cardiology. The bridge course and the pilot courses should be available this September. It will be up to the Health Program to determine when the regular Intermediate courses will be taught. Chemeketa Community College is anticipating teaching an Intermediate course this fall.

Tim Hennigan said that he could not provide Paula Wilson with a firm date as to when the EMT-Intermediate curriculum will be available to be taught. He said the start date depends on the timing of the approval of the scope of practice, changing the Department of Human Services-EMS administrative rules, designing the bridge course, training the instructors and having everything come together at the same time. The EMT- Intermediates will need to have completed the bridge course by 2007 and EMS will incorporate new drugs and new techniques into the continuing education required in 2007.

DISCUSS NEED TO POLL SUPERVISING PHYSICIANS ON THE CHANGES IN THE EMT-INTERMEDIATE CURRICULUM

Jon Tardiff felt it would be a good idea to ask the supervising physicians if they intend to use any of the medications listed in the new Intermediate curriculum, and if they do not say yes to all of them, the Committee might think twice about adding them to the scope of practice.

Dr. Rostykus said he proposes not doing the survey at this time, because he feels that Peggy Andrews and her group have already done all this work in order to draft the Intermediate curriculum. It would be worthwhile to wait for a couple of years and see whether the drugs and procedures are working and if there are any areas of the curriculum that need adjusting, such as hours of instruction, a drug. At this time the Committee should move forward with the proposed changes to the EMT-Intermediate scope of practice and then do a survey in a couple of years.

ACTION PLAN: DRAFT A SURVEY OF SUPERVISING PHYSICIANS AFTER THE INTERMEDIATE CURRICULUM HAS BEEN TAUGHT AT LEAST TWO YEARS TO SEE IF ANY ADJUSTMENTS OR CHANGES ARE NEEDED IN THE CURRICULUM.

PRESENTATION ON THE SUPERVISING PHYSICIAN FORUM, SUNRIVER, 02/05

Dr. Rostykus had a portion of the annual conference by the Oregon College of Emergency Physicians in Sunriver scheduled for a meeting of the EMT supervising physicians. He would like to continue gathering supervising physicians from around the state together to share brain-power. At the meeting at Sunriver there was a lot of information to learn and the EMT supervising physicians who attended talked about meeting again, as they felt there was much more they needed to learn and share amongst themselves.

Who are the supervising physicians and how do you get in touch with them? The EMS office has the list of supervising physicians, which is not accurate, since physicians have moved out of state, and some physicians whose name is listed are no longer the supervising physician of the agency. The list does not name the EMS agency or agencies the physician supervises. There are about 200 EMS supervising physicians in Oregon.

A lot of work has already been done by Gregg Lander, who has put a lot of effort into a manual on training for supervising physicians and medical directors over the years. Right now the state is more regionalized following the ATAB areas, and the EMS areas are working better together and they are interested in doing more specialty discussions.

Dr. Rostykus requested that standardization of the term used for the *supervising physician*. The Department of Human Services' statute (ORS 682.015 (18)) defines *supervising physician* and their administrative rules define *medical director* (OAR 333-255-000 (11)), but also uses the term *supervising physician* in the definition of *medical director*. The Board of Medical Examiners' administrative rules (OAR 847-035-0001 (12)) defines *supervising physician*. Dr. Rostykus would like to see one term used and that it be *supervising physician*.

Dr. Rostykus moved and Dave Lapof seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS STATEWIDE CONSISTENT USE OF THE TERM “SUPERVISING PHYSICIAN” FOR PHYSICIANS WHO ARE RESPONSIBLE FOR OVERSEEING EMTs.

Motion passed unanimously.

CONSISTENT TERMINOLOGY FOR AIRWAY DEVICES IN THE FIRST RESPONDER AND EMT SCOPE OF PRACTICE

Jon Tardiff said he went through the administrative rules to look at terminology on airways. The EMT-Basic can use the *dual lumen airway*, which is now being changed to the *cuffed pharyngeal airway*. He suggests defining the *oropharyngeal* airway as a *non-cuffed airway*. This is important because the FDA has approved the King LT airway as an oropharyngeal airway. He wrote down what the assumed definitions were and a list of recommendations. He recommends deleting pharyngeoesophageal intubation from the EMT-Basic Umatilla scope as a housekeeping change since they can already use the CombiTube and PtL airway. The next proposed change is also a scope of practice change and is to call all the following devices a *cuffed pharyngeal airway*: CombiTube, King LT airway, or laryngeal mask airway (LMA). This puts the LMA at the Basic level. Or you can define all these but the LMA as a cuffed pharyngeal airway.

Dr. Rostykus asked the difference between needle cricothyrotomy and percutaneous cricothyrotomy. Jon Tardiff said that traditionally the Committee has included Nutrake and Petrake in the definition of needle cricothyrotomy. Nutrake does not require a cut but a nick of the skin.

Dr. Rostykus moved and it was seconded

THE EMT ADVISORY COMMITTEE RECOMMENDS THE BOARD APPROVE THE PROPOSED RULES CHANGE IN OAR 847-035-0030 (8) (b) “OPEN AND MAINTAIN AN AIRWAY THROUGH THE USE OF A NASOPHARYNGEAL AND NONCUFFED OROPHARYNGEAL AIRWAY [~~OROPHARYNGEAL AND NASOPHARYNGEAL~~] AND PHARYNGEAL SUCTIONING DEVICES,” DELETE “OROPHARYNGEAL-ESOPHAGEAL” IN OAR 847-035-0030 (9) (I) AND CHANGE “NEEDLE” TO “PERCUTANEOUS” CRICOTHYROTOMY IN OAR 847-035-0030 (11) (a) (C) (*Exhibit B*).

Motion carried unanimously.

DISCUSS IMPACT OF POTENTIAL CHANGES TO THE AMERICAN HEART ASSOCIATION’S INTERMEDIATE SCOPE OF PRACTICE

Jon Tardiff said that he did not realize that these changes will not be coming out until next year. The recommendations may be out in October 2005, but the text books will not be out for a year afterwards, so it is hard to anticipate any changes at this point.

