Northwest Community EMS System
Continuing Education Program – October 2017

ETHICAL and MEDICAL-LEGAL CONCEPTS

CREDIT QUESTION handout

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Name:	Date submitted:
EMS Agency	Credit awarded (date):
EMSC/Educator reviewer:	Returned for revisions:
	Revisions recd.:

This packet should take 2 hours to complete – which earns you the equivalent of the 2 hour live CE class.

References:

SOP: Introduction page; Scopes of Practice page

Policies:

A-1 Abandonment vs. prudent use of EMS personnel; A3: Initiation of ALS/BLS Care; Scopes of practice; C7 Confidentiality of Pt Records; D1 Due Process; D5 Illinois POLST form and Advance Directive Guidelines; E5 Code of Ethics; L1 Patients in Law Enforcement Custody; R-1 Relicensure/ Reinstatement/Dropping to lower level of licensure: EMT/PM/PHRN; R-6 Refusal of Care; R7 Reportable Incidents

OBJECTIVES:

After reading the class handout, select sections of the SOPs, and referenced policies and completing the class, each participant will independently do the following with at least an 80% accuracy and no critical errors:

1. Differentiate between legal and ethical responsibilities.
2. Identify and explain the importance of laws, rules, and ethical guidelines pertinent to EMS.
3. List the specific problems or conditions encountered while providing care that EMS personnel are required to report, and Identify in each instance to whom the report is to be made.
4. Explain the legal interpretation of each of these: abandonment, advance directive, assault, battery, breach of duty, confidentiality, consent (expressed, implied, informed, involuntary), do not resuscitate orders, duty to act, emancipated minor, false imprisonment, immunity, liability, libel, minor, negligence, proximate cause, scope of practice, slander, standard of care, tort.
5. Differentiate between the scope of practice and the standard of care for EMS practice.
6. Explain the four elements that must be present in order to prove negligence.
7. Explain the concept of liability as it might apply to EMS practice, including physicians providing medical direction and paramedic supervision of other care providers.
8. Describe the parameters to assess in determining decisional capacity to give or withhold consent for treatment.
9. Sequence the steps to take if a patient refuses care and/or transportation.
10. Identify the legal issues involved in the decision not to transport a patient, or to reduce the level of care being provided during transportation.
11. Describe situations that would constitute abandonment.
12. Differentiate between assault and battery and describe how to avoid each.
13. Describe the conditions under which the use of force, including restraint is acceptable.
14. Explain the importance and necessity of patient confidentiality and the standards for maintaining patient confidentiality that apply to EMS.
15. Explain how EMS should care for a patient who is covered by an advance directive.
16. Describe the importance of providing accurate documentation (oral and written) in substantiating an incident.
17. Describe the characteristics of a patient care report required to make it an effective legal document.
18. Participate in 3 minute scenarios involving the following: Abandonment, assault and battery, stander and libel, implied consent; false imprisonment, and violation of HIPAA;

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Ethical and Medical-Legal Concepts Credit Question Handout
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Introduction

EMS personnel must be prepared to make the best medical, legal and ethical decisions within the context of their scope of practice. To do this, they must be familiar with the legal and ethical issues they are likely to encounter and the laws, policies and procedures put in place for their practice and protection.

Common areas of legal liability for EMS include the following:

Acts of omission: failure to

1. properly assess; monitor; take timely action; appropriately screen (dispatch problems).
2. follow prescribed policies; properly communicate.
3. document thoroughly and accurately.
4. exercise reasonable due care in treating the patient or ensuring an appropriate disposition (abandonment)

   Of particular are concern are refusal of service/non-transport of patients calls and/or patients who have altered or impaired mental status (determining decisional capacity).

Acts of commission (wrongful acts)

1. Assault and battery; slander and libel
2. Performing skills or monitoring medical interventions/equipment outside of your scope of practice (chest tubes)
3. Improperly performing skills within your scope of practice: dropping patients; improper use of restraint; false imprisonment
4. Unsafe vehicular operation
5. Unsafe use of equipment and/or equipment failure or deficiency
6. Disclosure of personal information (HIPAA violation)

Other areas of concern: Failure to maintain a current license to practice; providers who are impaired, fatigued, or have questionable readiness for duty; care of patients in law enforcement custody

The **best legal protection** is to perform within your duties and responsibilities and scope of practice, provide safe and appropriate assessments, care, and transportation (if needed); coupled with factual, accurate, complete and timely documentation.

Caveat: Laws differ from jurisdiction to jurisdiction. Be familiar with Federal and State laws in Illinois that impact EMS practice; NWC EMS System policies and procedures; rules and guidelines of your place of practice and the policies of your employer. Get competent legal advice for specific legal questions.

Primary function and Branches of law (Background information)

Laws are created to enforce and bind general customs of a community whose goals are establishing and preserving social order, peace, and protection of our freedoms.

Criminal law: Crime and punishment

Purpose of criminal laws: Governmental entities create and/or enforce laws of society. Federal, state, or local governments prosecute an individual on behalf of society for violating a law meant to prevent harm to society. EMS personnel have been sued under criminal law for alleged misuse of drugs, theft, and alleged sexual misconduct with patients.

Provisions: Under the criminal system, the state, through a prosecutor, has complete discretion to determine when and how to prosecute.

Burden of proof must be proven by the prosecution. Guilt must be proven **"beyond a reasonable doubt"**. All 12 jurors must agree, thus it may be harder to get a guilty verdict. Trial may result in a "hung jury" if they cannot all agree.

Punishments if found guilty: loss of money (fine); incarceration; or loss of life

Civil Law

These laws deal with issues of personal injury, contract disputes, and matrimonial issues. One party (plaintiff) feeling harmed by a particular action or actions of another party (defendant) seeks redress or remedy from the other party for an illegal act or wrongdoing (tort). Tort law protects private rights of individuals and organizations (rather than against society).

Private wrongs (torts)

1. Assault, battery
2. Defamation: slander, libel
3. Breech of contract
4. Negligent conduct causing personal harm

Burden of proof is on the plaintiff. Much lower standard to prove than criminal cases. Resultant harm is more likely than not due to the defendant's act or actions (**preponderance of evidence**: if more than 50% true, probably true). Only 9 of the 12 jurors must agree.

Punishment if found guilty: fines, injunctions

Standards used in these cases

- Contracts
- Statutes
- Regulations
- Customs

For full explanation of the steps in bringing a lawsuit, how to prepare for a deposition and essential rules of courtroom conduct – see the NCH Paramedic Program full outline on Legal Concepts

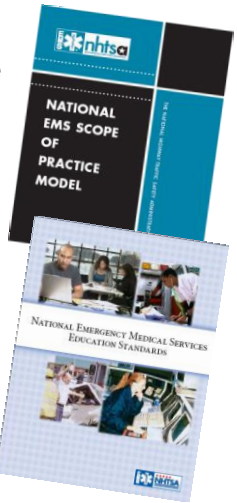
Standards of EMS practice/conduct

Legal **duties** are based on the **standards of care and the scope of practice** that are set by statue, rules, and local protocols.

Standards are considered to be broad, conceptual, and universally accepted. They may address professionalism, research, education, and practice.

- **Practice** is identified as the assessment and treatment of human physical and psychological problems.
- **Research** is the discovery and verification of knowledge on which EMS care is based.
- **Education** is the foundation of EMS and involves the EMS practitioner, patient, other members of the healthcare team, and the public.

The **Scope of Practice** is the range of duties and skills EMS personnel are allowed and expected to perform when necessary. In other words, how should an ordinary, reasonably prudent person perform given similar skills, training, and experience, under similar circumstances? **("Reasonable man theory")**



The professional EMS practitioner must exercise the superior judgment, skill and knowledge that they possess. They must **DO WHAT IS BEST FOR THE PATIENT within their SCOPE OF PRACTICE and local STANDARDS OF CARE.** Do not blindly follow orders that are medically or ethically inappropriate and may be harmful. Do not provide services that exceed your scope of practice.

Even within the **National Scope of Practice Model** (www.ems.gov) and the Illinois EMS Act, Rules, and Scope of Practice document, there are options that EMS Systems may or may not adopt. All entry level students must receive education as defined by the **National EMS Education Standards** on the full scope, but a System may not authorize them to be performed within their jurisdiction (surgical cric).

That is why ECRNs, paramedics, and increasingly EMTs, go through a process of **System entry** when they move to a new System. This process awards practice privileges in that System based on the local scope of practice and standards of care. For cause, an EMS MD may petition the state to allow expanded scopes of practice for their personnel.

EMS Act scope of practice in Illinois

Sec. 3.55. Scope of practice (selective sections).

