

Search and Rescue Topics

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Legal Aspects

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The Law

I AM NOT A LAWYER, nor do I play one on TV. However, I am a doctor, and I've even played one on TV.* And given the US's litigious society, especially where medicine is concerned, that means I have to know a lot about negligence and its subset, medical malpractice.

Once upon a time, there was a four-way street intersection with four vehicles approaching at the same time, perfectly timed to arrive at the same instant. There was a fire truck with lights and siren, a police cruiser with lights and siren, a presidential motorcade with lights and siren, and a post office truck. Which has right of way? The post office truck, because it says right in the Constitution that you can't impede a postal carrier. Well, not true, actually, see [the article](#) at snopes.com. And indeed, the only thing the Constitution says about the postal service is that

The Congress shall have Power ... To establish Post Offices and post Roads

That's too bad, as it would be a nice demonstration that the Constitution has precedence over all other laws. But it is a good example of why you need to look at the law carefully. So now, on to an overview of law in the US.

Laws, Civil Codes and Common Law

THERE ARE MANY DIFFERENT KINDS OF LAW and of laws. Not all law is laws. Some is just **LAW** without ever being written into *A* law. This is called "common law." More about that later.

Sometimes laws conflict. In that case, there is a fairly straightforward pecking order among laws. We should start at the top of the pecking order and work down.

The highest law of the land is the US Constitution. If something is prohibited in the Constitution, it's "unconstitutional" which is about as illegal (or "unlawful" as those in the know prefer to say) as it can get. If a law, **any** law, conflicts with the Constitution, the Constitution wins, hands down.

The next layer down is called "legislative law." Basically, if Congress (one of the three main branches of government) passes a law, it's now the law of the land (Federal law) and everyone has to do what it says or else. (Well, there has to be some enforcement mechanism or there's no "or else" but that's a story for another time and place.) If a legislative law conflicts with the Constitution, though, the Constitution wins. Who decides? The



second of the three branches of government: the Federal court system, up to and including the Supreme Court.

The third layer down in this legal cake is called "regulatory law." Congress can make laws that direct that something be done, but leave the details to someone else. The "someone else" is the third branch of government, the executive branch, headed by the President. The various departments and bureaus of the government make up regulations to carry out Congress's intent. These regulations have the force of law, and can be enforced as well. However, if a court finds that a regulation actually conflicts with legislative law, the court can strike down the regulation. And, a court can also find a regulation unconstitutional – regulations have to yield to everything above them, both legislative law and the Constitution.

In France and certain European countries, this is all the law there is. If it's not written down, it's not law. These countries said to have "civil code" or "Code Napoleon" law (since he's the one who imposed it), and there are remnants of this in Louisiana, which used to be French. A typical civil code deals with the fields of law known to English common law as law of contracts, torts, property law, family law and the law of inheritance. Basically, with a Civil Code, there are detailed laws about how to deal with the issues listed above, including tort claims, which are of interest to us.

But, for England and Wales and Scotland, and countries whose legal tradition derives from them, there's a **lot** more: common law. "Common law" is nearly synonymous with "case law" or "precedent." Basically, there are a lot of things that people should or shouldn't do that

Search and Rescue Topics

This is one of a planned series of educational essays, focused specifically on backcountry ground search and rescue as practiced in the mid-Appalachian mountains of North America. They draw on the experiences of the members and Groups of the Appalachian Search and Rescue Conference (ASRC).

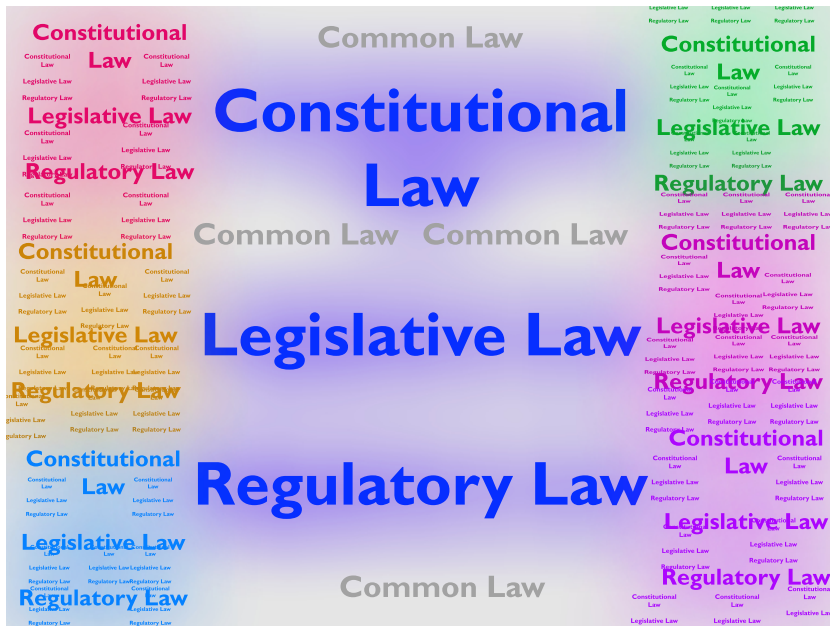
SAR Topics essays might serve as textbook chapters. I did write a somewhat influential SAR textbook back in 1972, but these essays are designed to be less formal, more personal. Occasionally they digress into stories peripheral to the main topic, but that illustrate important lessons.

SAR Topics provide the knowledge needed to meet the training standards of the ASRC (online at www.asrc.net). They will cover the knowledge for all levels from Field Team Member to Search Manager.

SAR Topics are freely available online in PDF format. (Maybe someday in HTML as well, but repurposing to HTML is still a painful task.) They are covered by a Creative Commons license (see last page) so that you can print and hand out to your SAR team or share with friends without fear of copyright violation.

I hope you enjoy them.

* Well, actually, just interviews on local news.



stitutional law, legislative law, and regulatory law; and individual jurisdictions within states can have their own, as well. In general, Federal law preempts state law, and state law preempts local ordinances, in fairly strict pecking order. And, the common law is not something that is written down in official legislative law form anywhere.

Please see the picture at the top left which illustrates this fractal nature of law in the US. Federal law is in the center (the “three-layer cake” with common law being the icing). The state and local law-cakes are clustered around the Federal law. To keep things simpler, I only show six states/territories instead of 60+.

The common law permeates the cracks between the layers, at all levels. Some states have law that is very similar to Federal law, others such as Louisiana are very different.

Say you’re interested in a particular topic, say, negligence for search and rescue in West Virginia. You find an appellate decision in West Virginia that sort of applies to your SAR (negligence for fire-rescue rescues). But you also find an appellate decision in Colorado that does apply directly to SAR negligence. Which one is more applicable? Well, you can get lots of legal advice from lawyers, but until the court actually decides, you really don’t know. So court decisions from within your own jurisdiction can set a strong precedent, but cases from other jurisdictions can be persuasive, too, especially if they apply to the case at hand better than your own cases.

If that wasn’t enough, think about this. There are many situations that are simply not covered by existing laws, whether constitutional, legislative, regulatory, **or** common law. And, unless there is reason enough for courts or legislatures to “fix” things, they may stay uncovered. Particularly if “fixing” the problem is a big hassle, and nobody cares enough about it to force the issue.

Here is an example. Once, Jack Grandey and I, both members of the ASRC’s Allegheny Mountain Rescue Group at the time, and also staff with the Eastern Region, National Cave Rescue Commission (ER-NCRC), decided there was a legal problem and tried to do something about it.

Medicine is regulated by the states. By the Constitution, the Federal government isn’t really allowed to control medicine in the states. (Though it is trying to do so by the power of the purse. The Feds simply threaten to cut off Federal money unless you play by their rules. But that’s a story for another time.)

A rescue a few years ago in Crossroads Cave, in Bath County, Virginia, had stretched cave rescue resources in the region to the max. A crew of a hundred responded from the ER-NCRC “weeklong” training class in West Virginia. By the time we arrived, all of the local resources were exhausted and had to come out of the cave. The patient needed medical care badly. We had a doctor from Pennsylvania, a doctor and a nurse from North Carolina, and medics from Ohio, Pennsylvania, West Virginia, and Maryland, all of whom were cave-rescue trained but none of whom were licensed in Virginia. Did we just stand there because Virginia regulatory law forbids us to practice in the state? No. In the first case, nobody cared about legalities at that point. And, on reflection, we realized that what we were doing was not only lawful

aren’t specifically found in legislative or regulatory law. And, over the past thousand years or so, courts have handed down decisions about what is right and what is wrong. Sometimes a court hands down a decision that is biased, confused, or just plain wrong. But over the centuries, a kind of Darwinian selection process has eliminated those bad decisions and replaced them with better decisions. So, after a long process, we’ve got a whole bunch of really good, well-refined ideas about what is good and bad. This is *the common law*.

Three notes about common law.

First, courts can only decide on cases that are brought before them. So if no cases involving a particular situation are ever brought before them, they can’t create common law. A good example is “medical restraint.” When someone’s ability to make decisions is impaired, for example by alcohol or hypothermia, and you are caring for the patient, you have a responsibility to make decisions for that person. But as far as “kidnapping” cases? Not much case law. Think about it. If you are a lawyer, and someone says “I was really, really drunk last night, and they wouldn’t let me out of the ED until I was sober or someone sober came to get me. I want to sue for kidnapping!” what will you say? Especially since you’re only likely to get paid if you win the case? Actually, you can’t sue for kidnapping, that’s a criminal offense, but you could sue for damages claiming a tort of assault or false imprisonment. Whatever.

A second note. Not all court decisions set precedent. In general, only appellate cases (ones that are appealed) get into the casebooks and become part of the common law.

Third. Over the years and centuries, lawyers and judges have tried to make some sort of sense out of all of these decisions, and to organize them into legal principles. These are the principles that are taught in law schools, usually through analysis of specific classic cases.

Now that this is all making a lot of sense (I hope) it’s time to throw in a monkey wrench. It turns out that every single US state and territory has its own Con-



– if, after responding to the rescue, we refused to render medical care, we would be guilty of common-law *abandonment*. And, the common-law *doctrine of necessity* made our caring for the patient, to the best of our ability, lawful, and in a way that made common law completely overwhelm the Virginia regulatory law.

Afterwards, Jack and I went to a meeting of the Atlantic EMS Council, which is the cooperative EMS body between several states in the mid-Atlantic area, including both Pennsylvania and Virginia. The state EMS directors were there, as were top lawyers for the Department of Health for the various states. We made a presentation about what had happened, and explained that they wanted to find a way to make such operations “lawful” in terms of *regulatory law* as well as *common law*. All of the state EMS directors and lawyers agreed that (1) the medical personnel there had done the right thing, (2) if something similar happened again in the near future the medical personnel should do it again, and (3) they would add this problem to their list as #11. Eleven what? Eleven things that we do right now where the doctrine of necessity conflicts with regulatory and legislative law in the states, and we should change the state laws to make them correspond with reality.

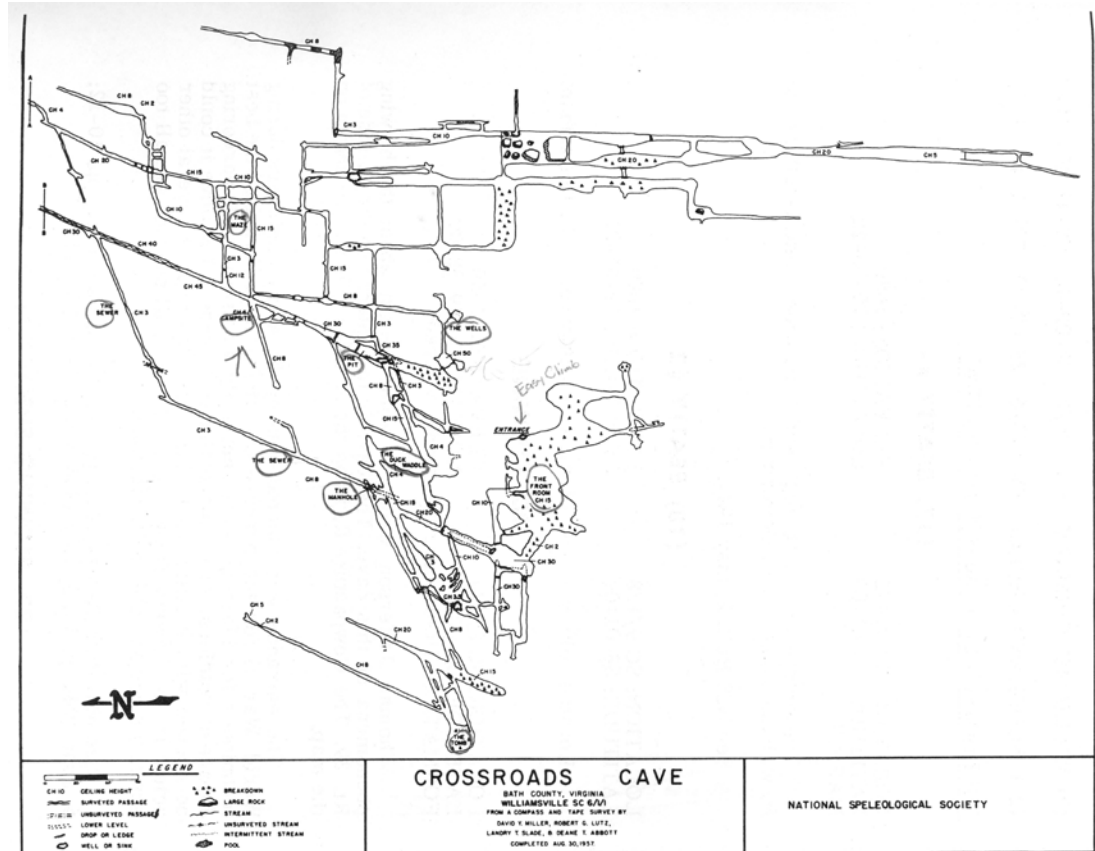
But this is very hard and takes lots of time. (Don’t hold your breath.) A classic example is medical flights and long-distance transports across state lines. According to legislative and regulatory law, as soon as one crosses a state line in a helicopter, fixed-wing aircraft, or ground ambulance, one is then required to be licensed in and practice under all of the laws, regulations, and EMS protocols in the new state. This is essentially unworkable, so the EMS services’ home base provides medical direction and medical protocols until the patient arrives at the destination. It’s quite unlawful, but I’ve never heard of anyone challenging it. Makes sense; if you challenge it, someone might make you fix it.

