REPORT ON THE PARAMEDIC COMMITTEE

August 1975

Report by the Task Force on Commissions and Committees

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PREFACE

In April, 1975, the Board of Supervisors approved the Economy and Efficiency Commission's report on the Committee on Emergency Medical Care. That report contained recommendations covering the role, responsibilities, principles of operation and composition of the committee.

We also addressed the question whether the Paramedic Committee should be consolidated with the Committee on Emergency Medical Care. We concluded that it should not be, primarily because the functions of the two committees are incompatible. We also recognized that there are substantive issues related to the operation of the Paramedic Committee. We, therefore, stated that in a subsequent report we planned to examine the composition and functions of the Paramedic Committee. Our findings and recommendations are contained in this report.

In conducting the study we have reviewed committee minutes and files and other documents associated with the operation of paramedic programs. We have also conducted over 70 interviews with members of the Paramedic Committee, County officials, and other participants and authorities in the paramedic field, including fire chiefs, ambulance operators, hospital administrators, and community college officials. (See Appendix A for a list of persons interviewed.) We thank them for their suggestions and assistance in the preparation of this report. The conclusions and recommendations, however, are solely the responsibility of the task force.

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I. FINDINGS AND RECOMMENDATIONS

This section summarizes the task force findings and presents its recommendations. Later sections of the report explain our reasoning in greater detail.

Development of Paramedic Programs

In 1967, the primary method of treating emergency patients in Los Angeles was to deliver them to hospitals as quickly as possible, with little or no care at the scene or during transport. There were no paramedics. Public safety and ambulance personnel were not trained to dispense definitive care or to describe patient condition and act on physicians' orders. The public was not generally aware of the probability that timely care of many heart patients, accident victims, and other emergency cases could save lives.

Now, in 1975, emergency patients in Los Angeles County are treated at the scene by medical technicians - called mobile intensive care paramedics - trained to describe the condition of patients by radio or telephone to a physician or nurse at a base station hospital and to act on the doctor or nurse's orders. The program extends over nearly all of Los Angeles County and is expected to be available throughout the entire County by January, 1976.

The County Fire Department provides paramedic services to 37 cities and the unincorporated area. Twenty-six other cities, including Los Angeles, provide their own services. There are now in the County nearly 800 paramedics manning 102 rescue squads. They are supported by 25 base station hospitals and respond to approximately 8000 calls per month.

The Board of Supervisors, particularly Supervisor Hahn, provided the leadership and the resources to accelerate the development and expansion of pre-hospital medical service throughout the County.

In 1970, following State legislation enabling Counties to provide paramedic services, the Board, on motion of Supervisor Hahn, established the Paramedic Committee to provide the County guidance and support in the development of training programs designed to assure a high level of quality. Under the leadership of Dr. Walter Graf, who has been chairman of the committee since its inception, the committee has provided a significant level of guidance and support in the development of paramedic programs. Paramedic services have saved countless lives and have markedly improved the prognosis for thousands of patients.

Need for the Paramedic Committee

Despite these truly remarkable accomplishments, problems and controversy remain unresolved. The existence of problems does not reflect adversely on County officials and others whose creative efforts have been responsible for the immense improvement in the delivery of emergency medical care. Rather, such problems are inevitable when innovative programs experience such rapid growth. This is particularly true in the complex and fragmented jurisdictional environment of Los Angeles County.

We believe the problems and controversy can be resolved. In order to understand the role we recommend for the Paramedic Committee in the resolution of these problems, it is necessary to understand the nature of the issues which confront the *County,* the Paramedic Committee, and other public and private agencies involved in paramedic programs.

The Control Problem - The programs have developed so rapidly and proliferated so extensively that effective management and control of the system has not kept up with its growth. There are 27 separate paramedic programs provided by various jurisdictions in Los Angeles County. Each has its own

management structure, policies and procedures. The Department of Health services is making progress in developing more effective standardization and quality control. However, the programs are still expanding. There is urgent need for the department to complete development of an equitable and comprehensive control system.

County Conflict of Interest - State law assigns to counties the responsibility for establishing standards and controlling paramedic programs by certifying paramedics and training programs and contracting with hospitals. (The Wedworth-Townsend Act of 1970, as amended. See Appendix B.) Los Angeles County also provides services and training through the Fire Department, the Sheriff, and the Department of Health Services. A number of authorities whom we interviewed stated that the County has adopted arbitrary and piecemeal standards that are advantageous to the County as a provider but interfere unfairly with the ability of municipalities, community colleges, and ambulance companies to provide services or training.

Our findings indicate that in some instances the department and the Paramedic Committee have adopted standards on a judgmental basis in the absence of performance data and without sufficient public review and debate. In the period of rapid expansion of the programs, it was necessary to adopt standards. It is true, as we have indicated, that they are piecemeal. In addition, like any judgmental standards they may be criticized as arbitrary. In some cases, there is cause also to question whether they are free of bias toward large governmental providers.

We have found no evidence, however, of improper motivation in these actions. Under the circumstances, the concern of the department and the committee was to maintain quality treatment and adequate safeguards to protect lives.

Regardless of the merits of these criticisms, the significant point is that the County lacks credibility, when as the provider of services, it adopts standards and controls which regulate the ability of others to provide similar services. Thus the County of necessity has a conflict of interest when it acts as both a provider and controller of services.

Public vs. Private Interests - A controversy has developed over the appropriate roles of the public and private sectors in providing paramedic services. One debate centers on the question whether fire department paramedics should transport patients to the hospital after treatment in the field or continue - as many do now - to call on private ambulance companies for transportation. A related debate centers on the question whether private ambulance companies should participate at all.

In the past, the combined circumstances of rapid expansion of programs and the absence of solid scientific data forced everyone involved, including the County and the Paramedic Committee, to make decisions or take positions based on untested assumptions. At present the department is making progress in acquiring and analyzing the appropriate data. Nevertheless, the controversy is growing.

Essentially, the origin of these issues is the fragmented management of emergency medical services. Paramedic programs, which constitute a segment of these services, are particularly weak in this area. The law governing paramedic services does not provide for management; it merely enables counties to provide services and to exercise some control. The problem is further aggravated by the hybrid nature of paramedic services which involve both rescue and health care. Rescue traditionally has been a public safety function, provided in Los Angeles County by a host of municipalities and private firms as well as

County government. Health care, to the extent that it is a governmental function, is provided principally by the County.

Some authorities contend that until some structure for centralized management of emergency medical services is established, there is little hope of resolving current problems. We question this conclusion. While centralized management would bring uniformity and standardization to the system, it is difficult to predict when and how it may be accomplished, in view of the current maze of public and private agencies involved.

The problems, however, are current and the need for solution is urgent. In the absence of centralized management what is needed to resolve them is a comprehensive system of standards and quality control based upon systematic study and research. As we have indicated, the Department of Health Services is engaged in developing such a system.

This control system will not be effective unless it gains a high degree of acceptance from those affected, including cities, fire departments, training institutions, ambulance companies, paramedics, nurses, hospitals, patients, and the patients' physicians. Such acceptance can only be achieved if all these elements of the community are assured that standards, methods and procedures for which the County is responsible will not be unilaterally imposed without an opportunity for public review and discussion.

It is urgent, therefore, at this time that the County take action to establish a mechanism for such public review. The urgency of this need is demonstrated by the history of the Paramedic Committee in recent years. Since 1973 those involved and concerned with paramedic programs have brought a number of issues to the committee for public review and resolution. The committee has advised the Director of Health Services on these issues, even though it has no

legal jurisdiction to do so. The ordinance on the committee specifies only that it will advise the Director of Health Services "on matters relating to the training and certification of Mobile Intensive Care Paramedics." (See Appendix C.)