(a) Any person currently licensed as an EMR, EMT, EMT-I, A-EMT, or Paramedic may perform emergency and non-emergency medical services as defined in this Act, in accordance with his or her level of education, training and licensure, the standards of performance and conduct prescribed by the Department in rules adopted pursuant to this Act, ***and the requirements of the EMS System in which he or she practices,*** *as contained in the approved Program Plan for that System. The Director may, by written order, temporarily modify individual scopes of practice in response to public health emergencies for periods not exceeding 180 days.*

(b) An EMR, EMT, EMT-I, A-EMT, or Paramedic may practice as an EMR, EMT, EMT-I, A-EMT, or Paramedic or utilize his or her EMR, EMT, EMT-I, A-EMT, or Paramedic license in pre-hospital or inter-hospital emergency care settings or non-emergency medical transport situations, under the written or verbal direction of the EMS Medical Director. For purposes of this Section, a "pre-hospital emergency care setting" may include a location that is not a health care facility, which utilizes EMS personnel to render pre-hospital emergency care prior to the arrival of a transport vehicle. The location shall include communication equipment and all of the portable equipment and drugs appropriate for the EMR, EMT, EMT-I, A-EMT, or Paramedic's level of care, as required by this Act, rules adopted by the Department pursuant to this Act, and the protocols of the EMS Systems, and shall operate only with the approval and under the direction of the EMS Medical Director.

This Section shall not prohibit an EMR, EMT, EMT-I, A-EMT, or Paramedic from practicing within an emergency department or other health care setting for the purpose of receiving continuing education or training approved by the EMS Medical Director. This Section shall also not prohibit an EMT, EMT-I, A-EMT, or Paramedic from seeking credentials other than his or her EMT, EMT-I, A-EMT, or Paramedic license and utilizing such credentials to work in emergency departments or other health care settings under the jurisdiction of that employer.

(c) An EMT, EMT-I, A-EMT, or Paramedic may ***honor Do Not Resuscitate (DNR) orders*** *and powers of attorney for health care only in accordance with rules adopted by the Department pursuant to this Act and protocols of the EMS System in which he or she practices.*

(d) ***A student*** *enrolled in a Department approved EMS personnel program, while fulfilling the clinical training and in-field supervised experience requirements mandated for licensure or approval by the System and the Department, may perform prescribed procedures under the direct supervision of a physician licensed to practice medicine in all of its branches, a qualified registered professional nurse, or qualified EMS personnel, only when authorized by the EMS Medical Director.*

(Source: P.A. 99-862, eff. 1-1-17; 100-108, eff. 1-1-18.)

#1 What defines a paramedic's local scope of practice within the NWC EMSS?

_____

#2. What 4 documents are considered the basis of our standards of practice?

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Other sources of EMS standards of practice (See Introduction page of SOP)

1. Statutes that impact EMS care – tons of them (HIPAA, EMTALA, emergency vehicle laws, Good Samaritan laws, Ryan White Act)
2. Local **policies and procedures:** local employers may set more stringent or specific standards through written and verbal treatment protocols.
3. Organizations may establish guidelines or recommendations that impact EMS practice
   - American Heart Association (AHA) CPR and Advanced Cardiac Life Support (ACLS) and Advanced Pediatric Life Support (PALS) Guidelines
   - American College of Emergency Physician (ACEP) International Trauma Life Support (ITLS) course

- American College of Surgeons (ACS) Prehospital Trauma Life Support Course
- Brain Trauma Foundation (BTF) standards for management of severe brain injury
- EMS textbooks and journal articles at the time of the incident; educational materials (CE handouts!)

LIABILITY: Something for which one is legally obligated

Scope of liability: Others, besides the EMS practitioner, may be co-liable for their negligence. This is known as indirect liability (employer, physician, educators).

Borrowed Servant Doctrine: Employer "lends" his or her employee's services to another who, under this doctrine, becomes co-liable for the borrowed servant's wrongful conduct (EMS personnel have a license, but provide medical care under the authorization of the EMS MD).

Respondeat Superior - "Let the master answer"

The question of liability rests on whether or not persons treating the patient are independent agents who are responsible for their own acts or employees answerable to an EMS agency and/or hospital medical control. Physicians are often independent contractors, but EMTs and paramedics are not.

This doctrine makes the employer liable for the consequences of their employee's wrongful conduct provided the employee is acting within the scope of their employment and the employer has some directing control over the employee's actions.

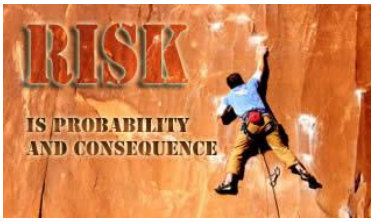
NEGLIGENCE

Definition: Conduct, act or omission, which falls below the standard established by law for the protection of others against unreasonable risk of harm and is caused by heedlessness or carelessness which makes the negligent party unaware of the results which may follow from their act. Under ordinary negligence, there is usually no intent.

The earliest appearance of what we know of negligence was in the liability of those who professed to be competent in certain "public callings" such as innkeepers, blacksmiths, or surgeons, i.e., those who held themselves out to the public as one in whom confidence might be reposed and hence, had an obligation to give proper service. A breach of service was considered a negligent act for which they might be liable.

When someone's negligence causes injury, the injured party can seek civil suit against the wrongdoer. This is to protect the private right not to be injured by someone's negligence, actions or acts.

Risk



Behavior involving unreasonable danger to others is a matter of risk. Even in doing things that are customary where common knowledge and judgment recognizes an unreasonable danger, **"what everyone else does" may still be negligent conduct.**

Foreseeable risk: A recognizable danger or possibility of injury based on knowledge of existing facts and some reasonable belief that harm may follow an action or intervention.

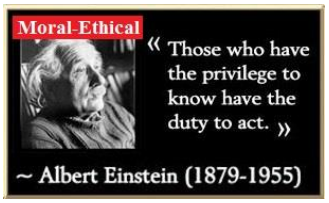
Risk/benefit analysis: EMS personnel must always weigh the degree of risk versus potential or expected benefit when providing care to a patient. If the risk is appreciable and the possible consequences are great, the precautions taken must be proportionately great.

When risk is slight, you are free to proceed on the assumption that others will exercise proper care.

When risk is great, reasonable care demands precautions against the occasional negligence which is one of the ordinary incidents of human life, and therefore to be anticipated. A duty (where the risk is great) arises to take precautions against the negligence of others, thus becoming a matter of customary process.

EMS personnel may generally rely on the routine functional duties of others. Yet if the risk is great, it is not reasonable to rely on the conduct of others (your partners) if you are equally responsible for the patient. **(Example, you should never give a drug in an unmarked syringe that someone else has drawn up unless there are extraordinary extenuating circumstances).**

ELEMENTS of NEGLIGENCE: All four must be proven to the satisfaction of the judge or the jury or the case will fail as a matter of law. The mere occurrence of a bad result or unsatisfactory outcome after treatment is not necessarily negligence or malpractice.



Duty

Duty is an obligation, to which law gives recognition and effect, to conform to a particular standard of conduct towards another for the protection of a patient against unreasonable risk of injury. This duty derives from the relationship between the patient and the practitioner that obligates the caregiver to act in a certain way toward the patient. **One of the first duties of EMS personnel is *Primum non nocere* which means, FIRST DO NO HARM.** If one fails to perform according to that standard, he or she becomes subject to liability to the person to whom the duty is owed for the damages sustained.

A plaintiff must first establish that an EMS practitioner had a duty to act (recognition of a legal relationship between the parties or an obligation on behalf of the practitioner to provide treatment to a patient) through a formal contractual or informal legal obligation.

Duty can always be assumed, and once assumed, the law presumes ordinary negligence standards. No duty is imposed upon a person to take precautions against events that cannot reasonably be foreseen. Duty is only owed to foreseeable plaintiffs (*foreseeability doctrine*).

EMS duties may include, but not be limited to the following:

- Duty to obey federal, state, and local laws and regulations
- Checking all drugs/equipment when coming on duty and taking all necessary actions to ensure that all are present and functioning properly. (Controlled substance counts and logs).
- Duty to respond to the scene safely in a timely manner and to render care to ill or injured patients
- Duty to operate an ambulance reasonably and prudently
- Duty to provide assessment, care, and transportation consistent with their scope of practice to the expected standard of care per local EMS protocols
- Duty to continue care through to appropriate conclusions

Personal duties

- Obligation to maintain current license
- Duty to attend CE and maintain knowledge and skills
- Duty to maintain physical and emotional well-being to the best of your ability to remain fit for duty

Review new policy R1: Relicensure/ Reinstatement/Dropping to lower level of licensure: EMT/PM/PHRN

3. What actions are needed in order to renew an EMS license? What must the individual do? Who must contact the Resource hospital? What must Connie do at the Resource hospital?