USE OF CERVICAL COLLAR BY FIRE RESCUE PERSONNEL

A request was made by Chief Todd Carpenter for input from the EMT Advisory Committee on use of cervical collar by fire rescue personnel. This is an ALS medic system out of the Dallas Fire Department, and at times they will have firefighters extricating a patient out of a car and they will

have their EMTs or ALS people at another vehicle and there is not direct supervision of an EMS person with this group of 3 or 4 firefighters. The firefighters have been internally trained on spinal immobilization and basic patient assessment, but they are not First Responders. Where do these firefighters fall; is there a special category for them, or special training for them?

Dr. Rostykus said that if the firefighters are not First Responders and they are not EMTs, the Board does not have any responsibility for them. That agency needs to have training and protocol in place for what those firefighters do. What is the standard training for firefighters?

Someone from the audience said that in his agency extrication is part of patient care, and if the patient needs an airway, extrication may have to cease while an airway is established, and then continue, but that there should be an EMT involved in the overall extrication decision-making process.

The Fire Department could provide some internal training that teaches the firefighters some basic EMS skills. A Prehospital Trauma Life Support (PHTLS) class would protect them from liability. There is also first aid classes offered by the American Red Cross or the American Heart Association, although John Herbold said these courses do not talk about putting on a cervical collar.

The Board will write Chief Todd Carpenter a letter informing him that the application of a medical device requires training and the Board does not supervise or coordinate activities of firefighters. The First Responder is the first certification level that is trained on how to put a cervical collar on. The EMT Advisory Committee cannot condone the use of any medical device without training.

DISCUSS EMT-B SCOPE OF PRACTICE ON OBTAINING A PERIPHERAL BLOOD SPECIMEN

Chris Benson, EMT-I, addressed the Committee about his proposed changes dealing with checking blood sugar at the EMT-Basic level, which is currently very specific about where the EMT can obtain the blood sample. His request is to expand the EMT's use of the blood sample. There are a number of diagnostic tests that have come out recently that allow the EMT to go beyond a blood glucose test still using capillary blood, such as cardiac enzymes. He is attempting to build into the scope of practice language that allows for future expansion of technology so that the Committee does not have to make a change each time something new comes out.

Mr. Benson said that, while it won't change how the patient is treated in the field, it will provide point of time specific information to the hospital Emergency Department and paramedic and transmitting agencies further down the line that will be treating the patient.

There was discussion of whether additional education would be required, and if the EMT was to take the blood and do the test, what is the accountability if the test gets lost or if it is inaccurate? Also, will doing the test make a difference to patient care in the field; will a different decision be made in the field based on the test results? There will be an additional cost either to the patient or the ambulance service; there will be a need for a CLIA waiver. Even though a blood test is done in the field, another test would be done in the ER. There is no standardization for point of site testing. Dr. Lorts requested data to support that this kind of testing impacts patient care.

An example was made of EMT-Basics providing 12-lead EKG readings, which they cannot interpret, to the hospital. Based on EMT-Basics being able to do a 12-lead, some hospitals are

staffing the cath-lab so that the patient can be taken there upon transport to the hospital. Dr. Rostykus said that supervising physicians, not the hospital, determine whether EMTs do 12-lead or blood tests in the field.

ACTION PLAN: THE COMMITTEE AGREED TO ALLOW EMT-BASICS TO OBTAIN CAPILLARY BLOOD SPECIMENS FOR BLOOD GLUCOSE MONITORING, AND DELETED "FOLLOWING WRITTEN STANDING ORDERS" FOR THE ADMINISTRATION OF ACTIVATED CHARCOAL FOR POISONINGS IN OAR 847-035-0030 (8).

The Committee did not wish to expand the EMT-Basic scope of practice beyond blood testing for glucose monitoring. This topic can certainly be brought back to the Committee in a year or two for further discussion.

FINAL REVIEW OF OAR 847-035-0030

In Peggy Andrews' presentation at the December 2004 Committee meeting, she said that the laryngeal mask airway (LMA) was not an optimal airway for the EMT-Intermediate. In response to a question by Dr. Rostykus, Ms Andrews said that instructors do not want to teach the laryngeal mask airway (LMA) and they do not want it in the curriculum. She suggested leaving it at the paramedic level.

Dr. Rostykus suggested putting the LMA in the EMT-Paramedic scope of practice in OAR 847-035-0030 (11) (a), but as a first review so it does not hold up the Board adopting the new EMT-Intermediate scope of practice.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE BOARD OF MEDICAL EXAMINERS ADOPT CHANGES IN THE EMT-INTERMEDIATE SCOPE OF PRACTICE IN OAR 847-035-0030 (10) THAT REFLECTS THE NEW DEPARTMENT OF HUMAN SERVICES-EMS EMT-INTERMEDIATE CURRICULUM (*Exhibit C*).

Motion carried unanimously.

It was moved and seconded that

THE EMT ADVISORY COMMITTEE RECOMMENDS THE BOARD OF MEDICAL EXAMINERS APPROVE MOVING THE LARYNGEAL MASK AIRWAY TO THE EMT-PARAMEDIC SCOPE OF PRACTICE UNDER OAR 847-035-0030 (11) (b) (A).

Motion carried unanimously.

ANNOUNCEMENT OF EMT POSITION ON THE COMMITTEE

The Committee selected Friday, June 3, 2005 as the date of next Committee meeting and interviews of applicants for the EMT-P position on the EMT Advisory Committee.

Dr. Rostykus asked if the State EMS Committee and the EMT Advisory Committee discussed the same issues, and if so were the committees redundant.

People in the audience said that issues that each committee discusses impact each other, particularly scope of practice and training, but they were not necessarily the same issues.

OTHER BUSINESS

FDA WARNING LETTER TO PHYSICIANS ON SIDE EFFECTS OF AMIODARONE

It was determined that the side effects seemed to be with the medication in long-term oral use and not a single IV use for a traumatic or acute event. Jon Tardiff was also worried about the 40-day half life and wondered if that applied to the IV version of the drug.

