REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

Emergency Medical Services Personnel Training and Certification and Recruitment and Retention

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 3

COMMONWEALTH OF VIRGINIA
RICHMOND
1990

MEMBERS OF THE JOINT SUBCOMMITTEE

Clarence A. Holland, Chairman

Joseph P. Crouch, Vice-Chairman

Elmon T. Gray

Virgil H. Goode, Jr.

William C. Wampler, Jr.

Franklin P. Hall

Mary A. Marshall

W. Henry Maxwell

Coan G. Agee

L. Delano Britt, M.D.

STAFF

LEGAL AND RESEARCH

Norma E. Szakal, Staff Attorney

Brenda H. Edwards, Research Associate

Stephen B. Evans, Intern

Marcia Ann Melton, Secretary

ADMINISTRATIVE AND CLERICAL

Office of the Clerk, Senate of Virginia

REPORT OF THE JOINT SUBCOMMITTEE STUDYING EMERGENCY MEDICAL SERVICES PERSONNEL TRAINING AND CERTIFICATION AND RECRUITMENT AND RETENTION

TABLE OF CONTENTS

REPORT OF THE
JOINT SUBCOMMITTEE STUDYING
EMERGENCY MEDICAL SERVICES
PERSONNEL TRAINING AND CERTIFICATION
AND
RECRUITMENT AND RETENTION

TO
THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA
RICHMOND, VIRGINIA
JANUARY, 1989

To: The Honorable Gerald L. Baliles, Governor of Virginia,
and
The General Assembly of Virginia

I. ORIGIN OF THE STUDY

In response to growing concerns over the adequacy of the supply of skilled emergency medical services volunteers, two resolutions were introduced during the 1988 Session of the General Assembly. Senate Joint Resolution 86, patroned by Senator Clarence A. Holland, and House Joint Resolution 134, patroned by Delegate Joseph P. Crouch, recognized the need for a Joint Subcommittee to address issues related to recruitment, retention, training and certification of emergency medical services volunteer personnel in the Commonwealth.

Senate Joint Resolution 86 called for a study of "...alternative methods for training and the certification requirements for emergency medical services personnel." House Joint Resolution 134 called for a study of "...the recruitment and retention of emergency medical services personnel." Both resolutions required the determination of the extent of the training needs for emergency medical services personnel including dispatchers, the identification of appropriate training alternatives, e.g., the use of communications technology such as interactive television, teleconferencing and computer instruction. Both studies also required the evaluation of the funding of any training alternatives identified as appropriate.

In addition to these parallel charges, SJR 86 required an evaluation of the appropriateness of the certification requirements and HJR 134 required the identification of ways to enhance and improve the recruitment and retention of emergency medical services personnel. HJR 134 and SJR 86 were approved; thereby establishing two Joint Subcommittees. Because of the overlapping issues, these studies were combined into one study upon agreement of the patrons of the resolutions; therefore, all issues set forth in HJR 134 and SJR 86 were within the scope of this study.

The Joint Subcommittee consisted of four members of the Senate, Virgil H. Goode, Jr. of Rocky Mount, Elmon T. Gray of Waverly, Clarence A. Holland of Virginia Beach and William C. Wampler, Jr. of Bristol; four members of the House

of Delegates, Joseph P. Crouch of Lynchburg, Franklin P. Hall of Richmond, Mary A. Marshall of Arlington and W. Henry Maxwell of Newport News; and two citizen members, Mr. Coan G. Agee of Keysville and Dr. L. Delano Britt of Norfolk. Senator Holland served as chairman and Delegate Crouch served as vice-chairman.

II. A SHORT ANALYSIS OF THE ISSUES

Physical trauma is the major cause of death for individuals from age 1 to age 44 in Virginia and the nation. Among the many causes of injuries and death, motor vehicle accidents are the primary cause of physical trauma. High speed travel coupled with increased numbers of vehicles of a variety of sizes have caused the incidence of multiple, severe trauma to escalate rapidly in the last fifty years. However, since the Korean War and the development of triage and sophisticated treatment modalities, individuals who would have died from multiple trauma, severe head injuries, or spinal cord injuries are now being saved.

The historical evolution of Virginia's EMS system was of significance to the deliberations of this Committee. Since 1968, the Board of Health has been responsible for setting standards for licensure of ambulance services and certification of prehospital personnel. In 1974, the General Assembly authorized the Board to develop "...a comprehensive, coordinated emergency medical care system in the Commonwealth." The regional emergency medical services councils and the Virginia Rescue Squads Assistance Act were statutorially created in 1978 (See Chapter 517, Acts of Assembly, 1978). In 1981, need for the development of a statewide air medical evacuation system was recognized and statutorily mandated in Virginia law (see §32.1-112, Chapter 170, Acts of Assembly, 1981). We now have medevac coverage in all areas of the Commonwealth.

In 1983, a major step in state financing of the emergency medical services system was initiated through the passage of Senate Bill No. 10, the so-called "One for Life" bill. This bill added $1 to the motor vehicle registration fee, which is dedicated to financing emergency medical and rescue services. The development of a source of state funding for the emergency medical services system in Virginia was particularly fortuitous at this time in view of the major reductions in federal funding which took place in 1981, as a result of the consolidation of the EMS Systems Act funding into the Preventive Health and Health Services block grant.