_____

_____

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4. What actions are necessary if a paramedic wishes to drop to EMT-B status? Who must they contact and what must they submit to the Resource Hospital?

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5. What actions are necessary if a paramedic wishes to reinstate their paramedic license after dropping to EMT-B status?

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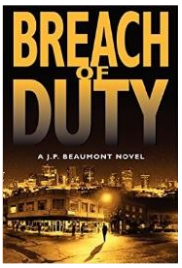
Breach of duty

A defendant's conduct falls short of that required by the standard of care. This is often referred to as a departure or deviation from good and accepted practice. The plaintiff must prove that the defendant failed to act as would a reasonably prudent person with the same or similar training facing similar circumstances.



Malfeasance: Performance of a wrongful or unlawful act. Paramedic assaults a patient.

Misfeasance: Performance of a legal act in a manner that is harmful or injurious. Gave the wrong medication or an inappropriate dose, intubated the esophagus.

Nonfeasance: Failure to perform a required act or duty. Examples: Failed to take vital signs in a timely manner, failed to defibrillate VF, failed to inform medical control of adverse patient changes.

Proof of breach is twofold

- It must be shown what, in fact, happened. This may be established by direct or circumstantial evidence. Other matters may also be entered into evidence, i.e., custom or usage and applicability to a statue such as the Il EMS Act.
- It must be shown from these facts that the defendant acted unreasonably compared to how other persons would be expected to act under similar circumstances.

Res Ipsa Loquitur *(The thing speaks for itself).* In some cases, negligence may be so obvious that it does not require extensive proof. Three conditions must be met:

- An event must be of such a kind that does not occur in the absence of someone's negligence.
- Must be caused by an agency or be instrumentally within the exclusive control of the defendant.
- Must not have been due to any voluntary action or contribution on the part of the victim.

***Negligence per se*:** If a person violates a statute and injury to a plaintiff occurs - automatic negligence. After this doctrine is invoked, the burden of proof shifts from the plaintiff to the defendant. Defendant must prove why they are not guilty of the charge. These cases are often settled out of court.

Damages:

The patient must have suffered an injury that the law recognizes and for which it will provide monetary compensation. There is a Latin phrase in legal literature, *de minimis non curat et lex*, meaning, the law has no cure for trifles or small things.

Compensatory: Six categories can be used to determine patient damages:

1. **Medical expenses:** Plaintiff can recoup costs for certain medical expenses incurred due to the defendant's actions. (i.e., esophageal intubation).
2. **Lost earnings:** Sum total of money the patient did earn or might have earned if the capacity to earn had not been interrupted by subsequent injury or death. They include not only the current earning power, but also future earning potential. This may be particularly high if the patient was young, upwardly mobile, and had legal dependents.
3. **Conscious pain and suffering:** To recover these damages, the patient must have remained conscious for "at least a momentary period of time".
4. **Disability**
5. **Wrongful death:** The breach of duty resulted in the death of the plaintiff. The actual amount of damages awarded depends on individual state statutes or culpability rules.
6. **Loss of consortium:** It must be argued that the alleged negligence prematurely took the expectancy of companionship from the living spouse.

Punitive damages: Awarded when the defendant is found to be "wanton and reckless" or to have intentionally violated statutes in the commission of the negligent act. Designed to punish the defendant to such a degree so as to set an example for others not to commit the same action. Can only be awarded for acts of gross negligence or willful and wanton misconduct. Most insurance companies will not cover punitive damages. Paramedics or their employer may become personally liable for any punitive damages awarded to the plaintiff.

Proximate cause

The plaintiff must prove a reasonable direct causal connection between the defendant's conduct and the resulting injury. The defendant's action or inaction must have caused or worsened the damages suffered by the plaintiff. The suit will not be successful unless the plaintiff can prove that the defendant's negligent conduct (breach of duty) caused injury that would not have otherwise occurred. This is one of the most difficult elements to prove.

It also deals with the foreseeability of the consequences of one's actions or omissions. If proximate cause is foreseeable, a duty is established to prevent unreasonable risk of harm.

Legal responsibility must be limited to causes that are so closely connected with the result and of such significance that the law is justified in imposing fault and liability.

Degrees of negligence

Slight: Failure to exercise great care; or that degree of care and vigilance which persons of extraordinary prudence and foresight are accustomed to use.

Ordinary or simple: Failure to use reasonable standards of care resulting in a mistake in treatment that a reasonable provider would not have made. Basis of most malpractice suits.

Gross: Failure to use scant or slight care that even a careless person would use.

Willful and wanton: A person proceeded in a manner that was so reckless as to be beyond the scope of simply being negligent or careless to the point of being dangerous. It is assumed that the **person acted with knowledge that a harm was substantially certain to occur due to their actions**. This may be so severe as to subject the person to criminal prosecution. Malpractice insurers may disallow claims for acts of gross or willful and wanton negligence.

Malpractice: Negligence suit against a professional

Definition: Any professional misconduct, *unreasonable* lack of skill or fidelity in one's professional or fiduciary duty. More specifically, it means wrong or injudicious treatment of a patient and a failure to use such reasonable and ordinary care, skill, and diligence as other reasonably prudent persons in good standing with the same education and experience would use under the same or similar circumstances. It results in injury, unnecessary suffering, or death to a patent. It refers to one proceeding from ignorance, carelessness, lack of proper professional skill, disregard of established rules or principles, neglect, or a malicious or criminal intent.

An allegation of malpractice does not necessarily mean the professional is incompetent. It does imply that one may have made a mistake for which compensation is allowed. Only the conduct in that specific circumstance may be examined, not the person's conduct in general.

Professional misconduct toward a patient is considered reprehensible because it is immoral in itself; contrary to law; and is expressly forbidden by law.

Defenses and immunity (exemption from legal liability)

Liability may be avoided if a defense can be established to the plaintiff's claim. **Defenses to negligence include the following:**

- Show no liability - no duty to act.
- Crush plaintiff's credibility; what is claimed is not true
- Show no damages
- Show no causation; no linkage to your actions or conduct
- **Assumption of the risk**: This is the defense when consent/refusal forms are signed or injury occurs when instructions are ignored. Thus, the patient has assumed responsibility for the risk and is also responsible for the injury. Protection for EMS includes the use of very specific refusal forms that are signed by the patient/guardian and the PM.

Comparative negligence: Determines if negligence was shared by the defendant and plaintiff and to what extent or percentage. The defendant must be judged to be 51% negligent for an award to be made to the plaintiff.

Contributory negligence: The plaintiff's conduct contributed to the harm that they suffered in that their conduct fell below the standard to which he or she is required to conform for their own protection, i.e., use of vehicle restraint devices. In these cases the burden of proof falls to the defendant.

Immunity provisions: A plaintiff is prohibited from pursuing a claim or collecting damages, even if it appears valid if one of the following are invoked:

- **Good Samaritan Laws**: Provides immunity to those who assist at the scene of an emergency. See EMS Act immunity statement below (c3). Good Samaritan laws go into effect when a "duty to act" does not exist. By accepting compensation you assume a "duty to act". The situation must be a true emergency with potential for loss of life or limb. Care must be given in good faith (no gross negligence); and no abandonment may occur once care is commenced. Good Samaritan laws vary from state-to-state. Some states obligate a person who encounters a medical emergency to provide assistance to the best of their ability.
- **Statutes of limitation are exceeded**: Sets the maximum time period during which certain actions can be brought in court and vary from state to state. Also vary for cases involving children.
- **Immunity statutes/governmental immunity - Illinois Immunity Statue from EMS Act** (210 ILCS 50/3.150) Sec. 3.150. Immunity from civil liability. (Source: P.A. 95-447, eff. 8-27-07.)

