Ethical & Legal Concepts in EMS

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NWC EMSS Administrative Director

Introduction
Must be prepared to make the best medical, ethical, and most appropriate legal decisions
Must be familiar with ethical and legal issues encountered by EMS personnel

EMS operates in a risky world!

Objectives
Upon completion of the class & reading handout and policies, each participant will do the following with the degree of excellence that meets or exceeds standards established for their practice with no critical errors:

- Compare and contrast standards, scopes of practice and major areas of legal liability for EMS.
- Describe major legal torts; differentiate the elements of negligence and defenses to negligence.
- Value and defend the need to consistently care for all patients using legal and ethical standards.

Common areas of EMS liability

Acts of omission: failure to
- properly assess; monitor; take timely action; appropriately screen (dispatch problems).
- follow prescribed policies; properly communicate.
- document thoroughly and accurately.
- exercise reasonable due care in treating the patient or ensuring an appropriate disposition (abandonment)
- High risk: refusal of service/non-transport calls; AMS- determining decisional capacity
Common areas of EMS liability

Acts of commission (wrongful acts)
- Assault and battery; slander and libel
- Performing skills or monitoring equipment outside your scope of practice
- Improperly performing skills within scope of practice
- Unsafe vehicular operation
- Unsafe use of equipment; equipment failure or deficiency
- 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

Laws vary jurisdiction to jurisdiction – know those that apply to you

Read handout: pp. 1-2 on branches of law; burdens of proof

See also System & employer policies

Get competent legal advice

Standards used in Civil law cases

Contracts
Statutes
Regulations
Customs

Standards of EMS practice

Based on Standards of Care & Scopes of Practice set by statute, rule, local protocol
Level against which EMS actions will be compared
The Golden Rule
EMS personnel must use the superior judgment, skill and knowledge they possess

ALWAYS DO WHAT IS BEST FOR THE PATIENT
Within your Scope of Practice and local Standards of Care

What defines the scope of practice?
Created by NASEMSO & Ntl Council of State EMS Training Coordinators; published by NHTSA: Delineates provider practice & licensing levels
Intended to ensure consistency between states and promote reciprocity (2007)
Revision due date: Fall 2018

Implementation of Ntl documents varies across jurisdictions
Reason for System Entry process
Need practice privileges based on local standards and scope

Where is the national EMS Scope of Practice Model posted?
NHTSA website: www.ems.gov

What defines the Ntl requirements for EMS Education?
Approved by NHTSA 1/30/2009

See Illinois Scopes of EMS Practice from EMS Act handout p. 3
What defines EMS scopes of practice within the NWC EMSS?
See SOP
EMS Scopes of practice
IDPH 5/16
Region IX: 12/16

Liability
Something for which one is legally obligated

What documents are the basis of our Standards of Practice?

Deviations may be justified based on new information, updated guidelines, or new situations but must be approved in advance by EMS MD

Where else do guidelines come from?

Organizational guidelines
ACEP: ITLS course
ACS: PHTLS course
Brain Trauma Foundation: Standards for mgt of severe brain injury
Textbooks, journals
Educational materials
Scope of liability: Indirect liability

**Borrowed servant doctrine**: Employer lends employee to another who becomes liable for the borrowed servant's wrongful conduct (EMS MD)

**Respondeat superior**: Let the master answer. Did you act as an agent of the employer or independently?

Non-intentional torts

Definition: Civil wrong committed against a person or property; other than a contractual wrong

TORT LAW

Negligence

Conduct, act or omission which

- Falls below standards established for the protection of others against unreasonable risk of harm
- Is caused by carelessness - makes negligent party unaware of results that may follow their actions

*Usually no intent*

Duty is owed to foreseeable risks

Recognizable danger or *possibility of injury* based on knowledge of existing facts and reasonable belief that *harm may follow* an act or intervention

Risk/benefit analysis: Weigh degree of risk against potential or expected benefit when providing care

Risk abatement

Even in doing things that are customary, where common knowledge and judgment recognizes an unreasonable risk of danger - doing "What everyone else does" may still be negligent conduct

*What examples of this are seen in EMS?*
**Examples**

- Taking pt to ambulance before treatment is started (asthma, allergic reactions) or completed (cardiac arrest)
- Walking pt to stretcher/ambulance with AMS, neuro deficits, chest pain
- Giving drugs prepared by someone else
- No medication cross-check