Virginia still has, as do many other states, primarily volunteer emergency medical services personnel. The commitment and devotion of these volunteers can not be exaggerated. Most of the rescue squad volunteers work hard at full-time jobs and then spend countless hours working as emergency medical services personnel, frequently under very stressful conditions. In some localities, notably rural areas, increasingly stringent certification requirements have been resisted. Local officials and rescue squad volunteers have sometimes objected to the training standards for certification. In 1979, a provision authorizing the Commissioner of

Health to grant variances and the Board of Health to grant waivers from the EMS regulations was enacted (see §32.1-154). The applications for variances and waivers have not been numerous. The training programs for the volunteer and paid EMS personnel have been continually improved in Virginia as the technology in the prehospital treatment of patients has advanced.

Unlike many states, Virginia has an eighteen-year history of aggressive state leadership in the development of an effective EMS system. However, as the EMS system in Virginia has evolved, controversy has erupted on a regular basis. Training standards, volunteer versus paid squad conflicts and reporting requirements, etc. are not new issues in Virginia. Although the basic themes appear familiar, the underlying problems are quite different now from those issues facing the EMS system several years ago. Because many of the Commonwealth's EMS personnel are volunteers, Virginia's EMS system is extraordinarily sensitive to societal and economic changes. Some examples of this interaction are:

1. The aging of the population. Traditionally, EMS volunteers have been young to middle-aged adults. The potential for tapping the older population as volunteers in EMS has not received enough attention.

2. The increase in the number of women working outside the home. In the past, women provided a stable pool of volunteers to work in many areas including EMS. With more and more women working in positions which, in the past, were held by men, the eagerness of women to find intellectual stimulation or rewards through volunteerism has diminished.

3. The increase in the number of single parent families. The responsibilities of single parents are frequently too time consuming and numerous to allow for extensive volunteer work.

4. The increase in the number of individuals who work outside the community in which they live. Commuting time and its attendant stress and fatigue have reduced people's capacity for volunteer work. Many are still willing to volunteer, but they may not be willing to work the long hours that were contributed by previous generations.

5. The increase in the availability and variety of recreational activities. Workers have the option of going home to television or movies on the VCR, tennis, swimming, racquet ball, aerobics, nautilus, etc.

6. Changes in motivation. Some experts allege that Americans have shifted their focus from a concern about community well-being to a concern for personal well-being.

7. Changes in attitudes. Personality conflicts abound in rescue squads, although in prior years, anecdotal evidence indicates that internal conflict was not a great problem. It would appear that, in the 1980's, people are less polite and much more willing to engage in confrontations with others. This impacts the retention rate among EMS personnel.

8. Employers are less willing to grant time-off for volunteer work. Economic stresses, particularly on small businesses, have made it less feasible for employers to provide this flexibility.

9. Concerns about injuries and infectious diseases. The lack of any insurance coverage while performing an activity with high risk potential for injuries and, to a lesser extent, the fear of exposure to infectious diseases such as AIDS and hepatitis have acted as deterrents for many individuals.

10. Rapid growth in traditionally rural areas. Many factors exacerbate the effects of rapid growth on the EMS system such as the lack of community relationships and commitments among new residents, increased needs for services as the population increases and the inability to integrate transient populations into the community.

11. Increase in the demand for volunteers. The number of charitable and nonprofit organizations recruiting volunteers has increased significantly in recent years at the same time that the number of people willing to volunteer appears to have decreased and the available time for volunteering has decreased.

Perhaps part of the problem is that a second generation of EMS volunteer is being seen. The earlier volunteer was a community-spirited, "good old boy" or "good old gal," who rushed out to the scene of an accident, scooped up the victim and hurried back to drop him at the local hospital. Accidents were less frequent - in fact, motor vehicle accidents of any significance were almost always the subject of media coverage. The rewards of EMS service were great in terms of self-esteem and lending a helping hand and the powerful stimulus-response to emergency lent excitement to lives that may have been otherwise dull.

Today's volunteer is expected to attend extensive training programs, to pass tests and to renew his certification at regular intervals. Frequently, today's volunteer feels that this is asking too much of one offering free services.

Today's volunteer may work side by side with paid personnel and may resent this situation bitterly. There is no doubt that some volunteer personnel have experienced feelings of isolation from the paid personnel and that incidences of conflict have occurred between the volunteer and paid personnel in some parts of the state. The reasons for these feelings and conflicts are diverse; however, they appear to be created primarily by the resentment felt among the volunteers when paid agencies or personnel are initiated. Some volunteers may feel that the public and local government officials are ungrateful for the long hours and hard work they have contributed without pay to the EMS system and may feel that instituting paid personnel implies that they have not done a good job. Others perceive the local government as wanting to take over the local EMS system.

Today's volunteer is in great demand and may require more motivation and recognition. The earlier EMS volunteer was self-motivated to serve. Today's volunteer may have to be "romanced" through aggressive, innovative, high profile

recruitment campaigns. Today's volunteer may already be subject to inordinate levels of physical and emotional stress. Service as an EMS volunteer can provide significant personal rewards, but it can also substantially increase an individual's stress level. In addition, the physical demands can be extreme, e.g., interrupted sleep and physically tiring tasks.