  (a) *Any person, agency or governmental body certified, licensed or authorized pursuant to this Act or rules thereunder, who in good faith* ***provides emergency or non-emergency medical services*** *during a Department approved training course, in the normal course of conducting their duties, or in an emergency, shall not be civilly liable as a result of their acts or omissions in providing such services* ***unless such acts or omissions****, including the bypassing of nearby hospitals or medical facilities in accordance with the protocols developed pursuant to this Act,* ***constitute willful and wanton misconduct****.*

  (b) No person, including any private or governmental organization or institution that ***administers, sponsors, authorizes, supports, finances, educates or supervises the functions of emergency medical services personnel*** *certified, licensed or authorized pursuant to this Act, including persons participating in a Department approved training program, shall be liable for any civil damages for any act or omission in connection with administration, sponsorship, authorization, support, finance, education or supervision of such emergency medical services personnel, where the act or omission occurs in connection with activities within the scope of this Act,* ***unless the act or omission was the result of willful and wanton misconduct.***

  (c) Exemption from civil liability for emergency care is as provided in the ***Good Samaritan Act****.*

  (d) No local agency, entity of State or local government, or other public or private organization, nor any officer, director, trustee, employee, consultant or agent of any such entity, which sponsors, authorizes, supports, finances, or supervises the ***training of persons in the use of cardiopulmonary resuscitation, automated external defibrillators, or first aid*** *in a course which complies with generally recognized standards shall be liable for damages in any civil action based on the training of such persons unless an act or omission during the course of instruction constitutes willful and wanton misconduct.*

  (e) No person who is certified to ***teach the use of cardiopulmonary resuscitation, automated external defibrillators, or first aid*** *and who teaches a course of instruction which complies with generally recognized standards for the use of cardiopulmonary resuscitation, automated external defibrillators, or first aid shall be liable for damages in any civil action based on the acts or omissions of a person who received such instruction, unless an act or omission during the course of such instruction constitutes willful and wanton misconduct.*

  (f) No member or alternate of the State Emergency Medical Services Disciplinary Review Board or a local System review board who in good faith exercises his responsibilities under this Act shall be liable for damages in any civil action based on such activities unless an act or omission during the course of such activities constitutes willful and wanton misconduct.

  (g) No ***EMS Medical Director*** *who in good faith exercises his responsibilities under this Act shall be liable for damages in any civil action based on such activities unless an act or omission during the course of such activities constitutes willful and wanton misconduct.*

  (h) Nothing in this Act shall be construed to create a cause of action or any civil liabilities.

Government privilege: Example - need to save a life or put out a fire etc. Public Duty Rule: Judicial doctrine that prohibits a person from bringing a lawsuit against a government or individual without its consent is usually assumed under a "Public Duty Rule". The Illinois Supreme Court struck down this rule on January 22, 2016 in a split decision MARCUS COLEMAN, as Successor Adm'r of the Estate of Coretta Coleman, Deceased, Appellant, v. EAST JOLIET FIRE PROTECTION DISTRICT et al., Appellees. …"Accordingly, we **hereby abolish the public duty rule and its special duty exception.** Therefore, in cases where the legislature has not provided immunity for certain governmental activities, traditional tort principles apply. Obviously, if the legislature determines that the public policy requires, it may codify the public duty rule, but we defer to the legislature in determining public policy. Supra ¶ 59." **IDPH upholds EMS immunity to ordinary negligence** as it is codified in law.

CONFIDENTIALITY (Policy C-7 Confidentiality of Pt Records)

All records and information related to the emergency care rendered to a patient must be kept strictly confidential. Medical information about a patient must not be shared with any third party without the patient's consent unless there is a legitimate medical or legal reason to do so. Unwarranted intrusion into the private affairs of another such as releasing or allowing someone else to reveal private information about a patient to any unauthorized person/agency becomes a **breach of confidentiality**.

The **Privacy Rule** published by the U.S. Department of Health and Human Services (HHS) is a significant portion of **HIPAA** (Healthcare Insurance Portability and Accountability Act of 1996). Major provisions include the following:

1. All agencies that have electronic patient care records must appoint a **Privacy Officer** to guide compliance efforts.
2. All **Protected Health Information (PHI)** related to patient care must be kept strictly confidential within the provisions of the Privacy Rule.
3. Organizations must provide a **"Notice of Privacy Practices"** to all patients.
4. Unwarranted intrusion into the private affairs of another such as releasing private information about a patient to any unauthorized person/agency becomes a **breach of confidentiality**.
5. The revealed information does not have to be harmful - it only needs to have violated privacy.
6. **To avoid**: Do not discuss or release private patient information with or to unauthorized individuals or in a public place. Print only de-identified PCRs for Field Internship paperwork. Incidental disclosures are addressed by the Rule. **Do not post anything relative to PHI on social media.**

Patient information may generally be released under the following conditions:

1. Patient consents for release of records to a physician, an insurance company, an attorney, or some other party
2. Medical necessity: Sharing of information with other members of the healthcare team who are caring for the patient
3. Billing and insurance purposes
4. Properly executed subpoena
5. Mandatory reporting statutes
6. Quality improvement/management reviews
7. Law enforcement: Review local rules regarding release to police officers

Violations and Penalties for HIPAA noncompliance

The consequences, as a HIPAA-covered entity or business associate, for not complying with the Privacy and Security Rules can put you into serious debt to the HHS Office of Civil Rights (OCR).

Failure to conduct and execute a Security Risk Assessment

Example: Triple-S Management Corporation (11/30/2015): After receiving five breach notices from Triple-S from November 2000 through March 2015, OCR investigated and alleged widespread violations, including failure to implement appropriate administrative, physical and technical safeguards; failure to use minimum necessary PHI, failure to conduct a thorough risk analysis of all IT equipment and data

systems; failure to implement security measures sufficient to reduce risks and vulnerabilities to ePHI; failure to implement procedures for terminating access by separated employees; and impermissible disclosures to vendors of ePHI without business associate agreements. **Result: $3,500,000 settlement and three-year Corrective Action Plan (CAP).**

Device Encryption & Controls (examples of violation)

Advocate Health Care reported the second largest HIPAA data breach to date (2013) after four unencrypted laptops were stolen from its facility, compromising the protected health information and Social Security numbers of more than 4 million people. It is alleged that the unencrypted laptops were stolen from an unmonitored" room, one with "little or no security to prevent unauthorized access." Advocate announced that the theft occurred at one of its Medical Group administrative buildings in Park Ridge. Patient names, addresses, dates of birth, Social Security numbers and clinical information – including physician, medical diagnoses, medical record numbers and health insurance data were all contained on the computers.

Data Access Controls

New York-Presbyterian Hospital & Trustees of Columbia University: The ePHI of 6,800 individuals was inadvertently made accessible through Internet search engines after a Columbia physician, who developed applications for both NYP and Columbia, attempted to deactivate a personally-owned computer server from a hospital network containing ePHI. After the breach was reported, OCR investigated and alleged that neither NYP nor Columbia had conducted a security risk assessment or complied with their own data security policies and procedures. *Result:* $3,300,000 settlement by NYP, $1,500,000 settlement by Columbia, three-year CAPs.

Malware Protection

Anchorage Community Mental Health Services, Inc. The ePHI of 2,743 individuals was inadvertently disclosed due to malware that compromised security of the covered entity's information technology systems. After the breach was reported, OCR investigated and alleged that ACMHS failed to conduct a security risk assessment or implement necessary patches and upgrades to its information technology systems. Result: **$150,000 settlement and two-year CAP.**

Social Engineering

University of Washington Medicine An employee opened a phishing email attachment, releasing malware that compromised approximately 90,000 patients' ePHI in the organization's IT system, including Social Security numbers and insurance ID cards. After UWM reported the breach, OCR investigated and alleged that, though UWM's security policies required affiliates and partners to have up-to-date, documented system-level risk assessments and to implement safeguards, UWM did not ensure its affiliates were properly conducting their risk assessments and responding to risk and vulnerabilities. *Result:* $750,000 settlement and two-year CAP.

Physical Security

Lahey Hospital and Medical Center : A laptop with ePHI of 599 individuals, attached to a portable CT scanner, was stolen from an unlocked room during overnight hours. After Lahey notified OCR of the breach, OCR investigated and alleged failure to conduct a thorough risk assessment for all ePHI, failure to physically safeguard workstation with ePHI, failure to implement unique user names to identify and track users, and failure to document workstation activity. *Result:* $850,000 settlement and three-year CAP.

So, what lessons can we learn from these HIPAA enforcement actions to avoid risk for EMS?


The News&Observer
Verdict in agent's libel case against N&O could top $6M
In contentious debate, Tru refuses to say he'd accept

- OCR enforcement is on the rise, and penalties for HIPAA violations are high and likely will remain high. OCR indicates it will focus on covered entities with patterns of violations, and while larger entities are often in the cross-hairs, smaller organizations are also at risk.
- Almost every settlement agreement emphasizes the duty to conduct, and continuously update, an enterprise-wide risk assessment for ePHI, both internally and externally, and owned or controlled by the covered entity,
- Remember that you must also safeguard PHI in **paper records**! Cornell Prescription Pharmacy learned this the hard way in April 2015, after OCR discovered through local Denver news reporting that Cornell disposed of unsecured documents containing PHI of 1,610 patients in an unlocked, open container on Cornell's premises. Cornell settled for $125,000 and a two-year Corrective Action Plan, a less painful result than the $800,000 settlement in 2014 by Parkview Health System for unsecure handling of paper patient medical records (Hiser, 2016).

DEFAMATION of character

This involves injury to a person's character, name or reputation by intentional false or malicious accusations that injure another person's reputation or good name without legal privilege or consent of the individual. May also include publishing by videotape.

