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Prehospital Nursing

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Prehospital Nursing in Maryland -
Legal Considerations
Teresa M. Thorley
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Prehospital Nursing

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Prehospital Nursing in Maryland-

Legal Considerations

Introduction

↙ Prehospital care is a recent expansion of the health care system. One of the first indications that systematic emergency medical services were needed, was the publication of the "White Paper" - "Accidental Death and Disability: The Neglected Disease of Modern Society" in 1966 by the National Academy of Sciences-National Research Committee (NAS/NRC). During the intervening years, federal and state agencies along with the medical community have developed what is known today as the Emergency Medical Services system (EMSs). Maryland was one of the first states to implement a statewide EMS (Boyd, 1983).

Nurses have been and continue to be involved in all aspects of health care delivery. By the early 1900's, state boards of nursing were being established to define and regulate the practice of nursing (Bullough, 1980). Today, all states have boards of nursing who receive their authority from state legislation. Who can be a nurse and what a nurse can and cannot do is regulated by five sources of law:

(a) U. S. Constitution and individual state constitutions; (b) statutes; (c) regulations; (d) court decisions; and (e) Attorney General opinions (Feutz-Harter, 1989).

A profession should be regulated by members of that profession. This is the case in most aspects of nursing at the national and state levels, including the state of Maryland. However, nurses who wish to practice nursing in the prehospital environment in Maryland find themselves in an ambiguous legal situation. By law, regulation of all health care practice within the EMSs in Maryland has been delegated to the medical community. In some instances, the directives of the medical board regarding type of care rendered by a nurse are in direct conflict with the definition of scope of nursing practice as set forth by the Maryland Board of Nursing.

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1-3- The purpose of this paper is to explore the legal considerations of nurses practicing in the prehospital arena in Maryland today. In order to fully understand where the nurse fits in the EMSs, the origins of the Emergency Medical Services system will be reviewed. Relevant legal terms which apply to nurses in the prehospital health care area will be defined. A

comparison of the Emergency Medical Services system and nursing regulatory bodies in Maryland will be made and a proposed reason for the present day conflict will be offered. Based on the concepts explored, implications for the nurse practicing in the prehospital environment in Maryland will be discussed.

Chapter 1

History of EMS

Emergency medical care in the prehospital environment has developed from crude, haphazard beginnings to the present day system, steeped in technological advances. The original concept of prehospital care was developed by the military. In this context, the primary goal was to remove the injured soldier from the battle field and transport him to a hospital area. Beyond applying bandages to control bleeding, little medical care was rendered during transport. The Korean and Vietnam conflicts resulted in vast improvements for transporting patients. With the employment of helicopters, the length of time from initial injury to arrival at a medical facility during the Vietnam conflict averaged 35 minutes (Nell, 1968).

In the civilian sector, prehospital care evolved slowly. Ambulance services were generally privately owned, with varying capabilities. Drivers and attendants had little, if any, medical care training. There was no system in place to triage patients to hospitals with the ability to care for them. Many hospitals were, in fact, ill-equipped to care for the

critically ill or injured patient (Rockwood, Mann, Farrington, Hampton, & Motley, 1976).

The emergency medical system as seen today can trace its official origin to 1966 with the publication of "Accidental Death and Disability: The Neglected Disease of Modern Society" (NAS/NRC, 1966). This report outlined the problems seen in the emergency medical care system. It proposed a plan to remedy these problems. The NAS/NRC recommendations included: (a) extending first aid training to the public, using standardized text, training aids, and course material; (b) national standardization of ambulances, equipment carried, services provided, and drivers; (c) centralized communications, including the use of 911 for public access to the emergency services system; (d) implementation of designated definitive care centers; and (e) formation of state and national committees to collect data, perform research, and recommend methods to improve prehospital care (NAS/NRC, 1966).

In 1969, the Department of Transportation-National Highway Traffic Safety Administration (DOT-NHTSA) contracted for the development of a standardized course of instruction for paraprofessional prehospital care providers. The American College of Surgeons' Committee

on Trauma in 1970 published a guideline listing what they believed to be essential equipment for all ambulances. This became the nationally accepted standard. The Committee on Injuries of the American Academy of Orthopaedic Surgeons provided courses for training ambulance drivers and attendants. These attempts at rectifying the problems identified in the 1966 report were done sporadically and often times were confined to the region where the authors were located. Very little was done to address the problem on the national level in a coordinated manner (Rockwood et al., 1976).

In 1973, the U. S. Congress passed the Emergency Medical Services Systems Act (Pub. L. 93-154). This act mandated development of a nationwide, comprehensive, emergency medical care system. Functional components of the system were identified and geographic areas of responsibility were laid out. The emergency medical service was administrated by the Department of Health, Education, and Welfare (DHEW). Monies were provided to the states from federal funds for feasibility studies, planning, establishing, and initial operation, and expansion and improvement of existing systems. Special consideration was given to

those states which were implementing a statewide, comprehensive system. The initial timeframe for federal funding and control was three years (Rockwood et al., 1976). The Emergency Medical Services Systems Act was extended by amendments passed in 1976 (Pub. L. 94-573) and 1979 (Pub. L. 96-142). Between 1973 and 1981, vast improvements were made in the care of the critically ill and injured patient. Many of these improvements were the direct result of the rapid technological advances that were occurring in medical science. Research further supported the theories that early, appropriate intervention, particularly for cardiac arrest and trauma, greatly decreased morbidity and mortality of these patients.

By 1981, the federal government was seeking ways to reduce its spending. In the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35), funding for emergency medical services was included in a block grant to states for Preventative Health. EMS program activities and direction were now delegated to individual states. Along with the control of EMS, the majority of its funding must also come from within the state. At this point, federal involvement in EMS was

reduced to technical assistance and guidance (Boyd, Edlich, & Micik, 1983).

Chapter 2

History of EMS in Maryland

The Maryland Emergency Medical Services system had its beginning in 1962 with the creation of a two-bed trauma unit at the University of Maryland Hospital. During the next eleven years, this unique setting provided considerable research supporting the efficacy of early intervention for care of the critically injured patient (Ramzy, 1988). A statewide Emergency Medical Services system was created by an Executive Order issued by Governor Marvin Mandel in 1973 (Exec. Order No. 01.01.1973.04, Feb. 26, 1973). By provisions of the order, authority for control and planning were located in two areas. The Division of Emergency Medical Services (DEMS) contained within the Maryland Department of Health and Mental Hygiene and the University of Maryland's Institute for Emergency Medicine (MIEM) had joint responsibility for planning, developing, and implementing a statewide, comprehensive emergency care system. The blueprint for this system was published in 1975 (Cowley, 1975). In 1977, the MIEM and DEMS were combined into the present system of the Maryland Institute for Emergency Medical Services

Systems (MIEMSS) within the Department of Health and Mental Hygiene (Ramzy, 1988).