Today's volunteer does not want to spend his time conducting fund raisers which he may view as demeaning. The volunteer may, in fact, demand innovative approaches to incentives. Without additional incentives for working in the EMS system, the pool of volunteers could become even more constricted.

Management of EMS services may have to be reevaluated to focus on aggressive recruitment campaigns, on access to and availability of training, on ensuring that volunteers feel needed and personally satisfied with their activities, on coordination of paid and volunteer services and on providing incentives for retention of trained personnel (volunteer and paid).

III. WORK OF THE JOINT SUBCOMMITTEE

The Joint Subcommittee conducted seven meetings, four of which were public hearings.

During the first meeting, the Joint Subcommittee received a briefing from its staff, including an overview of issues facing emergency medical services operations and the results of a staff-conducted telephone survey of thirty emergency medical facilities throughout Virginia. Additionally, the Joint Subcommittee received presentations from Dr. C.M.G. Buttery, Commissioner of the Department of Health; Ms. Susan McHenry, Director of the Division of Emergency Medical Services, State Department of Health; Mr. Edward E. Rose, III, Assistant County Attorney and Legislative Liaison for Fairfax County; Mr. Thomas Owen, Volunteer Coordinator of the Fairfax County Fire and Rescue Squad Department; and Mr. Stanley Goldsmith, Town Manager of Altavista, Virginia.

During the staff briefing, it was noted that one of the factors cited as affecting the strength of the volunteer force is that EMS personnel are expected to attend extensive, time-consuming initial training and recertification training programs. Many individuals experience severe test anxiety when confronted with examinations. Some people state that they are unwilling to continue undergoing this stress. It was also noted that fear of infectious diseases and inadequate recognition of the contributions of volunteers appear to be exacerbating the situation.

For the telephone survey, thirty respondents were chosen randomly from four geographic regions of the Commonwealth (northern, central, southwestern and the Tidewater). With two exceptions, all respondents indicated that there is a definite need for more EMS volunteers to serve on all work shifts, especially between six a.m. and noon. The majority of the respondents noted that recruitment and retention problems have become much more pronounced in the last eighteen

months to two years. Respondents from rural areas cited the need to travel to training seminars and the difficulty in coordinating volunteers' personal schedules with times allocated for training as problems. The survey indicated that the concerns of many individuals are more focused on their jobs and personal commitments than in the past; therefore, these individuals place a high premium on their available free time. Over three-fourths of the survey respondents believed that innovative approaches to recruitment and new incentives for EMS volunteers are essential to address the problem effectively.

Dr. Buttery told the committee that the success of emergency services is dependent upon the ability of providers to quickly and accurately assess a patient's condition. He noted that in rural or sparsely populated areas of Virginia the need for good training and technical equipment is much more pronounced than in urban or more populous areas.

Ms. McHenry detailed certification and training requirements for Virginia emergency medical services personnel. All personnel are required to attend training programs and to pass relevant tests prior to certification and recertification. Forty hours of initial training are required for the first responder, the certification term is three years and fifteen hours of training are required prior to recertification. One hundred and ten hours of initial training are required for an emergency medical technician, the certification term is three years and thirty hours of training are required prior to recertification. Thirty additional hours of training are required for the emergency medical technician instructor, the certification term is two years and such individuals are required to teach fifty hours and to attend an eight hour workshop prior to recertification. The shock trauma technician is required to attend sixty-six hours of initial training for a certification period of two years with thirty-six hours of additional training required prior to recertification. The cardiac technician is required to attend one hundred and sixty-two hours of initial training for a certification period of two years with fifty hours of additional training required prior to recertification. A paramedic is required to attend three hundred and eighty-five hours of initial training for a certification period of two years; sixty-six hours of training are required prior to recertification. Ms. McHenry explained that training is based on nationally established programs, although she noted that certification levels are not standardized throughout the country.

Mr. Rose described the Fairfax County recruitment and retention program to the Joint Subcommittee. He explained that the county uses a combined approach which includes advertising in the print media, radio and television and periodic fund drives. Mr. Rose noted that the county's annual attrition rate among emergency volunteers stands at twenty-two percent, compared with a national average of thirty percent.

Mr. Owen addressed the issue of retention of volunteer personnel. He told the committee that a commitment to respect the contributions of volunteers, rather than treating such persons as free help, is crucial to any retention effort.

Mr. Goldsmith relayed to the Joint Subcommittee the problems facing emergency medical services as seen from a rural community perspective. He said

that in sparsely populated areas of the Commonwealth it is difficult to provide training for emergency medical services personnel. He recommended that training requirements for personnel be revised to incorporate alternative methods of instruction. Pointing to the increasing demands placed on individuals who already have little free time for community service, Mr. Goldsmith told the committee that Virginia needs to prepare for the demise of the volunteer emergency medical system. He said he believes this will happen within five to ten years.

The second meeting was a public hearing in Fredericksburg. The Joint Subcommittee received testimony from fourteen individuals.

