

Provider Response to AORE

To: Tim Mertz
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From: WFA Signatories

Re: Response to Comments from AORE dated Feb 9, 2010 on the Draft Wilderness First Aid Scope of Practice Document v Nov 4, 2009

Introduction

One of the many challenges wilderness medicine providers face as we develop Scope of Practice documents is what should or should not be included at each level of certification (WFA, WAFA, WFR, and WEMT). We must balance the needs of a large spectrum of students, from outdoor trip leaders to camp staff and non-institutional outdoor recreationists, with the length of the course and our ability to deliver the material effectively. As we move through the process of writing each SOP document, we consider the available medical evidence, input from a variety of sources including practitioners, educators, and consumers, and our collective experience as trip leaders and professional medical educators.

It remains the responsibility of individual program managers to balance the medical training requirements of their staff with the inherent risks of their trip or outdoor program, the existing policies of their respective institutions and both state and federal laws. In some cases, prudent risk management practices may necessitate a longer wilderness medicine course, together with its associated expenses in time, dollars, etc., than would otherwise be preferred.

It is a goal of this process to foster content consistency, realistic content for the timeframe, and content that is relevant to the needs of the consumer and supported by the available data. It is not our intent to dictate which credential is appropriate for a specific program.

We anticipate that SOP documents will undergo review and revision on a regular schedule as emerging research and technology unveil new information regarding type, prevention, assessment, and treatment of the injuries and illnesses encountered in remote environments. We appreciate AORE's on-going assistance as we move forward.

Many comments made by the AORE community to the first draft of the WFA SOP have alerted us to wording, that while understood by the medical providers, requires further clarification. We will take this into account in subsequent drafts. Some comments (e.g.: backboard & litter use) have been combined into a single question and response.

Question

Does the term Standard or certification endanger the practitioner? Should providers be using different terms?

Response

The use of the term "certification" by individual wilderness medicine providers simply states that the person receiving the certification has been trained to a pre-defined level by the provider according to their in-house criteria.

Many states require outfitters and guides to have to have licenses; and most outfitter and guide licenses require guides to meet and maintain a minimum level of first aid training; some actually specify WFR or WFA in the statute.

SOP documents are an attempt by the professional wilderness medicine providers to establish minimum first aid content standards for generally accepted course types within the industry (WFA, WAFA, WFR, and WEMT). There is no attempt to create standards for licensure as this is a state function. In any case, standards exist whether they are obscure and may require some effort for an attorney or program manager to discover, or whether they are stated and easy to discern. We are not adverse to well crafted standards, and we are well aware of the dangers of ill considered and inflexible standards.

Question

Not sure that providers should dictate intended audience of their courses. Program managers should make decisions based on their program and needs; and based off the curriculum, i.e. some programs can run a week long/extended trip that may be close enough to definitive care and they only require staff to have WFA.

Response

Our intent is to clarify the context in which a given credential is appropriate and in doing so help the consumer and program manager to decide which credential—WFA, WAFA, WFR or WEMT—best meets their needs. It is not our intent to dictate which credential is appropriate for a specific program. Ultimately, it is the program manager's responsibility, to balance the competency and training required of their staff with the design of the trip.

Question

Has the list of signatories changed since the WFA SOP document was released? Why is Remote Medical not listed?

Response

Yes. Remote Medical International is one signatory added since the original draft was posted; there are others. A current list of signatories will be included in the final SOP.

Question

A minimum set of qualifications should be established. Program managers, hosts of wilderness medical trainings, and students of wild med courses want to know their instructors meet specific qualifications. While most instructors are highly trained/experienced, several AORE members reported experiencing instructors that

were below expectations and deeply incongruent with the co-instructor qualifications/experience causing.

Response

We agree. However this is more of a matter for accreditation than individual Scope of Practice documents. We see SOP documents as the first step in a process that may eventually lead to accreditation.

Question

Consider defining the levels of Wilderness Medical training or mapping a Wilderness Medical training structure.

Response

Agree. It's in the works...or at least on the "To Do" list.

Question

There are many different formats for a SOAP Note or a SAMPLE form. Signatories should consider a uniform document for both SOAP and SAMPLE

Response

SOAP (Subjective, Objective, Assessment, Plan) is a universal medical rubric. Individual SOAP notes reflect the individual provider's curriculum and delivery strategies. Individual outdoor programs have different emergency reporting and documentation systems. No hospital, clinic or EMS service can agree on one format. It is not our intent to dictate a reporting format to an industry with widely varying programs with widely varying needs.