MIEMSS is currently the lead agency for emergency medical services in Maryland. The members of this agency are appointed by the governor and are responsible for coordinating all aspects of emergency medical services throughout the state, including care of the patient from the site of injury or illness through rehabilitation. This involves the training of all prehospital EMS providers, developing and maintaining a statewide communications system, designating trauma centers and specialty referral centers, data collection and analysis, establishing quality assurance programs, and generating research in emergency medical services (Md. Code Ann. Educ. Art. §§ 13-103-108, 1991).

All non-physician prehospital care providers practicing in Maryland, whether in a paid or volunteer status, must be certified by the Maryland State Board of Physician Quality Assurance (formerly the Board of Medical Examiners) (Md. Regs. Code tit. 10, subtit. 32, ch. 8, 1991). There are four categories of certified prehospital care providers in Maryland, Emergency Medical Technician (EMT-A), Cardiac Rescue Technician

(CRT), Aviation Trauma Technician (ATT), and Emergency Medical Technician/Paramedic (EMT-P) (Ramzy, 1988). As set forth by the Maryland Regulations (1991), these personnel operate from an established set of medical protocols.

Nurses must be licensed to practice in the state of Maryland. The Maryland rules and regulations stipulate who may provide prehospital care within the EMS system, there are only two categories of personnel identified: licensed physicians and state-certified, non-physician individuals (Md. Regs. Code tit. 10, subtit. 32, ch. 8, 1991). Therefore, if a nurse wishes to provide prehospital care in Maryland, he or she must complete the state requirements and be certified as an emergency medical technician or cardiac rescue technician.

Chapter 3

Legal Concepts Related to Nursing

Sources of Law

The practice of nursing is regulated by five sources of law: (a) U. S. Constitution and individual state constitutions; (b) statutes; (c) regulations; (d) court decisions; and (e) Attorney General opinions (Feutz-Harter, 1989).

United States constitutional law is the fundamental law to which all other laws must conform. It regulates the relationship of government and its citizen and prescribes a method according to which the public affairs are to be administered (Black, 1990). The patient's right to privacy, making medical records confidential, is an outgrowth of Constitutional law (Cournoyer, 1989). Constitutional laws can be changed by amending the existing Constitution. The federal constitution is considered the supreme law of the land and all other laws, including state constitutions, may not violate it.

Statutes are those laws written and established by the a legislative body of government (Black, 1990). A statute, or legislative law, may establish and give authority to regulatory agencies. The Nurse Practice

Act is a state statute which defines the practice of nursing and establishes the licensing and regulatory boards for nursing. Other statutes define time limitations for filing lawsuits, consent for medical treatment, tort reform measures, and guidelines for civil detention and guardianship (Feutz-Harter, 1989). The individual Emergency Medical Services systems have been established by state statutes. Statutes are changed through legislative action. A statute may be repealed or re-written as an amended law. The most recent publication of a statute (except when a future time of implementation is included) is the prevailing law.

A third source of law is regulations. Regulations are rules set forth by a regulatory agency which receives its power from statutes (Black, 1990). A state board of nursing generally has the authority to determine criteria for licensing, establish and certify curriculums for nursing education, and hold investigations and hearings to determine potential or actual violations of the nurse practice act or board of nursing regulations (Feutz-Harter, 1989). Regulations are changed or repealed by established procedure within the regulatory agency.

Court decisions comprise the fourth body of law. The functions of the courts are to apply the law to controversies brought before it and the public administration of justice (Black, 1990). There are two basic types of courts: trial and appellate. In a trial court, the initial civil or criminal case is heard and a decision is rendered by either a judge or jury. The appellate system is used when a party in the initial case believes that the judge made an error in interpretation of the prevailing law that was applied in the particular case. The U. S. Supreme Court is the final court of appeal for both state and federal cases. An appellate court is not required to review a trial court decision. If the appellate court refuses to review a trial court decision, the ruling of the trial court will stand (Feutz-Harter, 1989). The decisions rendered within a state at the supreme or superior court level, are binding to all other courts in that state. Decisions rendered by the U. S. Supreme Court are binding to all courts within the United States.

The fifth source of law which influences nursing practice comes from Attorney General opinions. The Attorney General is the chief attorney for the government. There are both state and federal Attorneys

General. Attorneys General are requested to render opinions regarding the legality of an action before the action is taken. These opinions are requested to clarify a statute, regulation, or court decision. The legal power of these opinions varies from state to state but, generally, an individual can expect reduced legal risk if their actions are based on the opinion rendered (Feutz-Harter, 1989). One must bear in mind, however, the courts are not bound by the opinions of Attorneys General (Cournoyer, 1989).

Specific Terms

There are many legal concepts that can potentially be encountered when practicing nursing. The legal concepts of negligence, malpractice, duty, standard of care, liability, respondeat superior, and stare decisis are by no means inclusive. They do, however, represent the very basic concepts which a nurse in the prehospital environment needs to understand.

Negligence is the failure to do something that a reasonably prudent and careful person would have done or doing something that a reasonably prudent and careful person would not have done under same or similar circumstances (Black, 1990). Negligence per se (automatically presumed negligent) may be inferred when

there has been a violation of a statute (Black, 1990). Gross negligence is the intentional failure to perform a duty with knowledge that a great risk to life or property may result (Black, 1990). When negligent acts are committed by a person in the performance of his or her professional duties, this is malpractice (Cournoyer, 1989). Nursing malpractice is, therefore, the failure of a nurse rendering professional services to exercise the degree of skill, learning, and care that an average, prudent, and reasonable nurse would have exercised under like or similar circumstances (Black, 1990; Creighton, 1986).

Negligence and malpractice have four components which must be proven before liability can be established. For negligence to be present, (a) a duty must exist; (b) there must be a breach of duty (a standard); (c) injury occurs; and (d) causation, that is, the injury resulted directly from the breach of duty (a standard) (Cournoyer, 1989). Nursing malpractice requires (a) existence of a duty, that is, nurse-patient relationship; (b) violation of the applicable standard of care; (c) occurrence of a compensable injury; and (d) the violation of the standard caused the injury (Black, 1990; Cournoyer,

1989). It is the responsibility of the plaintiff (injured party) to prove that all four elements of negligence or nursing malpractice exist (Black, 1990; Cournoyer, 1989; Creighton, 1986).

Duty implies an obligation. According to Black (1990), a duty occurs when a person is required by an obligation created by law, contract, or voluntary action to perform in such a manner that not to do so subjects the person to liability for any injury sustained by the individual to whom the duty is owed. Before a duty exists, a relationship must be established (Creighton, 1986). No one is obliged by law to assist a stranger (Cournoyer, 1989; Creighton, 1986; Feutz-Harter, 1989). However, once a relationship is established, the person rendering assistance incurs a duty and is held to the standards of care that a reasonable, prudent person would give in like or similar circumstances (Creighton, 1986). Maryland does not mandate that its citizens render assistance in an emergency; there exists no legal duty for a nurse to render assistance if he or she happens upon an emergency situation (Md. Cts. & Jud. Proc. Code Ann. §5-309, 1991).