We conclude that the Paramedic Committee should be reorganized into a new Paramedic Commission to provide a properly constituted legal body to meet this need.

Function of the Proposed Paramedic Commission

The new commission will serve as a public review and arbitration board to insure that anyone having an interest in paramedic programs has the opportunity to debate or appeal controversial County decisions and policies. We do not mean that the commission should assume the responsibility of the Department of Health Services to develop and enforce a control system. To do so would destroy the ability of the Board of Supervisors to hold the department accountable for its actions. We do mean that the commission should act for the Board of Supervisors to hear and arbitrate matters in which others concerned with paramedic programs differ strongly with the department.

The task force recommends that the commission report directly to the Board of Supervisors. It would be inappropriate for the new commission to report to the Director of Health Services. The commission would lack credibility if It reported to the official whose decisions it was reviewing.

This change in the reporting structure will not make the commission's decisions 1ega11y binding on the Director of Health Services. As we have noted, present State 1aw specifies that the County Health Officer is the certifying authority for paramedic training programs and paramedic candidates. The County Counsel advises us that under the provisions of the current law (Appendix B)

the County cannot legally establish a commission whose decisions are binding on the Certifying Officer. In addition, the County Counsel informs us that the Board of Supervisors itself has no authority to direct the Health Officer in making a decision on certification or to overrule a decision once made, since the law does not mention the Board.

If the Board of Supervisors wishes to invest itself and the Paramedic Commission with binding authority, the County Counsel states that it will be necessary to amend the Wedworth - Townsend Act. We do not recommend that the Board seek such an amendment at this time. The current Act expires in July, 1976. Work is already under way throughout the State for a comprehensive revision. Any amendment proposed by Los Angeles County should take other proposed changes into consideration. Therefore, legislation to clarify the authority of the Board of Supervisors should be deferred until the 1976 revision. In the interim, the Board, the commission, and the department should determine from experience whether the change is necessary.

At present, our conclusion is that the omission in the law will not impair the ability of the Paramedic Commission to act as an effective arbitration and hearing board. The necessity for public review and debate and the desire of all providers of paramedic services, including the County, for such an agency will inevitably give strong authority to the commission's findings. In addition, the change in reporting structure will enhance the commission's credibility and effectiveness. Commission effectiveness, however, will also require that County officials inform those disagreeing with a County decision that they can appeal to the commission.

It is important to note that although the commission will report to the Board of Supervisors, it will communicate its decisions to the Director of Health Services and other responsible County officials. We would expect that

the department would normally concur with the findings of the commission. In the event that a decision of the commission conflicts with a decision of the Director of Health Services, the Director may choose either to concur with the commission or to confer with the Board of Supervisors for final resolution.

We would anticipate little discord between the Department of Health Services and the commission. As we have emphasized, it is much to the advantage of the department to have its decisions reviewed in public in controversial cases.

Recommendations

We recommend that the Board of Supervisors amend the present ordinance (Article LXX of the Administrative Code) to dissolve the Paramedic Committee and establish by ordinance a Paramedic Commission. The new ordinance should contain provisions providing for the following:

Objective of the Commission

To promote, within a framework of fair treatment of all sectors of the community having an interest in providing paramedic training or services, uniform, high quality paramedic care to the people of Los Angeles County.

Responsibilities

The Board of Supervisors will appoint the Paramedic Commission and it will report directly to the Board. To meet its objective, the Paramedic Commission will perform the following functions:

1. To provide public review on any issue involving paramedic services and training when requested by a County department, other sectors of the community, or on its own initiative.

2. To arbitrate, in the field of paramedic services and training, differences between the Department of Health Services and other sectors of the community, including but not limited to municipalities, public safety agencies, community colleges, hospitals, private companies and physicians.

3. To hear appeals of decisions made by the Department of Health Services on the following matters:

    a. Decisions to establish and enforce policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics.

b. Decisions to accept or reject proposals of any public or private organization to initiate or modify a program of paramedic services or training.

4. To hear appeals of certification decisions by the Department of Health Services and the certifying officer.

5. To review and advise the Board of Supervisors on County action to propose, support or oppose State legislation and regulations affecting paramedic programs.

Scope

In performing the above duties, the commission's review authority will cover standards and controls governing the following subject matter:

1. All equipment, operations, and personnel controlled by and controlling the performance of the paramedic team at the scene of an emergency and during transport.

2. Didactic and clinical curricula of paramedic training and continuing education programs; screening of applicants; and testing, certification, recertification and internship of mobile intensive care nurses and paramedics.

3. Equipment and staffing of base station hospital emergency departments which have an impact on the performance of paramedics in the field.

4. Any County legislative programs affecting the provision of pre-hospital emergency care by mobile intensive care paramedics.

Composition

The commission shall have 10 members as follows:

1. A physician - Director of an emergency department in a paramedic base station hospital not operated by the County

2. A physician - On the faculty of a university affiliated major teaching hospital

3. A physician - A member of the full-time professional staff of a County hospital

4. A physician - On the staff of a community, proprietary, or voluntary hospital

5. A physician - In private practice

6. A lawyer

7. An educator

8. A registered nurse

9. A public member

10. A public member

Appointment and Term of Office

The Board of Supervisors will appoint commission members for two-year terms upon nomination of two by each Supervisor. The Board should determine which of the following methods it prefers to use in assigning positions for nomination by individual Supervisors.

- Assignment by the Chairman of the Board, based on consultation with other Board members

- Assignment by lot

With either method the Board could elect to assign one physician to each Supervisor.

Qualifications of Members

Physicians

- should have current experience in a field within the scope of the commission's responsibilities, such as emergency medical care, critical care, or the training and utilization of paramedics;

- should be specialists in one of the following areas: emergency medicine, cardiology, traumatology, neurosurgery, orthopedics, internal medicine, anesthesiology, or psychiatry.

Lawyer

- should be a member of the California bar;

- should have substantial experience participating in adversary proceedings or hearing and adjudicating disputes;

- should have some background or experience in governmental administrative law;

- should have some background in medical, insurance, and education law;

- must not be litigating or otherwise actively involved in any case involving paramedic base station hospitals, mobile intensive care nurses or paramedics, or providers of paramedic services, during his or her tenure on the commission;

- should not be a physician.

Educator

- should have current experience and advanced education in curriculum development, standardization and documentation, or the design and validation of evaluation instruments, preferably in the health sciences;

- should not be a physician.

Nurse

- should have current experience in the guidance of mobile intensive care paramedics or the operation of mobile intensive care programs;

- preferably has current or prior experience in the provision of critical care;

- currently works at a level of first line supervision in a paramedic base station hospital.

Public Members

- should be knowledgeable and concerned about the delivery of medical services to the public at large;

- must not be medical or health professionals or providers of paramedic services or support services such as training, equipment, or transportation.

Membership Limitations

- must not be County employees, except for the physician on the County hospital staff and possibly the physician on the faculty of the major teaching hospital. In no case should the County physicians be employed in the Division of Emergency Systems in the Department of Health Services;

- must not be the owner or manager of any organization, public or private, which furnishes paramedic services, training, equipment, or supplies;

- must not be a member of the Committee on Emergency Medical Care;

- must not be an employee of another member of the Paramedic Commission;

- must not be an official representative of a labor union or federation whose members are directly involved in the provision of paramedic services.

Self-Governance

- The commission shall appoint its own staff, upon authorization of number, classification, and budget by the Board of Supervisors.