Question

Why not backboards, litters, and/or improvised litters in the WFA SOP?

Response

There is not enough time in a WFA course to achieve competency. Lifting, moving, and packaging a spine injured patient in a commercial backboard or litter requires multiple skill labs and additional simulation time; improvised spine stable litters requires more of both. We have defined a WFA as a person trained for a context where evacuations are primarily walkouts, and litter carries engage the assistance of local resources. A review of the current literature shows evacuations that require a litter are a rare event when compared with soft-tissue injuries, environmental illnesses, and wounds, and do not warrant inclusion in a basic course.

Question

Consider adding information about First Aid kit contents, maintenance and organization.

Response

While WFA students learn the common splinting tools, wound, and blister care products, time in a WFA is tight and best devoted to prevention, assessment, and treatment skills, especially in an industry where first aid kit contents vary program by program. In the final analysis, the content and packaging of any first aid kit—whether personal or individual—depends on a number of variables (cost, state laws, weight & size limitations as dictated by the activity or trip, training of the medical officer and group participants, length of the trip, potential for specific injuries or illnesses, etc.). This is a topic best reserved for a longer course.

Question

How much focus on AED will be placed? AED knowledge is listed as a recommended skill participants obtain prior to WFA coursework just like CPR. Often times AED and CPR are taught simultaneously. What is the practicality of AED utilization in most outdoor practitioner programs? Very little.

Response

We recommend that a separate CPR course with AED training accompany the WFA credential. AED's have extremely limited utility in wilderness locations where prompt access to the Advance Life Support system is impossible. However, many people trained to the WFA level work in day and residential camps that are close to EMS. AED's may be helpful in specific situations where such access exists (remote lodges with air strips, day raft trips close to a road or with prompt med-flight response, etc.)

Question

Assessing BP and Pupils seems like skills a WFA could perform. Why not include these? Especially since BP is a vital sign that would be helpful when determining volume shock. Pupil checks do not require any additional equipment.

Response

This is again a question of what skills can and should be taught in a limited course time. Few programs carry BP cuffs and a stethoscope in the field; the additional information provided by a BP is not necessary to assess internal bleeding/volume shock. Patients whose pupils do not respond to light have an obvious depressed level of consciousness/ response (V,P, or U on the AVPU scale) and require an urgent evacuation; assessing pupil reactivity is not necessary to make this decision.

Question

Does use of medications at the WFA level as currently described in the WFA SOP need clarification.

Response

WFA graduates should not be making decisions on whether a patient should or should not take their personal Rx medications (unless it's an obvious situation of abuse or harm). WFA graduates are taught to assist trip participants in the administration of personal Rx medications and may offer OTC medications according to the package label.

Question

Consider adding effect of and withdrawals from caffeine, nicotine, alcohol, and drugs to causes of abnormal mental status.

Response

While withdrawal symptoms may alter a participant's mental status and other vital signs and, if serious enough, trigger an evacuation, there is not enough time to include detail interpreting the nuances of specific substances in the WFA curriculum and have it remain educationally effective. WFA is a introductory course utilized by a number of different populations: A summer camp for pre-teens doesn't need time devoted to nicotine, caffeine and alcohol withdrawal, nor does the game and fish

employee or the person who guides day trips on a local river. The elder hostel argues for cardiac curriculum, the therapeutic program for mental health curriculum, the ocean based program for marine toxins, the high latitude program for more on cold injury.

Question

WFA SOP is applicable when EMS is 8 hrs or less removed. Nothing in this SOP should state treatment or monitoring for anything over 8 hrs.

Response

The 8 hour reference in the current WFA SOP refers to the evacuation time; the 12 hours refers to an assessment period. Some programs will have trip leaders with WFA certification on an overnight where a patient may complain of general abdominal pain for an extended period of time. If the trip ends and the patient is still in pain, they should be referred to their personal physician. If the pain persists for greater than 12 hours and they are still in the field, they should be evacuated to a physician for evaluation.

Question

Further explain what is intended by "program specific parameters" in relation to assessing spine injuries.

Response

There are three widely accepted algorithms for assessing spine injuries: Canadian C-Spine Rule, NEXUS, and modified NEXUS. Research shows that although slightly different, all are effective. Until such time as the research shows an advantage of one algorithm over another, we've left it up to individual providers or programs to choose the one that best fits their needs.