One concept of duty to which a nurse is obligated is the duty of affirmative action. If a nurse observes another health care provider performing in such a manner that injury to a patient will likely occur, that nurse has a duty to intervene on behalf of the patient, either by stopping the other individual from doing what they are doing or notifying the appropriate persons of the situation observed (Feutz-Harter, 1989). Although the nurse may not have initially had a duty to the patient, once the behavior that may result in injury is observed, the nurse becomes accountable to that patient (Feutz-Harter, 1989).

The level of conduct, or care, for which a person is held accountable is referred to as the standard of care (Black, 1990; Feutz-Harter, 1989). Standards of care are those actions that a reasonably, prudent nurse under like or similar circumstances would take (Creighton, 1986). Specialists are held to higher standards as defined by a reasonably, prudent specialist practicing within the same field (Black, 1990). Standards of care are established by professional organizations such as the American Nurses' Association, specialty associations, and by

institutional policies and procedures (Feutz-Harter, 1989).

Liability follows the concept of duty. It is a broad legal term simplistically defined as the condition of being responsible for one's own actions (Black, 1990). Personal liability holds that each person is responsible for the consequences of his or her actions (Cournoyer, 1989). This can be an obligation that is incurred through any act or failure to act (Feutz-Harter, 1989).

A vicarious form of liability is *respondeat superior*. This is based on the master-servant rule. "Let the master answer" (Black, 1990, p.1311). The servant is the person who is employed to perform services for another and the master is the employer (Feutz-Harter, 1989). According to the concept of *respondeat superior*, the employer is held responsible (liable) for the acts of the employee so long as the employee is performing within the scope of his or her employment (Feutz-Harter, 1989).

Stare decisis, or precedent, is the final legal concept to be considered. This is a doctrine which states that the decision for a particular case will be the basis for deciding similar cases in the future

(Black, 1990). Precedents are established by appellate and trial courts and equal or lower courts are bound by these rulings when deciding cases where facts are substantially the same (Cournoyer, 1989).

Nurses must be aware of the legal constraints that exist regarding their practice. The five sources of law which determine what they can and can not do are:

(a) U. S. Constitution and individual state constitutions; (b) statutes; (c) regulations; (d) court decisions; and (e) Attorney General opinions (Feutz-Harter, 1989). Legal concepts which a nurse may encounter during the professional practice of nursing include, but are not limited to, negligence, nursing malpractice, duty, standard of care, liability, respondeat superior, and stare decisis. The nurse should be knowledgeable of the Nurse Practice Act of the state within which he or she is practicing and his or her legal responsibilities in order to minimize the chance of losing one's license to practice or being named in a lawsuit.

Chapter 4

Good Samaritan Law

Common law indicates that unless the person has caused the emergency situation, that person is not obligated to render assistance to the one in distress barring a previously established relationship (Mapel & Weigel, 1981). However, should a person voluntarily choose to render aid in an emergency situation, that person incurs a duty to exercise reasonable care to avoid further injury of the distressed individual. Once a duty is established, the person giving the assistance now becomes liable for his or her acts and omissions (Mapel & Weigel, 1981). This could place the individual who volunteers to assist another in distress at risk of a lawsuit.

The concern of law makers that physicians and other health care providers would not render aid in emergency situations for fear of malpractice litigation prompted the passage of Good Samaritan laws. Good Samaritan laws are "...designed to provide immunity from civil liability to physicians and others for negligent torts [civil wrong as opposed to criminal wrong] committed in the treatment of an injured party at the scene of an accident" (Mapel & Weigel, 1981, p.

327). The first Good Samaritan statute was enacted by the California legislature in 1959. Other states followed California's example and today, all 50 states and the District of Columbia have Good Samaritan laws (Louisell & Williams, 1990; Mapel & Weigel, 1981).

Unfortunately, Good Samaritan laws are not uniform throughout the country. Vermont, for example, requires that a passer-by stop to render aid in an emergency situation. The Vermont Good Samaritan statute does provide immunity from civil liability (ordinary negligence) for the Good Samaritan (Vt. Stat. Ann. tit. 12 §519, 1989). Other states such as California have written specific Good Samaritan laws for each category of person covered (see, for example, Cal. Bus. & Prof. Code §2727.5 - Nurses, 1989). Good Samaritan laws of still other states such as Alabama and Kansas, cover only those persons who are licensed to practice medicine or nursing within the respective state. Arizona, Delaware, and Maryland are examples of states whose Good Samaritan laws cover medical professions regardless of the state in which they are licensed (Wills-Long, 1988).

It should be noted, the Good Samaritan laws give various degrees of immunity from civil liability under

conditions of a true emergency. This does not mean that a person responding to an emergency can not be named in a lawsuit. The Good Samaritan law may be used as a defense and if the situation is determined to have been a true emergency and the person rendering aid is covered under the law, barring evidence of gross negligence, the judgement generally will be made in favor of the defendant - the Good Samaritan (see, for example, Held v. City of Rocky River, 1986; Malone v. City of Seattle, 1979).

The state of Maryland enacted its first Good Samaritan law in 1963. The original law provided some immunity from civil liability only to physicians licensed by the state of Maryland who provided care at the scene of an accident. In 1964, the law was amended to include trained members of volunteer ambulance and rescue squads. Legislation in 1965 further extended immunity from civil liability to registered and licensed practical nurses. In 1969, members and employees of fire departments were added and in 1972, trained members of the National Ski Patrol System were included. In 1973, the law was again amended to include police, sheriffs, and other law enforcement officers. The General Assembly repealed and re-enacted

the Good Samaritan law, consolidating the previous amendments into two laws: Chapters 558 and 689, Laws of Maryland 1976 (Md. Op. Atty. Gen., 064-169, 1979).

The current Good Samaritan law of Maryland (see Appendix) declares specific categories of people immune from civil liability for any act or omission in giving assistance or medical care (a) at the scene of an emergency; (b) in transit to a medical facility; or (c) through communications with personnel providing emergency assistance (Md. Cts. & Jud. Proc. Code Ann. §5-309, 1991). A specific reference to registered nurses is no longer included. According to Attorney General Sachs in an opinion rendered in 1979, all registered and licensed practical nurses are included as "...[a] person licensed by the State of Maryland to provide medical care; ..." (Md. Op. Atty. Gen., 064-169, p. 172).

Paid paramedics are immune under the Maryland Good Samaritan law "... if the victim is not charged by the one rendering the assistance and seeking immunity then even a salaried employee is entitled to immunity absent gross negligence" (Md. Op. Atty. Gen. 064-175, 1979, p. 179). A case on point is Tatum v. Gigliotti in which the ruling held that "...immunity provided by

good samaritan statute applies to salaried emergency medical technician[s]..." (Tatum V. Gigliotti, 80 Md.App. 559, 1989, p. 559).