The speakers addressed issues related to manpower and training for emergency medical services personnel. It was noted that problems in these areas are not new. One speaker noted that six priority areas are simplification of EMS certification and recertification, personnel burnout, daytime staffing levels, an increase in and change of field representatives under certification and training, the contents of the statewide drug box and protocols, as well as a need for emphasis on funding for teaching aids, particularly audio visual materials.

It was also noted that there is a need for equal concern for paid and volunteer personnel since the problems are the same. The speakers described difficulties in recruitment, the critical status of daytime coverage, internal squad conflicts, providing management training for volunteers and the role of local governments in sharing the funding responsibilities for emergency medical services, particularly by providing funding for daytime personnel.

Some of the recommendations of the speakers were to increase the funding provided to the Division of Emergency Medical Services and to extend preferential treatment to volunteers in the form of tax and retirement incentives, as well as workman's compensation benefits, in order to recruit new volunteers while providing existing personnel with substantial reasons to remain active.

It was also recommended that recertification, like initial training, should be standardized throughout Virginia and that it may be important to recognize the differences between urban and rural emergency operations when considering any change or introduction of new EMS policy. It was noted that rapid response times are critical to the survival rate of patients, especially those suffering from cardiac arrest and multiple trauma. Communications systems were said to play a crucial role in this regard, e.g., two-way radios. One speaker recognized the potentially beneficial effects of the newly implemented quality assurance program.

The testimony indicated that, overall, insufficient daytime staffing levels and slow response times to emergency calls are two of the major problems facing emergency medical services in Virginia. Developing innovative training methods for EMS personnel and investigating retirement and benefits programs, which are alleged to be already in place in other states, were other topics presented during this public hearing.

The third meeting was a public hearing held in Roanoke, during which fourteen citizens aired their concerns about EMS operations. Several individuals registered to speak deferred to other speakers and noted that the presenters to whom they deferred had expressed their positions. Testimony focused primarily upon the need for alternatives to existing training programs, funding strategies for rural and sparsely populated areas of the Commonwealth, the need for increasing public awareness of EMS through advertising, and creating worthwhile incentives for existing EMS personnel to continue serving and to entice new recruits with perquisites such as retirement benefits. In addition, speakers emphasized the desirability of the Commonwealth providing funding to purchase the Hepatitis vaccine in order to eliminate the fear of this disease on the part of EMS personnel. The growing problem with liability insurance -- its costs and the adequacy of the coverage -- was also noted.

During the Roanoke public hearing, it was also recommended that the "Good Samaritan" law be revised. Mr. Kenneth C. King, a member of the Western Virginia EMS Council and a practicing attorney, suggested that the specificity of the "Good Samaritan" law was diluting its intended effects. He cited as evidence for this opinion the fact that rescue squads purchase malpractice liability insurance. He offered several recommendations for changes in the law which included authorizing the Attorney General to defend claims filed against individuals and governmental units for which a "Good Samaritan" defense applies, providing coverage under the "Good Samaritan" law for all licensed EMS agencies, providing a presumption that the "Good Samaritan" law applies in any case brought against an individual or agency rendering emergency care or assistance (and that clear and convincing evidence would be required to rebut this presumption), and requiring the payment of costs, expenses and attorneys' fees for all defendants, if the presumption of immunity is not rebutted.

During the fourth public hearing, which was held in Warsaw, the Joint Subcommittee received testimony from nine speakers who represented EMS operations throughout Virginia. Comments and discussion during the public hearing, as with previous meetings, continued to focus on training issues -- accessibility, the amount of required training, personnel requests that training programs be tailored to fit practical experiences in the field, funding for training and purchase of training materials, the need for alternative delivery methods for training programs -- as well as the desire of many speakers that medical benefits, retirement packages and other perquisites be established to provide EMS volunteers with some tangible reason for pursuing and maintaining involvement in local EMS operations. Several individuals commented that in their service area the need for volunteers is so strong, while reduced staffing levels place greater time demands on existing personnel, that service delivery is compromised during certain times of day. This was noted to be especially true during daytime hours. It was also stated that the $1 for life funds are inadequate to meet the needs of the emergency medical services system. Several speakers recommended that this fund be increased to a $2 for life fund. Statements were made which indicated that there is a need to educate the public about the volunteer nature of most emergency medical services in Virginia, because the public perceives EMS personnel as either individuals with time on their

hands who are excited by sirens and blood or they assume that the volunteers are paid. Other speakers emphasized the need for improvement in the management of EMS agencies through training. Speakers also commented that the position of the operational medical director needs to be enhanced. Other issues which were mentioned during this hearing included the critical incidence stress debriefing teams, the possibility of requiring continuing education in conjunction with a specific number of runs per month for certain recertifications rather than formal training and testing, the potential for and the problems of involving college students, self-insurance as a solution to the liability issues, the problems with call volumes and nonemergency runs, the efficacy of mobile training units, the need to simplify the training manual for the EMT, the development of training modules, and the possibility of implementing public relations programs at the high school level in order to recruit students when they become adults.