Dr. Rostykus said that in reading the bulletin it indicates the concern is with the drug in pill form, not IV form. The IV form does have a 40 day half-life, and the potential hazard of the drug may not be the 40 day half-life, it may be the long term use of the drug.

REPORT ON USE OF CRICOTHYROTOMY

The Committee discussed the patient case that had been faxed to the Board by Denise A. Giard, EMS Chief, Albany Fire Department, which involved the use of a cricothyrotomy needle, and had a question on the outcome of the patient. The Committee thanked Ms. Giard for sending in the patient report form.

ADJOURNMENT

There being no further business to discuss, the meeting was adjourned at 12:30 PM.

Senate Bill 698

Sponsored by COMMITTEE ON HEALTH POLICY

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced**.

Authorizes licensed physician assistant to establish written authorization and standing orders for emergency medical technician. Requires Board of Medical Examiners to adopt standards for qualifications and responsibilities of physician assistants serving as supervising practitioners of emergency medical technicians.

A BILL FOR AN ACT

1
2 Relating to authority of physician assistant to authorize patient care by emergency medical techni-
3 cians; amending ORS 682.025, 682.220, 682.224 and 682.245.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1.** ORS 682.025 is amended to read:

6 682.025. As used in this chapter, unless the context requires otherwise:

7 (1) "Ambulance" or "ambulance vehicle" means any privately or publicly owned motor vehicle,
8 aircraft or watercraft that is regularly provided or offered to be provided for the emergency trans-
9 portation of persons suffering from illness, injury or disability.

10 (2) "Ambulance service" means any person, governmental unit, corporation, partnership, sole
11 proprietorship or other entity that operates ambulances and that holds itself out as providing pre-
12 hospital care or medical transportation to sick, injured or disabled persons.

13 (3) "Board" means the Board of Medical Examiners for the State of Oregon.

14 (4) "Department" means the Department of Human Services.

15 (5) "Emergency care" means the performance of acts or procedures under emergency conditions
16 in the observation, care and counsel of the ill, injured or disabled; in the administration of care or
17 medications as prescribed by a licensed physician, insofar as any of these acts is based upon
18 knowledge and application of the principles of biological, physical and social science as required by
19 a completed course utilizing an approved curriculum in prehospital emergency care. However,
20 "emergency care" does not include acts of medical diagnosis or prescription of therapeutic or cor-
21 rective measures.

22 (6) "Emergency medical technician" or "EMT" means a person who has received formal training
23 in prehospital and emergency care, and is state certified to attend any ill, injured or disabled person.
24 Police officers, firefighters, funeral home employees and other personnel serving in a dual capacity
25 one of which meets the definition of "emergency medical technician" are "emergency medical tech-
26 nicians" within the meaning of this chapter.

27 (7) "First responder" means a person who has successfully completed a first responder training
28 course approved by the department and:

29 (a) Has been examined and certified as a first responder by an authorized representative of the
30 department to perform basic emergency and nonemergency care procedures; or

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.
New sections are in **boldfaced** type.

1 (b) Has been otherwise designated as a first responder by an authorized representative of the
2 department to perform basic emergency and nonemergency care procedures.

3 (8) "Fraud or deception" means the intentional misrepresentation or misstatement of a material
4 fact, concealment of or failure to make known any material fact, or any other means by which
5 misinformation or false impression knowingly is given.

6 (9) "Governmental unit" means the state or any county, municipality or other political subdivi-
7 sion or any department, board or other agency of any of them.

8 (10) "Highway" means every public way, thoroughfare and place, including bridges, viaducts and
9 other structures within the boundaries of this state, used or intended for the use of the general
10 public for vehicles.

11 (11) "Nonemergency care" means the performance of acts or procedures on a patient who is not
12 expected to die, become permanently disabled or suffer permanent harm within the next 24 hours,
13 including but not limited to observation, care and counsel of a patient and the administration of
14 medications prescribed by a physician licensed under ORS chapter 677, insofar as any of those acts
15 are based upon knowledge and application of the principles of biological, physical and social science
16 and are performed in accordance with scope of practice rules adopted by the Board of Medical Ex-
17 aminers in the course of providing prehospital care as defined by this section.

18 (12) "Owner" means the person having all the incidents of ownership in an ambulance service
19 or an ambulance vehicle or where the incidents of ownership are in different persons, the person,
20 other than a security interest holder or lessor, entitled to the possession of an ambulance vehicle
21 or operation of an ambulance service under a security agreement or a lease for a term of 10 or more
22 successive days.

23 (13) "Patient" means an ill, injured or disabled person transported in an ambulance.

24 (14) "Person" means any individual, corporation, association, firm, partnership, joint stock com-
25 pany, group of individuals acting together for a common purpose or organization of any kind and
26 includes any receiver, trustee, assignee or other similar representative thereof.

27 (15) "Prehospital care" means that care rendered by emergency medical technicians as an inci-
28 dent of the operation of an ambulance as defined by this chapter and that care rendered by emer-
29 gency medical technicians as incidents of other public or private safety duties, and includes, but is
30 not limited to, "emergency care" as defined by this section.

31 (16) "Scope of practice" means the maximum level of emergency or nonemergency care that an
32 emergency medical technician may provide.

33 (17) "Standing orders" means the written protocols that an emergency medical technician fol-
34 lows to treat patients when direct contact with a physician is not maintained.

35 (18) "Supervising physician" means a medical or osteopathic physician licensed under ORS
36 chapter 677, actively registered and in good standing with the board, who provides direction of
37 emergency or nonemergency care provided by emergency medical technicians.

38 (19) **"Supervising practitioner" means a physician assistant licensed as provided by ORS**
39 **677.495 and 677.505 to 677.525.**

40 [(19)] (20) "Unprofessional conduct" means conduct unbecoming a person certified in emergency
41 care, or detrimental to the best interests of the public and includes:

42 (a) Any conduct or practice contrary to recognized standards of ethics of the medical profession
43 or any conduct or practice which does or might constitute a danger to the health or safety of a
44 patient or the public or any conduct, practice or condition which does or might impair an emergency
45 medical technician's ability safely and skillfully to practice emergency or nonemergency care;

1 (b) Willful performance of any medical treatment which is contrary to acceptable medical stan-
2 dards; and

3 (c) Willful and consistent utilization of medical service for treatment which is or may be con-
4 sidered inappropriate or unnecessary.