A review of Maryland Appellate court cases from 1963 through 1990 revealed no lawsuits involving registered nurses rendering care in an emergency situation. Until a case involving a registered nurse who invokes Good Samaritan immunity reaches the appellate court, it can not be said for certain that, in the state of Maryland, a registered nurse is the same as one who is licensed to provide medical care. A registered nurse who also is a Maryland certified emergency medical technician (EMT) or cardiac rescue technician (CRT) does have immunity when rendering emergency care as an EMT or CRT (Md. Cts. & Jud. Proc. Code Ann. §5-309, 1991).

Chapter 5
Regulation of Nursing Practice
in Maryland

The movement for the regulation of nursing practice resulted from the activities of trained nurses in the early 1900s. These nurses wanted legal recognition of educational standards to thwart the rapidly growing, irresponsible, nursing training schemes that were occurring (Birnbach, 1985). The underlying purpose of regulation and licensing of nursing is the protection of the public (Creighton, 1986).

By virtue of the tenth amendment of the U. S. Constitution, it is the right of each state to enact legislation for the licensing and regulation of health care professionals. Today the practice of nursing is regulated in all 50 states and the District of Columbia. The statutes of each state generally contain criteria for entry into the profession and the regulations define the standards and scope of practice (Cournoyer, 1989; Eccard, 1977). Generally, the means of implementing and enforcing these regulations are also defined in the statutes (Cournoyer, 1989).

There is no nationally recognized legal definition of nursing practice. Consequently, the definition and scope of nursing practice varies from state to state. The American Nurses' Association's (ANA) Congress for Nursing Practice published a model definition in 1981. However, every state legislature has the authority to enact its own definition and is not bound by that of the ANA (Cournoyer, 1989).

The first legislation for the registration of nurses in Maryland was passed by the Maryland General Assembly in 1904 (Md. Laws Ch. 172, 1904). The Act to provide for the state registration of nurses included the establishment of the Board of Examiners. Authority given to the board included licensing power, rule-making power, and adjudicatory power. The legislation also restricted the use of the title "registered nurse" or "R.N." to only those individuals who received "...his or her certificate according to the provisions of this Act..." (Md. Laws Ch. 172, 1904, p. 291).

Since that time, the code covering nursing practice regulation has been amended many times reflecting the changes within the profession and society in general. Currently, the Maryland Nurse

Practice Act is Title 8 Sections 8-101-802 of the Maryland Health Code Annotated (1991).

Title 8 contains definitions of nursing practice, registered nurse, and practical nurse (§8-101). The membership, functions, authority, powers, and duties of the Maryland State Board of Nursing (also referred to as "the Board") (formerly the Board of Examiners) are found in §§8-201-208. Title 10 Subtitle 27 of the Maryland Regulations (1991) delineates the standards of practice for registered nurses (Ch. 09) and licensed practical nurses (Ch. 10). For purposes of this paper, only those sections of the code and regulation pertaining to registered nurses shall be discussed.

The Maryland Nurse Practice Act defines the registered nurse as "...an individual who is licensed by the Board to practice registered nursing" (Md. Health Occu. Code Ann. §8-101(g), 1991, p. 152). The practice of registered nursing in Maryland is legally recognized as "...the performance of acts requiring substantial specialized knowledge, judgement and skill based on biological, physiological, behavioral or sociological sciences as the bases for assessment, nursing diagnosis, planning, implementation and evaluation ... [in the care of patients]..." (Md.

Health Occu. Code Ann. §8-101(f), 1991, p. 152). The Maryland regulations further define what is meant by assessment, nursing diagnosis, planning, implementation, and evaluation (Md. Regs. Code tit. 10 subtit. 27 ch. 09.02, 1991). This regulation is, therefore, the legally accepted set of standards for the practice of registered nursing in Maryland. Any Maryland registered nurse charged with professional negligence in Maryland will be held to the standards set forth by the Maryland Board of Nursing at the time of the alleged negligent act.

The Maryland Board of Nursing has the power and duty to "...adopt rules and regulations for the performance of additional nursing acts [and independent nursing functions] that: ...may be performed under any condition authorized by the Board, including emergencies..." (Md. Health Occu. Code Ann. §8-205(a)(4)(a)(5), 1991, p. 156). Rules and regulations for delegated medical functions must be developed jointly by the State Board of Physician Quality Assurance and the State Board of Nursing (Md. Health Occu. Code Ann. §8-205(a)(3), §14-304(d), 1991).

An individual must be licensed by the Maryland State Board of Nursing before he or she may practice

registered nursing in this state and all acts that are deemed the practice of registered nursing, except those which may be delegated as specified in the regulation, can only be performed by registered nurses (Md. Health Occu. Code Ann. §8-301(a), 1991). This individual is required to (a) satisfactorily complete a registered nursing program approved by the Board, (b) satisfactorily pass an examination approved by the Board, and (c) demonstrate competency in the English language (Md. Health Occu. Code Ann. §8-303, 1991). The Board also has the authority, with due process of law, to deny, reprimand, suspend, or revoke licenses for the practice of registered nursing (Md. Health Occu. Code Ann. §§8-316-319, 1991). This includes the authority to administratively discipline an individual who "...[d]oes an act that is inconsistent with generally accepted professional standards in the practice of registered nursing..." (Md. Health Occu. Code Ann. §8-316(a)(8), 1991, p.168).

Registered nurses in the state of Maryland are required to maintain professional competency. This includes, among other stated behaviors, knowledge and compliance with changing procedures and standards in the nursing field and obtaining additional education,

training, and supervision as needed when performing additional nursing acts or independent nursing functions (Md. Regs. Code tit. 10 subtit.27 ch 10.03, 1991).

A review of the Maryland Appellate Court cases from 1960 through 1990 revealed no lawsuits which question the legality of the Board of Nursing's authority. Maryland Attorney General opinions have stated that the State Board of Nursing has the authority to accept or reject courses of study for the preparation of registered nurses according to the requirements of the Board (Md. Op. Atty. Gen., 037-329, 1952). No recent published opinions regarding the Board of Nursing were found.

The Board of Nursing does not differentiate between registered nurses working for compensation or as volunteers (Md. Health Occu. Code Ann. §§8-101-802, 1991). Since the legislative intent of the Maryland Nurse Practice Act is to impose liability for its violation, registered nurses, whether in a volunteer or paid position, are bound by the standards of practice as defined in the regulations (Md. Laws Ch. 172, 1904; Md. Health Occu. Code Ann. §§8-101-802, 1991; Md. Regs. Code tit. 10 subtit. 27 ch. 09.02, 1991).