So how are they working on this? They have to have an interstate agreement, signed by at least the Secretary of Health, and more likely the Governor, for all the states. Will this happen quickly? Not likely. And what about states outside the Atlantic EMS Council? Just use that doctrine of necessity again.

It is also worth looking at such between-the-cracks situation at three levels:

- LEGAL: What do applicable laws and common-law principles say? Sometimes you just don’t know, so then you may move to another level:
- ETHICAL: What will most reasonable people say is the right thing to do, according to commonly-accepted ethical principles? You may sometimes need to move to even another level:
- MORAL: What do you think is the right thing to do?

This three-level analysis will help you out of most dilem-



mas. Rarely, what the law says is unethical or immoral, which is so far outside the scope of this essay that we will not discuss it further.

There are two cheap paperback must-read books to learn more about “the law.”

Karl Llewellyn, The Bramble Brush

Great book, easy to read. A classic. Next is:

Oliver Wendell Holmes, The Common Law

This is the definitive book on the common law, but not an easy read. Get a law dictionary (Black’s is standard) to refer to while reading.

Consent and Restraint

THERE IS MUCH LITERATURE on the topic of consent for medical procedures, particularly surgery. Most

of this is irrelevant to our needs in the field. However, the literature about consent in the *Emergency Depart-*

Educational Objectives

Field Team Member

- Define the terms "implied consent," "expressed consent," "informed consent" and "abandonment."
- Define four facts necessary to prove negligence.
- Describe at least two methods of reducing liability exposure.
- Describe the circumstances when entry upon private property may be justified; define the problems involved with this action and possible solutions.
- Briefly explain how the following legal concepts apply to search and rescue operations:
 - Civil suits and criminal actions;
 - Standards of care;
 - The right to emergency assistance and duties to provide emergency assistance;
 - Crime scene protection;
 - Declaration of death and confirmation of death; and
 - Confidentiality.
- Outline basic principles of SAR ethics and public relations, including
 - Two basic principles for dealing with families
 - Two practical methods to help assure confidentiality and
 - Two principles for members when dealing with the media.

Search Manager IV (Incident Staff)

- Outline the delegation of authority and responsibility for search and rescue in states where ASRC is located.
- Explain how the following legal concepts apply to search and rescue operations:

- Good Samaritan Laws;
- Civil suits and criminal actions;
- Standards of care;
- The right to emergency assistance and duties to provide emergency assistance;
- Abandonment;
- Implied consent;
- Entry, during incidents, on property posted "No Trespassing";
- Crime scene protection;
- Declaration of death and confirmation of death; and
- Confidentiality.

Search Manager III (Incident Commander III)

Demonstrate an understanding of certain legal issues related to SAR including:

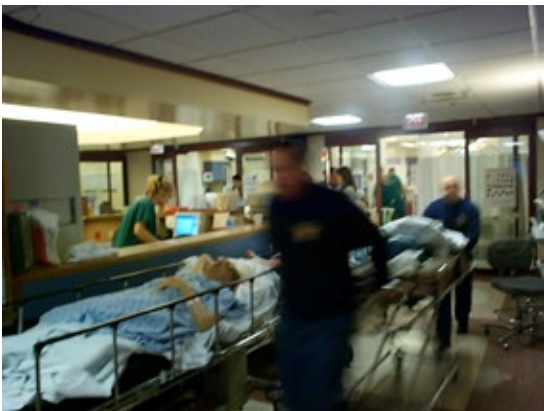
- Trespassing
- Confidentiality
- Criminal investigations
- Management of deceased subjects
- Restricted airspace
- Restricting access to various areas
- Site security and surveillance
- Maintaining the chain of evidence
- Use of minors in SAR incidents
- Liability for supplies, equipment, and services lent or donated for use during an incident
- Use of SAR personnel for apprehension of criminals and crime scene investigation, and
- Discovery of non-incident related illegal activities.

These objectives are taken from the Training Standards of the Appalachian Search and Rescue Conference (v7.1, 5/12).

Note: some ASRC certifications do not require specific knowledge of legal aspects, or, in the case of certifications such as Field Team Leader or Search Manager I/II, require no more legal knowledge than Field Team Member or Search Manager III.

ment, well, that's quite relevant to what we do in the field. So first we will pretend we're in the Emergency Department (ED), where these issues arise daily in hundreds of EDs, and then generalize this to SAR in the field.

This is really quite important, so we'll spend some time on it.



It's obvious that in the ED you need to restrain drunks; confused, head-injured patients; and those delirious from fever or whatever. You don't want them to walk in front of a bus, or drive over a two-year-old. In fact, if you don't restrain them, and something bad happens, you can be found *negligent* in a *civil court*, or even guilty of *criminal negligence* in a *criminal court*. Both the bus and the 2 year-old child incidents happened, and the

medical personnel were found liable. This applies not just to physicians but to all "medical personnel" and on a SAR operation, **you** are the "medical personnel" whether you're a doctor, nurse, medic, EMT, or first-aider.

So what's your legal backing for restraining someone against their will to protect them? Won't you get sued for

assault or locked up for kidnapping? (Well, actually, in the law, it's called *false imprisonment*.)

First, let's look at involuntary psychiatric commitment.

If you look at the involuntary psychiatric commitment law in each state, they're pretty similar. In order to commit someone under state law, you basically have to fill out a multipage form, and get it approved by some court or other government official. This takes time. So if you're confronted with a belligerent drunk patient in the ED, or a delirious head-injured patient in the field, this just isn't going to happen in time. And, under the laws of most states, head injury or intoxication are not considered mental illness, or grounds for an involuntary psychiatric commitment, anyway.

It turns out that in Pennsylvania it's section 302 of the Pennsylvania Mental Health Code, so we talk about "302ing" a patient. Each state has its own term for this. The Pennsylvania 302 law, however, specifically states that alcohol is excluded. A family can't 302 an alcoholic relative who is gradually "drinking himself to death" unless the person is suicidal. So no 302 for drunks in Pennsylvania. However, a few states do allow involuntary psychiatric commitment for drugs or alcohol.

But, basically, involuntary psychiatric commitment under state law is irrelevant to SAR, unless you're maybe searching for someone who has been committed but escaped. Instead, you'll have to rely on the common law, specifically, the:

Doctrine of Medical Restraint

THE COURTS GIVE physicians (and, by extension, medical personnel supervised by a physician) very wide latitude in restraining patients. The general principle is simple: if you think restraints are needed to protect against harm, and you have doubts about the capacity of the patient to make an informed decision to refuse treatment, restrain the patient in the least-restrictive manner you can. Don't worry, the courts will support you. A sage MD/JD (someone with both law and medical degrees) once said "Treat the patient the same way you would treat your mother – with concern for her Constitutional right to make her own decisions, even if it kills her, but when her decision-making is impaired, you make decisions for her."

In the ED, I am often confronted by a drunk, belligerent patient, often brought in for no other reason than "acting intoxicated in public." Some of these patients used to go to jail ("drunk tanks") but after a few bad outcomes (head-injured, not drunk!) it was thought best for such patients to go the ED where (1) a physician could make sure that there wasn't something other than alcohol involved, and (2) the ED staff could supervise the patient sobering so no harm came to the patient. So it's 2 AM and: "YOU CAN'T F**ING HOLD ME AGAINSH T MY WILL, THASH F**ING KIDNAPPING! I'M A F**ING MURICUN CITIZEN! I GOT F***ING RIGHTS! I WANNA CALL MY F***ING LAWYER!" "Here's my cellphone. May I dial the number for you?"

This guy's lawyer should share some of my 2 AM pain. And every lawyer is familiar with the doctrine of medical restraint; it's well-documented in the law books. And the phone call will document in the lawyer's mind that

no, the patient was not at that time capable of informed decision-making regarding signing out of the hospital AMA (against medical advice).

Implied and Express Consent

IN THE CASE OF AN UNCONSCIOUS or stuporous patient, any reasonable person would assume that they want your care, and that's what the courts hold, too. It's called *implied consent*. If you walk up to someone your team has just found and say "Hi, I'm Joe Rockjock, I'm a Wilderness EMT and I'm the team medic" and you start examining and treating the patient and they don't object, that's implied consent, too.

There is also *express consent*, which is what happens if you also say "It looks like you have an injury to your leg. Is it OK if I examine and treat you?" When the patient says "yes" they have expressed consent.*

Informed Consent

ABIGGER ISSUE is *informed consent*. Informed consent is needed not only for agreeing to medical care, but also for *refusing* care or evacuation/transportation.

When someone wants to refuse care or transportation, you need to inform them of what, in your best judgment, the outcomes are both if they accept care and if they refuse it, and answer to the best of your ability any questions they have. Then, you have informed consent, or informed refusal.

Some people are so impaired they don't have the *capacity* to make good decisions. We don't talk about *competence*; competence is determined only by a court. We medical/first aid personnel only determine *capacity* to consent or refuse. It's splitting hairs, but that's why there are lawyers and judges.

Can the drunk in the ED I mentioned above sign an AMA (against medical advice) form, leave, and drive his car home? Well, he could, but if I let him go (or you abandoned a similarly-drunk patient you found in the woods) then you or I could be found liable for his death, or for his injuring someone else.

But what about someone who is just a little bit confused? Can that person refuse care?

Once upon a time, we had a search for a 72-year old retired boxing coach, an experienced outdoorsman. He was hiking along the Appalachian Trail in Virginia's largest wilderness area, near Mount Rogers. He got separated from his wife in dense fog. There were many interesting features of this search, including the Sheriff's political need to include the off-road motorcycle club in the search. The patient was lost for seven days. He said the only time he was afraid for his life was twice when people on trail motorcycles searching for him almost ran him over (without noticing him).

When found, he wasn't in good shape. He was tired, hungry, cold, and a bit beat-up from bushwhacking for miles and miles. He'd almost made it out, too; he was maybe a quarter-mile from the road. He was delusional, likely



simply from being lost for so long. He was convinced the search dog was a horse, and wasn't making much sense. At that point, we assumed he wasn't capable of providing informed consent, or what was more to the point, informed *refusal of consent*. We assumed *implied consent*, and started feeding and watering and warming him up. After an hour or so, he was totally with it, and was an interesting and articulate conversationalist. At that point, he certainly had the capacity to refuse care. We had contacted local EMS, who was responding. He thought about it for a while, and finally agreed to go to the hospital. But if he'd refused, we'd have to have let him go.

There was one other learning point from that search that sticks in my mind. Andy Peet and I were both attending to the patient. We were both physicians, but we were in (somewhat dirty) Appalachian Search and Rescue Conference (ASRC) uniform shirts. When the local EMS crew arrived – two EMT-Basics – in their eagerness to get to the patient, they literally pushed us apart "Move aside! We're EMTs!" "Oh, hi. This is Dr. Andy Peet and I'm Dr. Keith Conover. Would you like a report on our patient?" "Ummm, yes, sorry..." "As it turns out they were both very nice and interested in learning more about SAR teams.

But the more important lesson is that sometimes people are capable of providing informed consent, and sometimes they're not. And if they're not – whether because of intoxication, head injury, dementia, whatever – if they're not, then you have to act *in loco parentis*, which is Latin for "in the place of a parent." You may infringe on people's liberties in their own best interests when their decision-making capability is impaired. Even if that means saying "No, you're going to the hospital because you need to be checked out more fully than we can do right here." And back that up with physical force if needed, though always the minimum of force needed for the patient's best interests.

So how do you decide whether someone has the capacity to provide informed consent?

*It's a bit confusing. The terms express consent and expressed consent are used in slightly different ways. In the law, *express consent* is used more often, the word "express" an adjective modifying "consent."

Capacity to Consent

UNLESS A COURT has declared a person *incompetent* and assigned a *power-of-attorney* for making medical decisions, an individual is assumed to be competent to make medical decisions. But an ordinarily-competent individual may have impaired decision-making, whether from alcohol or other intoxication, side effects of medications, illness or injury. Sometimes patients are so impaired (e.g., unconscious) that one assumes implied consent. In cases not so severe, the courts expect physicians, and certain medical personnel supervised by a physician (you) to be able to judge capacity to provide informed consent.

The right or responsibility to restrain a patient is determined by whether or not he or she has the ability to make an informed decision. In the words of Mark Plaster, M.D., J.D.: *The test is the same whether the patient is a Jehovah's Witness who refuses life-saving blood or the fearful elderly person who refuses life-sustaining protective measures.*

And, quoting from *Emergency Department Law* 1993;4(23), p. 8-7, relating to questions I posed after a difficult night shift, with 2.5 inappropriate AMA discharges from our hospital:

"...What are the attendant duties and liabilities of medical restraint in the following not so atypical scenario? An elderly man is brought to the ED by his family. When asked what the problem is, the man reveals no specific medical complaints except for 'being sick.' The man recalls something about throwing up blood, but says that it happened 'several days ago.'

"The patient's vital signs are unremarkable, as is his physical exam, except for some mild epigastric tenderness. His stool is hemetest negative [*no blood -KC*] and his blood pressure shows no orthostatic instability. His answers to questions reveal no evidence of any overt psychiatric illness, but he is disoriented as to place and time.