Approximately twenty-five individuals registered to speak at the fifth meeting, a public hearing held in Halifax. During this night meeting a number of registered speakers chose to submit written statements and relinquish their speaking time because of the lateness of the hour. Many of the issues discussed at prior meetings were reiterated by speakers attending this meeting. In addition, speakers noted that continuing education should be enhanced through the development of user-friendly programs which would make training accessible and available to personnel when not engaged in answering calls, that the defibrillation program should be emphasized in order to improve the outcomes of heart attacks, that there are insufficient instructional resources available, that the low salaries for instructors impacts the availability of training, that volunteer/paid personnel conflicts could be minimized through appropriate management, that lack of practice can result in inappropriate treatment, that it would be helpful if personnel could review their test results, that ride-along programs for high school students are effective ways of recruiting, that a five member coalition has been formed under the auspices of the Department of Volunteerism to address methods to increase the administrative skills of rescue squad personnel, and that the public must be educated to use the EMS system appropriately and to understand that the EMS system benefits everyone.

The sixth and seventh meetings were work sessions during which a number of proposals for remedying the EMS crises were presented.

IV. FINDINGS AND RECOMMENDATIONS

During the second work session, a motion was made and carried to continue the Joint Subcommittee's study in order to prioritize funding initiatives, examine the total funds generated by the $1 for Life program and ascertain the amounts received by local rescue squads. The Joint Subcommittee agreed that the second year of the study would consist of work sessions designed to promote decision making. The decision to continue the study was based on concerns about the funding of any new initiatives and the Joint Subcommittee's recognition of its need to take the time to digest the many proposals which had been presented to it in a careful, thorough manner.

In the opinion of the Joint Subcommittee, additional funds will be required to implement solutions for the retention and recruitment problems about which it had heard repeatedly during the public hearings. However, the members were aware that it is usually more effective to seek appropriations for new

incentives during a long session when the biennium budget is being prepared. Therefore, it was agreed that funding requests for this year would be kept at a minimum. For this reason, the Joint Subcommittee decided to request general fund appropriations for only the following items: a public awareness program in the amount of $68,000; technical assistance workshops for local government officials in the amount of $75,000; management training workshops for EMS agencies and distribution of publications and materials on management in the amount of $32,500; revision of the training programs to incorporate continuing education, appropriate analysis of test results and feedback to agencies in the amount of $73,000; and $35,000 for special training programs for Advanced Life Support in rural areas. The Joint Subcommittee believes that these initiatives would provide a modicum of assistance for the EMS system by promoting recruitment, educating the public and local government officials, developing sorely needed management skills for EMS agencies and alleviating some of the recertification problems.

The Joint Subcommittee also decided to recommend that the recertification period for the First Responders and EMT's be extended from three years to four years. Test anxiety and difficulties with meeting the retraining requirements for recertification are, in the opinion of the Joint Subcommittee, among the primary causes for volunteer and paid personnel leaving emergency medical services. The Joint Subcommittee believes that alternative methods of maintaining skills can be identified which will be easier for EMS personnel to satisfy. However, the Joint Subcommittee wishes to make it clear that this recommendation is in no way intended to indicate that the Subcommittee endorses a reduction in the quality of the emergency medical services system in Virginia. The Joint Subcommittee recognizes that complex skills are required to render prehospital care effectively. However, there are areas in the Commonwealth in which the availability of prehospital care is being seriously threatened because of the shortage of EMS personnel. It is the hope of the Joint Subcommittee that extension of the recertification period can be combined with opportunities to practice skills and for continuing education that will maintain the expertise of Virginia's EMS personnel while providing some small measure of relief from the shortage of personnel.

Further, during the course of the hearings, the Joint Subcommittee became convinced that the "Good Samaritan" law should be revised. Therefore, the Subcommittee decided to propose a bill to reorganize this law by separating the medical personnel from others such as the hazardous materials workers and providing the additional protections suggested by Mr. Kenneth King during the Roanoke public hearing.

V. CONCLUSIONS

Over the months of the first year of this study, the Joint Subcommittee has become convinced that a crisis is facing the emergency medical services system in Virginia. Shortages of personnel, most of them volunteers, dissension among the ranks of the EMS personnel, particularly between paid personnel and volunteers, the threats of infectious diseases, the difficulties in obtaining, maintaining and

affording liability insurance, lack of access to training, the time demands of the required training and the inevitable anxiety and conflicts created by changes in the system from the old club-like atmosphere to a stressful professionalism are just some of the issues that must be faced and ameliorated.

Further, there does not appear to be a consensus on the most appropriate method for remedying this situation among the people who are involved as paid personnel, volunteers, medical advisors and Department of Health administrators. It is a fact, however, that neither the state nor the local governments can afford to have the emergency medical services system deteriorate. Therefore, the Joint Subcommittee believes that another year of study is indicated in order to develop flexible and viable remedies designed to save the volunteer emergency medical services system in this Commonwealth.

The Joint Subcommittee wishes to thank the many individuals who appeared before it during this year of its study. Many of these people traveled great distances to the meetings and all of them devoted substantial time and thought to the suggestions presented at the public hearings.

Respectfully submitted,

Clarence A. Holland, Chairman

Joseph P. Crouch, Vice-Chairman

Elmon T. Gray

Virgil H. Goode, Jr.

William C. Wampler, Jr.