Chapter 6

Regulation of Prehospital
Care Providers in Maryland

The Maryland State Emergency Medical System was established by an executive order in 1973 (Exec. Order No. 01.01.1973.04, 1973). The Division of Emergency Medical Service (DEMS) was initially created within the Department of Health and Mental Hygiene. Together with the University of Maryland's Institute for Emergency Medicine (MIEM), DEMS was given the authority to implement, administrate, and operate a state-wide emergency medical service. Included in the shared responsibilities of DEMS and MIEM was the training of emergency medical personnel (Exec. Order No. 01.01.1973.04, 1973). In 1977, DEMS and MIEM were combined to form the Maryland Institute for Emergency Medical Services System (MIEMSS) within the Department of Health and Mental Hygiene (Ramzy, 1988).

There are two categories of non-physician prehospital care providers in the Maryland emergency medical system: (a) Basic Life Support (BLS), and (b) Advanced Life Support (ALS) (Ramzy, 1988). The BLS category contains the Emergency Medical Technician - Ambulance (EMT-A). EMT-As are trained through the

Maryland Fire and Rescue Institute and certified by MIEMSS (Ramzy, 1988). These individuals are generally the first responders, for example police officers, and can administer only basic life support interventions such as chest compressions (Ramzy, 1988).

The ALS category contains three levels of trained individuals: (a) Cardiac Rescue Technicians (CRTs), (b) Aviation Trauma Technicians (ATTs), and (c) Emergency Medical Technician - Paramedics (EMT-Ps) (Ramzy, 1988). These individuals are also trained by the Fire and Rescue Institute. However, they are certified and regulated by the Board of Physician Quality Assurance (Md. Health Occu. Code Ann. §§14-303-305, 1991; Md. Regs. Code tit. 10 subtit. 31 chs. 06-07, 1991). This is in line with the requirement for medical control of the state-wide emergency medical system contained in the Emergency Medical Systems Act of 1973.

Certified CRTs' scope of practice includes performing all phases of cardiopulmonary resuscitation including administration of drugs and intravenous solutions (ACLS) as directed by a licensed physician, and obtaining blood for laboratory analysis (Md. Health Occu. Code Ann. §14-303, 1991). Certified ATTs, who

man the MedEvac helicopters, may perform all phases of prehospital advanced life support (ATLS), administer drugs and intravenous solutions as directed by a licensed physician, and obtain blood for laboratory analysis (Md. Health Occu. Code Ann. §14-304, 1991). Certified EMT-Ps, who are considered the highest level of prehospital care (Ramzy, 1988), may perform all of the procedures that can be assigned to a CRT or ATT (Md. Health Occu. Code Ann. §14-305, 1991). The preceding definitions, which contain a degree of ambiguity regarding the definitive areas of practice, are from the Maryland Code. The Maryland Board of Physician Quality Assurance's authority to regulate the CRTs, ATTs, and EMT-Ps includes the power to reprimand, place on probation, suspend, or revoke the certification of any of these individuals who violates the rules and regulations set forth by the Board (Md. Health Occu. Code Ann. §14-303(c), §14-304(c), and §14-305(c), 1991).

Licensed physicians are permitted to delegate specific duties to the non-physician prehospital care provider as determined by the Maryland Board of Physician Quality Assurance (Md. Health Occu. Code Ann. §14-306, 1991). The medical functions which are

permitted to be delegated are contained in a set of protocols, Program Standards Manual - Delegation of Duties by a Licensed Physician - Aviation Trauma Technician; Emergency Medical Technician - Paramedic, written by the Maryland Board of Physician Quality Assurance and published by the Medical Director of MIEMSS (Md. Regs. Code tit. 10 subtit. 32 ch. 08.01(14), 1991).

An individual who desires to practice as a paid or volunteer CRT, EMT-P, or ATT in Maryland, must comply with the state educational, experience, and certification requirements. Presently, there are no provisions in the state law which take into consideration any other non-physician health care education. Therefore, if a Maryland registered nurse desires to practice in the prehospital environment, he or she must complete the entire educational, experience, and certification process as required for a person with no previous health care education.

One final aspect of control is regional jurisdiction. The EMS in Maryland is divided into five regions (Ramzy, 1988). Each county within these regions has the authority to determine the level of emergency medical services needed: BLS or ALS - CRT or

EMT-P (D. Gainor, personal communication, February 8, 1991). An individual who is certified as an EMT-P may not be able to function at that level if there are no ALS units which use EMT-Ps within the jurisdiction where he or she wishes to affiliate. For example, an EMT-P who is in a paid position in Anne Arundel County, where EMT-Ps are utilized, may perform as an EMT-P when affiliated with an ALS unit that includes EMT-Ps as part of its personnel. However, if this same individual wishes to volunteer in Baltimore City, he or she may only perform at the level of a EMT-A or CRT as there are no EMT-P positions in Baltimore City. In whichever capacity the individual performs, that person must have the appropriate certification and abide by the rules and regulations set forth by the Maryland Board of Physician Quality Assurance and MIEMSS.

Chapter 7
Nursing Licensure versus
EMT Certification

The Maryland Board of Nursing has the authority to regulate the practice of registered nursing including establishing educational standards and requirements (Md. Health Occu. Code Ann. §§8-101-802, 1991; Md. Laws Ch. 172, 1904). The Nurse Practice Act does not differentiate between paid and volunteer practice of nursing. Therefore, any registered nurse practicing in Maryland is legally under the regulatory control of the Maryland Board of Nursing. In response to a personal query, the Maryland Board of Nursing stated "...when you are functioning as a volunteer in a rescue situation, you are still licensed to practice as a registered nurse and are expected to carry out your role as a nurse to the fullest extent" (D. M. Dorsey, personal communications, May 12, 1988; used with permission D. Jones, personal communications, February 9, 1991). An Attorney General opinion has been requested by the Board of Nursing to clarify this interpretation and they are presently awaiting a response (B. Newman, personal communications, September

28, 1990; P. Epifanio, personal communications, February 7, 1991).

A review of the Maryland Appellate Court cases and communications with B. Newman, Maryland Board of Nursing, reveal no cases where action has been taken against a registered nurse practicing with a rescue squad. There is one case in another state which partially supports the principles that (a) the Board of Nursing generally has the authority to regulate all nursing practice, and (b) as a registered nurse, the individual is expected to fully function in that capacity under all circumstances.

In Leigh v. Board of Registration in Nursing (1985), Ms. Leigh, who was a registered nurse licensed by the Massachusetts Board of Registration in Nursing, protested suspension of her license by the Board for inappropriately practicing lay midwifery. In Massachusetts, the Board of Registration in Nursing is authorized to establish conditions and regulations for nursing practice in the expanded role (Leigh v. Board of Registration in Nursing, 1985). The court ruled that the Board was within its authority to suspend Ms. Leigh's license because as a registered nurse, she could only practice midwifery after complying with the

Board's rules and regulations regarding that expanded role. Maryland is not bound by rulings of the Massachusetts Supreme Court. However, considering the similarity of the Maryland Code for regulation of nurses and that of Massachusetts, it is not inconceivable that should a similar case occur, Maryland courts may rule in the same manner.