"According to the family and medical records, the patient had recently been admitted to the hospital with the diagnoses of alcohol intoxication, pancreatitis, and an upper GI bleed. He had been scheduled to be transferred to an alcohol detoxification center in three days. However, he had signed out from the hospital "Against Medical Advice" just three hours earlier.

"The patient had walked about a block from the hospital, where he had been found collapsed in a snowdrift, confused and unable to walk. [*by his family -KC*] The cause of the confusion was not clear to the examiner, but it appeared to be alcohol withdrawal. [*or the Valium he'd been given to treat the withdrawal; also, this was in Pennsylvania, where alcohol-related issues were specifically excluded from the involuntary psychiatry commitment law -KC*]

"During the process of re-admitting the patient to the hospital, his family expressed great concern that the patient had been allowed to leave the hospital, since he could have died of exposure. They expressed willingness to sign psychiatric commitment papers, but the emergency physician did not feel that the patient had any primary psychiatric problems.

"Should the patient be restrained in this situation? What are the legal risks and liabilities?"

"ANALYSIS: The analysis of any patient's situation should always begin with establishing what course of action is likely to promote his or her good health. In this case, wandering aimlessly in inclement weather was obviously not to the patients' advantage.

"If weather is not a factor, is the patient able to care for his medical condition? Is he or she able to obtain and take medications and food? Is there someone willing to assist the patient? If there would be any doubt by a reasonable person as to the patient's ability to care for him- or herself, at least there is a proper motivation to intervene. While the analysis does not stop here, this alone should be enough to defend against a charge of false imprisonment.

"In fact, there may be liability if you do not act on the patient's behalf. In an emergency condition where the patient is unconscious, the patient has the right to presume consent to treatment. Failure to do so would undoubtedly result in a claim of negligence.

"For example, one hospital found itself liable for the wrongful death of an intoxicated patient who had presented to the emergency department requesting help for this drinking problem. After making his request, the patient left the ED with another alcoholic and was struck by a car while attempting to cross a nearby highway. A court later found that once the patient presented asking for assistance, the hospital had the duty to comply with that request until he regained the capacity to protect himself."

On this same shift, another family brought in a woman, against her will, who also had just signed out AMA and found by the family in a bar drinking. She was alert, seemingly able to give a good history, including a running commentary on her past life, smiling, cooperative, and ready to sign out again AMA. I was ready to let her, until I talked to the family, who said she had been nearly dead of hepatorenal syndrome (combined liver and kidney failure), and had been told that if she drank again she would die. When I went back to her, she was still alert, smiling, and a good historian, but with a completely *different* history both past life and recent events. She remembered nothing about having hepatorenal syndrome. She was a classic Korsakoff's syndrome* glib confabulator. I admitted her against her will, on the grounds that based on her poor memory she wasn't capable of informed consent to an AMA.

A couple of hours before the end of my shift (which by this time I thought would never end) one of our (excellent) third-year internal medicine residents called me from the floor. He said his internal medicine attending had told him to let his patient sign out AMA but he had some questions and wanted to consult me first. (Nice when even the residents on the other services consult the emergency medicine attendings for advice.) I asked what the patient's medical problem was. He said DTs (delirium tremens, which is severe alcohol withdrawal, often with seizures, and death is not uncommon). I asked if the patient was hallucinating. He said yes. Only raising my voice a little (I was very proud of this at the

* A type of brain damage from excessive alcohol abuse that results in the syndrome described above. People have basically no memory, but aren't aware of that, and make things up, seemingly without knowing it. This has parallels with cortical blindness, where people are after a stroke or head injury are blind in part of their visual field, but are unable to admit this; their imagination fills what they can't see. They refuse to, or more accurately, cannot believe that they are partially blind.

time) I told him that, not to mention suing him for malpractice, I would personally strangle him if he let the patient sign out AMA. I explained the above and he restrained the patient.

Determining Capacity

THERE ARE TWO PRINCIPLES TO EMPLOY, and four tests to use, when deciding capacity for informed refusal of care.

FIRST: when in doubt, *do what's best for the patient*. This may mean restraining until it is clear the patient can make an informed decision.

SECOND: the needed *level of capacity varies* with the seriousness of the decision. A drunk refusing to have a minor laceration sewed should have his wishes honored. But a patient with DTs and Valium on board shouldn't walk out into a snowy winter night in a hospital gown.

The four tests for capacity are:

- **Does the patient understand the relevant information?** *Ask the patient to paraphrase what you told him; this is better than asking him to simply regurgitate information. As a first cut at understanding: if the patient is disoriented to time or place, he probably can't appreciate the personal danger.*
- **Does the patient have the ability to process the information?** *Ask the patient about hypothetical situations based on what a rational person would do. A patient with normal capacity, but differing values, can still demonstrate that understanding. If the patient is willing to risk death from a potential myocardial infarction to be home with his sick dog, we may not agree, but we have to respect his decision.*
- **Does the patient have the ability to make a choice?** *Changing responses within a short period suggest the patient's capacity to organize thoughts and choose a course of action is impaired.**
- **Can the patient put all of these together to appreciate the situation and its consequences?** *The patient should appreciate the seriousness of the likely outcome of his or her plan of action.*

And that's what it comes down to. No matter how much you disagree with patients, if they have the capacity to make an informed decision to refuse your care or evacuation/transportation, then you have to let them go. If they don't, then you need to restrain them, with the minimum of force; however, you are not required to endanger yourself. The hard part is determining if they have that capacity.

*I once restrained a distraught patient in an ED room, rather than letting her sign out against medical advice. She needed a lumbar puncture (LP, a spinal tap) to rule out meningitis, solely because she kept changing her mind about what she wanted to do. The nurses were concerned about this, so we got a stat consult from the hospital ethics committee, including a doctor of pharmacy, a senior administrator, and a priest. All agree it was right to restrain her. She finally calmed down, we did the LP and it was negative and we discharged her normally.

Duty to Act; Negligence

Duty to Act and Abandonment

ARE YOU UNDER ANY DUTY to help someone in distress? Frew, writing in his book *Street Law*, cites an

Liability for Medical Restraint

THE ONLY CASE I know where someone was found liable for medical restraint was from many years ago. An anaesthesia resident rotating in the ED at New Orleans' Charity Hospital had a drunk who needed a forehead laceration sewn.

This resident decided to sew the guy's ears to the stretcher so he would hold still for the laceration repair. The resident lost the case when the guy sued. And that's pretty much it for case law on the subject. So if you don't do something quite that egregious, then you're probably safe in restraining someone.

By the way, after a few hours, your normal skin flora (the layer of bacteria that coats our skin) crawls into the wound and sets up housekeeping. We talk of the "golden 8 hours" in which to close a wound, else you will get a bad wound infection, but sometime's its more or less than 8 hours, which is a good discussion but for another forum.

If you keep the wound clean, and there is no evidence of infection four days after the injury, then you can close it just like it was brand-new and it will do fine. By that time, your white blood cells will have gotten into the wound and cleaned it up. So, you can always wait four days after a laceration and do what's called a *delayed primary closure*.

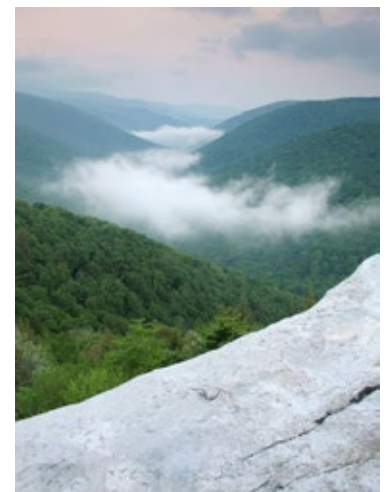
Consent for Minors

Children ("minors" in the law) don't have the capacity to make informed decisions on their own behalf, thus the role of parents (or guardians) in making decisions for them. Oh, only if it were that simple.

Relax. Most of the complications regard such things as minors of certain older ages seeking psychiatric care, or care for pregnancy, or for possible sexually-transmitted diseases. As far as emergency care, it's quite a bit simpler. A particular case should make this clear.

Once upon a time, a child fell and broke his arm. It bent in the wrong place, and hurt a lot. Someone (not a parent or guardian) took him to the Emergency Department. The hospital, doctors and nurses refused to treat him for hours, whether to reduce or splint it, as they couldn't reach the patient's parents. The parents sued, saying it was negligent to not provide emergency care just because you can't reach the parents. The parents won.

So, in an emergency, the principle is quite simple: try to get parental permission, but if you can't, assume implied consent on the part of the parents. The principle of "treat the patient as if she were your mother" above applies: treat the child as if he was your own.



Red Creek Canyon, WV (credit: [Misty Mountain Photography](#))

example: "You are walking down the street while vacationing in a neighboring state. Across the street, you observe a man in his late fifties suddenly clutch his chest and fall to his knees and then to the pavement. His wife

is frantically calling for help. You are an EMT . . . Is there a duty to help this person? In these circumstances, the legal concept of duty [in the US, as derived from British common law -KC] says that you are under no duty to aid a person to whom you had no special relationship and to whom you had not caused injury. There is no legal duty requiring you to be a Good Samaritan.”

In the United States, as of 2009 ten states had laws on the books requiring that people at least notify law enforcement of and/or seek aid for strangers in peril under



certain conditions: California, Florida, Hawaii, Massachusetts, Minnesota, Ohio, Rhode Island, Vermont, Washington, and Wisconsin.

However, if you are a member of an organized search and rescue team, a court might decide that you, indeed, have a duty to act, as you have assumed some responsibility for SAR in your area, which might prevent others from volunteering for this duty. This is, in an organizational sense, the same as an individual being found liable for **abandonment**.

The legal theory of abandonment is summed up like this. What if you see someone on a city street who needs help? Further, what if you take one step toward the person? In that case, you are obligated to continue on your way to help the person. Why? Because other people might have seen you take that first step. And, though they were initially going to help, they saw you heading toward the person and distress, and decided that the situation was well-in-hand.

There are other issues related to the doctrine of abandonment, too. What if you are a paramedic expert on taking care of hypothermic patients, and you turn a hypothermic patient over to an EMT-Basic for transport to the hospital? If something bad happens en route to the hospital, the patient might have a claim against you, because (a) you were certified to a higher level of prehospital care, and (b) you have specific expertise applicable to this patient.

I can remember one summer rescue (Red Creek Canyon at Dolly Sods wilderness area in West Virginia) in which I had to balance (A) getting on a helicopter to aid in a quite-stable patients' care, vs. (B) the added weight's

effect on the helicopter. In thin summer air in a narrow canyon the danger of the added weight outweighed the small potential benefit from my riding along in the helicopter for 20 minutes.

Good Samaritan and Similar Laws

MEDICAL PRACTICE is regulated on a state-by-state level, and every state has a different “Good Samaritan Law.” But there are several general principles that apply for almost all states.

Good Samaritan Laws generally provide immunity from civil actions (being “sued” in a tort claim) for those who provide emergency care:

- without compensation,
- in good faith, and
- without gross negligence.

Note that the first point may or may not apply to the salaries of EMTs, paramedics and doctors who are paid to provide prehospital care – some states specifically include such people in Good Samaritan protection, other states exclude them.

The second point means that you aren't pretending to help and really trying to kill the person. Sometimes this is termed “wilful negligence.”

The third point specifically says “gross” negligence, which requires a higher standard of proof than plain negligence. Gross negligence is just that, so negligent that your average Joe (or average EMT or doctor) will say “that was incredibly stupid.”

Good Samaritan laws sometimes combine these second and third points, saying that the protection excludes “gross or wilful negligence.”

Some states offer protection specifically to those who have CPR, AED or other medical certifications, others apply to everyone. The first Good Samaritan laws were specifically to encourage physicians to stop at the scene of an emergency without fear of being sued.

There is no such thing as a national Good Samaritan law, but there is somewhat of a national equivalent: the US *Volunteer Protection Act of 1997* (VPA). Like most state Good Samaritan laws, it provides what is known as *qualified immunity* (as opposed to absolute immunity) against claims of simple or ordinary negligence. Similarly, it excludes gross or wilful negligence. However, whereas state Good Samaritan laws are designed mostly to protect spontaneously-acting individuals, the VPA also aims to protect members of charitable nonprofit organizations such as SAR teams (IRS 501(c)(3) status is required). However, it allows states to “opt out” of these provisions, or to limit the act to those organizations with insurance. It also excludes liability for the use of motor vehicles.

As with state Good Samaritan laws, the VPA may dissuade a lawyer from filing a case or two, but likely will not have a major effect on the outcomes of tort claim suits.

Negligence

LAW SUITS (*civil suits*) are a legal action where a person attempts to get money from someone who allegedly wronged him. This is distinguished from a **criminal**



action, which is brought by the government against a person for violating the law. Civil suits may arise from claims of negligence, or from claims of intentional damage. A civil suit can be brought by anyone against anyone else, irrespective of how poorly grounded the claim, Good Samaritan and other laws notwithstanding. (That is, providing a lawyer will take the case, which means a reasonable chance of winning and making money.) An example of a tort claim would be a claim of battery, when you treated (touched) a patient who was alert, oriented, and legally competent, and who refused treatment. Another would be a claim that through your negligent emergency care on the mountainside, the patient suffered harm. A good Samaritan law may be cited in the defense of such a claim, but is only one of many items that are taken in consideration.

Indeed, there was an abstract in *Prehospital and Disaster Medicine* that is apropos:

Liability Immunity as a Legal Defense for Recent Emergency Medical Service System Litigation, David L Morgan, MD, Vicky A. Trompler, MD, William R. Trail, JD.

This study looked at EMS tort claims from 1987 to 1992 (only those that were appealed, as those are the only ones that are generally available for inspection). Good Samaritan laws were used in 53 of the 86 cases. Citing a Good Samaritan law was associated (slightly) with a better verdict: 72% vs 68% for the defense.