*Can you think of more?*

**Risk abatement**

- If risk is slight = proceed on assumption that others will exercise proper care
- If risk is great = must take precautions against negligence of others

**Negligence**

Failure to exercise a level of care necessary to protect others from harm

**All 4 elements must be proven** to the satisfaction of the judge or jury or case will fail as a matter of law

- Duty of care
- Breach
- Harm
- Causation

**4 elements of negligence**

- Duty to act
- Breach of duty
- Damages (harm)
- Proximate cause (causation)

**Duty to act**

Obligation to conform to a particular standard of conduct for protection of a pt against unreasonable risk of injury

- Derives from relationship that obligates EMS to act in a certain way toward the patient

*Primum non nocere*

**FIRST DO NO HARM**

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*Bad outcomes don’t always suggest negligence*

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*Who has the privilege to know the duty to act?* — Albert Einstein (1879-1955)
Duty to act
Plaintiff must establish defendant’s duty
Once duty is assumed, law presumes ordinary negligence standards
Duty is only owed to foreseeable plaintiffs
No duty to take precautions against events that cannot be reasonably foreseen

General Paramedic Duties – p.5
Inventory checks; controlled substance logs
Respond in a safe and timely manner
Obey Federal, State, and local laws
Operate vehicle safely
Provide care and transport within scope of practice & to expected standard of care
Continue care through to appropriate conclusions

Personal duties
Maintain current license
Attend CE; maintain knowledge & skills
Maintain physical and emotional well-being; fitness for duty

Breach of duty
Conduct falls below standard owed to plaintiff
Failed to act as a reasonably prudent person with same or similar training
Proof: Plaintiff must show what happened by direct or circumstantial evidence
Facts must show that defendant acted unreasonably

Ways to breach duty
Malfeasance: Wrongful or unlawful act
Misfeasance: Performance of a legal act in a manner that is harmful or injurious (commission)
Nonfeasance: Failure to perform a required duty (omission)

Res Ipsa Loquitur
Negligence is so obvious that it does not require extensive proof
“The thing speaks for itself”
Could not occur without negligence
Caused by something within the exclusive control of the defendant
Not due to any voluntary action or contribution on the part of the plaintiff
Damages (Harm)
Plaintiff suffered an injury for which law will provide monetary compensation

*De minimis non curat et lex*, means the law has no cure for trifles or small things – these awards can be staggering

Compensatory damages – p. 6
Medical expenses
Lost earnings or profits
Conscious pain & suffering
Disability
Wrongful death
Loss of consortium

Punitive damages
“Willful, wanton and reckless” conduct: defendant intentionally violated a statute
Designed to punish and set an example
Insurance companies may not cover punitive damages
Employer or PM may be personally liable

Proximate cause
Causal connection between defendant’s actions & plaintiff’s injuries

*Most difficult element to prove*
Causation must be linked to show the law is justified in imposing fault and liability
Back to foreseeability – duty to prevent a risk of harm

Degrees of negligence

**Slight**: Failure to exercise great care or that which persons of extraordinary prudence and foresight are accustomed to use

**Ordinary**: Failure to use ordinary care

**Gross**: Failure to use slight care that even a careless person would use

**Willful and wanton**: Proceeding with the knowledge that harm is certain to occur

Malpractice

Professional misconduct
Wrong or injudicious treatment of a pt & failure to use reasonable & ordinary care
May stem from ignorance, carelessness, want of professional skill, disregard of rules or principles, neglect, or malicious & criminal intent
Does not mean incompetent
Defenses to negligence
No duty to act
Crush plaintiff’s credibility; false accusations
Show no damages
Show no causation
Assumption of the risk

Defenses & Immunity – p. 7
Good Samaritan laws
Statutes of limitation
Immunity statutes
Comparative/contributory negligence
Governmental immunity

See EMS Act Immunity Provisions p. 8
Immunity for ordinary negligence
No immunity for willful or wanton negligence
Exercise reasonable due care

Government privilege struck down by Ill Supreme Court
Marcus Coleman v. East Joliet Fire Protection District et al. (1/2016)
THE ABOLITION OF The Public Duty Rule For Local Governments
EMS Immunity remains intact – in law

Confidentiality of PHI
All protected health information must remain strictly confidential
It may not be shared with 3rd parties without patient’s consent unless they have a need to know
Unwarranted intrusion into HPI by an authorized person is a breach of confidentiality

Think this is a problem?
Florida hospital suspends employees after inappropriate photos with newborns surface

UPMC fires several employees after they ogled, photographed anesthetized patient with genital injury

Invasion of privacy

Breaches do not have to be harmful
DO NOT discuss patients in public places or release PHI to unauthorized persons

Who has a need to know?