The Nurse Practice Act of Maryland provides guidance regarding nursing practice in emergencies. Section 8-101(f) defines the practice of registered nursing, in part, as assessment, making nursing diagnosis, planning, implementing, and evaluating care for the ill, injured, or infirmed. This includes the execution of a therapeutic regimen, including the administration of medications (Md. Health Occu. Code Ann. §8-101(f), 1991). Section 8-205(4)(i) authorizes the Board to "...adopt rules and regulations for the performances of additional nursing acts that may be performed under condition[s] ...[of] emergencies..." (p. 156). Therefore, it would seem that it is within the authority of the Maryland Board of Nursing to regulate registered nurses practicing with rescue squads.

The Maryland Board of Physician Quality Assurance has the authority to regulate the paraprofessionals within the EMS system (Md. Health Occu. Code Ann. §§14-303-305, 1991). MIEMSS is the legitimate regulatory department for determining personnel within the EMS system including prehospital care providers (Md. Educ. Code Ann. §13-103, 1991). The Maryland Fire and Rescue Institute has the authority to educate and train all career and volunteer fire and rescue personnel (Md. Educ. Code Ann. §11-503 and §13-104, 1991). The Maryland Board of Physician Quality Assurance has the authority to determine which medical duties may be delegated by licensed physicians (Md. Health Occu. Code Ann. §14-306, 1991). However,

[i]f a duty that is to be delegated under this section is a part of the practice of a health occupation that is regulated under this article by another board, any rule or regulation concerning that duty shall be adopted jointly by the Board of Physician Quality Assurance and the board that regulates the other health occupation (Md. Health Occu. Code Ann. §14-306(d)(1), 1991, P. 297).

These statutes taken together and applied to a registered nurse practicing in the prehospital

environment leave no clear cut picture of who is ultimately the legitimate authority for regulating this individual's practice.

Consider the following. As discussed previously, an EMT-A is not allowed to administer medications under any circumstances. The Maryland registered nurse's scope of practice includes the administration of medications when ordered by an authorized prescriber. In order for the registered nurse to provide prehospital care in Maryland, he or she must be certified as an EMT-A, CRT, ATT, or EMT-P. To begin training for certification as a CRT, an individual must first be certified by MIEMSS as an EMT-A and have at least one full year of continuous experience or 150 ambulance runs providing prehospital care as an EMT-A (Md. Regs. Code tit. 10 subtit. 32 ch. 08.03(B), 1991). Under these conditions, there is a real potential that the following hypothetical situation may occur.

A registered nurse has obtained his or her EMT-A certification. He or she is now in the process of completing the required experience as an EMT-A before beginning training for CRT. A call is received requesting an ambulance for a patient who is experiencing chest pain. The registered nurse/EMT-A is

the only prehospital care provider dispatched. Upon arrival, it is determined that the patient is experiencing multiple premature ventricular contractions. After relaying this finding to the physician at the base station, the EMT-A/registered nurse is instructed by the physician (who knows that the EMT-A is also a registered nurse) to start an intravenous solution and give 100mg Lidocaine intravenously. By law, as an EMT-A, the prehospital care provider is forbidden to do this. The physician is also restricted from delegating this function to an EMT-A but is allowed to delegate this to a registered nurse. As a registered nurse, the prehospital care provider is authorized to carry out the physician's order. Also, as a registered nurse, if the individual does not comply with the order, he or she can be disciplined by the Board of Nursing for "...[doing] an act [refusing to follow a valid physician order] that is inconsistent with generally accepted professional standards in the practice of registered nursing" (Md. Health Occu. Code Ann. §8-316(a), 1991, p. 168).

As an EMT-A, the registered nurse who follows the physician's order and gives the medication, may well be disciplined by MIEMSS for functioning outside of the

EMT-A scope of practice. The individual's certification may be revoked and then he or she would be unable to continue affiliation with any rescue squad in Maryland.

The above hypothetical scenario illustrates the very real obscurity of the legal position of the registered nurse practicing in the prehospital care environment in Maryland. This one individual is potentially under the regulation of the Board of Nursing, the Board of Physician Quality Assurance, MIEMSS, and the Fire and Rescue Institute when in fact, the Board of Nursing should have the final authority governing the practice of registered nursing.

Part of the problem that has created this obscurity is the close association of the fire department and the rescue squads. Emergency services in Maryland are defined as "...fire, rescue, and ambulance services" (Md. Educ. Code Ann. §11-501(b), 1991, p. 273). Rescue squads are co-located with the fire departments. All fire department personnel are required to have EMT-A certification and all rescue squad personnel report to the Chief of the fire department where the rescue unit is located (Morhaim, 1989). Consequently, the fire departments seem to

consider rescue personnel as entirely under their authority. The apparent purpose of a fire department is to prevent property damage from fire. Their focus is, therefore, not health care delivery.

The practice of a registered nurse who works in the school system, where the primary focus of the employer is education, is regulated by the Board of Nursing. So then, the practice of a registered nurse who is affiliated with a rescue squad co-located with a fire department should also be regulated by the Board of Nursing.

Chapter 8

Nursing Implications

The evolution of the Medical Emergency System (EMS) as seen today began in the mid 1960s when the National Academy of Sciences' National Research Council (NAS/NRC) published a report titled "Accidental Death and Disability: The Neglected Disease of Modern Society" (NAS/NRC, 1966). It was not until 1973 that a federal act addressed the standardization of EMS organizations. Until that time, each EMS reflected the needs of the region as perceived by the controlling agency for that region. Inequalities in EMS still exist today due to the state control of most of the regulatory and certification processes (Nard, 1990). Although the federal EMS Systems Act of 1973 recommends medical control and direction of prehospital care providers, there are some states where specially trained nurses provide the medical direction to prehospital care providers (Nard, 1990). The education of prehospital care givers is still considered to be a major function of the regional EMS. There are various levels of medical control and the authority overseeing the practice of prehospital caregivers ranges from local fire departments to central medical control

centers at trauma care facilities. Therefore, there still remains some degree of lack of standardization in training, titles, scope of practice and control.

A medical emergency is, to a citizen, a health-related event. With that in mind, the emergency medical response is therefore a health care delivery system. Since the person requiring the emergency medical care is unable to choose the EMS, it becomes the responsibility of emergency medical systems to provide prehospital care which is standardized and of the highest quality possible (Krentz & Wainscott, 1990). Nursing has established a national standard in educational facility accreditation and licensure examination. The American Nurses Association (ANA) has defined the scope of practice for the nursing profession as a whole. The Emergency Nurses Association (ENA), as a professional organization of specialty nurses within the nursing profession, has further defined the scope of practice for those nurses functioning in emergency health care delivery (Emergency Nursing Scope of Practice, 1989). ENA and the National Flight Nurses' Association (NFNA) issued a joint position statement on the role of the registered nurse in the prehospital environment. Included in the

position statement are recommendations for minimal educational requirements and standards of practice for the prehospital nurse (ENA/NFNA, 1990). Quality of care is an integral part of the ANA, ENA, and NFNA positions.