Libel: Intentional tort that consists of making **false written statements** about another person with knowledge of the falsity of the statements or with reckless disregard for whether the statements were false. These statements are of a nature that may injure a person's character, name, or reputation.

To avoid: Write thorough, accurate, and confidential written reports. Avoid using slang terms or labels. Truth is an absolute defense.

Slander: Intentional tort consisting of **oral false statements** made about another person with reckless disregard for whether or not the statement was false. These statements are of a nature that could injure a person's character, name or reputation decreasing an individual's personal esteem by the community; place of employment or in their position.

To avoid: Limit oral reporting to appropriate personnel and don't discuss patients ANYWHERE other than privately in the appropriate place and only with those who have a need to know.

CONSENT

Definition of consent: Voluntary permission is given to another to act, operate or function in a certain manner. The most common examples are consents for medical treatment and consents for disclosure of medical information.

Purpose of consents: In the absence of unusual and special circumstances, giving emergency care requires a patient to give consent for that care. Consents serve to protect both the patient from unwanted, unapproved touching or treatment and the health care provider against legal claims of unauthorized treatment.

At common law, a *decisional* patient must consent before medical treatment is rendered. He or she has the right, arising out of the constitutional right of privacy, to refuse treatment, even if doing so will result in serious consequences or death. Every individual has the right to the possession and control of his own person, free from all restraint or interference of others unless by clear and unquestionable authority of law.

Scenario #1

You are called for a 65 y/o male found walking with a tilting gait across a golf course toward the clubhouse following a large tournament. His speech is slurred and he is moving slowly with significant ataxia. He cannot touch his fingers to his thumb, his pupils are large and his eyes are bloodshot. He has the strong odor of alcohol on his breath. He knows his name but cannot remember where he parked his car and says he called his wife to come pick him up. He does not want you to do any assessment, and is refusing to come with you to the hospital. He's threatening to sue you if you so much as touch him.

6. Does this patient have the legal capacity to consent or to refuse care? Explain your answer:

When he is asked why he does not wish an assessment or transport, he states that he already has a DUI on his record and does not want an ED visit showing him to be intoxicated while he is on probation and is required to stay sober.

7. Should you allow him to refuse and leave him at the club house to wait for his wife as he wishes? If this option is selected, could it constitute abandonment?

8. Should you sit with him until his wife arrives without completing an assessment? Why or why not?

9. What assessments are critical for you to attempt to complete?

IMC special considerations:

10. If those assessments show him to be hemodynamically stable without clinical deficits, and his ataxia continues to clear over time, what is your best course of action?

Factors considered in determining if a patient can consent to or refuse care:

1. Does the patient have the **legal capacity to consent**? Is the patient of legal age? In most states, this is 18 or they must be declared a mature or an emancipated minor.
2. Does the patient have the **decisional capacity to consent at the moment**? Decisional capacity is not a permanent state.

- Assess the patient's mental status. Evaluate their ability to respond appropriately to questions.
- Does the patient understand the extent and severity of their condition?
- Do they have the ability to manipulate the information?
- Can they understand the consequences associated with accepting or refusing the recommended care? Does the patient have the ability to communicate a choice?

Magauran writes, “Courts have recognized that patients who do not acknowledge their illness (often referred to as ‘lack of insight’) cannot make valid decisions about treatment.”

3. Decisional capacity ***could*** be impaired by the following so must be carefully assessed:

- Presence of hypoxia, hypercarbia, hypoperfusion, severe pain, and shock
- Drug or alcohol intoxication producing impairment. A patient with a breath blood alcohol level of 0.41, an extremely unsteady gait, impaired rapid alternating movements, slurred speech, and/or nystagmus has impaired capacity to make medical decisions. Once the patient metabolizes the alcohol, they’ll regain capacity, but it’s intoxication with impairment and not mere consumption of alcohol that makes the patient incapable of medical decision-making (Selde, 2015).
- Unusual behavior; combativeness, altered mental status, excited delirium, brain injury, delirium, or dementia
- Mental illness

A patient who is not alert and oriented can't have decisional capacity. Nor can a patient who is psychotic, suicidal, or homicidal. If providers believe in their medical judgment that the patient lacks decision-making capacity, actions should be undertaken to ensure the patient's best interest. **A patient's lack of insight into their medical condition can show a lack of capacity** (Selde, 2015).

Expressed consent: An expressed consent is made known by a patient in a direct and positive manner, usually by the patient orally, communicating his/her consent or by the patient signing a consent form. Expressed consents are unequivocal and clear so as not to require any inference to support the fact that it was given by the patient. Expressed consent is not necessarily informed.

Informed consent

- Informed consent is an **ethical and legal** concept that relates to medical decision-making. It's a generally accepted duty of the care provider, and right of the patient, to obtain informed consent. It can be defined as the process by which the care provider seeks the affirmative allowance of the patient to provide healthcare after apprising the patient of the benefits and risks of the proposed treatment. In this way, the provider respects the **autonomy** of the patient and their **right to goals.** Ridley states, "Maximization of respect for patient autonomy and bodily integrity—rather than the imposition of the doctor's professional values—is what application of the doctrine of informed consent should endeavor to achieve" (Selde, 2015).

  - An informed consent is given by a decisional patient after the patient has been advised of the probable risks and other related information about the proposed treatment. True informed consent is meant for higher risk activities such as surgery. EMS is not held to that same standard.

- Whenever possible, EMS personnel shall explain proposed treatments or procedures to the patient and, when appropriate, the family. In cases of extreme emergency or urgency, explanations of care may need to occur simultaneously with the interventions.

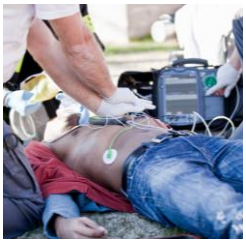
Five basic tenants are accepted as the foundation of informed consent (Lu & Adams, 2015)

- The patient must have sufficient information about his or her medical condition.
- The patient must understand the risks and benefits of available options, including the option not to act.
- The patient must have the ability to use the above information to make a decision in keeping with his or her personal values.
- The patient must be able to communicate his or her choices.
- The patient must have the freedom of will to act without undue influence from other parties, including family and friends.

- Consent for EMS care is generally expressed verbally, but the System requires written signatures for withholding of consent for assessments, interventions, and/or transport.

Implied consent: Consent is not expressed but results from the circumstances of the particular case or the status of the patient.

- **Circumstantial consent:** Patient's conduct, action or even inaction acknowledges the act is occurring cooperatively or without objection. Implied consents are not expressed by speech or by signing a consent form. Ex: Patient extends his arm when you tell him you need to take his blood pressure; holding out a hand to take a pill with the expectation of receiving and swallowing the pill. It is permissible to accept this type of implied consent with the treatment poses **no inherent or expected risks** to the patient.



- Incompetent or **nondecisional** patients cannot make any decisions about their care, either to consent or to withhold consent. When the patient lacks the ability to make a rational judgment about treatment due to impairment, it is reasonable to believe that they would grant consent if conscious and decisional (**emergency doctrine**). This "emergency exception" would probably extend to virtually any medical procedure necessary to preserve the life of a patient. **However, "where a patient is in full possession of all his mental faculties and in such physical health as to be able to consult about his condition," the patient's consent is required (Barnes v Hinsdale Hospital).**

To rely on this doctrine, the provider must show that a real medical emergency existed and that the patient was unable to understand the nature of his injuries and the potential risks and alternatives associated with accepting or rejecting treatment.

Implied consent is only in effect until the patient no longer requires emergency care or until they regain decisional status.

Situations where consent is thorny and possibly disputed

- **Incompetents:** If a patient has been adjudicated an incompetent through court proceedings, there will typically be a guardian, a trustee, or a conservator who will have legal authority to grant consent for treatment.
- **Refusals** (Policy. R-6 Refusal of Care) – Largest area of EMS litigation.

Informed refusal applies the concepts of informed consent to refusal of care. It's similar in that informed refusal seeks to **best respect the decisions of the patient while balancing the provider's duty to care for the patient** (Selde, 2015). EMS' duty is to inform a patient of the need for care or transportation and reasonably known consequences of failing to accept that course of action. However, EMS cannot force such care on a patient. Courts have consistently ruled that the right to refuse medical care is a fundamental right that has origins both in common law and the constitutional right to privacy, as long as the patient is decisional. Any authorized party who has the authority to consent to care has the authority to refuse it.

Despite that, releases and refusals may not be legally binding. A refusal signed by a patient is, under the best of circumstances, an easily attacked document during litigation.

The standard for informed refusal is the same as for informed consent.

Many people refuse treatment out of fear, denial and emotional distress. EMS personnel have a duty to attempt to convince the patient to receive care. However, a conscious, decisional adult or emancipated minor has the right to refuse care.