Franklin P. Hall

Mary A. Marshall

W. Henry Maxwell

Coan G. Agee

L. Delano Britt, M.D.

APPENDICES

Senate Joint Resolution No. 86, 1988 - Enabling legislation

House Joint Resolution No. 134, 1988 - Enabling legislation

Senate Joint Resolution No. 208, 1989

Senate Joint Resolution No. 209, 1989

Senate Bill No. 770, 1989

SENATE JOINT RESOLUTION NO. 86

Establishing a joint subcommittee to study alternative methods for training and the certification requirements for emergency medical services personnel.

Agreed to by the Senate, February 10, 1988

Agreed to by the House of Delegates, March 9, 1988

WHEREAS, the primary responsibility for providing emergency medical services still rests with volunteer personnel in most areas of Virginia; and

WHEREAS, every citizen of Virginia is indebted to these dedicated volunteers for the long hours and hard work that they contribute to helping the injured and sick; and

WHEREAS, the severity and incidence of trauma appear to have increased as the population has grown and the use of motor vehicles has become ubiquitous; and

WHEREAS, frequently, prehospital personnel are called upon to exercise sophisticated skills in the care of trauma victims with multiple injuries; and

WHEREAS, advances in medical technology for the treatment of trauma have made it necessary to increase the requirements for certification of emergency medical services personnel; and

WHEREAS, in some areas of the Commonwealth, instructors in emergency medical services are scarce and it has already become difficult for many volunteer personnel to attend the traditional training programs in a classroom setting for the required hours; and

WHEREAS, the training needs are significant, however, and alternative ways to provide this training must be found in order to maintain the skills of prehospital personnel in the treatment of multiple trauma patients; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That there is hereby established a joint subcommittee to study alternative methods for training and the certification requirements for emergency medical services personnel. The joint subcommittee shall determine the extent of the training needs for emergency medical services personnel including dispatchers, the appropriateness of the certification requirements, and identify appropriate training alternatives, e.g., the use of communications technology such as interactive television, teleconferencing and computer instruction. Further, the joint subcommittee shall evaluate the funding of any training alternatives which it identifies as appropriate.

The joint subcommittee shall consist of nine members as follows: two members of the Senate Committee on Education and Health and one member of the Senate Committee on Finance to be appointed by the Senate Committee on Privileges and Elections; three members of the House Committee on Health, Welfare and Institutions and one member of the House Committee on Appropriations, all to be appointed by the Speaker of the House; and two citizen members, one of whom shall be a member of the Medical Society of Virginia and one of whom shall be a member of the Virginia Association of Volunteer Rescue Squads to be appointed by the Governor.

The joint subcommittee shall complete its work in time to make recommendations to the 1989 Session of the General Assembly.

The indirect costs of this study are estimated to be $10,650; the direct costs of this study shall not exceed $6,480.

GENERAL ASSEMBLY OF VIRGINIA -- 1988 SESSION

HOUSE JOINT RESOLUTION NO. 134

Establishing a joint subcommittee to study the recruitment and retention of emergency medical services personnel.

Agreed to by the House of Delegates, March 11, 1988
Agreed to by the Senate, March 9, 1988

WHEREAS, the primary responsibility for providing emergency medical services still rests with volunteer personnel in most areas of Virginia; and

WHEREAS, every citizen of Virginia is indebted to these dedicated volunteers for the long hours and hard work that they contribute to helping the injured and sick; and

WHEREAS, the severity and incidence of trauma appear to have increased as the population has grown and the use of motor vehicles has become ubiquitous; and

WHEREAS, frequently, prehospital personnel are called upon to exercise sophisticated skills in the care of trauma victims with multiple injuries; and

WHEREAS, advances in medical technology for the treatment of trauma have made it necessary to increase the requirements for certification of emergency medical servic personnel; and

WHEREAS, in some areas of the Commonwealth, instructors in emergency medic... services are scarce due to stringent job requirements, the demand for great personal sacrifice and the difficulty of many volunteer personnel to attend the traditional training programs in a classroom setting for the required hours; and

WHEREAS, ways to enhance and improve the recruitment and retention of emergency medical services personnel must be found in order to maintain an adequate supply of skilled prehospital personnel for the treatment of multiple trauma patients and other persons in need of emergency health care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That there is established a joint subcommittee to study the recruitment and retention of emergency medical services personnel. The joint subcommittee shall determine the extent of the training needs for emergency medical services personnel including dispatchers and identify appropriate training alternatives, such as the use of communications technology, interactive television, teleconferencing and computer instruction, and evaluate the funding of any training alternatives which it identifies as appropriate. It shall also identify ways to enhance and improve the recruitment and retention of emergency medical service personnel.

The joint subcommittee shall consist of eight members as follows: three members of the House Committee on Health, Welfare and Institutions and one member of the House Committee on Counties, Cities and Towns, all to be appointed by the Speaker of the House and two members of the Senate Committee on Education and Health and one member of the Senate Committee on Local Government to be appointed by the Senate Committee on Privileges and Elections and one representative of the Virginia Association of Volunteer Rescue Squads to be appointed by the Governor.

The joint subcommittee shall complete its work in time to submit its recommendations to the 1989 Session of the General Assembly.