Negligence claims hinge on the plaintiff (the individual suing) proving that a chain of five elements occurred. To prove negligence, the plaintiff must prove

- that you had a **duty** to act on behalf of the plaintiff,
- that you **committed** an unreasonable act or omission in the context of this duty,
- an **injury** occurred to the plaintiff,
- proximate cause (your act or omission must have **caused** the injury), and
- foreseeability: you must have been able to **foresee** the possibility of injury.

For a tort claim to succeed, all five of these must be present. If any link in this chain of five findings fails, then the claim fails. Duty, act, injury, proximate cause, and foreseeability; all must be present for a finding of negligence.

Duty, act, injury, proximate cause, and foreseeability; all must be present for a finding of negligence.

There is basically no literature on liability for volunteer search and rescue; as far as I know, there are no cases of volunteer US SAR teams being sued and making it to appeal and thus being reportable. The most notable case recently was in British Columbia, where Golden and District Search and Rescue was sued, along with the Royal Canadian Mounted Police, when two people were skiing out of bounds of a ski area and one died before the SAR effort found them. There were issues including whether the RCMP should initiate a search once a SOS stamped out in the snow is reported. The SAR team briefly ceased operations due to lawsuit, but is now back up and running. There was massive negative publicity, not against the SAR team, but against the man suing. The province

quickly passed a Good Samaritan law. In 2012, the case was settled out of court, and the details are not publicly available.

So how do you prevent claims for negligence?

Well, you can **document well**, so that people can't make outrageous claims about what you did; your documentation will prove them wrong. Lawyers tell doctors "if you didn't chart it, you didn't do it." As a physician, I may be paranoid about this, but... on any operation I keep a small, Rite-in-the-Rain water-resistant notebook in my shirt pocket.* I save them all in a file folder at home. They don't take up much room. I suppose if you are really paranoid, you could use the camera on your cellphone to take pictures of your TAFs and other documentation before you turn it back in. Related to this: in September 2011, I was deployed with a federal Disaster Medical Assistance Team to Binghamton, NY after the Hurricane Irene floods. I used a program called Document Scanner on my Android phone to scan (take pictures of) all the paper documentation and then to encrypt it in a ZIP file and email it to the appropriate people in DC. It wasn't very hard. There are similar programs for the iPhone.

Being poor helps. There's not much point in suing poor people.

If giving away everything you own and becoming a mendicant friar isn't an option, then consider **doing the right thing**.

What's the right thing? It's doing things according to the **standard of care**. What is a standard of care? Well, it varies, depending on the discipline involved, and where you are.

Standard of Care

STANDARD OF CARE is a slippery concept. It means very different things to different people.

From a philosophical standpoint (see [Plato's Cave](#) in [Wikipedia](#)), there is a standard of care that exists independently of all published materials, and it is the consensus of informed opinion of how to care for a given medical condition or pursue a search and rescue operation in the context at the time and place of the condition or SAR operation. This ideal Form of the standard of care may occasionally be expressed clearly in the appellate decision of a medical malpractice case (case law = common law), and the sum of these judgments provides

* There are 4"x6" spiral-bound Pocket Journals, but I prefer the stapled 3.5"x5" Field-Flex Memo Books as they are quite a bit smaller; available from amazon.com.

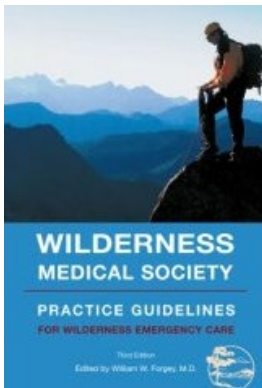


Black's Law Dictionary

Standard of care. In law of negligence, that degree of care which a reasonably prudent person should exercise in same or similar circumstances. If a person's conduct falls below such standard, he may be liable in damages for injuries or damages resulting from his conduct. *See* Negligence; Reasonable man doctrine or standard.

In medical, legal, etc., malpractice cases a standard of care is applied to measure the competence of the professional. The traditional standard for doctors is that he exercise the "average degree of skill, care, and diligence exercised by mem-

bers of the same profession, practicing in the same or a similar locality in light of the present state of medical and surgical science." *Gillette v. Tucker*, 67 Ohio St. 106, 65 N.E. 865. With increased specialization, however, certain courts have disregarded geographical considerations holding that in the practice of a board-certified medical or surgical specialty, the standard should be that of a reasonable specialist practicing medicine or surgery in the same special field. *Bruni v. Tatsumi*, 46 Ohio St.2d 127, 129, 346 N.E.2d 673, 676, 75 0.0.2d 184. *See also* Malpractice.



WMS Practice Guidelines Contents

- 1 Wilderness Evacuation
- 2 Myocardial Infarction, Acute Coronary Syndromes, and CPR
- 3 Submersion Injuries
- 4 Traumatic Brain Injury
- 5 Spinal Injury
- 6 Wound Management
- 7 Burn Management
- 8 Orthopedic Injuries
- 9 Eye Pathology
- 10 High-Altitude Illness
- 11 Hypothermia
- 12 Frostbite/Immersion Foot
- 13 Heat-Related Illnesses
- 14 Lightning Injuries
- 15 Field Water Disinfection
- 16 Oral Fluid and Electrolyte Replacement
- 17 Botanical Encounters
- 18 Marine Envenomations and Poisonings
- 19 Wild Land-Animal Attacks
- 20 Reptile Envenomations
- 21 Arthropod Envenomations
- 22 Tick-Transmitted Diseases
- 23 Substance Abuse in Wilderness Settings
- 24 Anxiety and Stress Reactions in the Wilderness
- 25 Wilderness Medical Kits
- 26 Immunizations

a broad view of what is considered medical malpractice and what is considered meeting the standard of care. But this is limited to the particular time and context of the case in question, and medicine changes over time, and contexts vary. For wilderness medicine and wilderness search and rescue there is little if any case law, certainly not enough to establish a standard of care. Current editions of relevant textbooks are seen, to a degree, as expressing this ideal standard of care. Articles in journals may be somewhat persuasive but not so much as a more widely-read textbook.

If we consult *Black's Law Dictionary*, we find the definition at the right – a definition that is used after the fact to judge if negligence occurred. The idea that the standard of care varies in different areas is gradually going away, a victim of globalization and the Internet. It is still widely-accepted that the standard of care varies depending on training and experience, and as we will see below, the idea that standard of care changes when the *context* changes is gaining traction.

Types of Standard of Care

IN 1990, the Institute of Medicine published a report that serves as the foundation of modern theories of the medical standard of care.*

Here we find the following categories:

- **STANDARDS OF QUALITY:** statements of the minimum acceptable level of performance or results, what constitutes excellent performance or results, and the range in between.
- **MEDICAL (OR CLINICAL) PRACTICE GUIDELINES:** systematically developed statements to assist practitioners in their decision making in specific clinical settings.
- **MEDICAL REVIEW CRITERIA:** statements used to assess the appropriateness of specific decisions, services, and outcomes in the delivery of health care.
- **PERFORMANCE MEASURES:** specific measures of a quantitative nature that estimate or monitor compliance with medical quality standards, medical practice guidelines, and medical review criteria by health care professionals.

This leaves out standards of training and testing, which apparently the IOM defers to medical schools and residencies, nursing schools and the like.

When we speak of “altered standards of care” we usually think of a truly catastrophic disaster, where there is:

- a lack of equipment and supplies,
- a lack of adequate trained personnel,
- an austere environment, and
- a lack of access to specialized medical capabilities.

This implies that the usual standards of quality cannot be met, and standard medical review criteria and standard performance criteria aren't appropriate. Some or all of these factors may apply during:

- wilderness search and rescue,
- wilderness expeditions,

- tactical operations,
- military operations, and
- missions to medically-underserved areas.

For the first two, we are fortunate that there is little financial incentive for lawyers to be involved, and a high level of interest among the wilderness medical community. The *WMS Practice Guidelines*,[†] first appearing as position statements in the 1980s, have been refined to provide a definitive set of medical practice guidelines for wilderness search and rescue and expeditions. There is no widely-recognized set of practice guidelines for disasters, but there are persuasive arguments that a disaster is, in essence, a wilderness, and that the WMS guidelines should suffice.

There are currently efforts by the Department of Homeland Security to standardize disaster and wilderness medical care by all its medical assets (Coast Guard, Border Patrol, Secret Service, Federal Emergency Management Agency), which probably presage a general government effort to standardize. While this focuses more on wilderness than disaster settings, the standards will apply to both. This focuses more on EMS than physician-level care.

Standards of care for wilderness and truly catastrophic disasters, at least in the ideal Platonic sense, are fairly well established. But for later phases of catastrophic disasters, or in disasters that are not quite as catastrophic (i.e., some hospitals are still functioning), what should be the standard of care?

In August 2004, the Agency for Healthcare Research and Quality (AHRQ) convened a conference to discuss the need for altered standards of care for public health emergencies. Their report, *Altered Standards of Care in Mass Casualty Events, Bioterrorism and Other Public Health Emergencies*, came up with ten suggestions, six of which start with “develop,” two of which start with “identify,” one of which starts with “create” and one of which starts with “continue.” These boil down to a research agenda; little has been done to advance these.

Unlike more-unified nations such as Israel or Britain, the US is a federation of more than 50 states, territories and Indian nations, each of which establishes its own laws regarding the practice of medicine. There is a mechanism for getting uniform state laws – known as the National Conference of Commissioners on Uniform State Laws (NCCUSL), which has representatives from every state, and whose recommendations are taken very seriously by state legislatures. The NCCUSL has had a number of successes over the years – the Uniform Commercial Code is a good example. After Hurricane Katrina, the Gulfcoast states desperately needed physicians, and there were many physician volunteers from other states – but they were not licensed in the Gulfcoast states. The NCCUSL started working on the Uniform Emergency Volunteer Health Practitioners Act. Originally the Act provided for malpractice protection for unpaid volunteer physicians, but the Association of Trial Lawyers of America – recently renamed the “American Association for Justice” – got it removed, and it only later got put back, in watered-down form.

* Field MJ, Lohr KN, eds. Institute of Medicine. Clinical Practice Guidelines: Directions for a New Program. Washington, DC: National Academy Press; 1990. Available at: <http://books.nap.edu/books/0309043468/html/index.html>.

† Wilderness Medical Society., Forgey WW. Wilderness Medical Society practice guidelines for wilderness emergency care. 5th ed. Guilford, Conn.: Falcon Guide; 2006.

So what does this mean for SAR teams? It means that the standard of care for wilderness EMS is fairly well set, in the *WMS Practice Guidelines*, though not in case law (common law). And some SAR organizations have practice guidelines, for instance, the Appalachian Search and Rescue Conference has its Operations Manual posted on its website (asrc.net).

Since there is no one accepted “bible” for SAR, we may reasonably conclude that the standard is what is taught

in widely-available courses, such as *Managing Search Operations*, and what appears in SAR standards and training materials such as those of the Appalachian Search and Rescue Conference, Mountain Rescue Association, National Cave Rescue Commission, and the various states. With SAR as well as wilderness EMS, there is no case law. It’s ultimately up to the courts to decide the standard of care, but for now, what’s listed above is what we’ve got.

Q&A: Wilderness EMS

1. I have just taken a [wilderness first aid][Wilderness First Responder][Wilderness Emergency Medical Technician] course, and they taught me to [use an Epi-Pen][reduce shoulder dislocations][give oral antibiotics][perform field appendectomies]. Is it legal for me to now do these things?

It depends. If you are a physician licensed in your state, and you’re operating in your state, the answer is yes.

If you are a first aider, and believe you are just performing first aid, the answer is yes. You may have to persuade a judge and/or jury of this later on. If it’s just splinting a broken leg, no problem. If it’s using an Epi-Pen on someone who just got stung by a bee and who swelled up and turned blue and almost died, or even did die, you’re probably in good shape. If you are a first aider and botch a field appendectomy, I wouldn’t bet on you – most judges and juries would see that as practicing medicine without a license (a criminal offense), or perhaps a reason to award civil damages against you for grossly exceeding your ability. (If, when we discussed gross negligence in the section on liability, you wanted an example, well, now you have one.) Other medical procedures fall in between. Sorry for the fuzzy answer, but that’s the way the law works.

If you are a Wilderness First Responder, and have not been trained to the level of a non-wilderness First Responder, nor received state Emergency Care—First Responder certification, you’re just another first-aider and the above applies.

If you are indeed certified as an Emergency Care—First Responder, you may or may not be regulated by the state EMS act – it depends on the state. If you are regulated by the state, then you’re supposed to do only what the state says you can do. (Same for EMT-Basics, EMT-Paramedics and in between, and for nurses, PAs, CRNPs, etc.) If, as part of your regular job as a [First Responder][EMT][paramedic], do something well outside of your “scope of practice” your supervisor will not like it. The state will not like it. Bad things may or may not happen to you. You’re unlikely to face criminal charges of “practicing medicine without a license” but you may receive a reprimand, get fired, have your license as a [First Responder][EMT][paramedic] suspended, or be assigned to care for only demented nursing home patients with diarrhea for the next month. However, if you did a good job of what you did, and it really helped the patient, and you didn’t act like an a**hole about it, you may even get a commendation. Many EMS systems have provisions for personnel occasionally exceeding the scope of practice. Ideally this occurs with online consultation with a medical direction physician who will

back you up.

If you expect to do things “outside your scope of practice” on an occasional basis, see below for more.

If you expect to perform advanced medical procedures above your “scope of practice” on a regular basis with your SAR team or EMS agency, and there’s no state law permitting it, you should coordinate with your state EMS people and see about changing the laws or regulations, or be in a state like Pennsylvania with a broad delegated-practice provision in the Medical Practice Act and have a supportive physician in charge of your care.