- The commission should establish internal operating policies and procedures, consistent with the ordinance, covering such matters as the time and place of meetings, selection of officers, terms of office, obligations of commission members, structure of subcommittees or advisory councils, if any, and the general conduct of its business.

II. PROBLEMS AND CONTROVERSY

This section expands on the problems and controversy discussed in Section I.

Proliferation of Paramedic Programs - The Control Problem

Paramedics are field medical technicians, who operate outside of the clinical and institutional environment which usually supports other medical technicians as well as nurses and physicians. The concept of systematic medical intervention in the field, although well developed for military applications, is less than a decade old for civilian populations.

As we indicated in Section I, paramedic services have developed from an experimental base established in 1969 to nearly full coverage of Los Angeles County in 1975. At present there are 27 separate paramedic programs provided by various jurisdictions in the County. Each has its own management structure and method of operation. For example, some cities train firefighters to be paramedics, others contract with ambulance companies; some transport patients, others contract with an ambulance company for transportation.

The programs have developed and are operating in the absence of a comprehensive system of quality control or standards. There are historical reasons for this situation. In contrast to several other newly developed medical technologies, there was no professional tradition to provide conceptual support to paramedic development, as for example the tradition of registered nursing provided for licensed vocational nursing. Systematic development was also hindered by opposition to the entire concept. There were in the beginning many medical professionals who were opposed to the provision of medical services in the field by non-physicians. To some extent such opposition still exists.

According to the basic legislation allowing public operation of paramedic programs (see Appendix B), County government is responsible for establishing standards and controlling paramedic programs operated from County hospitals or hospitals with County contracts.

The County has two major methods of controlling paramedic services. The first is the certification process. Without certification no individual can practice as a paramedic. To be certified he or she must successfully complete a training program which also must be certified. The legislation specifies that the County Health Officer is the certifying authority. Therefore, the County controls both the labor supply and the training for all paramedic programs.

The second County control is the system of Emergency Aid Program contracts - contracts with hospitals and ambulance companies that insure that the County will pay for emergency aid for indigent patients. Through these contracts, the County controls, at least partly, the organizations which will provide paramedic services.

With the proliferation of programs, a much more structured and comprehensive system of control based upon systematic study and research is clearly needed. The County, as we have stated, has now established an Emergency Systems Division. While it therefore is developing the resources needed to establish a comprehensive system of controls, its efforts to do so have been and will continue to be highly controversial. Its decisions influence the costs and effectiveness of programs operated by independent political jurisdictions and private firms. The decisions also will directly affect the careers of the people involved and the lives of patients.

The control problem was highlighted in 1973 when Pasadena City College applied for certification of a new training program for paramedics. The college viewed its proposed program as a natural extension of the health occupation training it already offered.

The program, however, differed in major respects from that conducted by the County, and some County officials were strongly opposed to it. Their opposition was not based on evidence that the proposal failed to measure up to a standardized curriculum incorporating performance objectives. No such curriculum existed. Rather the opposition of County officials was based primarily on their opinion that community colleges lacked teaching resources equivalent to those in the County. Pasadena City College was able to implement its program at that time only because it had the opportunity to review its proposal in public with the Paramedic Committee.

The Emergency Systems Division of the Department of Health Services is now developing a standardized curriculum which will serve as a rational and objective yardstick for selecting proposed paramedic training programs and evaluating existing ones. Standardization and control is similarly needed for other elements of the paramedic program. The Emergency Systems Division is also working to develop a system to apply to these elements.

The Pasadena City College case demonstrated the need for public review in the absence of a standardized system of controls. As we have stated, however, the system itself is bound to be controversial and will require public review for acceptance.

The Paramedic Committee has to some extent been performing this review function. The problem is that it is not legally authorized to do so.

County Conflict of Interest

Through its control of the certification process, the County can

- prevent any organization from offering training programs to compete with County training programs;

- prevent any organization from training and certifying paramedics to operate a paramedic service;

- adopt standards of training, certification and operation which are preferential to the County's method of providing services;

- adopt standards which are prohibitively costly for smaller units of government or private operators, thus preventing them from providing paramedic services.

The County not only controls but also provides paramedic services and training. In unincorporated territory and in contract cities, County fire-fighters are the paramedics. The Sheriff also employs paramedics for search and rescue operations. The County's major teaching hospitals, Harbor General Hospital and the County USC Medical Center, offer paramedic training.

Thus, other potential providers of service, such as municipalities, community colleges, proprietary hospitals, and ambulance companies, have found that to begin to provide service, they must obtain the approval of an organization that competes with them - Los Angeles County government.

As we noted in Section I, in this situation the County of necessity has conflict of interest. The potential is high that the other providers of service will allege that the standards adopted by the County are arbitrary and are designed merely to obstruct the provision of services and training by others. We have, in fact, during the course of our study heard such allegations. Two standards adopted and enforced in the past illustrate this point.

For example, the County has established the requirement that before an individual can be admitted to a paramedic training program he or she must

be employed by a sponsoring ambulance company or fire department. One may ask the question - why paramedics? There are no comparable governmental standards restricting any person's freedom to undertake training as a physician, nurse, respiratory therapist, radiological technician, or similar vocation. While there may be valid reasons to justify the County policy, such as the limited capacity of existing training programs, it seems clear that the possibility of the policy favoring large tax-funded organizations like the County, makes imperative public debate and review of such policies.

Even when a standard has been accepted as fair and practical, it may still be susceptible to abuse and manipulation. The County, for example, requires that each paramedic complete an internship of twenty shifts of twenty- four hours with a working paramedic rescue squad prior to certification.

The primary purpose of internship is to give the trainees some basic field experience before they assume operating responsibility. The problem is that the number and types of rescue calls encountered in twenty shifts is strongly dependent upon the service area of the unit to which the trainee is assigned. Consequently, those who centrally administer the assignments control the quality and effectiveness of internships.

While we can cite no evidence that the County has abused its authority to assign internships, the possibility that it could do so clearly reflects the need for impartial review of assignment methods and resolution of disputes if they arise.

These are two examples of standards which the County has been enforcing and which some authorities allege are unfair. Others could be cited.

Regardless of the merits of these allegations, the County lacks credibility, when, as a provider of services, it adopts standards and controls which

restrict the ability of others to provide similar services. Again, we conclude there is a compelling need for public debate and review before some agency which is free of conflict of interest and can objectively arbitrate differences and disputes when they occur.

Public vs. Private Interests

Although paramedic programs to date have been widely acclaimed and have received a broad base of public support, a controversy has developed over the appropriate roles of the public and private sectors in the provision of services.

As we noted in Section I, the debate centers on the use of private ambulance companies. In particular, the controversy involves the establishment of standards for determining when an ambulance company qualifies to enter the field, and if it does, the manner in which it should share responsibility with governmental units. Some companies allege that present County standards create a bias toward approving governmental programs which utilize firefighters in a dual role as paramedics and ambulance companies only in the role of transportation.

There is some evidence that County standards have had a preferential effect, if not intent. At present, 24 of 26 cities providing their own paramedics use firefighters, and two, Los Angeles and Pasadena, use civilians employed in the fire department. Only four use an ambulance company for first response service. In addition, County firefighters serve 37 other cities as members of the Consolidated Fire Protection District.

The County requires an ambulance company applying for certification of its service to limit the service of a unit to a contiguous geographic area containing a specified number of people and not covered by a fire department

unit. In addition, before a company can operate a paramedic unit for emergency medical response, the County requires the company to have commitments that the city governments of the area it serves will use the service. To meet such standards, a company may have to forego any consideration of achieving economies of scale because of the limitation of geographic boundaries.