5 **SECTION 2.** ORS 682.220 is amended to read:

6 682.220. (1) The Department of Human Services may deny, suspend or revoke licenses for am-
7 bulances and ambulance services in accordance with the provisions of ORS chapter 183 for a failure
8 to comply with any of the requirements of ORS 820.350 to 820.380 and this chapter or the rules
9 adopted thereunder.

10 (2) The certification of an emergency medical technician may be denied, suspended or revoked
11 in accordance with the provisions of ORS chapter 183 for any of the following reasons:

12 (a) A failure to have completed successfully a department approved course.

13 (b) In the case of provisional certifications, failure to have completed successfully a department
14 approved course.

15 (c) Failure to meet or continue to meet the physical and mental qualifications required to be
16 certified under ORS 682.208.

17 (d) The use of fraud or deception in receiving a certificate.

18 (e) Practicing skills beyond the scope of practice established by the Board of Medical Examiners
19 for the State of Oregon under ORS 682.245.

20 (f) Rendering emergency or nonemergency care under an assumed name.

21 (g) The impersonation of another EMT.

22 (h) Unprofessional conduct.

23 (i) Obtaining a fee by fraud or misrepresentation.

24 (j) Habitual or excessive use of intoxicants or drugs.

25 (k) The presence of a mental disorder that demonstrably affects an EMT's performance, as cer-
26 tified by two psychiatrists retained by the department.

27 (L) Subject to ORS 670.280, conviction of any criminal offense that reasonably raises questions
28 about the ability of the EMT to perform the duties of an EMT in accordance with the standards
29 established by this chapter. A copy of the record of conviction, certified to by the clerk of the court
30 entering the conviction, shall be conclusive evidence of the conviction.

31 (m) Suspension or revocation of an emergency medical technician certificate issued by another
32 state:

33 (A) For a reason that would permit the department to suspend or revoke a certificate issued
34 under this chapter; and

35 (B) Evidenced by a certified copy of the order of suspension or revocation.

36 (n) Gross negligence or repeated negligence in rendering emergency medical assistance.

37 (o) Rendering emergency or nonemergency care without being certified except as provided in
38 ORS 30.800.

39 (p) Rendering emergency or nonemergency care as an EMT without written authorization and
40 standing orders from a supervising physician **or supervising practitioner** who has been approved
41 by the board in accordance with ORS 682.245.

42 (q) Refusing an invitation for an interview with the department as specified in this section.

43 (3) The department may investigate any evidence that appears to show that an EMT certified
44 by the department is or may be medically incompetent, guilty of unprofessional or dishonorable
45 conduct or mentally or physically unable to safely function as an EMT. The department may inves-

1 tigate the off-duty conduct of an EMT to the extent that such conduct may reasonably raise
2 questions about the ability of the EMT to perform the duties of an EMT in accordance with the
3 standards established by this chapter. Upon receipt of a complaint about an EMT or applicant, the
4 department shall conduct an investigation as described under ORS 676.165. An investigation shall
5 be conducted in accordance with ORS 676.175.

6 (4) Any health care facility licensed under ORS 441.015 to 441.087 and 441.820, any medical or
7 osteopathic physician licensed under ORS chapter 677, any owner of an ambulance licensed under
8 this chapter or any EMT certified under this chapter shall report to the department any information
9 the person may have that appears to show that an EMT is or may be medically incompetent, guilty
10 of unprofessional or dishonorable conduct or mentally or physically unable to safely function as an
11 EMT.

12 (5) If, in the opinion of the department, it appears that the information provided to it under
13 provisions of this section is or may be true, the department may request an interview with the EMT.
14 At the time the department requests an interview, the EMT shall be provided with a general state-
15 ment of the issue or issues of concern to the department. The request shall include a statement of
16 the procedural safeguards available to the EMT, including the right to end the interview on request,
17 the right to have counsel present and the following statement: "Any action proposed by the De-
18 partment of Human Services shall provide for a contested case hearing."

19 (6) Information regarding an ambulance service provided to the department pursuant to this
20 section is confidential and shall not be subject to public disclosure, nor shall it be admissible as
21 evidence in any judicial proceeding. Information that the department obtains as part of an investi-
22 gation into emergency medical technician or applicant conduct or as part of a contested case pro-
23 ceeding, consent order or stipulated agreement involving emergency medical technician or applicant
24 conduct is confidential as provided under ORS 676.175. Information regarding an ambulance service
25 does not become confidential due to its use in a disciplinary proceeding against an emergency
26 medical technician.

27 (7) Any person who reports or provides information to the department under this section and
28 who provides information in good faith shall not be subject to an action for civil damage as a result
29 thereof.

30 (8) In conducting an investigation under subsection (3) of this section, the department may:

31 (a) Take evidence;

32 (b) Take depositions of witnesses, including the person under investigation, in the manner pro-
33 vided by law in civil cases;

34 (c) Compel the appearance of witnesses, including the person under investigation, in the manner
35 provided by law in civil cases;

36 (d) Require answers to interrogatories; and

37 (e) Compel the production of books, papers, accounts, documents and testimony pertaining to the
38 matter under investigation.

39 (9) The department may issue subpoenas to compel compliance with the provisions of subsection
40 (8) of this section. If any person fails to comply with a subpoena issued under this subsection, or
41 refuses to testify on matters on which the person may lawfully be interrogated, a court may compel
42 obedience as provided in ORS 183.440.

43 **SECTION 3.** ORS 682.224 is amended to read:

44 682.224. (1) The Department of Human Services may discipline, as provided in this section, an
45 ambulance service or any person certified as an emergency medical technician or first responder in

1 this state who has:

2 (a) Admitted the facts of a complaint which alleges facts which establish that such person is
3 guilty of violation of one or more of the grounds for suspension or revocation of a certificate as set
4 forth in ORS 682.220 or that an ambulance service has violated the provisions of this chapter or the
5 rules adopted thereunder.