2. What is a Medical Practice Act and why should I care?

In the US, each state has a Medical Practice Act that restricts the practice of medicine to those who are licensed by the state. There are two primary reasons for licensing physicians from the state’s view: 1) it provides money for the state in the form of licensing fees (a form of tax), and 2) it provides the state’s citizens some protection from quacks by establishing criteria for licensing. From the physicians’ viewpoint, it both elevates the profession to a higher level and restricts entry to those who meet the criteria, allowing more prestige, higher fees, and some protection against incompetents in their midst. Again, controlling the practice of medicine is entirely a state prerogative, and the federal government basically isn’t involved at all. This means that the privilege to practice medicine ends at the state line.

3. What is Delegated Practice and how does it apply to Wilderness EMTs?

From the earliest time, physicians didn’t want to do everything themselves. They wanted to delegate certain tasks (drawing blood, administering medications, applying leeches) to others. States have universally allowed this “delegated practice” in their Medical Practice Acts. So, a physician could tell an office medical technician to give a vaccination, or tell an office orthopedic technician to apply a cast, and it was OK (not a violation of the Medical Practice Act). However, the physician has to directly order the “technician” (the generic term used in most Medical Practice Acts), and accept responsibility for the technician’s work quality. Delegated practice provisions vary widely from state to state.

My notes from discussions with Pennsylvania Department of Health and Board of Medicine lawyers: “Pennsylvania’s legal provisions for delegated practice by physicians are broad, and can include the kind of delegated practice that SAR teams use.” “Delegated practice isn’t limited to just the office, or just the hospital.” “The Medical Practice Act places no restrictions on when or

where a physician may delegate practice.” “However, there may be liability concerns for both physician and delegatee – this kind of delegated practice doesn’t have the same liability protection as afforded under the EMS Act, limited as it is.”

4. How do nurses fit into Delegated Practice, then?

After a while, nursing became a profession, with standardized training. Nurses, too demanded licensure, for the same reasons as physicians. Physicians agreed, too, because it gave them a big benefit. Just like the industrial revolution allowed us to build things with uniformly manufactured interchangeable parts, registered nurses became (somewhat) interchangeable. This meant the physician didn’t have to take total responsibility for the nurse’s training; a R.N. could be assumed to meet certain minimum standards. As part of this process, state laws laid out what RNs could and couldn’t do. Similar state laws for Physician’s Assistants, Nurse Practitioners, and other “technicians” also evolved.

As EMS developed, paramedics and later EMTs were placed in a similar “interchangeable parts” category by state laws. However, as with nursing and to a lesser extent medicine, the state laws vary.

5. What is the role of the physician in Emergency Medical Services and Wilderness EMS?

Some prehospital personnel (e.g., many SAR team members) just provide first aid. Most states don’t see first aid as the practice of medicine and don’t regulate it. The Wilderness First Responder sometimes falls into this “first aid” category, sometimes not – depends on who you ask, even state health department lawyers.

Some (let’s use the new term “out of hospital” from now on) out-of-hospital personnel clearly practice medicine: paramedics. In the US, paramedics can generally only practice medicine at the direction of a physician. This can be “on-line command”/“direct medical control” where the paramedic and physician are talking over the radio, or “off-line command”/“indirect medical control” where a physician medical director provides protocols and standing orders, and reviews the performance of paramedics. To provide the “interchangeable” (see 3, above) paramedic and physician “parts,” state laws provide specific authorization for paramedic’s delegated practice.

In England, though, paramedics have a distinct independent right to practice a subset of medicine independent of physician medical direction. And there is a growing tendency in a few US states to recognize, in legislation, some independent right to practice by paramedics. Most states, however, emphasize the dependence of the paramedic’s right to practice on a physician’s license.

Do EMTs practice medicine? The EMT-Basic Curriculum includes medication administration (epinephrine, nitroglycerin, and albuterol), so the answer is clearly yes. Under the old Curriculum, some states, deliberately or by ignoring the issue, classed EMT-Basics with first aiders and let them practice without medical direction. However, the trend is clearly away from EMTs as “first aiders.” And there is a new emphasis on the need for medical direction for EMT-Basics.

6. What happens when a paramedic or an EMT goes across state lines?

Well, basically, the EMT or paramedic has no right to practice medicine in the other state unless specifically granted by that state. And, indeed, many states have established “reciprocity” arrangements for both EMTs and Paramedics. The Atlantic EMS Council consists of PA, NJ, RI, DE, DC, MD, VA, and WV. It has arrangements for “granting reciprocity” between EMT and paramedic levels between all member states. Specifically, this agreement allows providers of equivalent levels to apply for certification and licensure in another state. Providers have to apply for this, it’s not automatic. But among these states, it’s generally easy to get EMT or paramedic licensure in another state.

Your state EMT certificate is good in another state only if your state and the other state has a special agreement, and you have previously applied for EMT certification in that state. In general, granting EMT certificates is a state responsibility, and they can’t automatically offer “reciprocity” for other states’ EMTs. But, states can and often do make arrangements to make it easier for EMTs to get a license in another state (e.g., maybe all you have to do is submit paperwork rather than take the state test).

Unfortunately, however, this doesn’t apply to the physicians who are providing medical control. This means you, as an EMT or paramedic, can practice your limited kind of medicine in a “foreign” state only under the medical direction of a medical control physician who is licensed in the “foreign” state.

The Atlantic EMS Council has long been working on a cooperative agreement that will cover many different problems with EMS between its member states, including helicopter transports between one state and another. (Note that the standard practice for cross-state emergency medical flights – that the sending facility provides medical direction until the aircraft arrives at the receiving facility – has no basis whatsoever in law.)

Once upon a time, Jack Grandey and I attended one of the Atlantic EMS Council meetings and spoke about the need for making out-of-state providers able to provide advanced care, even beyond the paramedic level. We gave as example a rescue at Crossroads Cave in Bath Co., Virginia several years ago (see page 3). By the time the entire National Cave Rescue Commission Eastern Region cave rescue class (about 100 students and instructors) learned of the incident and drove to the site (and just after the final exercise, we might add), the local cave-rescue trained people were exhausted and had to come out of the cave.

As we continued the rescue over the next twelve hours, we used a North Carolina orthopedic surgeon, a Pennsylvania emergency physician, and out of state paramedics. We used all sorts of “EMS-unapproved” medications (e.g., ketorolac IM) and procedures (e.g., shoulder dislocation reduction, clearing the cervical spine in the field, medical direction by an orthopedic surgeon for orthopedic problems).

When we explained to the assembled lawyers and state EMS directors that we wanted to figure out a way to make this all have some semblance of lawfulness, they said “OK, we’ll add that to the list of other unlawful things we have to do all the time. Let’s see, that’s #11 on

the list.”

We hope this makes you feel more sanguine (or at least less fearful) when you decide to do something that’s unlawful but in the patient’s best interest. Remember that helicopter and fixed-wing crews are doing similar unlawful things all the time and nobody’s suing them or taking away their certification.

7. So if I’m an First Responder, EMT or paramedic, what is my legal status in the backcountry in another state, both for unexpected emergencies and if I respond to the other state regularly as part of a search and rescue team?

At present, the only state that we know of with officially state-certified Wilderness EMTs is Maryland, with West Virginia getting ready to do the same. So at present there is no way for these Wilderness EMTs to get “reciprocal” WEMT certification by another state. Several other states “recognize” WEMT certificates from various providers, but only for continuing education credit, and there are no reciprocity arrangements of which we are aware.

(A) Unexpected Emergencies: Assume you find yourself in an “exceptional” circumstance, such as this. You are an EMT from Virginia. You are hiking along a trail in Pennsylvania’s Potter County, a mile from the nearest road. You run across a hunter who was shot in the leg and has an open fracture. In such a case, you have no legal authority to provide medical care. But Pennsylvania has a Good Samaritan law, specifically designed to encourage people like you to render care. This suggests that, despite the letter of the law that requires you to have a Pennsylvania EMT to provide care, that you should go ahead and provide care for the patient.

In the unlikely situation where you end up in court or in a hearing, what standard of care would you be held to? If your training is EMT-Basic, you would be expected to control bleeding and dress and splint. If you are trained as a Wilderness EMT, you would also be expected to, if possible, irrigate the wound before dressing it; and possibly, depending on your WEMT training, giving an antibiotic to the patient.

(B) Routine Backcountry Care: What if you are part of a SAR team, and your team responds regularly into another state? Well, since there isn’t yet any Wilderness EMT “reciprocity,” you can’t do that. Maryland may decide to make it easy for EMTs with Wilderness EMT certificates to get Maryland WEMTs, but that’s still only a possibility at this point. It certainly would be a good idea to get training at the EMT or paramedic level even if, as in Pennsylvania, this doesn’t extend to the wilderness setting. If you get into court or into a hearing, it would be evidence of a good-faith intent to abide by the states’ laws as much as possible.

8. But what about aeromedical transports across state lines? We all know that the sending facility’s physician provides medical direction until the craft lands, and that the paramedics and nurses continue to follow the standing orders from their original medical director until the land.

“Legally,” medical direction for helicopter crews must stop at state lines. Though it has no grounding in law, only in common sense, there is an informal agreement

pretty much nationwide to allow the helicopter’s (or plane’s) medical direction to continue until it arrives at the receiving facility. A few helicopter services’ medical direction facilities are registered in more than one state, but overall most long-distance medical air transports have little legal backing for physicians or others providing medical care en route.

For those with questions about the “legality” of certain wilderness EMS issues, this should be reassuring – states have many bigger “legal” EMS problems than wilderness EMS.

More on the situation in Pennsylvania: Assume a “street” EMT or paramedic is in exceptional circumstances that are not a part of his or her “regular” or “street” EMS job, (e.g., in a wilderness rescue with life or limb potentially at risk). Assume the patient needs something that’s not acceptable for “street” EMS in Pennsylvania. E.g., the patient needs a patellar (kneecap) or shoulder dislocation reduction to facilitate evacuation, or needs a medicine such as phenytoin (e.g., Dilantin).^{*} Assume there is contact with a Medical Command Physician. Assume the Medical Command Physician has some understanding of wilderness EMS. In such a case, “Medical Command Physicians are expected to exercise broad discretion in what they direct the EMT or paramedic to do, consistent with their ability to practice medicine.” If the physician ordered the EMT to reduce a patellar or shoulder dislocation (and the EMT had previous training in this), or ordered the paramedic to give PO phenytoin, there might be the potential for disciplinary action. However, when considering a potential disciplinary action, the Board of Medicine and state EMS are expected to exercise broad discretion, particularly when the situation is one not foreseen by the EMS law. This is not ideal, but should suffice for most wilderness EMS situations.

However, note that the above applies to those who find themselves in exceptional circumstances outside their normal EMS practice. For medically-trained members of search and rescue teams, whose main EMS practice is taking care of wilderness patients, a wilderness patient would not be an exceptional case but the norm, and the non-EMS delegated medical practice option discussed below would be a better legal route to providing wilderness medical care.

9. Are there national “standards of care” for wilderness EMS?

There are national and regional clinical standards for the treatment of patients in the backcountry. These standards are in part reflected in the *Practice Guidelines* of the Wilderness Medical Society.

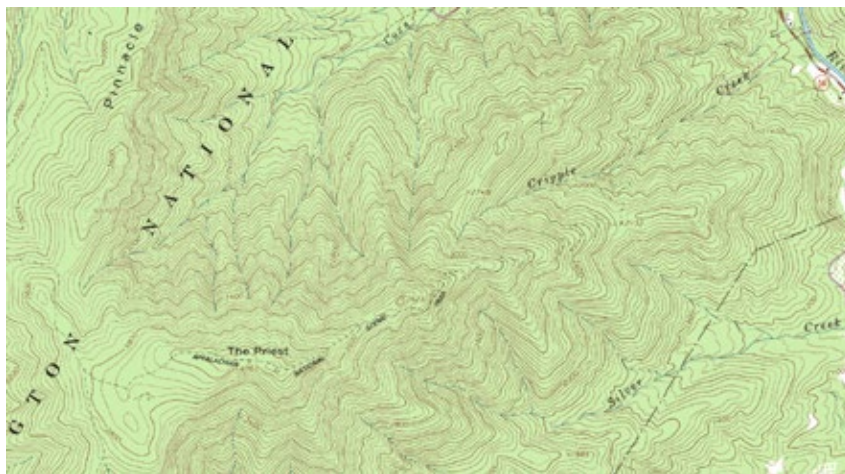
10. If I am faced with a patient in the backcountry, and I don’t know what it’s legal for me to do, what should I do?

The very bottom line is that when in doubt, do the very best for your patient that you can. Providing bad care because you’re afraid of the legal consequences is an almost sure way to get in both medical and legal trouble. Providing good care even if you’re not sure it’s “legal” is the best way to care for your patient and keep yourself clear of the court system.

^{*}All three have happened.

Just about any lawyer will tell you the same; lawyers are always giving doctors this advice in medical-legal seminars. A good example is a child who comes to the Emergency Department with a significant injury. In some legal sense, the doctor can't treat a minor without the parent's permission. However, if the doctor delays Emergency Department care pending the parent's permission, he or she is taking a big medical and legal risk. I don't even ask about parental permission until after I see the child and figure out if the child needs treatment. Unless the medical treatment the doctor is contemplating is clearly elective, or can wait without any detriment to the child at all, lawyers advise doctors to just go ahead and "do it": suturing a wound, giving an antibiotic, whatever. Only later should the doctor worry about parental permission. Since what the lawyers tell doctors to do what they want to do anyway, it's very satisfying.

If in the field and you have a choice between what is right and what you think is legal, choose what's right



IT ISN'T A CRIME SCENE until you know that (A) there's been a crime, and (B) you know you are at the scene of it. However, every search has the potential for a crime scene, and downed aircraft crash sites are treated as crime scenes, even if it's the National Transportation Safety Board rather than a detective or coroner who will be investigating.