To date, public provision of service through local fire departments has seemed highly advantageous. However, a number of local jurisdictions have recently begun to compare the costs of public and private services for similar levels of quality. Some are finding that the use of private providers may have a cost advantage. Others, such as Los Angeles City, have chosen to provide their own service using civilians.

It is not our intention here to argue the pros and cons of public vs. private provision of paramedic services. Our concern rather is that in the controversy over this issue there is little factual evidence to support standards and controls adopted in the past. The result has been that everyone involved, including the County and the Paramedic Committee, have been forced to make decisions and take positions based upon questionable assumptions.

For example, it is not necessarily true, as widely believed, that use of firefighters as paramedics is a cost free use of idle labor. First, fire departments can be penalized by the insurance grading process when firefighting manpower is used for paramedic rescue work. Second, labor is needed in the station for routine overhaul and maintenance activities. If the incidence of rescue calls is high, this labor must be replaced. For these reasons, a number of fire authorities reported to us that they will require a subsidy from the County to continue providing paramedic services. Thus, a number of cities are considering a change to contracting with ambulance companies for basic emergency service.

Again what is needed is a comprehensive system of controls and standards subject to public debate and impartial review.

III. OBJECTIVE, RESPONSIBILITIES AND SCOPE OF THE PARAMEDIC COMMISSION

The responsibility for which the Paramedic Committee was established - to advise the Director of Health Services on matters relating to paramedic training and certification - has not been a principal function of the committee for the past several years. Our conclusion, as presented in Section I, is that a new Paramedic Commission should be created. We are recommending the change from "committee" to "commission" to emphasize that the role and scope of the new commission differ substantially from those of the present committee.

Objective and Responsibilities

The objective and responsibilities of the new commission are designed specifically to meet the need for a mechanism to insure public review of quality control decisions for paramedic programs. As we pointed out in previous sections, the demand for public review of County decisions has been so strong that the current Paramedic Committee has acted to meet the need without explicit legal authority in the absence of any other agency authorized to do so.

In contrast to the original committee, the new commission will not make certification recommendations to the department. We believe that as the responsible legal authority, the Department of Health Services should be held accountable for certification of paramedic candidates and training programs. To be certified, paramedic candidates will be required to pass standardized examinations. Proposed training programs will be required to satisfy criteria incorporated in a standardized curriculum. Similar standardization will need to be established for continuing education, recertification, and decertification.

Thus, under our proposal the department will be fully accountable for certification decisions. As we have emphasized, what is needed is an appropriate avenue of appeal for those who dispute these decisions. This is the role we assign to the new Paramedic Commission. Since it will be acting as a review board when those involved appeal decisions, it would not be appropriate for it to participate in the original decision-making.

The control system will also incorporate performance standards to regulate the quality of such other elements of paramedic programs as drugs, equipment, and supplies. For these elements too the commission will serve as an avenue for arbitration and appeal.

We should point out that the Wedworth-Townsend Act will expire in July, 1976, and is now being reviewed for revision at that time. Consequently, paramedic programs are now undergoing evaluation throughout the State. Whatever the outcome, it is reasonable to assume that the roles of the State, counties, and other providers of service will be clarified by new legislation. We have not, therefore, delineated in detail the subject matter of the control system which the County may be required to develop and operate.

Under present legislation, the County has required deployment of two paramedics per unit. It is not certain under future legislation to what extent counties will be responsible for standards of operation which specify resource allocation and personnel deployment involving the management of programs by municipalities, fire departments, and other providers. We believe that whatever the role of the County becomes, it should be administered by the Department of Health Services, with the Paramedic Commission acting as an appeals board.

Clearly the responsibility we propose for the commission is substantial. But, *as* we have emphasized repeatedly, the Department of Health Services, because

of its conflict position as both a provider and a regulator of paramedic services, should not make these decisions without giving those affected an opportunity for public debate, arbitration and appeal.

We should also note that the hearing process of the commission is not a passive one. In the course of a review of some decision or set of standards, the commission may wish to recommend alternatives to the County 's proposals.

The functions of arbitration of differences and hearing appeals which we recommend for the Paramedic Commission could not appropriately be performed by the Committee on Emergency Medical Care. The Committee on Emergency Medical Care has two principal functions. The first is to advise the County in the establishment of policies, programs and standards for emergency medical care services, including paramedic services. The second is to evaluate the system and its impact as the County develops it. Consequently, this committee could not act as an objective and credible hearing board for arbitration and appeals, since it is a principal participant in the development of the County's system.

The task force concludes that the Committee on Emergency Medical Care cannot properly perform the responsibilities we recommend for the Paramedic Commission.

Scope of Commission Responsibilities

Paramedic programs are only one part of a complex and far-reaching system of emergency medical care. Many people and agencies, in addition to the paramedics at the scene, are directly involved: the doctors and nurses at the base hospital who instruct the paramedics over the radio; the doctors and nurses at the receiving hospitals who prepare for patient admission; the police, firefighters, and ambulance attendants at the scene. Many others are involved in the care of the patient, but with less impact on paramedic performance before

hospital admission: the staff of the emergency room in the receiving hospital; the staff of the critical or intensive care units to which the patient may be taken; the patient's physician and family.

The system of emergency medical care will in the future involve certain technicians other than those now designated paramedics. Today's paramedics are trained to a level of proficiency beyond advanced first aid. The advanced first aid level has been designated EMT-I (Emergency Medical Technician I); paramedics have been designated EMT-II. State and other agencies are developing criteria for the training of EMT-III's and EMT-IV's. The concept is that EMT-III's will provide more advanced field treatment and assist in emergency rooms, while EMT-IV's will act as physician's assistants in emergencies.

Criteria for doctors and nurses involved in emergency care are also being developed.

There is a question, then, of where the responsibility for local quality control in these fields should reside. Thus it is important to delineate the scope of the new commission's responsibilities in order to determine what decisions made by the Department of Health Services come within the province of the commission. (See Section I, p. 9.)

Since a system of standards and controls will be needed to insure quality of service in all areas of emergency medical care, it is reasonable to consider defining the scope of the commission's responsibilities to include these areas. However, it is not clear that the County would find itself in a similar conflict position in regulating these other areas. Moreover, the concepts in many of these other areas are not at present well developed. Consequently, it is difficult to determine what role, if any, the commission should have in their regulation.

If in the future it is determined that there is a need for a hearing board in other areas of emergency medical care, the County should consider expanding the scope of the Paramedic Commission, rather than creating separate commissions. We would caution the Board of Supervisors, however, that the amount of work that will be required of the Paramedic Commission in the paramedic area alone is bound to be substantial for the next several years. We think it wise, therefore, to limit the scope of the commission at this time to areas which have a direct impact on the quality of paramedic services.

IV. COMPOSITION AND METHOD OF APPOINTMENT

The primary purpose of the Paramedic Commission is to act as an arbitration and appeals board in order to insure both high quality paramedic services and fair treatment of all sectors of the community having an interest in providing these services. The commission, therefore, should be structured to incorporate the expertise required to understand, analyze and judge the issues coming before it. At the same time, if the commission is to have credibility as an impartial hearing body, its members must be as free as possible from conflict of interest.

To some extent these two criteria are conflicting. That is anyone who possesses experience and expertise in paramedic training and procedures is almost bound to have an interest which presumably at some time could impair his or her objectivity.

Our purpose in determining the membership for the commission was to balance as much as possible expertise and freedom from conflict. The recommended composition is designed to provide a balance of points of view, broad representation of the community, and the skills or expertise which will contribute to the decision-making functions of the commission. (See Section I, pp. 9-10.)