Before accepting a refusal, **obtain and document** the following (unless impossible to obtain due to persistent patient refusal to cooperate):

1. **Evidence of decisional capacity**: Mental status: level of consciousness, orientation, ability to understand circumstances and consequences of decision; lack of impairment from alcohol, drugs, disease
2. Vital signs; blood glucose level; SpO_2
3. Physical exam findings as known at the moment
4. Past medical history

To be binding, the person withholding consent must be able to understand what they are signing and the implications of the release. The patient should be counseled in plain language that they can understand without any undue attempt to influence their choice. EMS **disclosure of risk**:

1. Nature of the illness/injury
2. Nature of the recommended treatments
3. Purpose and need for the recommended procedure/treatment
4. Potential benefits and drawbacks
5. Known possible risks and complications of recommended treatment
6. Known possible results of non-treatment
7. Any significant alternatives for treatment

Risks that are very remote and improbable can generally be omitted from the disclosure as not material or important to the patient's decision.

Then the patient should be asked to recount in their own words what they've been advised. At this point, any misunderstandings can be addressed. A patient who is **unable to repeat back t**he risks you've advised them of is providing clear evidence that they don't understand their medical situation.

A decisional patient or healthcare surrogate can **change his or her mind** and withdraw consent for treatment at any time. If all attempts to gain consent fail, it is important to let the patient know that, should he change his mind, you are willing and ready to help them.

Decisional patients have the right to make medical treatment decisions that may result in deterioration and even death. A patient may not withhold consent (refuse care) if they are homicidal, suicidal, or deemed non-decisional.

CAREFUL DOCUMENTATION IS ESSENTIAL!! Having the patient sign a refusal form is not enough! You need supporting documentation. Note all attempts to convince the patient to receive care, evidence of decisional capacity, evidence that disclosure of risk was provided and understood, and obtain patient signatures in the appropriate sections on the form and/or PCR.

Call nearest System hospital from the scene unless exempted by policy.

Against Medical Advice (AMA) refusals – see Policy R6

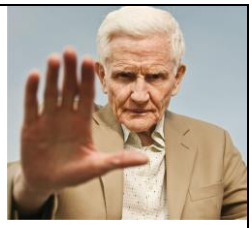
- **POLST forms with DNR Orders;** Non-decisional patient who has designated another with **Durable Power of Attorney for Healthcare. See System Policy D5.**

  POLST forms with DNR orders provide specific instructions regarding CPR, defibrillation and intubation. The provider should be sure to confirm that the order is valid before resuscitative efforts are withheld. If there is concern regarding validity or applicability of the DNR order, it's reasonable and appropriate to initiate resuscitation. When doubt exists regarding a DNR order, EMS personnel are encouraged to act under the principle of **beneficence** and proceed with full treatment and resuscitation (Lu & Adams, 2015).

  Power of attorney papers identify a decision-maker **when the patient is no longer able to make a decision.** This privilege can be **subdivided into legal and medical realms**. Often, local laws designate a surrogate decision-maker if the patient hasn't done so. For instance, a husband is usually the default decision-maker for his wife. By definition, the power of attorney doesn't apply until the patient can't make decisions. As with DNRs, EMS providers must verify the validity and applicability of the proxy decision-maker. In cases where a proxy decision-maker is refusing care on behalf of the patient, the decision-maker should be informed just as one would inform the patient (Selde, 2015).

  Living wills are documents that make a patient's wishes known if they're unable to express them. They're often broad in scope and vary in their specificity. Living wills help to guide the primary care practitioner and decision-makers but are not binding on EMS.

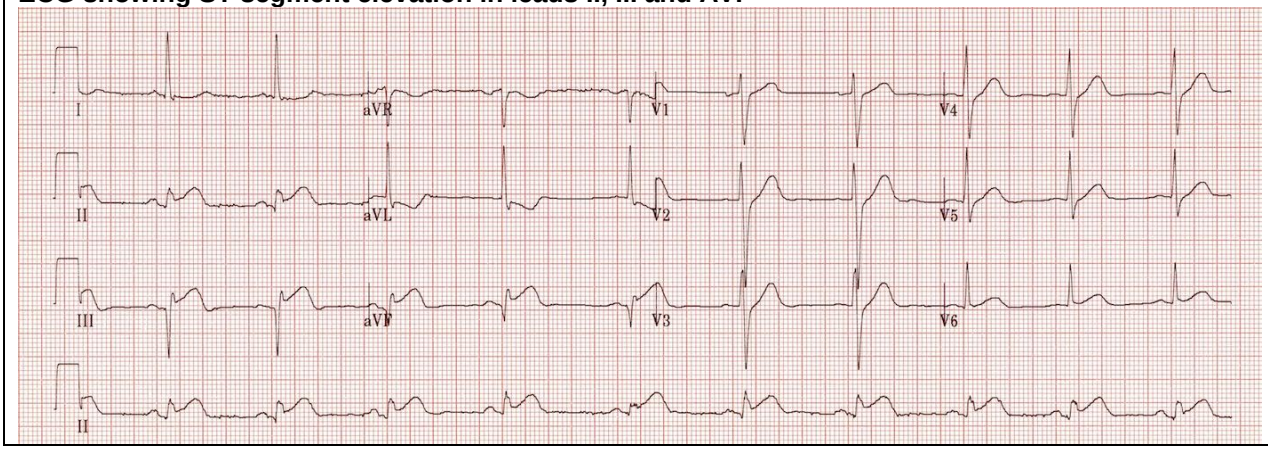
Scenario #2



An ambulance is called for a 72 y/o male who is having chest pain. The calling party states her father called her because he wasn't feeling well. She is not on scene. Upon arrival, you find an elderly male in some distress. He is ill-appearing and clutching his chest. He appears awake and alert, tracking you with his eyes as you approach. The patient states he had a sudden worsening of his daily chest pain and feels nauseous. This all started about three hours prior to your arrival.

VS: BP 102/68; P 80; R 16; SpO2 92% on room air.
12L ECG shows ST elevation in leads II, III, and AVF with some ST depression in AVL
The monitor readout says Acute myocardial infarction (See below).

ECG showing ST segment elevation in leads II, III and AVF



The patient tells you he already took his 325 mg aspirin today when you try to give him ASA. He also states that he already took three sublingual nitroglycerin tablets without relief.

His daughter arrives on scene and is understandably concerned about her ill-appearing father. You advise the patient it looks like he's having a heart attack. He says, "The heart doctor told me this might happen. He also said that I needed bypass surgery. I told them they aren't going to saw me in two and crack my chest open." You tell the patient that you strongly recommend that he go to the hospital to be evaluated and he declines. At this point his daughter steps in and says, "I'm his power of attorney; I want him to go to the hospital." She then produces official-looking paperwork (Selde, 2015).

11. Is this patient legally able to refuse? Why or why not?

12. How does the healthcare power of attorney present on scene impact the patient's right to refuse? What would you need to explain to the daughter about the POA status?

13. What would you need to ask the patient and what would he need to say back to you to ensure that he understands the gravity and consequences of his choice?

14. When you ask the patient why he doesn't want to go to the hospital, He says, "I don't want surgery. The heart doctor told me that's all there is to do at this point. I can't even walk to the bathroom without getting some chest pain these days." How should you respond to him?

15. If the patient continued to refuse, what course of action is appropriate per System policy?

- Those with certain **religious beliefs**

- **Patients in law enforcement custody (see policy L1):** If a patient in custody is non-decisional, they can be treated under implied consent. A decisional person in custody does not lose the right to make decisions regarding medical treatment. Law enforcement agents cannot compel healthcare personnel to act in disregard of the rights of any person, regardless of whether or not such person is in custody. If a police officer denies treatment of a prisoner that appears medically indicated, provide the officer with full disclosure of risk and attempt to gain their cooperation.

Review new policy L1: Patients in Law Enforcement Custody

Scenario #3: EMS is called to a road stop by local police for a driver who had been speeding. The police want EMS to evaluate the patient and take him to the ED because they believe he is intoxicated. He blew a 0.095 on the breathalyzer 15 minutes ago and "they don't run a drunk tank".

The patient is calm, cooperative, awake, alert, oriented X4 and admits to having a couple of drinks within the past 2 hours to celebrate a new promotion. He does have the odor of alcohol on his breath. He shows no evidence of ataxia, is able to perform rapid alternating movements, has no nystagmus. answers all questions rapidly and accurately. His VS, SpO_2, and blood glucose are normal. When asked why he was speeding, he admits to having to urinate and was hurrying to reach a bathroom. He denies any allergies, medications, PMH and is refusing any further exam and does not want to be transported. He admits to being a bit more than a social drinker and claims to be fine. EMS sees no evidence of illness or injury

16. Does this patient meet the criteria for decisional capacity? Why or why not?

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17. Should he be allowed to refuse EMS services? Why or why not?