When you're on an evidence search, then it's pretty well assured that whatever you find will be treated as a crime scene. And on most searches, there's always the possibility of a crime scene until you find the search subject and it becomes apparent there's no crime.

I can think of one search where, as soon as we found the search subject, it became quite clear that there was no crime involved. The story has a few other lessons about what to do when you make a find, so I will tell it. Bear with me. It's not related directly to crime scenes but still educational in many ways.

Once upon a time, during some nice summer weather, there was a school group going backpacking along the Appalachian Trail (AT) in central Virginia. The group was hiking north on the AT across The Priest, and heading down into the Tye River Gap. It's a many-mile descent, one of the bigger ones on the entire AT. There was this 13-year old girl named Marcy (I've changed the name) who was lagging behind, and never made it to the next rest stop.

and you'll probably do better in court, if it ever comes to that, than if you did what's "legal."

Here are some quotes from noted medical ethicist (and Mountain Rescue Association team member), Dr. Ken Iserson:

"Rather than concern about scope of practice, the ethical bottom line is always the patient. When physicians (or probably other licensed health care providers) are involved, there should be no problems, since they are legally covered as Good Samaritans. With others, someone has to bite the legal bullet to guarantee the best patient care. In our case, I simply use off-line control to extend the scope of practice. In many of our calls, on-line medical control is impractical or unavailable.

"Think of it this way: no EMS protocol takes wilderness medical scenarios into consideration; our patients need help; the law should not prevent this help if it can be safely delivered by wilderness personnel whether trained or not; it is our responsibility to make sure our personnel are as well trained as possible in safe practices for themselves and the patients.

"While we can squabble over minutiae involved with first-aiders, EMTs, etc. performing certain tasks in the field, there is no ethical squabble that if they can and do not help the patient, they violate the ethical principles associated with medicine (at all levels), the ethical principles associated with wilderness search and rescue, and the ethical principles associated with being a member of our society."

Incident/Crime Scene Procedures

I remember that Bob Koester and I argued over who would run the operation and who would go out into the field. I won, and got to go out into the field.

There's a place where the AT heads down one ravine, and then abruptly cuts left, up out of the ravine, before more-or-less descending another ravine all the way to the bottom. My hasty search team of two was assigned to the ravine where the trail makes the false start down the ravine, which seemed like a high-probability area. As soon as we left the AT, we found someone's tracks. Great! So I got out my tracking stick and started doing step-by-step mantracking. Actually, with the summer growth, and no recent rain, it was absurdly easy tracking. My teammate, who shall remain nameless for reasons soon to be apparent, was doing the usual stuff when working with a mantracker, handling the radio, keeping track of where we were on the map, and the like. As usual, we were calling out "Marcy!" from time to time.

We came across the best clue I've ever found: a plastic bag of clothes with Marcy's name on a tag inside the collar of every shirt. I can tell you we were pretty excited at that point, so I really buckled down to following those tracks.

Soon we came across an even *better* clue. After my nameless companion called out "Marcy!" there was an answering "I'm over here, dammit!"

Marcy appeared to be tired and hungry from her night out on the mountain, but she wasn't hypothermic or significantly injured. She'd done a bit of wandering around without her boots (she never was able explain to me

why) and her feet were a bit scratched up.

I guess I should also point out that this 13 year old girl also weighed about one hundred and sixty pounds. Maybe that explains why she was lagging at the back. The group she was hiking with apparently didn't have a "sweep" – an experienced, well-conditioned person who takes up the rear, which is a great idea when hiking in a group. She told use she "absolutely couldn't walk a foot further" and would have to be carried out. Hmm. OK.

We asked Base for a team with additional people and a Stokes litter. I turned to my companion, who was in an official Appalachian Search and Rescue Conference uniform, and was a certified Field Team Member, though he was from a different ASRC Group and I didn't know him. I asked, "what are our ASRC Grid coordinates?" at which point he placed his index finger on the map, and several times drew a circle about two inches in diameter "somewhere in here." Sigh.

They sent a team towards our approximate location. But when the team turned off from the Appalachian Trail, they realized that nobody in the team, *nobody*, had a compass. So another team (with a compass) was dispatched to meet them.

We'd been waiting for hours, and although I took advantage of the time to do a full History and Physical on Marcy (I was skipping a day of medical school and that was the week's assignment), we realized that maybe we should get moving before it got dark, as some clouds and mist were moving in. By this time, a couple of other hasty teams had arrived from nearby search tasks, and a few people (including my nameless mantracking companion) left. We ended up with three of us plus Marcy. We were listening to radio reports of teams (two of them now) trying to find us. It was now twilight, and we were using our whistles to try to direct the teams in. We'd also walked out a couple hundred meters in three directions, along which lines we'd placed fluorescent plastic flagging tape on tree limbs, the tree limbs always pointing towards us. We finally decided to do a piggyback carry up the ravine towards the AT.

We took some 2" seatbelt webbing (also usable as a load strap for carrying the litter) and put the middle of the webbing in the middle of Marcy's back. We then crossed the ends, and as I crouched down in front of and with my back up against Marcy's belly, passed the ends over my shoulders like backpack straps. I then took the ends down beside my hips, and then back under and between Marcy's legs. I then brought the ends around in front of me as just like a pack hip belt. Then, with two people helping hold me from either side, I tightened the webbing until she was really snug against my back. This carries a person as well as a backpack, quite comfortable really. The three of use took turns carrying her, with the other two on either side for support. I learned that when doing this you cannot bend your legs more than a few degrees or you *will* collapse to the ground. Stepping up more than a few inches required the people on either side to basically hoist you up the step. [Mountaineering: The Freedom of The Hills](#) has a good diagram of the carry. The only thing I always do compared with that diagram is I always have the rescuee sit truly piggyback, with her thighs actually over my hipbones. Seems to carry better that way. This and other references also mention a "split coil carry" where you use a coil of rope to aid in a piggy-

back carry. Seems to me that a split coil carry is actually worse than having someone on your back holding on in a plain old piggyback ride, and nowhere as good as the method described above.

Well, we progressed up this ravine, now in the dark, in thick mist, over slick moss-covered rocks and boulders. A team with a Stokes finally met us, which was good because we were exhausted. What was bad is they didn't have a full set of litter bearers so we had to help hump the litter up the ravine. We finally got to the Appalachian Trail where there were about a zillion people with headlights standing on the trail ready to take the litter. The only trouble was that this was an old Civilian Conservation Corps trail from the 1930s, and there was a nice four foot rock wall between us and the people on the trail up above. "Hand the litter up to us!" "We... can't..." "Come on, just hand the litter up!" We tried to hoist the litter up to shoulder level. It didn't move an inch upwards. "Alright, we'll come down there. Wimps." It was half an hour before I could straighten out my fingers again.

That wasn't the worst part. The worst that the whole rescue Marcy was asleep and loudly snoring.

Enough digression, even if educational about what to expect at incident scenes, and perhaps entertaining. Back to *crime* scenes.

The first rule is that incident/crime scene protection is secondary to rescue and medical care. That being said, it makes sense to take care of rescue and medical tasks in ways least damaging to potential clues at a crime scene.

There are three priorities for incident/crime scene management: medical care and rescue, securing and preserving the site, and documenting the site.

Securing and Preserving the Site; Determining Death

SECURING THE SITE IS APPROPRIATE. But for a downed aircraft or lost person search, what does it mean?

A joke heard around the Pentagon goes like this: One reason the Services have trouble operating jointly is that they don't speak the same language. For example, if you told Navy personnel to "secure a building," they would turn off the lights and lock the doors. Army personnel would occupy the building so no one could enter. Marines would assault the building, capture it, and defend it with suppressive fire and close combat. The Air Force, on the other hand, would take out a three-year lease with an option to buy.

We will follow the Army approach.

On most searches, if the subject has survived until you found him, he probably won't die if you don't have the whole team rush to him. A minute or even a few minutes is unlikely to make a significant difference.

Have the team's medic (best-qualified medical person) approach and determine if the subject is alive or dead. It's usually pretty obvious. If other team members need to approach the subject, make sure they do so along the same route, so tracks aren't trampled.

Do you need a doctor to pronounce the patient before you can report the patient as dead? No. State laws vary,

but in general, any EMT or paramedic may determine that you have, in fact, discovered a corpse rather than a live patient. Even if you're not an EMT, you can use the following criteria to determine if someone is alive or dead. If you find one of the following, you may assume the person is dead:

- decapitation
- transection of the torso
- patient is frozen so hard that the chest can't be compressed
- patient's rectal temperature is very cold, and the same as the environment
- well-progressed decomposition (but see below).

There are several other presumptive signs of death, but no one by itself is reliable.

- **RIGOR MORTIS:** postmortem rigidity is well-known, but not always present, and similar rigidity is seen in semiconscious deeply hypothermic patients.
- **DEPENDENT LIVIDITY:** dependent lividity (dark and bluish in the lower parts of the body) is common in corpses, but also is found along with pressure necrosis and frostbite in some patients exposed to the elements for a long time.
- **DECOMPOSITION:** odors of decomposition are common, but anyone who has worked in an urban EMS system can attest to the remarkable capacity of live humans to emit both strong and foul odors despite the ability of the body in question to walk, if not in a straight line. And, sometimes a live patient is brought to the Emergency Department with maggots in a wound (indeed, in some patients, the maggots keeping the wound clean are responsible for their survival).
- **LACK OF PRESUMPTIVE SIGNS OF LIFE:** hypothermia can mimic death, in that pulses may not be palpable, respirations undetectable, with dilated unreactive pupils and no signs of consciousness; nonetheless such severely hypothermic patients have occasionally been resuscitated with full neurological recovery.

If you have an EKG monitor (unlikely, but sometimes happens, and in a few years, you may be able to get a module to plug into your smartphone), and monitoring shows, in at least two leads, asystole (no electrical activity) that is a good sign of death.

There are a few situations in which you should take extra care to look for signs of life, as they may be difficult to detect, and you still might be able to resuscitate the patient: hypothermia; near-drowning; lightning strike; electrocution; drug overdose; and avalanche burial.

It's also true (see the *WMS Practice Guidelines*) that in the case of a backcountry traumatic cardiac arrest, or any cardiac arrest after a half hour of attempted resuscitation, you should conclude that the subject is dead. If you would like to learn more about termination of resuscitation in the field, I prepared a white paper on the topic for Pennsylvania back in 1998. It's available on the Pennsylvania Emergency Health Services Council website or at conovers.org/ftp/cease.pdf.

Once you have determined if the subject is alive or dead,

keeping (or at least moving) the majority of the team away from the subject is a good idea on many levels. Establish a sheltered rest area for team members as, at least in my experience, there will soon be other teams arriving and corralling them is appropriate. If someone has a stove, fixing some warm drinks or hot food helps attract incoming members to the team area and keeps them away from the subject. This applies whether you've got a crime scene or preparing the subject for an evacuation.

Some commonsense safety guidelines are always appropriate. If there are firearms around, make doubly sure nobody touches them in any way, as they may be loaded and cocked. If the appropriate responsible official (sheriff's deputy, police, coroner) approves, it may be appropriate to have someone knowledgeable to touch them just enough to ensure they are safe (unloaded, safety on, pointing away from the scene and any likely approach directions).

Task a team member with running flagging tape in a circle of appropriate size around the scene. Depending on the situation, the area you secure may need to be smaller (dead hunter with bullet hole in head) or larger (downed aircraft with debris spread about).

If and when more people arrive, post guards around the perimeter to keep out unwanted people. Unless you have local law enforcement, you don't have any actual authority to keep people out. However, a line of flagging tape with some burly, frowning SAR team members standing there with crossed arms may be a fairly good deterrent even without any actual authority to keep people out. It's also important to monitor the security of the site. If you can state with certainty that nobody other than your team members has been inside the secure area you have marked off, and when the investigator arrives, hand him a list of the team members' names and contact information (a page out of your pocket waterproof notebook will do), that will likely make him very happy. It means the evidence there is higher-quality than if you didn't do this and will stand up in court better. If you need to assign specific guards to the site, a roster of who was guarding when would also be appreciated by the investigator. This is referred to as a *chain of custody* and provides assurance that the evidence has not been tampered with.

Investigating law enforcement officers want the site just as you found it. They don't want anything taken away. They also don't want anything (such as footprints or bits of trash) added. To echo that conservationist maxim: "Leave No Trace." In particular, bodies should be left precisely as you find them, even if hanging from a tree.

Documenting the Site

THERE ARE MANY WAYS to document a crime scene. And if you have a chance to employ any of these right after the find, before there are opportunities for contamination of the scene, most investigators will appreciate your documentation. The simplest is to use a camera to take pictures; so many cellphones have cameras now that there should always be a camera available. Compared to when an official investigator arrives, you may have the advantage of better light, or light coming at a better angle. It's customary to take pictures from four different angles. Closeups are good, but stepping back a bit and getting some of the surrounding context is also often helpful.

Although photographs are useful, a sketch map of the site, identifying items that you found with labels, and identifying where team members had walked, may be even more useful. A set of written notes sometimes is a helpful supplement to the sketch. Taking pictures of the sketch and notes with two separate cellphone cameras might be a worthwhile backup strategy. This makes even more sense when you may have to review the sketch and notes when preparing for your testimony in court.

When turning over the scene to an investigator, make sure nobody can accuse you of abandoning the scene. Get a signed receipt for the scene from the investigator before you leave. They won't mind, they're used to it. If necessary, use a page from your waterproof notebook (you *do* always have a waterproof notebook in your pocket, right?) and write out a simple receipt. Remember to put a date and time on it.

Illegal Activities

IN OLDEN TIMES, one might be searching for a lost person and come across a moonshiner's still. These days, you're more likely to run across a meth lab (methamphetamine production facility) or a field of marijuana.

While reporting such to the agency having jurisdiction is appropriate, of much greater concern is team safety. Unless your team has a law enforcement officer with training in dealing with such situations, your best bet is to

- have the team immediately freeze in position, then
- carefully backtrack, preferably following the precise footsteps used to enter the area.