6 (b) Been found guilty in accordance with ORS chapter 183 of violation of one or more of the
7 grounds for suspension or revocation of certification as set forth in ORS 682.220 or that an ambu-
8 lance service has violated the provisions of this chapter or the rules adopted thereunder.

9 (2) The purpose of disciplining an EMT under this section is to ensure that the EMT will pro-
10 vide services that are consistent with the obligations of this chapter. Prior to taking final discipli-
11 nary action, the department shall determine if the EMT has been disciplined for the questioned
12 conduct by the EMT's employer, [or] supervising physician **or supervising practitioner**. The de-
13 partment shall consider any such discipline or any other corrective action in deciding whether ad-
14 ditional discipline or corrective action by the department is appropriate.

15 (3) In disciplining an EMT or ambulance service as authorized by subsection (1) of this section,
16 the department may use any or all of the following methods:

17 (a) Suspend judgment.

18 (b) Issue a letter of reprimand.

19 (c) Issue a letter of instruction.

20 (d) Place the EMT or ambulance service on probation.

21 (e) Suspend the EMT certificate or ambulance service license.

22 (f) Revoke the EMT certificate or ambulance service license.

23 (g) Place limitations on the certificate of the EMT to practice emergency or nonemergency care
24 in this state or place limitations on the license of the ambulance service.

25 (h) Take such other disciplinary action as the department in its discretion finds proper, includ-
26 ing assessment of the costs of the disciplinary proceedings as a civil penalty or assessment of a civil
27 penalty not to exceed \$5,000, or both.

28 (4) In addition to the action authorized by subsection (3) of this section, the department may
29 temporarily suspend a certificate or license without a hearing, simultaneously with the commence-
30 ment of proceedings under ORS chapter 183 if the department finds that evidence in its possession
31 indicates that a continuation in practice of the EMT or operation of the ambulance service consti-
32 tutes an immediate danger to the public.

33 (5) If the department places any EMT or ambulance service on probation as set forth in sub-
34 section (3)(d) of this section, the department may determine, and may at any time modify, the con-
35 ditions of the probation and may include among them any reasonable condition for the purpose of
36 protection of the public and for the purpose of the rehabilitation of the EMT or ambulance service,
37 or both. Upon expiration of the term of probation, further proceedings shall be abated if the EMT
38 or ambulance service has complied with the terms of the probation.

39 (6) If an EMT certified in this state is suspended, the holder of the certificate may not practice
40 during the term of suspension.

41 (7) If an ambulance service licensed in this state is suspended, the ambulance service may not
42 operate in this state during the term of the suspension, provided that the department shall condition
43 such suspension upon such arrangements as may be necessary to assure the continued availability
44 of ambulance service in the area served by that ambulance service. Upon expiration of the term of
45 suspension, the certificate or license shall be reinstated by the department if the conditions for

1 which the certificate or license was suspended no longer exist.

2 (8) Whenever an EMT certificate or ambulance service license is denied or revoked for any
3 cause, the department may, in its discretion, after the lapse of two years from the date of such re-
4 vocation, upon written application by the person formerly certified or licensed and after a hearing,
5 issue or restore the EMT certificate or ambulance service license.

6 (9) Civil penalties under this section shall be imposed as provided in ORS 183.745.

7 **SECTION 4.** ORS 682.245 is amended to read:

8 682.245. (1) The Board of Medical Examiners for the State of Oregon shall adopt by rule a scope
9 of practice for emergency medical technicians at such levels as may be established by the Depart-
10 ment of Human Services and for first responders.

11 (2) The board shall adopt by rule standards for the qualifications and responsibilities of super-
12 vising physicians **and supervising practitioners.**

13 (3) The standing orders for emergency medical technicians and first responders may not exceed
14 the scope of practice defined by the board.

15 (4) No emergency medical technician shall provide patient care or treatment without written
16 authorization and standing orders from a supervising physician **or supervising practitioner** who
17 has been approved by the board.

18 (5) The policies and procedures for applying and enforcing this section may be delegated in
19 whole or in part to the department.

20

OREGON ADMINISTRATIVE RULES

CHAPTER 847, DIVISION 035 - BOARD OF MEDICAL EXAMINERS

PROPOSED RULES CHANGES – APRIL 2005

FIRST REVIEW BY THE BOARD

847-035-0030

Scope of Practice

(1) The Board of Medical Examiners has established a scope of practice for emergency and nonemergency care for First Responders and EMTs. First Responders and EMTs may provide emergency and nonemergency care in the course of providing prehospital care as an incident of the operation of ambulance and as incidents of other public or private safety duties, but is not limited to "emergency care" as defined in OAR 847-035-0001 (5).

(2) The scope of practice for First Responders and EMTs is not intended as statewide standing orders or protocols. The scope of practice is the maximum functions which may be assigned to a First Responder or EMT by a Board-approved supervising physician.

(3) Supervising physicians may not assign functions exceeding the scope of practice; however, they may limit the functions within the scope at their discretion.

(4) Standing orders for an individual EMT may be requested by the Board or Section and shall be furnished upon request.

(5) No EMT may function without assigned standing orders issued by Board-approved supervising physician.

(6) An Oregon-certified First Responder or EMT, acting through standing orders, shall respect the patient's wishes including life-sustaining treatments. Physician supervised First Responders and EMTs shall request and honor life-sustaining treatment orders executed by a physician or a nurse practitioner, if available. A patient with life-sustaining treatment orders always requires respect, comfort and hygienic care.

(7) The scope of practice for emergency and nonemergency care established by the Board for First Responders is intended as authorization for performance of procedures by First Responders without direction from a Board-approved supervising physician, except as limited by subsection (2) of this rule. A First Responder may perform the following emergency care procedures without having signed standing orders from a supervising physician:

- (a) Conduct primary and secondary patient examinations;
- (b) Take and record vital signs;
- (c) Utilize noninvasive diagnostic devices in accordance with manufacturer's recommendation;
- (d) Open and maintain an airway by positioning the patient's head;
- (e) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;
- (f) Provide care for soft tissue injuries;
- (g) Provide care for suspected fractures;
- (h) Assist with prehospital childbirth; and
- (i) Complete a clear and accurate prehospital emergency care report form on all patient contacts and provide a copy of that report to the senior EMT with the transporting ambulance.