Composition

The Paramedic Committee was originally composed entirely of physicians. We think physician expertise will continue to be essential to the operation of the Paramedic Commission, since its primary objective is quality control of paramedic programs. Physicians have the most to contribute in this area. They also represent the major interest group because it is their patients who are involved.

However, in contrast to our recommendation regarding the Committee on Emergency Medical Care, the primary consideration in selecting physician members should be their institutional affiliations rather than their specialties.

The commission will be making decisions and resolving disputes involving the effects of quality control standards on the costs of public and private providers of service. The outlook of physicians from the large public hospital, the community-based private hospital, and the teaching hospital will contribute a necessary balance of the private and public sectors. The viewpoint of a physician in a paramedic base station and that of a practicing physician with no particular institutional affiliation should further enhance the balance on the commission.

We recommend that one member be a lawyer. The purpose of the lawyer on the commission is not to replace County Counsel. The advice of the County Counsel will always be available to the commission, and would take precedence on any point of law. Nevertheless, the commission will be responsible for providing an impartial forum for hearing the divergent views of various sectors of the health services community. A lawyer's training and experience should contribute substantially to the commission's effectiveness in insuring equitable and balanced debate.

We recommend that one member be an educator. The commission will be considering highly technical educational questions requiring an understanding of the best current educational practice involving curricula, testing, course structures, and training programs.

We recommend that one member be a registered nurse with mobile intensive care experience employed by a paramedic base station hospital. The direct experience of such nurses with paramedics acquaints them with the strengths and weakness of paramedic training. In addition, their insight into the ways that

paramedic services complement nursing and its responsibilities will assist the commission in its deliberations, especially with regard to the opposition of nursing groups to the paramedic concept.

We recommend that two members be public members, who are not medical or health services professionals or providers of such services. Public members contribute to specialized commissions of this type in two ways. First, they bring the perspective of detached but potentially affected people to the commission. Second, they tend to question the tacit assumptions of the professionals on the commission. Thus, they should further strengthen the commission's impartiality.

Excluded Alternatives

We have elected to recommend a composition which does not include members suggested by some authorities: The most important of these are a fire chief, an ambulance company operator, a working paramedic, and a hospital administrator. There are several reasons for each of these omissions. In general, we have tried to avoid recommending representation which 1) would unnecessarily increase the size of the commission or upset its balance, and 2) would create a potential conflict of interest.

For example, the recommended composition does not include the County Forester and Fire Warden, a member of the current Paramedic Committee. Including the Forester and Fire Warden would require, for balanced representation of both public and private operations, adding representatives of a large city fire department, a small city fire department, and private ambulance companies. All of these, like the Forester and Fire Warden, are providers of paramedic services. In addition, a representative of the Sheriff would have to be considered,

since he employs paramedics for his search and rescue operations. The resulting addition of four or five more non-physician members would upset the overall balance of the commission.

Moreover, each of these members would have a potential conflict, since each has a direct interest in the provision of pre-hospital care and the costs associated with the level of quality to be considered by the commission. For these reasons the task force concludes that none of these providers of paramedic services should serve on the commission.

Some of the authorities we interviewed have said that including a working paramedic would enhance the commission's effectiveness by adding the point of view of those whose performance, training, and careers will be directly affected by its actions. As others have pointed out, however, a working paramedic on the commission is likely to have conflicts which will impair his or her objectivity. First, decisions will be considered that will have a personal impact on the paramedic, thus weakening the impartiality with which the commission should operate. Second, the commission will consider matters on which the paramedic's superiors may have strong positions. Whatever the point of view of the paramedic, he or she would be in a difficult position to express it without obtaining the approval of a superior.

The absence of a hospital administrator from our recommendation is based primarily on the scope of commission operation. The commission will be primarily concerned with pre-hospital care. It will be concerned with hospitals only to the extent that their activities have a direct impact on paramedic operations in the field.

With *respect* to all such alternatives, we should emphasize that it is neither necessary nor desirable for a commission to include within its membership people with all the various skills that may possibly contribute to its work.

Excluding some types of expertise does not preclude the Commission from seeking advice from such experts, nor will it preclude anyone from requesting a hearing or giving testimony.

Membership Limitations

The Paramedic Commission will be considering highly controversial issues that have an impact on the lives of patients and on the careers of medical technicians. Its work will be a part of the decision-making process of County government. Therefore, not only its expertise, but also its credibility and prestige in the community are important to its success. All of the constraints on membership are based, in particular, on the need for credibility. Consequently, we have recommended strong restrictions in the general area of conflict of interest. (See Section I, pp. 11-12.)

The problem with such restrictions, as we noted in the introduction to this section, is that they can limit the range of the Board's search for expert members. Too strong a limitation - for example, excluding anyone with a professional or financial interest - would result in excluding all necessary expertise. The limitations on membership therefore are designed to exclude only those individuals who would clearly encounter a conflict of interest, that is, those with a major career, professional or financial interest that is likely to be affected by commission decisions.

Method of Appointment

The commission will hold hearings on issues which otherwise would require public debate before the Board of Supervisors. It should be structured therefore to effectively represent the Board.

In contrast to the Committee on Emergency Medical care, which has the highly technical job of systems evaluation, the Paramedic Commission will function

Primarily as arbitration and appeals board. Therefore, we have proposed that the Board of Supervisors select members of the Paramedic Commission directly, rather than through nominations by organizations that are in a position to locate the expertise needed for technical evaluation of the system.

As the ordinance provision which we recommend states (see Section I, p. 10), each Supervisor will nominate two members for appointment by the Board. We have not specified a method by which the Board should determine which positions are assigned for nomination to individual Supervisors. We have suggested, however, that it could be done either through assignment by the Chairman of the Board or by lot. In either case the Board could elect to assign one physician to each Supervisor.

Whatever the method, we urge the Board to give consideration to the expertise which current members of the Paramedic Committee possess in this area based on their years of experience serving on the committee. We would also suggest that Board members consult with each other regarding the nomination of physicians to insure a balance of specialty fields, such as emergency medicine, cardiology, traumatology and surgical specialties.

V. SELF-GOVERNANCE

The ordinance we recommend specifies that the commission shall adopt its own internal operating policies and procedures consistent with the provisions of the ordinance. (See Section I, p. 12.) The rules should cover time and place of meetings, selection of officers, terms of office, obligations of commission members, structure of sub-committees or advisory councils, if any, and the general conduct of commission business.

The chairman of the current Paramedic Committee, Dr. Walter Graf, was appointed to the chair by the Board of Supervisors when the committee was established in 1970. The new Paramedic Commission may choose to continue this practice or adopt some other method of selecting its officers.

The ordinance also specifies that the commission will appoint its own staff as authorized by the Board of Supervisors. Experience can only determine what staff positions and classifications will be required.

Daniel Freeman Hospital is now furnishing administrative and clerical support to the present Paramedic Committee free of charge. Since most of the information required by the new commission to perform its duties will be presented to it in public hearings, and since the present committee is already functioning in a similar manner, we would conclude that additional staff requirements will be minimal.