The indirect costs of this study are estimated to be $13,045; the direct costs of this study shall not exceed $6,300.

LD6884121

SENATE JOINT RESOLUTION NO. 208

Offered January 24, 1989

Requesting the Division of Emergency Medical Services within the Department of Health to reevaluate and revise its training and testing materials and requirements and to extend the certification period for certain personnel.

Patrons--Holland, C. A., Wampler, Goode and Gray; Delegate: Maxwell

---

Referred to the Committee on Rules

WHEREAS, physical trauma is the major cause of death for individuals from age 1 to age 44 in Virginia and the nation; and

WHEREAS, Virginia still has, as do many other states, primarily volunteer emergency medical services personnel; and

WHEREAS, unlike many states, Virginia has an eighteen-year history of aggressive state leadership in the development of an effective EMS system; and

WHEREAS, the evolution of the EMS system in Virginia has generated controversy on a regular basis; and

WHEREAS, training standards, conflicts between volunteer and paid personnel, reporting requirements, and a shortage of personnel to cover daytime and weekend hours are some of the many issues facing this system at this time; and

WHEREAS, the Joint Subcommittee Studying Emergency Medical Services Personnel Training and Certification pursuant to Senate Joint Resolution No. 86 and House Joint Resolution No. 134 of the 1988 General Assembly has held four public hearings at different sites in the Commonwealth; and

WHEREAS, the Joint Subcommittee has heard much testimony concerning the need for the reevaluation of training information, particularly for first responders and emergency medical technicians, in order to eliminate nonessential information and to ensure that the required knowledge will relate to service in the field; and

WHEREAS, the Joint Subcommittee is profoundly aware of the need to maintain a viable and effective emergency medical services system and that at this time neither the state nor the local governments can afford to support a paid system of EMS; and

WHEREAS, the Joint Subcommittee has also received many presentations focused on the need to develop alternative training methods such as videotapes, computer programs, interactive television for classroom and conferences, preceptor programs, on-the-job credit, and allowing the review of technical articles for continuing education credit; and

WHEREAS, many individuals expressed concerns about the content and the frequency of the tests for recertification and alleged that there are individuals who simply quit rescue squad work because they will not take the test again; now, therefore, be it

RESOLVED by the Senate of Virginia, the House of Delegates concurring, That the Division of Emergency Medical Services within the Department of Health is hereby requested to reevaluate and revise its training and testing materials and requirements while bearing in mind the comments heard during the Joint Subcommittee's public hearings and deliberations. In addition, the Division is directed to extend the certification period for First Responders and Emergency Medical Technicians from three years to four years. The Division is further requested to report on its progress in this evaluation and revision to the Joint Subcommittee during the next year of its study.

LD9179121

SENATE JOINT RESOLUTION NO. 209

Offered January 24, 1989

Continuing the Joint Subcommittee Studying Recruitment, Retention, Training and Certification of Emergency Medical Services Personnel.

Patrons–Holland, C. A., Wampler, Goode and Gray; Delegates: Hall, Maxwell, Ealey, Marshall and Crouch

---

Referred to the Committee on Rules

WHEREAS, the Joint Subcommittee Studying Recruitment, Retention, Training and Certification of Emergency Medical Services Personnel has diligently pursued its charges; and

WHEREAS, the joint subcommittee has held seven meetings, four of which were public hearings at sites located in the four corners of the Commonwealth; and

WHEREAS, the joint subcommittee has heard much testimony concerning the crisis in the emergency medical services system in Virginia; and

WHEREAS, the joint subcommittee believes that Virginia's system is one of the best in the country and wishes to preserve the viability of this system; and

WHEREAS, many of the persons making presentations before the joint subcommittee spoke about the recertification requirements and the contents of the tests; and

WHEREAS, allegations were made that volunteers may be dropping out of the emergency medical services system because of the reluctance to take the test and to commit to long hours of continuing education; and

WHEREAS, there are many unmet needs in the emergency medical services system such as ways to promote retention, incentives and programs for recruitment, education of the general public about the services and the volunteer nature of the personnel; and

WHEREAS, the joint subcommittee has proposed several pieces of legislation which it believes to be of benefit to the emergency medical services system; however, the members believe that the issues related to recertification and training require additional study and that there is a need to assess the funding of the emergency medical services system; now, therefore, be it

RESOLVED by the Senate of Virginia, the House of Delegates concurring, That the joint subcommittee studying the recruitment, retention, training and certification of emergency medical services personnel is hereby continued. The current membership of the joint subcommittee shall continue to serve as a joint body representing the membership appointed pursuant to Senate Joint Resolution No. 86 and House Joint Resolution No. 134 of 1988. In its deliberations, the joint subcommittee shall consider:

1. The efficacy of allowing continuous certification for active rescue squad members;

2. Alternatives to classroom study for recertification;

3. The funding of the emergency medical services system including a survey of licensed agencies to determine the amount of funds received by individual and unit agencies from the $1 for Life Fund; and

4. Any other related matter which the joint subcommittee determines to be necessary.

All agencies of the Commonwealth shall provide assistance upon request as the joint subcommittee deems appropriate. The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 1990 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents. The indirect costs of this study are estimated to be $15,440; and the direct costs of this study shall not exceed $10,800.

