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Digest of Significant Classification Decisions and Opinions
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Standard: **Fire Protection and Prevention, GS-081** (September 1991)
Practical Nurse, GS-620 (May 1983)
Factor: Factors 1, 2, and 3
Issue: Evaluating Emergency Medical Duties

Identification of the Classification Issue

This issue arose in an OPM oversight division's adjudication of a group appeal filed by GS-5 Firefighters. The appellants sought greater credit in recognition of their medical training and certification in emergency procedures which surpassed those typically expected of Firefighters. Their certification included operating a semi-automatic defibrillator, inserting advanced airways, e.g., the esophageal obturator airway (EOA), esophageal gastric tube airway (EGTA), and intravenous (IV) maintenance (changing fluids, setting drip rates, monitoring, and discontinuing IVS). State law allowed them to administer already prescribed medications in the possession of those they treated, such as inhalers, nitroglycerin, and oral glucose. They operated without the professional supervision available to medical technicians in a hospital setting, performing some tasks not permitted higher graded technicians or nurses. Nevertheless, firefighting and prevention functions demanded about 80 percent of the appellants' time.

Resolution

Duties demanding less than a substantial, i.e., 25 percent, amount of time, are not usually considered in classifying a position. However, when evaluating emergency-related duties in occupations such as Firefighter, Police Officer, and Emergency Medical Technician (EMT), credit is given for maintaining proficiency in higher graded tasks, although they occur infrequently, when there is no opportunity to reassign such tasks to higher graded staff and the employee is expected to be fully prepared to perform such duties that arise without advance notice. The agency expected the appellants to maintain EMT proficiency and provided for refresher training and practice.

The GS-081 standard recognizes that GS-5 Firefighters frequently apply first aid measures such as immobilizing the injured for safe transport, applying tourniquets to stop bleeding, checking for windpipe obstructions, and performing cardio-pulmonary resuscitation (CPR). Performing a wider range of or otherwise more demanding emergency medical duties, like the appellants', requires evaluation against an appropriate standard in the GS-600 occupational group, such as the Practical Nurse Series, GS-620 standard. Though the Health Aid and Technician Series, GS-640, encompasses EMT, Paramedic, and similar duties, it has no published grading criteria of its own. Therefore, a related standard must be used.

The GS-620 standard is a broad match to EMT work, since it focuses largely on medical care provided within a hospital, rather than in the field. Furthermore, Practical Nurses even at the highest grades may not perform some procedures EMT's do, e.g., intubation and defibrillation, and vice versa. Nevertheless, the occupations share a requirement for knowledge-based credentialing and other common features. These similarities permit application of the GS-620 standard grading criteria to evaluate EMT work.

At Level 1-4, Practical Nurses demonstrate knowledge of a large body of nursing care procedures, illnesses, and diseases and skill in assessing deviations from normal conditions and immediately modifying care. Such knowledge entails more extensive training and experience and more advanced procedures, or the equivalent wide variety of nonstandard assignments referenced in the standard, than at Level 1-3. EMT training is commonly divided into several skill levels, e.g., First Responder, EMT, Advanced, and Paramedic. Training progresses from basic life support systems to advanced life support systems. EMT's follow sequentially designed treatment protocols, e.g., basic, intermediate, and paramedic protocols, keyed to their training and competency with life support systems. Protocols are commonly devised by professional and EMT boards. They cover dozens of cardiac, environmental, medical, trauma, and pediatric emergencies. An EMT may employ only that part of the protocol consistent with his or her training and certification. For example, a medical emergency protocol for chest pain allows basic EMT's to perform CPR and administer oxygen at a flow rate dependent upon patient symptoms. The basic EMT, however, may not employ advanced treatment procedures such as starting a normal saline IV, inserting large bore catheters in a vein for antithrombolytic agents, or administering nitroglycerin or lidocaine.

Many basic emergency medical procedures are analogous to Level 1-3 knowledge and procedures that Practical Nurses use, while many advanced procedures are comparable to Level 1-4 or higher knowledges. The appellants employed basic procedures and were not expected to use or maintain proficiency in advanced procedures, with but two exceptions. Consequently, their EMT duties were properly characterized as Level 1-3 rather than Level 1-4.