Patient authorized physicians, insurance co, attorney or other party
Medical necessity
Billing/insurance purposes
Subpoena
Mandatory reporting
QI reviews
Law enforcement

Healthcare Insurance Portability and Accountability Act of 1996 - HIPAA

Privacy rule (4/14/03)
All agencies must have a privacy officer
Must provide a "Notice of Privacy Practices" to all patients

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Law enforcement
Penalties for Committing a HIPAA Violation

Whether a violation is intentional or accidental, individuals and organizations can face civil and criminal penalties.

- Fines:
  - $100 to $50,000 per violation
  - Up to a total of $1.5 million per year

- Jail time:
  - Up to a year for “knowingly” committing a violation
  - Up to 10 years for committing a violation with the intent to use the PHI for personal or commercial gain.

Northwest Community EMS System

Defamation: Libel vs. Slander

Libel

Injury to person’s character, name or reputation by false or malicious written accusations

May include making video recordings public

Defense: Thorough, accurate, and confidential written reports

How could EMS be guilty of libel?
To avoid:
- Write thorough, accurate & confidential reports; avoid slang or labels
- Chart only the facts

Slander
Injury to a person’s character, name or reputation by false or malicious spoken words decreasing an individual’s personal esteem by the community, place of employment or their position.

How could EMS be guilty of slander?

To avoid:
- Limit oral reporting to appropriate personnel
- Minimize abbreviations
- Don’t discuss patients except in private with those who have a need to know

We have a patient that is SOB and belligerent…

Consent
Voluntary permission is given to another to act, operate, or function in a certain manner

Purpose:
- Protect patient from unwanted or unapproved touching or treatment
- Protect health practitioner against legal claims of unauthorized treatment

Right to accept/refuse care is rooted in
- Common-law right to informed consent
- Liberty interest under due process clause of 14th amendment
- State constitution and laws governing care and treatment of incompetent adults

Patient rights under law
Consent is: CLEAR, COHERENT, WILLING, ONGOING
**Cruzan v. Director Missouri Department of Health (1990)**

Supreme court held that the 14th Amendment gives every mentally competent adult the right to refuse unwanted medical care, even lifesaving treatment.

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**Autonomy**

Right to **make own choices**

Requires that pt has capacity to act intentionally, with understanding and w/o controlling influences that would mitigate against a free and voluntary act

Basis for "Informed consent"

Advance directives

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**Determining decisional capacity**

Legal capacity to consent?

- Must have decisional capacity to consent
  - Mental status
  - Responds appropriately to questions
  - Patient must understand the extent and severity of their condition
  - They must be able to manipulate the information and understand the consequences of their decision

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**Decisional capacity could be impaired by:**

- Hypoxia, hypoxia, hypercarbia, hypoperfusion, severe pain, shock
- Intoxication: drugs/alcohol
- Combativeness, AMS, excited delirium, brain injury, delirium, dementia
- Unusual behavior
- Mental illness

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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)
Express consent
Made known by patient in a direct and positive manner
Sign consent form
Does not require any inference to support assumption of consent
Not necessarily informed

Informed consent
Consent given after patient advised of probable risks and other related information about proposed treatment
Full disclosure of risk is mandatory prior to high risk procedures
Can be verbal or written

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

Implied consent
Not expressed but results from the circumstances of the patient status
Circumstantial:
Conduct or action or inaction infers consent
OK if no expected risks

Implied consent
Emergency doctrine: Incompetent or non-decisional patients cannot give or withhold consent
Care provided assuming a decisional patient would consent
Must show an emergency exists

Consent challenges
Incompetents: need guardian/trustee to consent
Refusals
Patient who has designated a durable power of attorney for healthcare
Religious objections
Prisoners in custody
POLST orders
Treatment of minors
Refusals

Seek to respect patient’s decisions while balancing provider’s duty to act

A decisional pt has the right to refuse treatment, even if doing so will result in serious consequences or death.

Refusals

To be binding, person withholding consent must be able to understand what they are signing and the implications of the release.

Counsel pt in plain language they can understand without any undue attempt to influence their choice.