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18. The officer has not charged this patient with a crime and does not have a warrant. Can the police officer legally compel you to draw his blood for a blood alcohol level? Why or why not?

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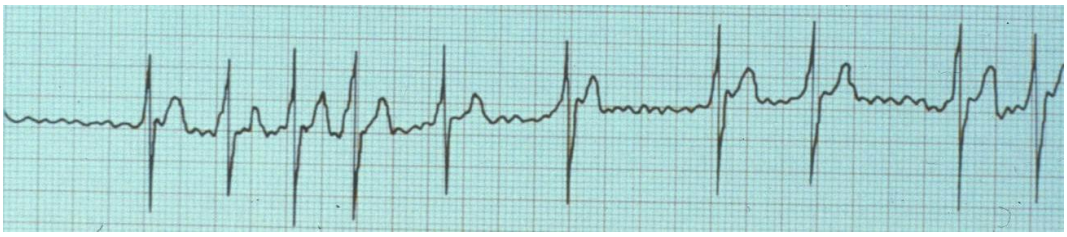
_____

- **Treatment of minors:** Wait for parental consent unless an emergency. When an emergency exists, treatment can be provided to minors under implied consent. It is presumed that the parent or guardian, if available, would grant consent. Under certain circumstances a minor can provide consent; see System Policy R6.

Legal torts related to consent

Scenario #4: An anxious 75 y/o adult is complaining of severe shortness of breath for the past 30 minutes that began right after dinner. PMH: AMI last year, HTN and high cholesterol. Pt denies chest pain, fever, recent illness, asthma or COPD. Meds: captopril, Lipitor, and ASA although they are noncompliant in taking them. Exam: Productive cough with frothy sputum. VS: BP 180/110; P 100; ECG rhythm below; 12 L ECG shows no acute ischemia; R 28 and labored; SpO_2 78%; capnography 45 with square waveform. Breath sounds: bilateral wheezes in the posterior bases.



After IMC, application of CPAP and 2 NTG, the patient's distress was visibly relieved and transport was uneventful. Upon arrival at the hospital, the patient was disconnected from the cardiac monitor (thus no ECG rhythm, SpO_2, $ETCO_2$, NIBP assessment were continued) for transfer into the ED. O_2 remained on via the CPAP mask. The triage nurse directed you to the trauma bay, but no staff were immediately there to greet you. You and your partner ran quickly out to see if anyone was coming to take report.

19. Upon returning to the room the patient was in cardiac arrest. **What legal tort may be successfully alleged in this case? Why?**

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_____

Abandonment - See System Policy A 1

Definition: Unilateral termination of the System-patient relationship without consent of the patient. This takes the form of leaving a patient without the patient's permission or knowledge, or doing so without reasonable notice that further medical treatment is required, or doing so without taking reasonable precautions for the patient's ongoing safety and care. Distinguished from negligence - the intentional severance from care, rather than the care itself, is the basis for the lawsuit.

Abandonment can occur when the patient is not appropriately transported; is released to a professional with inappropriate education, skills, training, or experience to care for the patient; **monitoring equipment is removed before pt responsibility is transferred to someone else**; and/or a patient is left at the hospital without report to a nurse or physician. One is only immune from abandonment liability if the patient is delivered into other hands of someone with equal or higher skills, education, and capability so that the person can reasonably expect to receive further necessary treatment and care.

Termination of the EMS-Patient relationship can only appropriately occur when the

- patient doesn't require further medical care;
- decisional patient terminates the relationship; and/or
- patient is transferred to a qualified medical professional of equal or higher education and capability who accepts the patient.

Assault

Definition: Threat of an unwanted or unconsented touching. Unjustifiable attempt to touch another or the threat to do so in a manner that would lead one to believe that it would be carried out and result in bodily harm. Apprehension of receiving a battery caused by another.

This is a very subjective allegation as it involves mental apprehension, not physical touch. To avoid, do not verbally threaten a patient with an unwanted touching; tell patients what you are going to do before you do it and gain their consent.

Battery

"When a person intentionally or knowingly without legal justification and by any means, (1) causes bodily harm to an individual or (2) makes physical contact of an insulting or provoking nature with an individual. "An intentional touching of a person in a harmful or offensive manner without legal justification or the patient's consent." This includes touching of the body, clothing, or held articles. The courts have recognized battery as an appropriate civil claim in cases of medical treatment without consent. In Illinois, this is a Class A misdemeanor, with a maximum penalty of up to a year in the county jail, and a fine of up to $2,500.

Aggravated battery: Use of a weapon (implement) to inflict unconsented touching.

Scenario #5: It is 2 pm and EMS is called to the home of a middle aged woman by her psychiatrist who had been told that 24 hours earlier, she had made suicidal statements. Given that the patient has a history of depression, the friend and therapist want EMS to bring her in for an evaluation. The psychiatrist says that she will sign the Petition form once EMS gets to the hospital.

Upon your arrival, the door is answered by a very surprised patient. She wonders why you are there. She calmly tells you that she never indicated that she intended to harm herself. She is awake, alert, oriented X4, answers your questions without apparent deception or manipulation, does not appear impaired in any way and steadfastly denies that she intends to harm herself or anyone else. The house appears clean and well-kept as does the patient. Upon calling OLMC they want you to transport based on the psychiatrist's direction. For one hour you try to get the patient to come with you willingly and she refuses.

20. Does she meet the threshold for transport against her will? Why or why not?

_____

_____

21. Does she meet the indications for physical restraint to bring her in? Why or why not?

_____

_____

22. If EMS had applied restraints, what could this patient allege?

_____

23. Are you able to sign the petition form based on the statements made by the psychiatrist? Why or why not?

_____

_____

24. What action could you take to resolve this impasse?

_____

_____

_____

_____

False imprisonment

See policy E1 EMOTIONAL ILLNESS and BEHAVIORAL EMERGENCIES Use of Petition forms; restraints

Definition: Unlawful restraint of an individual's personal liberty or freedom of movement. Common examples include transporting a person against their will and application of restraints without proper authority. However, it is not necessary that the individual be actually confined or assaulted. It is sufficient to show that at any time or place the person in any manner was deprived by another person of her/her liberty without sufficient legal authority. False imprisonment may also be subject to various federal civil rights claims arising out of violation of first amendment rights to liberty.

The risk of false imprisonment occurs most often with psychiatric and impaired patients. Abnormal behavior may be due to mental illness, medical illness, substance abuse or intoxication, or a traumatic event. If a mentally ill patient clearly needs treatment or if there is a real danger that he or she may be harmful to self or others, treatment must be provided under the Mental Health Code Involuntary Treatment & Informed Consent Act 405 ILCS 5/2-107.1.

If the patient is combative and uncooperative, reasonable caution must be exercised to avoid injury to the patient and others. Healthcare workers should use reasonable force, which is the minimum amount of force necessary to prevent the patient from harming self or others and to make it possible to provide emergency care. Excessive force may produce liability.

A major area of liability includes placing a patient into restraints. Follow System policies.

The elements to be considered by a jury in awarding compensatory damages in a false imprisonment case are physical suffering, mental suffering and humiliation, loss of time and interruption of business, reasonable and necessary expenses incurred and injury to reputation.

Defend by showing that the person was not falsely imprisoned, show medical necessity or patient consent. Document that restraint was necessary to defend self or coworkers when patient became hostile and violent or to protect the patient from harming self. Fill out petition form on those with mental illness.

Violation of civil rights

In addition to suing you for negligence, a patient may be able to sue you in federal court under certain circumstances for violating his or her civil rights guaranteed under the Constitution. Examples would be if you withhold medical care for reasons such as race, color, gender, national origin, status, condition, disease, or ability to pay. They may also invoke this clause if you restrain them improperly, stating that you violated their civil liberties. Increasingly, suits are taking this direction, as Illinois law provides immunity for ordinary negligence but Federal laws do not.

Scenario #6: A 30 y/o male presents at his home extremely agitated, kicking, flailing his arms, biting, spitting, and head butting anyone who approaches him. Upon EMS arrival, police officers have him on the ground, on his stomach with arms handcuffed and legs tied behind him. There is an officer on each limb attempting to control his movements. You ask him to stop fighting so you can help him and he just becomes more agitated.

His skin appears hot, flushed and diaphoretic and what you can see of his pupils, appear very large. He is breathing rapidly and making growling sounds. Periodically he yells that he can't breathe. His carotid pulse is very rapid. There is no other known history. He refuses to answer questions about who he is or what happened to him or any medications or drugs that he has taken and just wants to be left alone.