APPENDIX A
Persons Interviewed

Members of the Paramedic Committee

Gail V. Anderson, M.D.	Professor and Chairman, Department of Emergency Medicine, County-USC Medical Center
J. Michael Criley, M.D.	Chief, Division of Cardiology, Harbor General Hospital
Sister Frances Ellen, R.N.	Nursing Administrator, Queen of the Valley Hospital
Walter S. Graf, M.D,. Chairman	Clinical Professor of Medicine, University of Southern California and Loma Linda University
Julius W. Hill, M.D.	Professor of Surgery, Charles R. Drew School and Martin Luther King Hospital
David B. Homer, M.D.	Associate Clinical Professor of Medicine, University of Southern California
Richard H. Houts	Forester and Fire Warden and Chief Engineer, Los Angeles County
John W. H. Sleeter, M.D.	Director, Emergency Department, Santa Teresita Hospital
Paul A. Teslow	Administrator, Northridge Hospital

County Employees (Not members of the Committee)

John E. Affeldt, M.D.	Medical Director,Department of Health Services
Gaylord E. Ailshie	Director, Paramedic Services, Division of Emergency Medical Systems, Department of Health Services
Richard B. Baird	Division Chief, Program and Budget Division, Chief Administrative Office
Morrison E. Chamberlin	Chief Deputy Director, Department of Health Services

Robert Eskanos	Principal Administrative Analyst, Management Audit Division, Chief Administrative Office
R. T. Freeman	Inspector, Sheriff's Department
John Gelfuso	Firefighter Paramedic, Station 3, Consolidated Fire Protection District
Stanley Grant	Administrator, Division of Emergency Medical Systems, Department of Health Services
David L. Lemm	Captain, Station 3, Consolidated Fire Protection District
Ben E. Matthews	Chief, Operations Division, Department of Forester and Fire Warden
Daniel D. Mikesell, Jr.	Deputy County Counsel
John P. O'Connor	Deputy Director, Contracts and Community Services, Department of Health Services
Jess Perez	Firefighter Paramedic, Station 3, Consolidated Fire Protection District
Ronald Pierce	Firefighter Specialist, Station 3 Consolidated Fire Protection District
Nino F. Polito	Division Assistant Chief, Operations Division, Department of Forester and Fire Warden
Elliot Salenger, M.D., M.P.H.	Medical Director, Division of Emergency Medical Systems, Department of Health Services
Paul P. Schneider	Division Assistant Chief, Operations Division, Department of Forester and Fire Warden
Richard S. Scott, M.D.	Director of Special Projects, Department of Emergency Medicine, County-USC Medical Center
Paul G. Seehusen	Deputy County Counsel
Ronald D. Stewart, M.D.	Director, Paramedic Training, Division of Emergency Medical Systems, Department of Health Services

Gerald Surfus	Chief, Risk Management, Program Evaluation Division, Chief Administrative Office
Liston A. Witherill	Director, Department of Health Services

Others

Brian G. Adlington	President, Verdugo Hills Hospital
Robert B. Andrews, Ph.D.	Professor, Graduate School of Management, UCLA
Mrs. Colly Bakeman, R. N.	Past Coordinator-Instructor, EMT and Paramedic Program, Department of Nursing, Pasadena City College
Joseph N. Baker	City Manager, City of Burbank
Harry C. Bigglestone	Chief Protection Engineer, PacificRegion, Insurance Services Office
Rand Brooks	Owner, Professional Ambulance Company
Inice Chirco, R.N., M.A., M.S.	Chairman, Department of Allied Health, Rio Hondo College
Frank Clark	Director of Professional Affairs, Los Angeles County Medical Association
Mrs. Joan M. Davidson, R.N.	Chairman, Department of Nursing, Pasadena City College
Joseph M. Dolphin	President, Los Angeles County Ambulance Association
Charles Dovey	Los Angeles MICU Paramedic, MEDEVAC Paramedic Ambulance Inc.
Raymond L. Eden	Executive Director, American Heart Association, Greater Los Angeles Affiliate
Walter Edwards, M.D.	President, American College of Emergency Physicians and Director, Emergency Room Daniel Freeman Hospital
Ida L. Frisbee	Chairperson, Department of Human Services, Compton College
Winnie Hobbs	Paramedic Coordinator, Education Department, Daniel Freeman Hospital

Dennis Jorgensen	Vice President, Newhall Ambulance Inc.
George W. Kahl	Fire Chief, City of Monrovia
Glenn A. Langer, M.D.	President, American Heart Association, Greater Los Angeles Affiliate
Kenneth Long	Chief Engineer, Fire Department, City of Los Angeles
John R. MacFaden	Executive Vice President, Los Angeles County Ambulance Association
John H. Mahaffey	President, ANVAL Enterprises Inc.
John W. Mahaffey	Secretary-Treasurer, ANVAL Enterprises Inc.
Gene Mahoney	Chief, Fire Department, City of Arcadia
George D. Morgan	Captain, Paramedic Co-Ordinator, Department of Fire,City of Long Beach
Muriel M. Morse	General Manager, Personnel Department, City of Los Angeles
Gail Pleasance, R.N	Instructor, Education Department, Daniel Freeman Hospital
J. Walter Schaeffer	President, Schaeffer's Ambulance Service Inc.
Edward L. Schindler	Assistant Director for Emergency and Disaster Services, Hospital Council of Southern California
Joe G. Smith	Chief, Fire Department, City of Inglewood
Leslie R. Smith	Executive Director, San Pedro and Peninsula Hospital
John F. Sturges	Chief, Fire Department, City of Santa Monica
Mrs. Mary Taylor, Jr.	Chairman of the Board, American Heart Association, Greater Los Angeles Affiliate
William Trautman	Los Angeles MICU Paramedic, MEDEVAC Paramedic Ambulance Inc.

Robert B. White	San Fernando Valley Area Representative, Los Angeles County Federation of Labor, AFL-CIO
Robert F. Woehrmann	Owner, AIDS Ambulance and Medical Service
Mrs. Betty Wright, R.N.	Coordinator-Instructor, EMT and Paramedic Program, Department of Nursing, Pasadena City College
Howard Zuck	Assistant General Manager, Personnel Department, City of Los Angeles

APPENDIX B

HEALTH and SAFETY CODE

WEDWORTH-TOWNSEND ACT

MOBILE INTENSIVE CARE PARAMEDICS

1480. Pilot program

Any general acute care hospital operated by, or contracting with, a county may conduct a pilot program which provides services utilizing mobile intensive care paramedics for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care hospital, while in the emergency department of the general acute care hospital until care responsibility is assumed by the regular staff of the general acute care hospital, and during training within the facilities of the sponsoring general acute care hospital.

1480.1 Pilot program

The training of mobile intensive care paramedics may only be conducted by a community college, college, university, or hospital that has a certificate of approval for its curriculum and training program from the county health officer of the county in which it is located.

1481. Definitions

As used in this article:

(a) "Mobile intensive care paramedics" means personnel who have been trained in the provision of emergency cardiac and noncardiac care in a training program certified by the county health officer of the county giving certification or a certified training program in another county that has been evaluated and approved by the county health officer of the county giving certification, and who pass the performance and written examinations required for certification by the officer as qua1ifed to render the services enumerated in this article in the county giving such certification.

(b) "Mobile intensive care nurse" means a registered nurse who has been certified by a county health officer as qualified in the provision of emergency cardiac care and noncardiac care and the issuance of emergency instruction to mobile intensive care paramedics.

(c) "Mobile intensive care units" means any emergency vehicles staffed by mobile intensive care paramedics or mobile intensive care nurses and equipped to provide remote intensive care or cardiac care to the sick or injured at the scene of medical emergencies or during transport to general acute care hospitals.

(d) "Emergency department" means any department or separate area within a general acute care hospital which is staffed and equipped to provide emergency medical care to the sick or injured.

1481.1 Minimum training; experience

The training program for mobile intensive care paramedics shall consist of a minimum of 200 hours of didactic training, a minimum of 100 hours of clinical experience, and a field internship of at least 200 hours.

However, all or any portion of the required training program for a mobile intensive care paramedic may be waived by the county health officer of the county giving certification if the applicant passes the performance and written examinations required for certification or the appropriate portion of the performance examination.