EMS disclosure of risk:

- Nature of illness/injury
- Nature of recommended treatments
- Purpose and need for recommended procedure/treatment
- Potential benefits and drawbacks
- Known possible risks and complications of recommended treatment
- Known possible results of non-treatment
- Any significant alternatives for treatment

Refusals

May not be legally binding and easily attacked

Encourage consent
If they persist, appropriately execute refusal
Let pt know they should call back if they change their mind

When is a refusal unacceptable?

- Altered mental status
- Drug altering behavior
- Homicidal
- Suicidal
- Hypoglycemic
- Hypoxic

Refusals
Careful documentation is essential

- Mental status
- Reasoning ability
- Vital signs
- Physical exam (allowed)
- PMH (to extent given)
- Impairment/lack of impairment from drugs, alcohol, disease, hypoxia, hypoglycemia, hypoperfusion

Calling in refusals

Confirm with nearest System hospital from the scene while pt still present unless exempt by System policy

All ALS, elderly, peds, & high risk BLS refusals must be called in

AMA refusals

Some patients persist in refusing, even when there is foreseeable risk of harm.

If they are legally and mentally decisional, request an ED physician to talk with patient over phone/radio.

Document carefully!

POLST forms and DNR orders

Last update: April 2016

Review D5 policy after class

Scenario #2

Page 15
When can a minor provide consent?

- Armed forces – Active duty
- Pregnant female
- Child with an STD or a serious contagious disease
- Victim of a sexual assault
- Rx for drug/alcohol abuse
- Emancipated minor
- Parent of a minor child

Abandonment

- Unilateral severing of System-patient relationship without patient's consent
- Leaving pt w/o their permission or knowledge
- Failure to provide pt with reasonable notice that further medical Rx is required
- Failure to take reasonable precautions for the patient's ongoing safety
- May involve unreasonable refusal to treat

Examples of abandonment

- Not appropriately transported
- Released to someone of inappropriate skills, training, experience to care for pt
- Removing monitoring equipment before pt responsibility transferred to someone else
- Leaving pt at hospital without report
Medical tests later showed that HARB had suffered a life-threatening stroke, yet the first HALL ambulance crew called to the scene departed without him, according to the company’s own reports, leaving the patient sitting on the curb, one shoe off and lying in the gutter.

**Witness Says Calif. Paramedic 'Abandoned' Patient**

**OK to terminate EMS care**

Patient doesn’t require further care
Competent patient terminates relationship
Patient transferred to qualified medical professional of = or higher education and capability who accepts patient

**Northwest Community EMS System**

**POLICY MANUAL**

<table>
<thead>
<tr>
<th>Policy Title: ABANDONMENT vs. PRUDENT USE OF EMS PERSONNEL</th>
<th>No.</th>
<th>A - 1</th>
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<td>Board approved: 3/12/15</td>
<td>Effective: 3/12/15</td>
<td>Separation: 11/14</td>
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I. POLICY

A. Every time EMS personnel respond to or are presented with a patient with any sort of complaint, possible illness, or mechanism of trauma that could suggest injury, that person is considered a "patient".

B. A reasonable search of the scene must be completed to determine if a patient is present. All patients shall have a reasonable access to the stretcher if there is a potential for illness or injury based on the circumstances. If after a reasonable search, no patient is found, efforts to find the patient shall be documented in accordance with EMS agency policies.

C. Once EMS personnel establish contact with a patient, assessment, treatment, written documentation, and patient disposition shall be completed in a manner that complies with system standards of care. They shall never be abandoned unless a special evacuation occurs. Emergency "911" patients shall be transported to a hospital or other approved healthcare facility. Patients transferred to another EMS crew, or a decisional patient may refuse transport (see Refusal of Service policy).

D. There are times when two agencies are dispatched concurrently to a scene. When both may provide care to a particular patient, one will triage and the other will not. All patients must be cared for and transported or given oral/written notice to call and have an appropriate Refusal of Service executed by EMS personnel with education, training, and equipment appropriate for patient care needs. If questions regarding the appropriate agency to transport, transfer of care decisions by NCC EMS agency shall be made outside the scene.