One of the first prehospital health care delivery systems in which nurses were major participants as prehospital care providers was the St. Anthony's Hospital aeromedical transport program for trauma victims in Denver, Colorado begun in October of 1972 (Gabram & Jacobs, 1990). Since that time, many of the aeromedical transport crews have included specially trained nurses as their main components. In a study by Baxt and Moody (1987), the lowest mortality for head-injured patients (Glasgow Coma Score less than 8) was seen in those air transported by a physician-nurse team as compared with teams that had neither a physician nor nurse. They speculated that because the aeromedical crew was an extension of the trauma center, the continuity of care improved the survival rate of the patients. In 1987, Campbell compared the prehospital patient assessments made by flight nurses to those made by the emergency department physicians. It was found that there was a 75.19% agreement. The future of

aeromedical transport will see the use of more sophisticated devices which will require advanced education and training. The National Flight Nurses Association has already developed a national curriculum for the training of these highly skilled nurses in order to ensure the quality of prehospital care delivered nationwide (Gabram & Jacobs, 1990). In 1986, the Emergency Nurses Association and the National Flight Nurses Association presented a joint position paper recommending that minimal staffing for air medical services include at least one specially trained registered nurse with extensive experience and expertise in caring for critically ill and injured patients.

Currently there are four states which have mobile intensive care nurse (MICN) programs (Moore, 1987). Like the current EMS, these programs are under state control. In Illinois, the mobile intensive care nurse provides patient care in the field, including intubation, defibrillation and CPR. In New Jersey, the field nurse provides direct patient care as well as direction to the EMT-Ps in the field. Massachusetts regulations authorize the specially trained MICN to give medical direction to other prehospital care

providers under certain circumstances. In California, the MICN has been an integral part of the prehospital care delivery system since 1969 (Merritt-Lindgren & Pletz, 1985). Initially, the MICN in California issued instructions to the EMT-Ps in the field. Since 1970, the MICN has also provided direct patient care in the prehospital environment.

Texas has, within the EMS, a prehospital nurse clinician (PCN) position (Lyle, 1985). The primary function of the EMS PCN is teaching and evaluation. In order to maintain skill levels, the EMS PCN is "encouraged" to ride in ambulances frequently and provide primary patient care.

One of the major problems facing the nurse practicing in the prehospital arena is under which agency of regulation do they fall (Lyle, 1985; Merritt-Lindgren & Pletz, 1985; Moore, 1987; Selfridge & Dean, 1985). In Maryland, this is one of the major concerns of the registered nurse in prehospital care. Currently, four regulatory bodies contend that they have control over nursing practice in the prehospital environment: (a) Maryland Board of Nursing, (b) Maryland Board of Physician Quality Assurance, (c) MIEMSS, and (d) Maryland Fire and Rescue Institute.

As a profession, nursing must have only one legitimate authority for regulation of its practice. In 1904, the Maryland General Assembly gave this authority to the Board of Examiners (now called the Maryland Board of Nursing) (Md. Laws Ch. 172, 1904). Regulation of practice in the expanded nursing role is still retained by the Board of Nursing as evidenced by inclusion of standards for the practice of Certified Nurse Practitioner and Nurse Midwifery (Md. Health Occu. Code Ann. §8-306 & §§8-601-603, 1991). Prehospital nursing is not necessarily an expanded role any more than cardiac critical care nursing is. It is a specialty. Therefore, regulation of prehospital nursing practice is well within the scope of authority delegated to the Board of Nursing. Maryland nurses need to re-gain their legitimate right to regulate their own practice in prehospital care delivery.

There is evidence that the Maryland Board of Nursing is well aware of this problem. In 1989, the Board established a task force under its Practice Issues Committee to recommend guidelines for a process which will allow registered nurses to function in a prehospital setting (B. Newman, personal communications, September, 28, 1990). It has been

argued that nurses are not trained in prehospital care delivery, therefore, they should be required to attain the same certification as all other prehospital paraprofessionals (Ampolsk, 1989; Paturas, 1990). No one is arguing that entry level nursing education is inadequate for practice in the prehospital environment. The Maryland Board of Nursing, ENA, and NFNA all recommend that nurses who desire to practice prehospital nursing acquire the appropriate knowledge and skill proficiency unique to prehospital care (ENA/NFNA, 1990; B. Newman, personal communications, September 28, 1990). What nursing is asserting, however, is that, included within the power to regulate is the Board's authority to determine the educational requirements which are generally based on national standards. Nursing, specifically ENA, has developed an core curriculum to educate nurses for prehospital care (Garza, 1990).

There is also the argument that with a nursing shortage, nurses are needed more in the hospital and paramedics can adequately cover prehospital care (Ampolsk, 1989; Garza, 1990; Paturas, 1990). This too, is not the issue. Regardless of whether there is a nursing shortage, there are nurses who are currently

practicing in the prehospital environment and for whom there must be only one regulatory agency - the agency delegated to regulate nursing practice.

The Maryland Board of Nursing has begun the process of clearly defining its role and authority for regulating prehospital nursing care. The State Board Task Force for the RN in the prehospital environment has been meeting regularly and is scheduled to submit to the Maryland Board of Nursing in June 1991 its recommendations for a nursing curriculum that will provide the knowledge and skills necessary to provide competent prehospital nursing care (P. Epifanio, personal communications, February 7, 1991). Legally, only the Board of Nursing can approve or reject this curriculum. Once accepted and approved by the Board, completion of this course will most likely be mandatory for any nurse who practices in the prehospital environment. This, then, will openly conflict with the educational requirements stipulated by the Maryland Fire and Rescue Institute for prehospital care providers. Resolution of this conflict will not be easy.

Potentially, there are several methods that could be used to resolve this. The most productive method is

through legislative action since legislative law determines who the regulatory agencies are and defines the agency's scope of authority. As a nurse, one must be concerned about who has the authority to regulate the practice of nursing in any environment. The issue of regulating prehospital nursing is not just the concern of those nurses practicing there, but is the concern of all nurses.

To affect legislative actions, one must become politically active. Whether as an individual or as a group, there are basic requirements that must be met in order to be politically effective. First, and foremost, know the subject (issue). Research its history and background. Based on an analysis of the information gathered, develop a clear statement of the problem and recommended solutions. The next step is to educate all individuals who are affected by the issue regarding the identified problem and recommended solutions. In the case of prehospital nursing care this includes nurses, paramedics, fire departments, and all citizens in general. Find out who will oppose the recommended solution and what their reasons are. By working with organizations such as the political arm of the Maryland Nurses' Association, ENA, and others,

state legislators can be lobbied to introduce bills reflecting the stated position.

Once a bill has been introduced, nurses can influence its passage by actively lobbying their representatives as individuals or as groups. This can be done by letter writing, personal visits to representatives, and/or presenting testimony to the legislature. It is imperative that once a bill is written it is monitored daily. It can be changed at any time before a vote is taken and the changes may not reflect the original intent.