The appellants' advanced airways proficiency was indicative of Level 1-4 knowledge. By itself, however, it did not constitute the extensive body of knowledge or wide variety of nonstandard procedures expected at Level 1-4. Endotracheal intubation, EOA, and EGTA procedures are

advanced procedures that significantly exceed basic EMT knowledge and training. Basic EMT procedures, for example, allow for clearing airway obstructions by prompting conscious patients to cough or opening unconscious patient airways with finger sweeps or abdominal thrusts. EOA/EGTA requires insertion of a mask fitted with a tube into the back of the patient's mouth and advancing the tube down the esophagus while listening for breath sounds in each axilla and epigastrium and verifying chest movements. It requires greater skill in both technique and patient observation.

EOA/EGTA and intubation stood isolated from the wide variety of other advanced procedures unavailable to the appellants. For example, injections (other than with the patient's own autoinjector), starting IV's, preparing and administering medications, needle chest decompression, and intraosseous infusion are advanced procedures or part of many advanced protocols the appellants were neither required nor permitted to use. These advanced procedures demand greater knowledge of fluid therapy, pharmacology, and trauma management than the appellants' work.

Similarly, operation of automatic and semiautomatic external defibrillators (AED/SAED's) requires special skill, but not the advanced knowledge characteristic of Level 1-4. Different brands and models of AED/SAED's have a variety of features and controls, e.g., paper strip recorders, rhythm display methods, energy levels, and message displays. First Responders, who lack basic EMT knowledge, may be trained in their operation while even advanced EMT's may lack such training or have trained only on conventional defibrillators. The AED/SAED trained operator, however, may not employ a manual override, if the machine is so equipped, a task that conventionally trained, advanced EMT's might perform. Similarly, the AED/SAED trained EMT may not perform endotracheal intubation, establish IV line access, or administer epinephrine, advanced procedures that are part of the ventricular fibrillation protocol more knowledgeable EMT's or Paramedics might execute. Though the appellants were trained in endotracheal intubation, that procedure was only part of the larger body of knowledge expected at Level 1-4.

The appellants were expected to be proficient in more difficult, but still standard, procedures, such as CPR on the move, field treatment of wounds, management of fractures, treatment of head and back injuries, and emergency childbirth. These procedures require considerable training and experience to develop proficiency and to execute in the field. They are common skills required of basic EMT's and equivalent to the level of knowledge demanded of Level 1-3 Practical Nurses who inject medications, insert catheters, monitor IV fluids, change IV tubing, discontinue IV's, apply electrodes for cardiac monitors, and report abnormalities. They are also similar to work done at Level 1-3 by Health Technicians in other specialties who operate, calibrate, and maintain commonly used equipment and recognize abnormalities that would be obvious to those with their considerable training and experience. Some technicians at this level are also knowledgeable in the use of aseptic methods to draw blood samples from patients and the operation of commonly used electrocardiographic equipment.

The appellants' independence and responsibility was the one factor found to exceed the usual expectations for GS-5 technical work. Although they followed established protocols in treating patients and referred situations not covered by them to professionals, as is characteristic of Level 2-2, they also independently gauged patient condition, made a number of assessments, and chose from a variety of actions before contacting medical control for advice. The appellants were the eyes and ears of the medical control, i.e., the emergency room doctor or nurse responsible for patient intake and assessment, which relied upon the appellants' observational skills for the basis of its advice regarding any deviation from protocols. Their independence and responsibility in the decision to depart from protocols were assessed as equivalent to that exercised by Practical Nurses who, at Level 2-3, independently plan and carry out treatment plans without specific instruction for each patient's condition according to their previous training, instructions, and accepted practices.

The guidelines the appellants used in treating injuries and illnesses were consistent with normal GS-5 level expectations. The appellants relied upon more than 30 specific protocols approved by the post Medical Director. The protocols were specific regarding the emergency procedures to employ. Although the appellants had to select from among them according to their observations of each patient’s condition, drawing upon their training and experience, they could not deviate from the protocols. As is typical of EMT’s, they were required to refer developments not covered by the protocols to medical control for advice. Neither the guidelines used nor judgment exercised by the appellants in following them exceeded Level 3-2, the level typically credited to GS-5 technical work.

Based on its application of the GS-620 standard, the oversight division credited the appellants’ EMT duties at Level 2 on the remaining factors, resulting in a GS-5 level determination. In crediting Level 9-2, the oversight division noted that the appellants' EMT work involved moderate risks in contrast to the high risks involved in their other, but separate set of duties evaluated by the GS-081 standard. The division noted that Firefighting exposed the appellants to dangerous substances such as noxious gases, fumes, and explosives, but as EMT’s they dealt with lesser risks such as infection and contagious diseases requiring them to don special gloves, gowns, or masks as safety precautions.