**Battery**

Unauthorized touching of body, clothing, or held articles w/o another’s consent
Medical treatment w/o consent
Aggravated battery: use weapon to inflict unwanted touching

**Assault**

Threat of, or fear of, an unwanted touching
Subjective, mental only
Tell pts what you are doing before you do it
Gain their consent

**Legal & Regulatory issues**

Virginia nurse charged with sexual battery for appropriately touching patient

Prince William County Police on Monday arrested a nurse accused of inappropriately touching a patient at Sentara Northern Virginia Medical Center in Woodbridge, according to The Washington Post.

The police leveled multiple charges against Frederick Yezoh, including sexual battery. The incident allegedly occurred between Aug. 21 and Aug. 24. Police believe the matter was an isolated occurrence and that there are no other victims.

"Sentara Northern Virginia Medical Center is committed to the safety and care of our patients," said the hospital in a statement emailed to Doctors. "We are cooperating fully with authorities. The individual has been placed on administrative leave."

M. Yezoh was arrested without incident and is slated to appear before court in October.

More articles on legal issues:
- Northern Virginia Health Services Kaiser tried to manipulate market rates with ED underpayments
- Kansas City health sharing ministry under investigation
- Patient sues Illinois hospital, claims PTSD after hostage incident in May

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False imprisonment
Intentional and unjustifiable detention against a decisional patient's will
Often psych patients or those restrained
Defense: show medical necessity

Violation of civil rights
Sue in Federal court for violating their constitutional rights:
Withholding care because of race, color, gender, national origin, status, sexual orientation, condition, disease, or ability to pay
Restraint of liberty

Behavioral emergencies & AMS
Abnormal behavior may be due to mental illness, medical illness or injury, substance abuse or intoxication
Exercise reasonable caution to avoid injury
Follow E-1 policy regarding petition forms, involuntary transports, use of restraints

Scenario #6
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<table>
<thead>
<tr>
<th>Element</th>
<th>Was this element satisfied or not? Explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty to act</td>
<td>Yes: EMS personnel responded to this patient in the course of their employment and assumed care of the patient.</td>
</tr>
<tr>
<td>Breach of duty</td>
<td>Yes: Positioned inappropriately after sedation; both arms should not have been above the patient’s head. See L1 policy under restraints.</td>
</tr>
</tbody>
</table>

- The use of handcuffs, shackles shall be determined by the OFFICER unless such use is contraindicated by certain medical considerations specified by the patient’s condition and approved by OLMC (pt in labor). The escorting OFFICER(s) are responsible for notifying the appropriate individual(s) at the local law enforcement agency/correctional institution should the administrative restraints be removed for medical reasons per their internal policies. EMS personnel must be notified in all cases when administrative restraints are removed so appropriate medical restraint precautions can be applied concurrently.
- If physical and/or chemical restraint needed, EMS policy/procedures apply.
- Any conflicts in the degree and/or type of restraint-use will be resolved in consultation with OLMC and the OFFICER.
- For all situations that require a patient in law enforcement custody to be sedated by EMS, the OFFICER must remain with the patient.
- Officer should have relinquished key or been in the ambulance.
- EMS did not prepare suction for vomiting precautions.

<table>
<thead>
<tr>
<th>Damages</th>
<th>Prima facie cause</th>
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<tbody>
<tr>
<td>Yes – the patient died (wrongful death?)</td>
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- If proof can be found that EMS failed to position and monitor the patient adequately resulted in his death, then proximate cause may be established.

### Common areas of EMS litigation
- Dispatch
- Response
- Pt care
- Equipment
- Vehicle operation

### Spine trauma
- Examine patient before & after moving
- Document S&S, pertinent negatives
- Treat comatose/impaired pts w/ special care
- Follow selective spine precautions SOPs
- Know how to use your equipment
- Communicate all S&S to the ED

### Reporting laws
- Mandatory reporter obligations

### Failure to consider road & weather conditions
- Excess speed
- Tailgating
- Over-aggressive lane changes
- Inappropriate use of lights and sirens

### Approaching intersections w/o checking for traffic
- Going through red lights or stop signs w/o stopping
Best Legal Defense

Treat pt with respect at all times
Provide appropriate assessment & care
Accurate & complete documentation

Due process

Guaranteed by constitution
From Old English Common Law
- Right to be notified of a complaint
- Right to be heard by an unbiased tribunal prior to sustaining a permanent loss
Greater the potential loss, greater the due process
After class, review System Policy D-1

Questions?

How much do you charge to answer a question?

...I'll send you my bill!

Personal accountability requires mindfulness, acceptance, honesty, and courage.

Shelley Martin
www.liberonetwork.com