(8) A First Responder may perform the following procedures only when the First Responder is providing emergency care as part of an agency which has a Board-approved supervising physician who has issued written standing orders to that First Responder authorizing the following:

- (a) Administration of medical oxygen;
- (b) Open and maintain an airway through the use of ~~[an]~~ **a nasopharyngeal and a noncuffed oropharyngeal airway** ~~[oropharyngeal and nasopharyngeal airway]~~ and pharyngeal suctioning devices;
- (c) Operate a bag mask ventilation device with reservoir;
- (d) Provision of care for suspected medical emergencies, including administering liquid oral glucose for hypoglycemia; and
- (e) Administer epinephrine by automatic injection device for anaphylaxis;

(f) Perform cardiac defibrillation with an automatic or semi-automatic defibrillator, only when the First Responder:

(A) Has successfully completed a Section-approved course of instruction in the use of the automatic or semi-automatic defibrillator; and

(B) Complies with the periodic requalification requirements for automatic or semi-automatic defibrillator as established by the Section.

(9) An Oregon-certified EMT-Basic may perform emergency and nonemergency procedures. Emergency care procedures shall be limited to the following basic life support procedures:

(a) Perform all procedures that an Oregon-certified First Responder can perform;

(b) Ventilate with a non-invasive positive pressure delivery device;

(c) Insert a dual lumen airway device in the practice of airway maintenance;

(d) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;

(e) Provide care for suspected shock, including the use of the pneumatic anti-shock garment;

(f) Provide care for suspected medical emergencies, including:

(A) Obtaining a ~~[peripheral]~~ **capillary** blood specimen for blood glucose monitoring~~];—obtained via fingerstick, heelstick, or earlobe puncture];~~

(B) Administer epinephrine by subcutaneous injection or automatic injection device for anaphylaxis;

(C) Administer activated charcoal for poisonings~~];—following local written standing orders];~~ and

(D) Administer aspirin for suspected myocardial infarction.

(g) Perform cardiac defibrillation with an automatic or semi-automatic defibrillator;

(h) Transport stable patients with saline locks, heparin locks, foley catheters, or in-dwelling vascular devices;

(i) Perform other emergency tasks as requested if under the direct visual supervision of a physician and then only under the order of that physician;

(j) Complete a clear and accurate prehospital emergency care report form on all patient contacts;

(k) Assist a patient with administration of sublingual nitroglycerine tablets or spray and with metered dose inhalers that have been previously prescribed by that patient's personal physician and that are in the possession of the patient at the time the EMT-Basic is summoned to assist that patient; and

(l) In the event of a release of military chemical warfare agents from the Umatilla Army Depot, the EMT-Basic who is a member or employee of an EMS agency serving the DOD-designated Immediate Response Zone who has completed a Section-approved training program may administer atropine sulfate and pralidoxime chloride from a Section-approved pre-loaded auto-injector device, and perform endotracheal [~~or pharyngoesophageal~~] intubation, using protocols promulgated by the Section and adopted by the supervising physician. 100% of EMT-Basic actions taken pursuant to this section shall be reported to the Section via a copy of the prehospital emergency care report and shall be reviewed for appropriateness by Section staff and the Subcommittee on EMT Certification, Education and Discipline.

(m) In the event of a release of chemical agents the EMT-Basic, who has completed Section-approved training, may administer atropine sulfate and pralidoxime chloride, using protocols approved by the Section and adopted by the supervising physician, if:

(A) The supervising physician provides the EMT-Basic with a direct, verbal order through radio or telephone contact, or

(B) The EMT-Basic is under the direction of an EMT-Paramedic who is on the scene.

(10) An Oregon-certified EMT-Intermediate may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to the following:

- (a) Perform all procedures that an Oregon-certified EMT-Basic can perform;
- (b) Initiate and maintain peripheral intravenous (I.V.) lines;
- (c) Initiate and maintain an intraosseous infusion;
- (d) Initiate saline or similar locks when specifically authorized by the physician;
- (e) Infuse any physiologic isotonic crystalloid solution;
- (f) Draw peripheral blood specimens;
- (g) Initiate or administer the following medications:

(A) Epinephrine 1:10,000;

(B) Atropine sulfate;

(C) Lidocaine bolus for ventricular fibrillation, post ventricular fibrillation/ventricular tachycardia cardiac arrest, ventricular tachycardia, or wide complex tachycardia;

(D) Naloxone hydrochloride;

(E) Hypertonic glucose;

(F) Nitroglycerine for chest pain;

(G) Beta-2-specific nebulized bronchodilators;

(H) Morphine for pain management;

(h) Insert a laryngeal mask airway (LMA) device in the practice of airway maintenance;

(i) Insert an orogastric tube;

(j) Maintain during transport any intravenous medication infusions or other procedures which were initiated in a medical facility, and if clear and understandable written and verbal instructions for such maintenance have been provided by the personnel at the sending medical facility.

(k) Perform cardiac defibrillation with a manual defibrillator if the EMT-Intermediate has satisfactorily completed a Section-approved training course in manual defibrillation, including written and practical examinations and the EMT-Intermediate is, at the time of performing manual defibrillation, in the service of an agency which has been granted an “EMT-Intermediate Manual Defibrillation Waiver” by the Section.

(11) An Oregon-certified EMT-Paramedic may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to:

(a) Perform all procedures that an Oregon-certified EMT-Intermediate can perform;

(b) Initiate the following airway management techniques:

(A) Endotracheal intubation;

(B) Tracheal suctioning techniques;

(C) [~~Needle~~] percutaneous cricothyrotomy; and

(D) Transtracheal jet insufflation which may be used when no other mechanism is available for establishing an airway.