The risk of booby-traps is high enough that you should give the area wide berth. A later field team with appropriate law enforcement specialists can come back later and search the area with appropriate precautions.

Confidentiality, Media and Family Relations

MANY SAR CONTROVERSIES revolve about the media, or relations with families, or issues with disclosure of confidential information.

A cellphone video of SAR personnel receiving a message about a subject being found makes it onto YouTube. The press hear about the subject being found dead and are able to get to the family and ask them questions about their son's death before they have even been told about it. A newspaper gets and prints details about an injured hiker's injuries, and the family publicly blames your SAR team.

All of these are preventable. When a team makes a find, they should call Base on the radio and ask *Please secure the net*. Members with radios, once they hear this, are supposed to turn down their radios so that others can't hear. It's not as good as encrypted radios, but this simple measure probably has prevented many potential security breaches.

The press are neither enemies nor friends, they are people simply doing a job. But if you haven't been trained in dealing with the press, and even if you have, it's always correct to refer questions to your boss. If you're a Field Team Member (FTM), refer it up to the Field Team Leader (FTL). If you're a FTL, refer it to Base. At Base there should be someone identified as a Public Information Officer. The Appalachian Search and Rescue Conference website (ascrc.net) has a set of training standards for PIOs you may view to see what a PIO should know.

If you're not the PIO for this incident, you may give a member of the press general background on your SAR team, and what it's like to train for and do SAR. You can also give general information about what the SAR effort has been like: "It's been very hot, and we're monitoring all team members to make sure they drink enough fluids and don't get dehydrated." You should give no specifics of your tasks, and certainly, no information at all about the subject's condition. Indeed, there is even a Federal law, the Health Insurance Portability and Accountability Act, that allows criminal prosecution and civil suits for inappropriate disclosure of Protected Health Information (PHI; note the capitals), and indeed, individuals and organizations have already run afoul of this law. Simply chatting about the rescue at a public restaurant could

get you and your team in trouble. There is one "cutout" in this law: if preserving confidentiality interferes with urgent patient care, then urgent patient care takes precedence. Thus, when I'm in the ED, I can simply call one of my colleagues in a different ED and say "I'm seeing Joe Blow right now, and he was discharged from your hospital yesterday. Could you take a quick look at the records on your computer system and tell me what meds he was discharged on?" and it's OK.

Traditionally, confidentiality extended to attorney-client privilege, priest confessional privilege, and doctor-patient privilege, but now it applies to any personnel having access to medical information (you).

If you are assigned to be a family liaison, especially if you are the one to break news of a severe injury or death, here are some guidelines.

Death can be stressful to family or friends, but when someone is lost, ill or injured deep in a cave or wilderness area, it can be almost as stressful on them. If you can arrange to have a social worker or chaplain take over as family liaison, this will provide someone with appropriate training and experience.

If you have to do this yourself, be prepared. Learn people's names. Introduce yourself. Extend your hand; use your name. Inform the family of the injury or death as tactfully, yet as directly as possible. Present a caring attitude. Remember that the injured or deceased is important to the family regardless of the family dynamics or the situation that led to the death. Be empathetic. You can be empathetic without compromising your SAR role. Be fully accessible during your time together. Leave room for questions.

Manage the flow of emotions. Let the family emote and grieve. Reassure them. Be aware of all the potential emotional, physical, and medical responses of different family members. Acknowledge legitimate anger and redirect the focus of unreasonable anger. Don't be afraid to offer condolences. A simple and sincere "I'm sorry" can provide a comforting, lasting impression. When appropriate, don't be afraid to reach out and touch. Touching is essential for some people, but for others it's an intrusion. Trust your judgment. Don't become defensive or

take anger personally.

Watch your words. Use simple terms when discussing the patient's death. Families are intimidated and confused by some medical language. Use the patient's name. Avoid "body" and "patient." Use pronouns. Use "died," "dead," "death." Avoid indirect and odd references such as "expired," "passed on," "ceased to breath," "gone away," and "lost." Don't use cliches such as "at this stage of the game." Don't use graphic descriptors such as "mangled," "maimed," "crushed,"

or "ejected." Be conscious of your non-verbal behavior, especially eye contact. Interject reality to relieve the burden of responsibility and guilt. For example: "I'm sure you did everything possible."

Be patient. Give the announcement all the time it needs. Make yourself available in case the family has any further questions. Remember, your kindness makes a great difference in these situation. People will remember you.

One final but important note: medicating family members with sedatives just masks or delays grief, and may cause long-term psychiatric consequences. If the family asks for a sedative, politely but firmly explain that it is bad to do this, and we cannot provide this for them.



Entry onto Private Property; Special Use Airspace

WHEN SEARCHING, you are supposed to look in

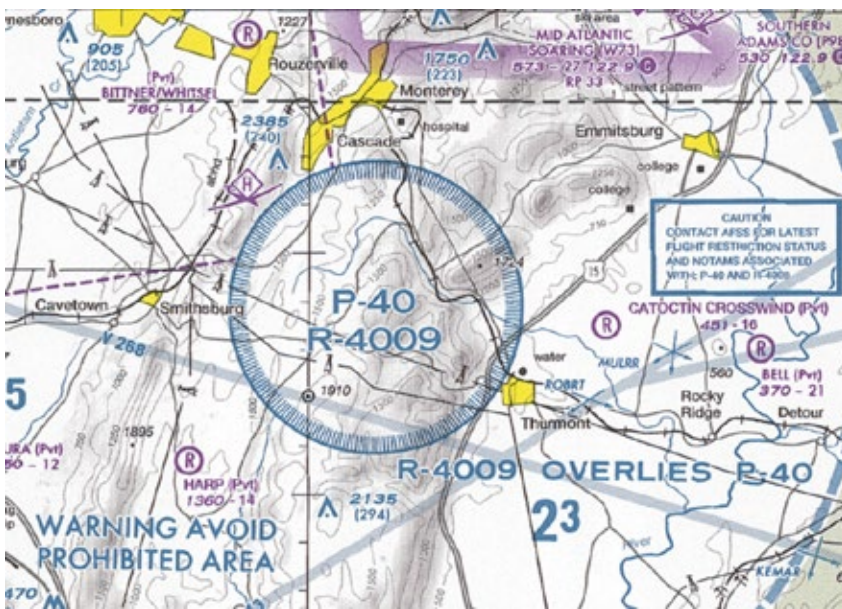
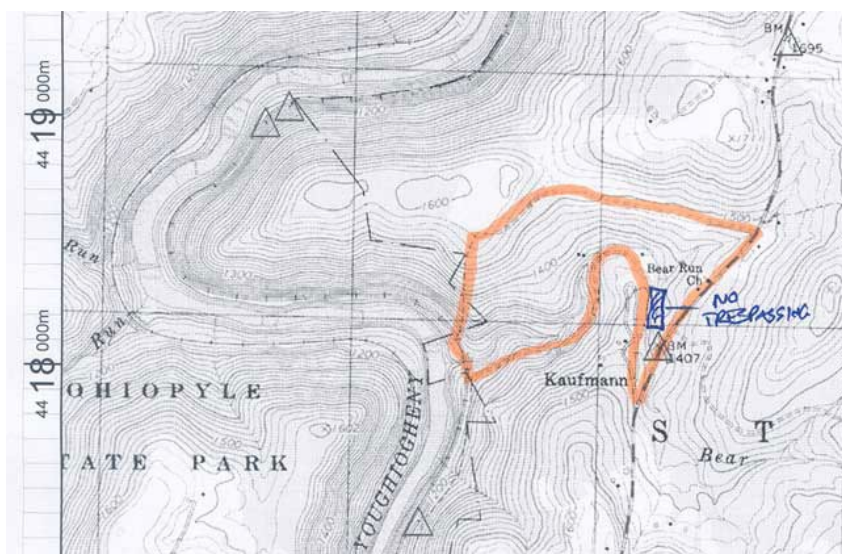
enter onto private property. In Great Britain, this isn't much of an issue, as hiking on private property ("hill-walking" they call it) has a tradition a couple of thousand years old. But in the US, there is a reluctance to walk across other's land. This may stem from our tradition of Appalachian mountain landowners protecting their moonshine stills with a shotgun loaded with rock salt. But these days, it's more likely that you'll run into someone on National Forest land protecting a meth lab with an assault rifle, or run into various lethal traps they've set. Regardless, entry on private property is a sensitive issue.

But, as long nobody objects, you are perfectly welcome to walk across someone else's property in the US. There is no crime in doing so. However, if you do something stupid, like not closing a farmer's gate behind the last member of your field team, then you may be liable for the loss of cattle. Or if you trample delicate first-growth fields, or knock down a fence, or leave trash from your lunch, likewise you may be liable for damages.

The only time that trespass comes into play is (A) when someone is standing there with a shotgun (or assault rifle) and telling you to stay off their property, or (B) the property is posted **No Trespassing**. Simply going onto someone's land in such a situation can result in a tort claim and "damages" (money), even though you've caused no physical damage at all.

But a defense against such claims is the doctrine of necessity, which was invoked in the Crossroads Cave rescue as discussed above. Assume you are searching for a downed aircraft, and you know from some prior radio messages that two people on board survived the crash. You see what looks like a fresh crash site in a field, and the only way to get there is to cross a barbed-wire fence with signs marked **No Trespassing**. If you entered onto the property to look for the injured, the landowner would, in the first place, not likely object, and in the second place, if he objected and actually could find a lawyer to sue you, the doctrine of necessity would be a very powerful argument in your favor, and would likely win the case for you. It's basically the same as *implied consent* for medical care, discussed above; you imply the consent of the landowner for such a potentially lifesaving situation. As with medical laws, each state is a bit different, but the common-law principles hold pretty much everywhere.

What if you're searching, and, absent a visible crash



all the areas where the subject might have ended up. Or do you?

In the course of searches and rescues, you may have to

site, you encounter an area posted **No Trespassing**? It's hard to justify trespassing on the "save a life" necessity doctrine, as there's only a small statistical chance that the subject is in that particular area.

It's quite possible to ask for and be granted permission by the landowner, which neatly takes care of the problem. It's best to document the name of the landowner and the time you were given permission (the back of a Task Assignment Form is a handy place to record this), and to report this to Base. If there's nobody around to ask for permission, or if the landowner refuses, just document and report the fact to the base and then go on with the rest of your task. I've found a couple of times when I asked the landowners they were quite gracious and actually helped us search their property and even in one case joined the search effort as a volunteer. And, having locals on the search team may make it much easier to get permission to search other private land, so be supportive of landowners who are interested in helping with the search. Remember to give landowners the phone number for the base in case they should find a clue or useful information later. If Base has created a flyer with information about the subject and the number to call with information, make sure you have some with you to pass out.

If you happen to have a law-enforcement officer with jurisdiction as part of your team, then things are a bit different. Sworn peace officers with jurisdiction may legitimately enter lands posted No Trespassing during a search, and may take the rest of the team along with them. Sometimes, local law enforcement teams will be assigned to specifically search areas marked No Trespassing. Spending a few moments of the Field Team's time to delineate the location and extent of the area marked No Trespassing will aid Plans in creating the law enforcement task to go back and search this area.

Let's also look (briefly) at searching from the air. While

this is a topic of intense interest primarily for CAP (Civil Air Patrol) and other search pilots, you may need to know at least the basics, so that you can participate meaningfully in discussions about where aircraft may and may not search.

Airspace regulations are quite complex, but it's worth reviewing a few of the most important types of *Special Use Airspace*.

Restricted Airspace is marked on aeronautical charts ("sectionals") with an R and a serial number; information is available to pilots by cross-referencing the serial number with the appropriate NOTAM ("Notice to Airmen" originally, now just "NOTAM"). NOTAMs are available to pilots through printed publications and online resources. Restricted Airspace may have invisible hazards such as artillery fire or missiles.

Prohibited Airspace areas have been established primarily for security reasons. A good example is in the Catoctin Mountains near Frederick, Maryland, where Appalachian Search and Rescue Conference groups train regularly. The presidential retreat at Camp David there has prohibited airspace above and around it. When the President is in residence, this area may be expanded, as noted in a NOTAM.

Controlled Airspace is found in areas around airports or other regions with a high level of aircraft traffic. All air traffic in such airspace must be under the control of an Air Traffic Control Center (ATC). There is also an Air Defense Identification Zone (ADIZ) around North America that requires aircraft to check in with an ATC.

In some searches, aircraft may obtain permission to search within restricted airspace. In other searches, this may simply not be permitted. The agency having jurisdiction over the airspace may arrange to search it by air themselves, for example, with military aircraft.

SAR Accounting

ACCOUNTING IS SELDOM what people envision when they think about wilderness search and rescue teams. Maybe for a paid team, but for volunteers?

But anyone who's worked in Base on a big search can tell you that search management is mostly accounting. Having the Staff close down Base and leave while a team is still in the field is embarrassing. Don't laugh, it's happened. A team that is overdue for a radio check-in, or late returning from a task, is seldom anything bad, but it just might indicate a life-threatening problem, or at least a team that might have to bivouac overnight. Knowing whether teams are upwind of a dog task may affect your interpretation of their reported alerts.

You have to account for people, for equipment, for tasks, for coverage and POD (probability of detection) for different areas.

Have you ever walked into the second day of a search, the only records of the first day is a single photocopied map of the area with some indecipherable scribbles on it? I have. Many times.

In a bank, bad accounting may be cost money. In a search, bad accounting may be life-threatening.

And that's why an essay on SAR legal aspects has a section on accounting: because bad accounting may be criminal negligence, or grounds for a civil claim of simple negligence. Indeed, liability for search and rescue is more likely to come from bad accounting than anything else.