LD7008119

SENATE BILL NO. 770

Offered January 24, 1989

A BILL to amend the Code of Virginia by adding sections numbered 8.01-225.1 and 8.01-225.2 and to repeal § 8.01-225 of the Code of Virginia, providing immunity from liability for certain persons.

Patron--Goode

Referred to the Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding sections numbered 8.01-225.1 and 8.01-225.2 as follows:

§ 8.01-225.1. Immunity from liability for persons rendering emergency care, assistance or treatment without compensation.--Liability for persons rendering emergency care, assistance or treatment shall be restricted as follows:

1. Any person who, in good faith, renders emergency care or assistance, without compensation, to any injured person at the scene of an accident, fire, or any life-threatening emergency, or en route therefrom to any hospital, medical clinic or doctor's office, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such care or assistance.

2. Any emergency medical care attendant or technician possessing a valid certificate issued by the Board of Health who, in good faith, renders emergency care or assistance, whether in person or by telephone or other means of communication, without compensation, to any injured or ill person, whether at the scene of an accident, fire or any other place, or while transporting such injured or ill person to, from or between any hospital, medical facility, medical clinic, doctor's office or other similar or related medical facility, shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care, treatment or assistance including, but not limited to, violations of Board of Health regulations or other state regulations in the rendering of emergency care or assistance.

3. Any person having successfully completed a course in cardiopulmonary resuscitation approved by the Board of Health who, in good faith and without compensation, administers emergency cardiopulmonary resuscitation, cardiac defibrillation or other emergency life-sustaining or resuscitative treatments or procedures which have been approved by the Board of Health to any injured or ill person at the scene of a fire, accident or other incident or while transporting the person to or from any hospital, clinic, doctor's office or other medical facility, shall be deemed qualified to administer such emergency treatments and procedures and shall not be liable for acts or omissions resulting from the rendering of such emergency treatments or procedures.

4. Any licensed physician who directs the provision of emergency medical services, as authorized by the Board of Health, through a communications device or who serves as the operational medical director for a licensed emergency medical services agency without compensation shall not be liable for any civil damages for any act or omission resulting from the rendering of such emergency medical services unless such act or omission was the result of his gross negligence or willful misconduct.

5. Any person who, in the absence of gross negligence, renders emergency obstetrical care or assistance to a woman in active labor who has not previously been cared for in connection with the pregnancy by the person or by another person professionally associated with the person and whose medical records are not reasonably available to the person shall not be liable for any civil damages for acts or omissions resulting from the rendering of the emergency care or assistance. The immunity granted by this subdivision shall apply only to provision of emergency medical care.

6. Any person who, in good faith and without compensation, administers epinephrine

to an individual for whom an insect sting treatment kit has been prescribed shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of treatment if he has reason to believe that the individual receiving the injection is suffering or is about to suffer a life-threatening anaphylactic reaction.

7. Any emergency medical services agency licensed by the Board of Health whose paid or volunteer personnel render emergency care, treatment or assistance to ill or injured persons without compensation shall not be liable for any civil damages for the acts or omissions of such personnel resulting from the rendering of emergency care, treatment or assistance.

In any civil suit in which a defense pursuant to this section may be raised, the plaintiff shall be required to rebut by clear and convincing evidence the presumption of immunity from liability as set forth above.

In any case in which the presumption of immunity from liability provided to any person or agency by this section is not rebutted by clear and convincing evidence, the defendant shall recover all of his costs and fees including attorney's fees against the plaintiff.

The immunity provided in this section shall also apply to an emergency medical care attendant or technician licensed or certified as such or its equivalent in another state when he is performing emergency services which he is licensed or certified to perform while transporting and caring for a patient in this Commonwealth and the care originated in such other state.

This section shall not be construed to limit liability incurred through the operation of a motor vehicle.

The term "compensation" as used in this section shall not include the salaries of police, fire or other public officials or emergency service personnel who render such emergency assistance.

§ 8.01-225.2. Immunity from liability for persons rendering assistance in an accident or emergency involving certain substances and in emergency rescue or recovery at a mine.— Liability for persons rendering assistance in an accident or emergency involving certain substances and in emergency rescue or recovery at a mine shall be restricted as follows:

1. Any person who, in good faith, provides assistance upon the request of any police agency, fire department, rescue or emergency squad, or any governmental agency in an accident or other emergency involving the use, handling, transportation, transmission or storage of liquefied petroleum gas, liquefied natural gas, hazardous material or hazardous waste as defined in § 18.2-278.1 or the regulations of the Virginia Waste Management Board shall not be liable for any civil damages resulting from any act or omission in rendering such assistance.

2. Any volunteer engaging in rescue or recovery at a mine or any mine operator voluntarily providing personnel to engage in rescue or recovery at a mine not owned or operated by such operator shall not be liable for civil damages for acts or omissions resulting from the rendering of such rescue or recovery work in good faith unless such act or omission was the result of gross negligence or willful misconduct.

This section shall not be construed to limit liability incurred through the operation of a motor vehicle.

2. That § 8.01-225 of the Code of Virginia is repealed.