(c) Initiate a nasogastric tube;

(d) Initiate electrocardiographic monitoring and interpret presenting rhythm;

(e) Provide advanced life support in the resuscitation of patients in cardiac arrest;

(f) Perform emergency cardioversion in the compromised patient;

(g) Attempt external transcutaneous pacing of bradycardia that is causing hemodynamic compromise;

(h) Initiate needle thoracentesis for tension pneumothorax in a prehospital setting;

(i) Initiate placement of a femoral intravenous line when a peripheral line cannot be placed;

(j) Initiate placement of a urinary catheter for trauma patients in a prehospital setting who have received diuretics and where the transport time is greater than thirty minutes; and

(k) Initiate or administer any medications or blood products under specific written protocols authorized by the supervising physician, or direct orders from a licensed physician.

(12) The Board has delegated to the Section the following responsibilities for ensuring that these rules are adhered to:

(a) Designing the supervising physician and agent application;

(b) Approving a supervising physician or agent; and

(c) Investigating and disciplining any EMT or First Responder who violates their scope of practice.

(d) The Section shall provide copies of any supervising physician or agent applications and any EMT or First Responder disciplinary action reports to the Board upon their request.

(13) The Section shall immediately notify the Board when questions arise regarding the qualifications or responsibilities of the supervising physician or agent of the supervising physician.

OREGON ADMINISTRATIVE RULES
CHAPTER 847, DIVISION 035 - BOARD OF MEDICAL EXAMINERS
PROPOSED RULES CHANGES – APRIL 2005
FINAL REVIEW BY THE BOARD

847-035-0030

Scope of Practice

(1) The Board of Medical Examiners has established a scope of practice for emergency and nonemergency care for First Responders and EMTs. First Responders and EMTs may provide emergency and nonemergency care in the course of providing prehospital care as an incident of the operation of ambulance and as incidents of other public or private safety duties, but is not limited to "emergency care" as defined in OAR 847-035-0001 (5).

(2) The scope of practice for First Responders and EMTs is not intended as statewide standing orders or protocols. The scope of practice is the maximum functions which may be assigned to a First Responder or EMT by a Board-approved supervising physician.

(3) Supervising physicians may not assign functions exceeding the scope of practice; however, they may limit the functions within the scope at their discretion.

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(5) No EMT may function without assigned standing orders issued by Board-approved supervising physician.

(6) An Oregon-certified First Responder or EMT, acting through standing orders, shall respect the patient's wishes including life-sustaining treatments. Physician supervised First Responders and EMTs shall request and honor life-sustaining treatment orders executed by a physician or a nurse practitioner, if available. A patient with life-sustaining treatment orders always requires respect, comfort and hygienic care.

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from a Board-approved supervising physician, except as limited by subsection (2) of this rule. A First Responder may perform the following emergency care procedures without having signed standing orders from a supervising physician:

- (a) Conduct primary and secondary patient examinations;
- (b) Take and record vital signs;
- (c) Utilize noninvasive diagnostic devices in accordance with manufacturer's recommendation;
- (d) Open and maintain an airway by positioning the patient's head;
- (e) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;
- (f) Provide care for soft tissue injuries;
- (g) Provide care for suspected fractures;
- (h) Assist with prehospital childbirth; and
- (i) Complete a clear and accurate prehospital emergency care report form on all patient contacts and provide a copy of that report to the senior EMT with the transporting ambulance.

(8) A First Responder may perform the following procedures only when the First Responder is providing emergency care as part of an agency which has a Board-approved supervising physician who has issued written standing orders to that First Responder authorizing the following:

- (a) Administration of medical oxygen;
- (b) Open and maintain an airway through the use of an oropharyngeal and nasopharyngeal airway and pharyngeal suctioning devices;
- (c) Operate a bag mask ventilation device with reservoir;
- (d) Provision of care for suspected medical emergencies, including administering liquid oral glucose for hypoglycemia; and
- (e) Administer epinephrine by automatic injection device for anaphylaxis;
- (f) Perform cardiac defibrillation with an automatic or semi-automatic defibrillator, only when the First Responder:

(A) Has successfully completed a Section-approved course of instruction in the use of the automatic or semi-automatic defibrillator; and

(B) Complies with the periodic requalification requirements for automatic or semi-automatic defibrillator as established by the Section.

(9) An Oregon-certified EMT-Basic may perform emergency and nonemergency procedures. Emergency care procedures shall be limited to the following basic life support procedures:

(a) Perform all procedures that an Oregon-certified First Responder can perform;

(b) Ventilate with a non-invasive positive pressure delivery device;

(c) Insert a ~~[dual-lumen]~~ **cuffed pharyngeal** airway device in the practice of airway maintenance;

(d) Provide external cardiopulmonary resuscitation and obstructed airway care for infants, children, and adults;

(e) Provide care for suspected shock, including the use of the pneumatic anti-shock garment;

(f) Provide care for suspected medical emergencies, including:

(A) Obtaining a peripheral blood specimen for blood glucose monitoring, obtained via fingerstick, heelstick, or earlobe puncture;

(B) Administer epinephrine by subcutaneous or automatic injection device for anaphylaxis;

(C) Administer activated charcoal for poisonings, following local written standing orders; and

(D) Administer aspirin for suspected myocardial infarction.

(g) Perform cardiac defibrillation with an automatic or semi-automatic defibrillator;

(h) Transport stable patients with saline locks, heparin locks, foley catheters, or in-dwelling vascular devices;

(i) Perform other emergency tasks as requested if under the direct visual supervision of a physician and then only under the order of that physician;

(j) Complete a clear and accurate prehospital emergency care report form on all patient contacts;

(k) Assist a patient with administration of sublingual nitroglycerine tablets or spray and with metered dose inhalers that have been previously prescribed by that patient's personal physician and that are in the possession of the patient at the time the EMT-Basic is summoned to assist that patient; and

(l) In the event of a release of military chemical warfare agents from the Umatilla Army Depot, the EMT-Basic who is a member or employee of an EMS agency serving the DOD-designated Immediate Response Zone who has completed a Section-approved training program may administer atropine sulfate and pralidoxime chloride from a Section-approved pre-loaded auto-injector device, and perform endotracheal or pharyngoesophageal intubation, using protocols promulgated by the Section and adopted by the supervising physician. 100% of EMT-Basic actions taken pursuant to this section shall be reported to the Section via a copy of the prehospital emergency care report and shall be reviewed for appropriateness by Section staff and the Subcommittee on EMT Certification, Education and Discipline.