As my wife explains to me all the time (she's a CPA: Certified Public Accountant), accounting is more than making the numbers add up. It has to do with which numbers signify what, and really the numbers are secondary. Well, that's what accountants say, anyway. But then, I once went to lunch with some of my wife's accountant friends. They spent 10-15 minutes making sure that the tip was figured out to the nearest cent. Not because they are obsessive/compulsive, but because it's fun.

People

ACCOUNTING FOR PEOPLE includes more than just making sure every team that was sent out gets back safely. Since that's well-covered in courses such as Practical Search Operations (PSO) and Search Operations for Staff (SOS), we will consider other liability issues with accounting for people here. (I will just note that as I am

typing this, I know of one search within the past month where several members of a Field Team wandered away from the team; the strays managed to find their way back to Base independently. All were members of Pennsylvania Search and Rescue Council teams. No additional comment is needed.)

For example: who can go out on a field team, and who cannot? For fire departments, pilots, and even a Commercial Driver's License (CDL), a regular history and physical exam and some lab screening is required. Few volunteer teams do this kind of screening, however.

Precise rules are up to SAR organizations to formulate, or for the Incident Staff or Field Team Leader to determine on the spot. This should be situation-dependent. Let's consider two illustrative examples.

A local volunteer wants to help out on search tasks. He has stable angina and tends to get chest pain walking uphill, quickly relieved by rest or a sublingual nitroglycerin. Can you use him? Certainly. You might not want to send him into the field, but he could run a car shuttle to pick up teams and bring them back to base.

This does point up that someone should do some basic screening of those who are going to go into the field. This may either be at check-in, if the Incident Staff sets this up, or by default, by the Field Team Leader prior to leaving Base. As with the above example, the more medical knowledge the screener has, the better the decisions are likely to be. If you've got a large search with a large number of volunteers, assigning one of your best medical people to do some screening might save later problems, or even a life.

If it's a SAR team member who participates in field training on a regular basis, then there's not much more you need to know, unless the team member wants to volunteer some personal medical information. The Appalachian Search and Rescue Conference has had members with Type I diabetes as well as epilepsy; these members were always careful to tell their leaders and team members about their medical problems and limitations. The member with epilepsy, though well-controlled, did not feel capable of belaying due to the risk, even though remote, of a seizure. Local volunteers, however, tend not to be as forthcoming about their medical problems, so a simple question to your Field Team members might be appropriate: "Does anyone have any medical problems that the rest of us should know about?"

Another example. It is late winter, temperature is in the teens, and there is about a foot of crusty snow on the Appalachian ridgetop fire road where Base is located. A small aircraft has gone down today, and there is good reason (from radar data) to suspect it is on the wooded mountainside below. It is getting dark, but the agency having jurisdiction insists that it wants to send a task out tonight to perform a scratch search along a trail that winds along halfway down the mountainside.

If you are Operations Section Chief, what requirements should you set for members of such a team? Certainly only people in top physical form, experienced at back-country winter travel, with appropriate gear including at least instep crampons ("creepers") should be detailed to such a task. And if there are not enough such people to field such a team, perhaps it is best to tell the agency having jurisdiction that you don't have adequate resources

for the task.

So screening is for basic medical conditions that might be in the field, but also for fitness for the particular task, whether this is aerobic fitness, experience, or equipment.

Minors

WHAT IF there are kids under 18 who show up and want to help with the search? This is a ticklish subject. While lawyers will generally tell you never to use a minor in a search and rescue operation, there are some Explorer Search and Rescue (ESAR) posts that do search and rescue on a regular basis. Explorers are 14-21 years of age, so some are minors. The Civil Air Patrol (CAP), which performs both air and ground search, also has a cadet program for those age 12-20.

Both organizations have strict guidelines on how their minors are used in search and rescue operations. Certain activities – such as body recovery – may be prohibited. Close adult supervision is required.

The Appalachian Search and Rescue Conference (ASRC) allows the use of minor members, who, if allowed to participate, do so fully, with no specific limitations except those imposed by the Field Team Leader or Incident Staff, and a few provisos in the ASRC Operations Manual. These were added due to an Explorer Search and Rescue Post becoming a member Group of the ASRC.

The ASRC Operations Manual (Version 3.1, April 1999) states:

***Use of Minors:** The AR [Agency Representative] may wish to limit the use of minors at an incident. Unless the AR specifically specifies that minors are to be limited (e.g., assigned only to base tasks, or not even allowed on-scene), it shall be assumed that minors are allowed.*

***On Scene Safety of Minors:** The AR is responsible for ensuring that the use of ASRC Group minors is supervised by an appropriate, willing, responsible adult. If the ASRC AR is fulfilling the function of IC [Incident Commander], then the IC is responsible for ensuring that all minors in ASRC Groups are supervised by an appropriate, willing, responsible adult. If there are no appropriate, willing, adult supervisors, then the minors shall not be used. The AR is not responsible for knowing the specific rules and regulations that apply to each ASRC Group's use of minors.*

Note: all ASRC members must undergo state police screening appropriate for those working with children.

If an organization does not have procedures for employing volunteer minors in search and rescue operations, it would be best – at least from a liability perspective – to gently but firmly refuse offers of assistance from such minors. For example, the ASRC has provisions for *member* minors, but no procedures for incorporating volunteer minors into teams coordinated by the ASRC. However, the ultimate call on use of such minors will always be up to the Agency Having Jurisdiction (AHJ), also sometimes termed the Responsible Agency (RA). If the AHJ/RA instructs you, as an Incident Staff member, to accept and use spontaneous minor volunteers, it would be best to very clearly document in the Log the full name and title of whoever gave this instruction, to whom, and at

what time.

Equipment

FOR ANY LARGE SEARCH AND RESCUE OPERATION, accounting for equipment is difficult. It seems that radios most often disappear, but occasionally other items like ropes and litters and generators disappear. We tend to devote a lot of time and effort to tracking people, but tracking equipment, even radios, takes less effort, so gets less attention. It's easy to lose a radio or spare battery because it's in the bottom of someone's pack, but this doesn't seem to happen to people (though occasionally they're asleep in a car). Tracking down these bits of equipment may also seem less important than tracking down bits of Field Team personnel. But trying to find radios or other equipment is much more difficult after the operation is winding down or over. It's even more important to track equipment if some of it is loaned to the SAR operation. Losing a \$5000 night-vision scope could be a serious liability for a volunteer SAR team.

I've often thought that SAR teams should consider recruiting the specific types of people who are good at obsessively tracking items, even under pressure. CPAs (Certified Public Accountants) who have had experience with tax season, or pharmacists who have responded to disasters, would be ideal recruits. This might sound tongue-in-cheek but it's quite true that we need these capabilities. **WANTED: ACCOUNTANTS LOOKING FOR EXCITEMENT AND ADVENTURE!**

Deputizing: Posse Comitatus

WESTERNS (MOVIES, THAT IS) famously feature a Posse, a group of civilians deputized by the Sheriff to help track down and punish evildoers. In today's real life, civilians are rarely deputized by police officers or sheriff's deputies, but it still does occur in more modern times, as with the University of Texas Tower sniper in 1966, in which a civilian with military experience, Allen Crum, was deputized by Officer Ramiro Martinez and took part in the tactical operation that killed sniper Charles Whitman, but not until this sniper had murdered sixteen people.

Posse Comitatus dates to medieval England. It was originally known as "hue and cry": the law that citizens must respond, with their weapons, when they heard the hue of horns and the cry of "Out! Out!" They would then assist in military or law-enforcement operations. Later termed Posse Comitatus, it gradually lost its military implications with the rise of organized militias. It became recognized in English and Welsh common law. The local leader – the Ealdorman, later known as the Shire Reeve (later corrupted to "Sheriff") – of the local district – originally called a "Shire," though this was changed to "County" after the Norman Conquest of 1066 – could require civilians to assist in law enforcement actions (e.g., as any child knows, helping arrest Robin Hood... which was actually cited in one legal opinion).

As US common law is based on English and Welsh common law, this principle was applied in the US as well. Given it is a common law principle, it applies in all jurisdictions. Some states have passed laws that either eliminate the common law Posse Comitatus, or enshrine it in state law.

I searched the state laws of states near me – Ohio, Pennsylvania, Virginia, West Virginia, Maryland and Delaware (for the keywords deputize, deputizing, and Posse Comitatus) – and I found nothing relevant. Assuming that I didn't miss something, that means that in these states, the standard common law interpretation of Posse Comitatus applies without modification. That is, any sworn peace officer can deputize anyone in an emergency, and while there is a common-law duty to accept this and carry out the instructions of the peace officer, there are no specific penalties for refusing.

Since we are discussing Posse Comitatus, we have to mention that in 1878, the US passed the Posse Comitatus Act. This basically forbids the US Army from being used as a Posse Comitatus for law enforcement. This was part of a compromise that ended the military occupation of southern states, part of Reconstruction after the Civil War. There are exceptions, for example, for major national disasters.

The word posse has also acquired additional meanings in the US, including as a synonym for a lynch mob. But most interestingly for SAR teams, many counties, particularly in the west (e.g., Maricopa Co., AZ; Inyo Co., CA) have a permanent "Sheriff's Posse" which functions as an auxiliary to the full-time Sheriff's Deputies. While these Posses may perform some law enforcement functions, a number focus strongly on search and rescue, and may serve as the county's primary volunteer search and rescue team. Some of the members, though volunteers, are deputized to be armed and to carry out certain law enforcement tasks.

As a final note about posses and deputizing, the 1887 British Sheriff's Act, which established penalties for those who did not assist the Sheriff when requested, was repealed in 1967.

Apprehension of Criminal Suspects

SOME SAR TEAMS are made up solely of sworn peace officers, for instance, the Los Angeles Co. (CA) SAR team consists of Sheriff's Deputies; or, some of the permanent Posses mentioned above are all Sheriff's sworn auxiliaries. These teams do law enforcement as well as search and rescue, and would see the apprehension of criminal suspects as a normal part of their duties.

Most volunteer SAR teams, however, are made up primarily of members who are not sworn peace officers. While some of the members might be peace officers in their day jobs, they may well be out of their jurisdiction when out on a SAR operation, especially in the eastern US, where jurisdictions are much smaller than in the west. This places fairly strict limitations as far as what they are able to do as far as arresting criminal subjects, although they may be deputized by a local peace officer to allow them to arrest criminal subjects in the local jurisdiction.

Some SAR teams and umbrella organizations specifically exclude the apprehension of criminal subjects from their services. For instance, the Appalachian Search and Rescue Conference Operations Manual states:

The ASRC may decline to participate in an incident for a number of reasons, including, but not limited to: ... When the incident involves searching for, or the apprehension of,

escaped criminals or suspected felons. ...

Carrying of, or Use of, Firearms or Weapons -- ASRC personnel will not use, wear, carry or display firearms or weapons of any size shape or form while responding as a member of ASRC to any incident, unless specifically re-

quired by statute or regulations for off-duty status for local, state or federal commissioned officers and those individuals are ASRC members. Failure to comply with this requirement may result in suspension or dismissal from the Conference. Standard tools, such as knives, shovels, saws, etc., are not considered to be weapons in this stipulation.

Legal, Ethical and Moral Advice

IF YOU HAVE READ THIS FAR, your mind may be full. Synthesizing this information into a set of simple rules may not be easy. You may find yourself in a situation that seems fraught with legal peril, yet unable to remember anything specific from this essay or your other training that seems to apply.

Engage your imagination. Come up with a specific SAR dilemma. A situation where it's hard to decide what's right to do, where there will be badness no matter what you decide. A no-win situation. If you've never had or heard of such a situation, just chat with senior members of your team.

Now, consider the situation on three levels: legal, ethical and moral. We discussed this above, but it's a useful exercise to go through it again.

Legal

THE LEGAL LEVEL has you consider: What does the law say I should do in this situation? Laws are generally a good guide to what society believes is the right thing to do. The law is a good guide for common situations, but SAR situations tend to be atypical.

Consider further: What laws apply? Are they Federal, state or local law? Are the statutory or regulatory law, or common law principles? Were the laws crafted to apply to the situation at hand, or are they a poor fit due to factors not imagined by the creators of the law? Do you need to invoke common law principles such as implied consent, abandonment, or the doctrine of necessity?

Ethical

The ethical level has you consider: what ethical codes apply? Ethics are systems of principles, often pro-pounded by members of a craft or profession, as to what this particular group of people believes is the right thing to do in situations common to their members. Codes of ethics may provide guidance when it's not clear how or even whether the law applies. In SAR situations, medical and SAR ethics might be of help. For example, consider the medical ethical principle in the ancient maxim *primum non nocere* ("First, do no harm."). Or, for SAR, consider the oft-cited principle "a dead rescuer never did anyone any good."

If there are no published codes of ethics you can apply, consider: What would your peers – other SAR team leaders or members – think is the right thing to do? Do you think there would be a consensus?

Moral

The moral level has you consider: What do I believe is right? What are my religious or philosophical principles? How do they apply in this situation?

Sometimes, when on the horns of a dilemma, the best reason to make a choice is that it feels right. We may not even be able to articulate all our moral principles, but we still may simply feel, emotionally, that one choice is better than the rest. This is generally a good guide as to what to do. While we may not consciously remember all the considerations that make the emotional parts of our brains select a best choice, they tend to do a good job in difficult situations.

Whatever choice you make, it's a good idea to document why you made the decision, and as soon after the decision as possible, while it's still fresh in your brain. You might also want to document the factors that required choosing from bad options, whether it's nightfall, a winter storm, an inadequate number of exhausted rescuers, or other factors.

It's easy to criticize a difficult decision after the fact. But if you document your decision, it's usually easier to defend it.

I hope you found this essay helpful. Even if it doesn't give a lot of answers, perhaps it has helped you ask better questions.

This is a work in progress, and will be updated on occasion. Please let me know how it can be improved.

Thank you.

–Keith Conover, M.D., FACEP

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