25. What observations from the patient's initial assessment make it acceptable to restrain him and transport him against his will? Would he be able to make a case for false imprisonment? Why or why not?

_____

_____

_____

_____

26. What type of consent applies in this case?_____

27. What type of sedation and restraint is indicated?

_____

_____

After sedating the patient, he is positioned supine and all four limbs are handcuffed (spread eagle) to the stretcher. The Police officer states he will not relinquish the handcuff key, but will follow you in the ambulance to the hospital. You agree to transport the patient in this manner to the hospital without notifying a supervisor or mention the manner of restraint to OLMC. Enroute, the patient vomits, aspirates because you did not have suction standing by and could not release the patient to a side lying position, and he later died at the hospital.

List the 4 elements needed to prove negligence and explain how the actions above would satisfy each:

Element	Was this element satisfied or not? Explain.
28. Duty to act	
29. Breach of duty	
30. Damages	
31. Proximate cause	.

32. In this case, did the negligence arise from malfeasance, misfeasance, or nonfeasance? Explain your answer:

_____

_____

_____

_____

Other common areas of EMS litigation

Dispatch: dispatchers have a duty to

- use correct radio procedures;
- obtain correct information in a timely manner;
- screen calls appropriately; and to
- dispatch appropriate resources in an accurate and timely manner.

Patient care: EMS personnel have a duty to

- respond appropriately within time limits set by law/rule;
- provide an appropriate assessment (as authorized by a decisional patient);
- recognize alterations from health within their scope of practice, training and experience;
- provide appropriate care within their scope of practice and SOP;
- execute an appropriate patient disposition; and
- communicate (verbal and written) appropriately with patient and OLMC per policy.

Equipment

- EMS personnel have a duty to inventory and check equipment in their ambulance at the beginning of every shift and after every use to ensure its presence and good functioning condition.
- Paramedics must view and count controlled substances at every shift change and sign the Controlled Substance Log.
- System's Drug and Supply List serves as the standard for supplies and equipment on ambulances.
- Employers are responsible for ensuring that EMS personnel are adequately oriented and competencied on the use of brands or models of EMS products or equipment used by that agency.

Emergency vehicle operations

- **UART--Uniform Act Regulating Traffic:** Authorized emergency vehicles as defined by state law must use proper warning devices in responding to bona fide emergency calls or fire alarms. They must operate the vehicle with due respect for the safety of others. Failure to comply with all elements eliminates emergency vehicle status for the driver.
- **Use of lights and sirens** – See System Policy L-2 Safe Ambulance Operation; Use of Lights and Sirens
- **Common driving errors**
  - Distractions (texting while driving, etc.); fatigued drivers
  - Excess speed; tailgating
  - Over-aggressive lane changes
  - Failure to consider road and weather conditions
  - Approaching intersections without checking for side traffic; failure to stop before proceeding through intersections with a red light or stop sign
- **Ways to avoid vehicular risks**
  - Use experienced and qualified drivers that are not fatigued
  - Follow "rules of the road"
  - Avoid distractions, risks and hazards
  - Drive defensively

Spine injuries

- Examine the patient before you move them unless the scene is unsafe
- Document signs and symptoms or lack of symptoms before and after moving the patient
- Avoid log rolling a patient with a possible SCI whenever possible – use scoop stretcher if possible
- Treat comatose or impaired patients with special care as their neuro exams will be unreliable
- If in doubt as to the presence of an injury, provide spine motion restriction per SOP
- Know how to position and move patients with possible SCI and how to use spine motion restriction equipment safely and appropriately
- Communicate all signs and symptoms to OLMC and the ED upon arrival

Reporting laws

Certain problems must be exposed for protection of the public. Often, the hospital becomes the mandated reporter unless EMS personnel are specifically named in the statutes:

- **Child abuse/neglect – EMS are mandated reporters (See SOP)**
- **Elder abuse/neglect – EMS are mandated reporters (See SOP)**

Do not communicate the reported information to any agency or person other than the one designated by the statute, and to hospital personnel for purposes of treatment. Never assume that someone else will take care of your responsibility under a reporting statute.

Risk management strategies for EMS

- Agencies should conduct a HIPAA risk assessment and have policies and training in place, Appoint an ambulance privacy officer.
- Watch for key areas of vulnerability, including portable devices.
- Provide training on ethical behavior and communication skills.
- Maintain current knowledge of laws, policies and procedures that apply to EMS care. Practice compliance with all laws, policies and procedures.

- Never refuse to examine a patient seeking treatment.
- Know your scope of practice and your level of competence.
- Exercise due care within your scope of practice. When in doubt, treat.
- Treat patients as you would want to be treated. Do what is best for the patient! If you are going to err, err on the side of the patient.
- Avoid interventions not covered by SOP and/or EMS Scope of Practice unless specifically ordered by a physician and medically defendable.
- **Maintain complete records.** Make certain your PCRs reflect response times as accurately as possible, the patient's condition upon your arrival, your initial history and physical exam, full sets of VS and diagnostic values (glucose, SpO_2, $ETCO_2$, ECG rhythm, 12 L ECG interpretation prn) are obtained and documented as often as protocols specify, all interventions and responses to interventions are timed and documented, any instructions given to the patient and any other pertinent information that would provide an evidentiary chronicle of the call are included in the comments section. **For jurors in a malpractice case, the best evidence of what really happened is usually considered to come from the patient care report.** Completeness in charting is important even when the PM is busy or tired because an incomplete run report suggests incomplete care.
- Make amendments to the record within one shift day following the call.
- Always report significant findings to OLMC as defined by SOP.
- Make certain that impaired patients are carefully examined for cause. Drugs and/or alcohol mask vital symptoms and these patients are at risk for hidden injuries. They often become violent and are difficult to treat. You may use "reasonable force" to protect them from harming themselves or others. Comply with rules re: involuntary transport and restraint.
- Take immediate action to ensure the safety and comfort of patients in labor.
- Keep family members or bystanders informed of the patient's situation and your transport plans.
- Treat the patient with respect at all times
- Develop strategies to deal with "compassion fatigue"; and
- Appoint supervisors who don't look the other way.

"Even smart people will do stupid things," (Wirth, 2017).

Due process

Due process rights are guaranteed by the constitution. They are derived from *Old English Common Law* where the accused has the right to be notified of a complaint and the right to be heard by an unbiased tribunal prior to being subject to a permanent loss. The greater the potential loss, the greater the due process should be.

NWC EMSS **Due Process policy** (D-1) protects the rights of all System members. If consequences for alleged misconduct are being considered or have been imposed; please review this policy to determine your rights within the System.

Remaining questions

33. EMS responders were unable to suction a patient with lots of airway secretions because the portable suction machine batteries went dead within one minute of activation and the patient ultimately died from airway impairment. The plaintiff's lawyer discovered that they failed to check the batteries the morning of the call as required by routine procedures. Which of these could the deceased person's family successfully allege?

    A. Negligence
    B. Incompetence
    C. Abandonment
    D. Involuntary homicide

34. Which intentional tort can be alleged if a paramedic brings an unstable patient into the ED with the oxygen, pulse oximeter, capnography and ECG monitors disconnected after being in place throughout transport?

    A. Abandonment
    B. Dereliction of duty
    C. Violation of civil rights
    D. Conduct unbecoming a paramedic

35. Which of these is an example of an act of omission for which a paramedic could be liable?

A. Defibrillating a patient in asystole
B. Giving a patient the wrong dose of a medication
C. Starting an IV without a decisional patient's consent
D. Transporting an unconscious patient with a glucose of 20 without intervention

36. A paramedic stands next to a combative adult holding a syringe full of midazolam threatening to place the patient into restraints and "knock him out" with a drug that could make him stop breathing if he does not keep quiet and lay still. What intentional tort could the patient allege?

A. Battery
B. Assault
C. Coercion
D. Intimidation

37. A paramedic contacts OLMC and states over the radio, "We have Jane Smith again and she is crazy and hyperventilating as usual." What civil legal wrong has this paramedic committed?

A. Libel
B. Battery
C. Slander
D. Violation of First Amendment rights

38. Which legal wrong is committed if a paramedic writes on a patient care report that a patient is "an obnoxious drunk that abuses EMS services"?

A. Libel
B. Perjury
C. Assault
D. Slander

39. To which person or entity may a paramedic legally release an adult patient's care report without a subpoena or the patient's signed consent?

A. A family member
B. The receiving hospital physician or nurse
C. News media under the Freedom of Information Act
D. A colleague on another shift who is interested in the call

40. For willful and wanton negligence to be proven against a paramedic, which of these must exist?

A. The patient was unhappy with his care
B. Improper treatment was given even if there was no harm
C. The person acted with recklessness to the point of being dangerous
D. The paramedic exercised reasonable care, but an injury resulted from their actions