(m) In the event of a release of chemical agents the EMT-Basic, who has completed Section-approved training, may administer atropine sulfate and pralidoxime chloride, using protocols approved by the Section and adopted by the supervising physician, if:

(A) The supervising physician provides the EMT-Basic with a direct, verbal order through radio or telephone contact, or

(B) The EMT-Basic is under the direction of an EMT-Paramedic who is on the scene.

~~[(10) An Oregon certified EMT-Intermediate may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to the following:~~

~~(a) Perform all procedures that an Oregon certified EMT-Basic can perform;~~

~~(b) Initiate and maintain peripheral intravenous (I.V.) lines;~~

~~(c) Initiate and maintain an intraosseous infusion;~~

~~(d) Initiate saline or similar locks when specifically authorized by the physician;~~

~~(e) Infuse any physiologic isotonic crystalloid solution;~~

~~(f) Draw peripheral blood specimens;~~

~~(g) Initiate or administer the following medications:~~

~~(A) Epinephrine 1:10,000;~~

~~(B) Atropine sulfate;~~

~~(C) Lidocaine bolus for ventricular fibrillation, post ventricular fibrillation/ventricular tachycardia cardiac arrest, ventricular tachycardia, or wide complex tachycardia;~~

~~(D) Naxolone hydrochloride;~~

~~(E) Hypertonic glucose;~~

~~(F) Nitroglycerine for chest pain;~~

~~(G) Beta 2 specific nebulized bronchodilators;~~

~~(H) Morphine for pain management;~~

~~(h) Insert a laryngeal mask airway (LMA) device in the practice of airway maintenance;~~

~~(i) Insert an orogastric tube;~~

~~(j) Maintain during transport any intravenous medication infusions or other procedures which were initiated in a medical facility, and if clear and understandable written and verbal instructions for such maintenance have been provided by the personnel at the sending medical facility.~~

~~(k) Perform cardiac defibrillation with a manual defibrillator if the EMT Intermediate has satisfactorily completed a Section approved training course in manual defibrillation, including written and practical examinations and the EMT Intermediate is, at the time of performing manual defibrillation, in the service of an agency which has been granted an "EMT Intermediate Manual Defibrillation Waiver" by the Section.]~~

(10) An Oregon-certified EMT-Intermediate may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to the following:

(a) Perform all procedures that an Oregon-certified EMT-Basic can perform;

(b) Initiate and maintain peripheral intravenous (I.V.) lines;

(c) Initiate and maintain an intraosseous infusion;

(d) Initiate saline or similar locks;

(e) Draw peripheral blood specimens;

(f) Administer the following medications under specific written protocols authorized by the supervising physician, or direct orders from a licensed physician:

(A) Physiologic isotonic crystalloid solution.

(B) Vasoconstrictors:

(i) Epinephrine 1:10,000,

(ii) Vasopressin;

(C) Antiarrhythmics:

(i) Atropine sulfate,

(ii) Lidocaine,

(iii) Amiodarone;

(D) Antidotes:

(i) Naloxone hydrochloride;

(E) Antihypoglycemics:

(i) Hypertonic glucose,

(ii) Glucagon;

(F) Vasodilators:

(i) Nitroglycerine;

(G) Nebulized bronchodilators:

(i) Albuterol,

(ii) Ipratropium bromide;

(H) Analgesics:

(i) Morphine,

(ii) Nalbuphine Hydrochloride,

(iii) Ketorolac tromethamine;

(I) Antihistamine:

(i) Diphenhydramine;

(J) Diuretic:

(i) Furosemide;

(g) Insert an orogastric tube;

(h) Maintain during transport any intravenous medication infusions or other procedures which were initiated in a medical facility, and if clear and understandable written and verbal instructions for

such maintenance have been provided by the physician, nurse practitioner or physician assistant at the sending medical facility;

(i) Perform cardiac defibrillation with a manual defibrillator [~~if the EMT-Intermediate has satisfactorily completed a Section approved training course in manual defibrillation, including written and practical examinations and the EMT-Intermediate is, at the time of performing manual defibrillation, in the service of an agency which has been granted an “EMT-Intermediate Manual Defibrillation Waiver” by the Section].~~

(11) An Oregon-certified EMT-Paramedic may perform emergency and nonemergency care procedures. The emergency care procedures shall be limited to:

- (a) Perform all procedures that an Oregon-certified EMT-Intermediate can perform;
- (b) Initiate the following airway management techniques:
 - (A) Endotracheal intubation;
 - (B) Tracheal suctioning techniques;
 - (C) Needle cricothyrotomy; and
 - (D) Transtracheal jet insufflation which may be used when no other mechanism is available for establishing an airway.
- (c) Initiate a nasogastric tube;
- (d) Initiate electrocardiographic monitoring and interpret presenting rhythm;
- (e) Provide advanced life support in the resuscitation of patients in cardiac arrest;
- (f) Perform emergency cardioversion in the compromised patient;
- (g) Attempt external transcutaneous pacing of bradycardia that is causing hemodynamic compromise;
- (h) Initiate needle thoracentesis for tension pneumothorax in a prehospital setting;
- (i) Initiate placement of a femoral intravenous line when a peripheral line cannot be placed;
- (j) Initiate placement of a urinary catheter for trauma patients in a prehospital setting who have received diuretics and where the transport time is greater than thirty minutes; and
- (k) Initiate or administer any medications or blood products under specific written protocols authorized by the supervising physician, or direct orders from a licensed physician.

(12) The Board has delegated to the Section the following responsibilities for ensuring that these rules are adhered to:

- (a) Designing the supervising physician and agent application;
- (b) Approving a supervising physician or agent; and
- (c) Investigating and disciplining any EMT or First Responder who violates their scope of practice.
- (d) The Section shall provide copies of any supervising physician or agent applications and any EMT or First Responder disciplinary action reports to the Board upon their request.

(13) The Section shall immediately notify the Board when questions arise regarding the qualifications or responsibilities of the supervising physician or agent of the supervising physician.