Two examples of nurses affecting change through the legislative process are the state level ENA involvement in (a) the Iowa medical services law (Haney, Peterson, Wagenknecht, & Butler, 1984), and (b) in the California mobile intensive care nurse role definition (Merritt-Lindgren & Pletz, 1985). The Iowa Emergency Department Nurses' Association (EDNA) (now the Iowa ENA) became involved when the issue of use of paramedics in emergency departments was brought up (Haney et al., 1984). The steps taken by the Iowa EDNA included (a) researching the history of EMT use in hospitals, (b) surveying all emergency department nursing supervisors of hospitals with more than 40 beds

in Iowa regarding present use of EMTs in the emergency department, and (c) analyzing all aspects of the issue. With the Iowa Nurses' Association, they were able to influence the formation of an emergency care task force to study the issue. The task force included representatives of the Iowa Hospital Association, Iowa Advanced Emergency Care Council, Governor's EMS Advisory Council, Iowa State Department of Health, Iowa Nurses' Association, and legislators. Together, these representatives wrote a house and senate bill which reflected consensus of all parties involved. As a result, legislation was passed which established needed guidelines for use of EMTs in emergency departments that was acceptable to all, including nursing (Haney et al., 1984).

In California, the issue was regulation of the mobile intensive care nurse (MICN). The original legislation concerning MICNs was passed in 1969. It gave control over the MICN to the county health officer because there was no statewide EMS system in place and the Nurse Practice Act had no provisions for addressing the expanded role of the nurse (Merritt-Lindgren & Pletz, 1985). In 1974, there was a major revision of the Nurse Practice Act and, in 1980, a statewide EMS

system was put into place. The role of the MICN still remained as written in the original EMS legislation of 1969. The California ENA and California Nurses' Association saw legal incongruities between the Nurse Practice Act of 1974 and the EMS legislation of 1980. Following a procedure similar to that described in the Iowa case, the California Nurses' Association was able to ensure that regulation of the MICN, including the definition of role, was retained by the California Board of Registered Nursing (see Cal. Bus. & Prof. Code §2725 - California Board of Registered Nursing, 1989). Those involved with the California issue reported the experience as enlightening. Among the many positive aspects of the experience, they stated that the "...responsibility for development of standards for our own practice" (Merritt-Lindgren & Pletz, 1985, p. 332) was a worthwhile benefit.

Both the Iowa and California experiences show that the legislative process can be used to effect change. One must be informed, patient, persistent, and organized. Maryland nurses are presently at the beginning stages of this very process. The Maryland Board of Nursing has recognized that there are legal incongruities between the Nurse Practice Act and the

EMS regulatory statutes regarding regulation of nursing practice in the prehospital environment. A nursing task force has analyzed the problem and concluded that a bridge course established by nursing for nurses who desire to practice in the prehospital setting is needed.

Once the Maryland Board of Nursing has a final draft of the curriculum, they need to communicate their problem analysis and recommended solution to all agencies and individuals involved. A task force similar to the one in Iowa may be beneficial. The Maryland Fire and Rescue Institute should also be included because of their current involvement with the education and training process of the prehospital care provider.

An acceptable nursing bridge course is only part of the solution. The EMS legislation must reflect the autonomy of nursing practice regulation and that a nursing license means that the individual has the right to practice nursing in the prehospital environment. The California EMS legislation states, "...nothing in this section shall be deemed to abridge or restrict the duties or functions of a registered nurse...as otherwise provided by law" (Danis, 1985, p.332). The

Maryland EMS legislation should contain a similar statement. The end result must be that the Board of Nursing is the only legitimate authority for regulating the practice of nursing.

Summary

The emergency medical system has evolved over the years from simply a means of transporting an ill or injured patient to the nearest hospital to a complex system of rendering health care delivery to the patient at the scene and during transport to a definitive care facility. With the advent of quality assurance and concerns for quality of patient care, it is advantageous for any system providing prehospital care to employ highly educated and trained individuals. Nurses have added to the quality of patient care in the prehospital environment. They are currently active participants in aeromedical transportation and field caregivers as PCNs and MICNs. As administrators and staff in trauma care centers, nurses have much to offer in the development of a profession model of practice for the emergency medical services/trauma care systems (Beachley & Snow, 1988).

Regardless of which agency regulates nurses in rendering care in the prehospital environment, the law holds them to the standards of a registered nurse working under the same or similar conditions (George & Quattrone, 1988). Legal obscurity can endanger a nurse's license to practice. Since a registered nurse

is held to the standards as defined by nursing, so then should the practice of nursing in the prehospital environment be defined and regulated by nursing. There must be no other laws which weaken the nursing regulatory agency's power.

Maryland nurses can change the current legal incongruities concerning the practice of prehospital nursing through the legislative process. The Maryland Board of Nursing has begun this process. Now the Board must actively educate all nurses in Maryland regarding the problem, solicit support for their recommended solution, and persist towards reaching their goal: control of all nursing practice by nurses.

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Appendix

Maryland Good Samaritan Law

§5-309. Emergency medical care.

(a) Immunity for special personnel.-A person described in subsection (b) of this section is not civilly liable for any act or omission in giving any assistance or medical care, if:

- (1) The act or omission is not one of gross negligence;
- (2) The assistance or medical care is provided without fee or other compensation; and
- (3) The assistance or medical care is provided:
 - (i) At the scene of an emergency;
 - (ii) In transit to a medical facility; or
 - (iii) Through communications with personnel providing emergency assistance.

(b) Special personnel included.-Subsection (a) of this section applies to the following:

- (1) An individual who is licensed by this State to provide medical care;
- (2) A member of any State, county, municipal, or volunteer fire department, ambulance and rescue squad or law enforcement agency or of the National Ski Patrol System, or a corporate fire department responding to a call outside of its corporate premises, if the member:
 - (i) Has completed an American Red Cross course in advanced first aid and has a current card showing that status;
 - (ii) Has completed an equivalent of an American Red Cross course in advanced first aid, as determined by the Secretary of Health and Mental Hygiene; or
 - (iii) Is certified by this State as an emergency medical technician, or cardiac rescue technician:
- (3) A volunteer fire department, ambulance and rescue squad whose members have immunity;
- (4) A corporation when its fire department personnel are immune under paragraph (2) of this subsection.

(c) Immunity for other individuals.-An individual who is not covered otherwise by this section is not civilly liable for any act or omission in providing assistance or medical aid to a victim at the scene of an emergency, if:

- (1) The assistance or aid is provided in a reasonably prudent manner;
- (2) The assistance or aid is provided without fee or other compensation; and
- (3) The individual relinquishes care of the victim when someone who is licensed or certified by this State to provide medical care or services becomes available to take responsibility.

Adapted from: Md. Cts. & Jud. Proc. Code Ann. §5-309, 1991, p. 323-324.