1481.2 Program evaluation report

Each county conducting a pilot program pursuant to this article shall submit an annual report to the Legislature and to the State Department of Health, not later than January 31 of each calendar year, evaluating any such pilot program conducted at any general acute care hospital operated by the county or under contract with the county. The report shall include an evaluation of the competency and effectiveness of the performance by the mobile intensive care paramedics in their duties in staffing rescue units and in the rendering of medical and nursing care pursuant to this article. The report may include recommendations relating to the extension or modification of the provisions of this article.

1481.3 Courses of instruction and training; certification; fees; reimbursement by federal funds

Any county conduct a pilot program under this article may provide courses of instruction and training leading to certification as a mobile intensive care paramedic. Where such instruction and training is provided to public employees other than employees of the county or employees of the fire protection district within the county, a fee may be charged sufficient to defray the cost of such instruction and training. Where such instruction and training is provided to any other persons such fee shall be charged. However, such fee may be reduced to the extent of any federal funds obtained by the county for the purpose of providing such instruction and training.

1482. Duties

• Notwithstanding any other provision of law mobile intensive care paramedics may do any of the following:

(l) Render rescue, first aid and resuscitation services.
(2) Perform cardiopulmonary resuscitation and defibrillation.
(3) During training and while caring for patients in the sponsor general acute care hospital under the direct supervision of a physician or registered nurse, or while at the scene of a medical emergency where voice contact or a telemetered electrocardiogram is monitored by a physician or a certified mobile intensive care nurse where authorized by a physician, and where direct communication is maintained, upon order of such physician or such nurse:

(a) Administer intravenous saline, glucose or volume expanding agents or solutions.
(b) Perform gastric suction by intubation.
(c) Perform pulmonary ventilation by use of esophageal airway.
(d) Obtain blood for laboratory analysis.
(e) Apply rotating tourniquets.
(f) Administer parenterally, orally or topically any of the following classes of drugs or solutions:
(i) Antiarrhythmic agents.
(ii) Vagolytic agents.
(iii) Chronotropic agents.
(iv) Analgesic agents.
(v) Alkalinizing agents.
(vi) Vasopressor agents.
(vii) Narcotic antagonists.
(viii) Diuretics.
(ix) Anticonvulsants.
(x) Ophthalmic agents.
(xi) Oxytocic agents.
(xii) Antihistaminics.
(xiii) Bronchodilators.
(xiv) Emetics.
(g) Assist in childbirth

1483. Liability for instructions given paramedics

No physician or nurse, who in good faith gives emergency instructions to a paramedic at the scene of an emergency, shall be liable for any civil damages as a result of issuing the instructions.

1484. Duration of article

(a) This article shall remain in effect only until July 1, 1976, and shall have no force or effect after that date.

(b) On or before July 1, 1975, the State Department of Health shall submit to the Legislature a comprehensive report on emergency medical services in California. Such report shall include a thorough review and evaluation of the mobile intensive care paramedic pilot program authorized by this article and shall make specific recommendations on the following:

(1) Development of statewide coordination of emergency medical service systems, including appropriate communications Systems and equipment;

(2) Development of manpower certification standards for all types of emergency medical service personnel to include specifically the training and scope of practice requirements for the categories of ambulance personnel (E.M.T. I) and paramedics (E.M.T. II);

(3) Standards for local paramedic programs including location, qualifications for appropriate teaching institutions, performance standards, and the curriculum necessary for state accreditation of the local program; and

(4) Standards for the staffing and equipping of hospital emergency rooms.

(c) In developing such report, the department shall solicit the advice and recommendations of the Advisory Committee on Emergency Medical Services.

1484.1 Duration of article

During the clinical internship portion of the training program specified in Section 1481.1, mobile intensive care paramedic interns shall be supervised continuously by a physician or registered nurse.

During the field internship portion of the training program specified in Section 1481.1, mobile intensive care paramedic trainees may perform all the services enumerated in this article, provided that they are supervised and accompanied by a certified mobile intensive care paramedic, a physician, or a mobile intensive care nurse.

1484.2 Duration of article

The county health officer shall establish criteria necessary to maintain certification as a mobile intensive care paramedic or a mobile intensive care nurse including, but not limited to:

(a) A formal program of continuing education
(b) Continuous service as a mobile intensive care paramedic or a certified mobile intensive care nurse.

(c) Retesting at two-year intervals, which shall include a performance examination and may include written examinations and oral examinations.

1484.3 Duration of article

No agency, public or private, shall advertise or disseminate information to the public that the agency provides paramedic rescue or paramedic ambulance service unless that agency does, in fact, provide mobile intensive care units on a continuous 24-hours-per-day basis. If advertising or information regarding the agency's paramedic rescue or paramedic ambulance service appears on any vehicle it may only appear on those mobile intensive-care-unit vehicles utilized solely to provide service on a continuous 24-hours-per-day basis.

1484.4 Duration of article

It shall be a misdemeanor for ambulance personnel to impersonate or refer to themselves as paramedics unless the person has been certified as a mobile intensive care paramedic and currently maintains that certification.

1485. Short title

This article shall be known and may be cited as the Wedworth-Townsend Paramedic Act. It is the intent of this article to respond to the critical shortage of professionally trained medical and nursing personnel for the fast, efficient medical care of the sick or injured at the scene of a medical emergency, during transport to a general acute care hospital, and in the emergency department of the general acute care hospital until care responsibility is assumed by the regular staff of the general acute care hospital. Improved emergency medical service is required to reduce the mortality and morbidity rates during the initial treatment phases of the onset of an acute illness or following an accident. Within the goals of this act is the provision of the best and most efficient and economical delivery of emergency medical care.

This has been prepared for your use by the office of State Senator James Q. Wedworth. It is the complete Wedworth-Townsend Paramedic Act effective January 1975, and includes the original act and subsequent legislation.

APPENDIX C

ORD. NO. 4099 274 - 10,846 Eff. 3-22-74

ARTICLE LXX
LOS ANGLLES COUNTY PARAMEDIC COMMITTEE
(10,846 3-22-74)

Sec. 1651. CREATION. There is hereby created the Los Angeles County Paramedic Committee, hereinafter referred to in this Article as the "Committee," which shall supersede the Los Angeles County Paramedic Committee heretofore established pursuant to Board Order.

Sec. 1652. MEMBERSHIP. The Committee shall consist of ten members and one ex officio member. All members, except the ex officio member, shall be appointed by the Board. Eight of the members shall be licensed to practice medicine in the State of California. The five physicians currently serving on the Los Angeles County Paramedic Committee, heretofore established pursuant to Board Order, shall be deemed members of the Committee. The ex officio member shall be the County Forester and Fire Warden.

Three additional physicians shall be selected as follows:

(a) One shall be a physician actively engaged in the practice of emergency medicine in a paramedic base hospital in the County of Los Angeles and be a current member of the American Col1ege of Emergency Physicians.

(b) One shall be a physician in charge of the emergency department of a paramedic base hospital in the County of Los Angeles.

(c) One shall be nominated, subject to Board approval, by the Medical Advisory Council of the City of Los Angeles and be currently engaged in practice in a paramedic base hospital in the County of Los Angeles.

The remaining two non-physician members shall be selected as follows:

(d) One shall be nominated by the Hospital Council of Southern California, subject to Board approval, and be currently employed as an Administrator of a paramedic base hospital in the County of Los Angeles, He shall not, however, be from the same hospital as any of the physicians appointed pursuant to sub-paragraphs a, b and c above.

(e) One shall be nominated by the Directors of Nursing Council, subject to Board approval, and be currently employed as a registered nurse in a paramedic base hospital in the County of Los Angeles, whose specialization is emergency care in an emergency setting, such as a trauma center, critical care unit, or intensive care unit.

Sec. 1653. TERMS. Each member or the Committee, except the ex officio member, shall serve for a term or one year from the date of appointment and until his successor is appointed and qualifies. For those physicians who are deemed members pursuant to Section 1652 of this Article, the date of appointment shall be the effective date or this Article. All appointments are subject to the right of the Board to remove any such member at any time at its pleasure and also subject to the provisions of Section 39.5 and all other applicable provisions of this Ordinance. In the case of the death, resignation, or removal of any member by the Board or pursuant to Section 39.5, or otherwise, his successor shall serve for the remainder of the unexpired term.

Sec. 1654. COMPENSATION. The compensation of members of the Committee and the Advisory Council shall be as provided from time to time in the current salary ordinance of the County of Los Angeles. In the absence of any provision therefor in said current Salary Ordinance, the members of the Committee and the Advisory Council shall serve without compensation.

Sec. 1655. SELF-GOVERNMENT. The Committee may prepare and adopt rules for the conduct of its business and designate the time and place of its meetings.

Sec. 1656. DUTIES. The Committee shall act in an advisory capacity to the Director of Health Services in matters relating to the training and certification of Mobile Intensive Care Paramedics.

Sec. 1657. ADVISORY COUNCIL. As a part of the Committee a separate advisory council is hereby created to consist of six members. Pursuant to Section 51 of the Charter of the County the Committee shall appoint the six members as follows:

(a) A representative proposed by the Los Angeles County Ambulance Association.

(b) A representative proposed by the Los Angeles County Heart Association.

(c) A representative proposed by the League of California Cities, said representative to be from a participating city and whose assignment is to supervise a Mobile Intensive Care Unit.

(d) A representative from the Communications Department of the County of Los Angeles.

(e) An educator proposed by the Southern California

(Continued)

Sec. 1657. (Continued)
Association of Community College who is skilled in the area of training of mobile intensive care paramedics.

(f) A practicing Paramedic proposed by the Director of Paramedic Training, County of Los Angeles.

The members of the Advisory Council shall serve for a term of one year from the date of appointment and until their successor is appointed and qualifies, subject, however, to the right of the committee to remove any such member at any time at its pleasure.

The Advisory Council shall act in an advisory capacity to the Committee.

APPENDIX D

COUNTY OF LOS ANGELES

OFFICE OF THE COUNTY COUNSEL
648 HALL OF ADMINISTRATION
LOS ANGELES, CALIFORNIA 9OOI2

974 1926

July 10, 1975

John H. Larson, County Counsel
Donald K. Byrne, Chief Deputy-

Mr. Burke Roche, Executive Secretary
Los Angeles County Economy &
Efficiency Commission
163 Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Re: Recommendations of Economy and Efficiency Commission Concerning the Organization and Operation of the Paramedic Committee

Dear Mr. Roche:

You have asked that we review the subject recommendations, dated July 2, 1975, to determine whether there are any legal impediments which would prevent their implementation. We have completed our review and note that several of the proposals seem contrary to provisions of the Wedworth-Townsend Paramedic Act, hereinafter referred to as "Act" (Health and Safety Code (HSC) Section 1480 et seq.). We refer specifically to those provisions contained in HSC ээ1480.1, 1481, 1481.1, and 1484.2.

HSC э1480.1 provides:

"The training of mobile intensive care paramedics may only be conducted by a community college, college, university, or hospital that has a certificate of approval for its curriculum and training program from the county health officer of the county in which it is located."

HSC э1481 provides:

"As used in this article:

(a) 'Mobile intensive care paramedics' means personnel who have been trained in the provision of emergency cardiac and noncardiac care in a

training program certified by the county health officer of the county giving certification or a certified training program in another county that has been evaluated and approved by the county health officer of the county giving certification, and who pass the performance and written examinations required for certification by the officer as qualified to render the services enumerated in this article in the county giving such certification.

(b) "Mobile intensive care nurse' means a registered nurse who has been certified by a county health officer as qualified in the provision of emergency cardiac care and noncardiac care and the issuance of emergency instruction to mobile intensive care paramedics."

"*****"

HSC ∋1481.1 provides:

"The training program for mobile intensive care paramedics shall consist of a minimum of 200 hours of didactic training, a minimum of 100 hours of clinical experience, and a field internship of at least 200 hours."

"However, all or any portion of the required training program for a mobile intensive care paramedic may be waived by the county health officer of the county giving certification if the applicant passes the performance and written examinations required for certification or the appropriate portion of the performance examination."

HSC ∋1484.2 provides:

"The county health officer shall establish criteria necessary to maintain certification as a mobile intensive care paramedic or a mobile intensive care nurse including, but not limited to:

(a) A formal program of continuing education.

(b) Continuous service as a mobile intensive care paramedic or a certified mobile intensive care nurse.

(c) Retesting at two-year intervals, which shall include a performance examination and may include written examinations and oral examinations."

These statutory provisions clearly give the county health officer (our Director of Health Services) exclusive authority (1) to approve mobile intensive care paramedic training programs providing paramedics for his county (if the minimum standards of HSC ∋1481.l are satisfied), (2) to certify all mobile intensive care paramedics and mobile intensive care nurses providing services in his county, and (3) to establish criteria necessary to maintain certification as a mobile intensive care paramedic or nurse.

Under the referenced recommendations, it is proposed that a reorganized Paramedic Committee, whose members would be appointed by the Board of Supervisors, would be given, among other responsibilities, the following duties:

"A. To arbitrate differences between the Department of Health Services and other sectors of the community including but not limited to physicians, private companies, community colleges, municipalities, and hospitals in the field of paramedic services and training.

B. To hear and decide appeals of decisions made by the Department of Health Services on the following matters:

1. Decisions to establish and enforce policies, procedures, and standards to control the certification of mobile intensive care nurses and paramedics.

2. Decisions to accept or reject proposals of any public or private organization to initiate or modify a program of paramedic services or training.

C. To hear and decide appeals of certification decisions by the Department of Health Services and the certifying officer."

"****"

Decisions reached by the Paramedic Committee could be appealed to the Board of Supervisors.

The effect of these proposals would be to give the Paramedic Committee, and finally, the Board of Supervisors, apparent authority to override decisions of the Director of Health Services concerning matters which, by virtue of the cited Health and Safety Code provisions, have been vested by the Legislature solely in the Director. It is, of course, settled that a county possesses only those powers specifically granted by law and those necessarily implied from the powers expressed. San Vincente Nursery School v. County of Los Angeles (1956), 141 Cal. App. 2d 79, 85. It is also settled that where the law prescribes a particular mode by which a county shall exercise a power, that mode must be followed in order to make it a valid exercise of power. Hilton v. Board of Supervisors (1970), 7 Cal. App. 3d 708, 714.

As noted, it is the Wedworth-Townsend Act which sets forth the powers of a county in the paramedic area, and it is the cited provisions of the Act which prescribe the mode by which paramedic training programs, and paramedics and mobile intensive care nurses, are certified. That mode does not provide for decisions relative to such certification to be vested in any public officer other than the county health officer. Accordingly, such decisions by the Paramedic Committee or the Board of Supervisors would be ultra vires, would be illegal, and could not be binding upon the Director of Health Services. Cf. Skidmore v. West (1921), 186 Cal. 212, 217.

Therefore, it will be necessary to amend the Act in order to provide the Paramedic Committee and Board of Supervisors with the necessary authority to make these decisions. If you wish, we would be pleased to assist you in drafting an appropriate amendment.

Sincerely yours,

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