

# EMERGING ISSUES IN EMS LIABILITY EXPOSURES

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# INTRODUCTION

- THE STANDARDIZATION OF EMS
- RAISING THE BAR IN EMS
- THE SPECIALTY CARE TRANSPORT
- CONTRACTED LIGHTS & SIRENS

# THE STANDARDIZATION OF EMS

- EMS INCREASINGLY BECOMING A STANDARD BASED PRACTICE.
- LOCAL STANDARD OF CARE STILL APPLICABLE LEGAL STANDARD.
- BUT LOCAL AND NATIONAL STANDARDS OF CARE ARE INCREASINGLY CONVERGING.

# STANDARDIZATION OF EMS

- **INCREASED STANDARDIZATION**

- » IMPROVED PATIENT CARE

**BUT**

- » INCREASED LIABILITY EXPOSURE

# THE STANDARDIZATION OF EMS

- EMS Adoption of National Standards
  - DOT National Standard Curriculum.
  - NHTSA Emergency Vehicle Operation Initiative.
  - Industry Policy Statements & Initiatives (AAA).
  - Education Curriculums (ACLS, EMD, APCO, CEVO, EVOC).
  - Contractual Standards ( response time standard).
  - Company Standards (Policies & Procedures).

# THE STANDARDIZATION OF EMS

- NAEMSP Position Paper: “*Use of Warning Lights and Siren in Emergency Medical Vehicle Response and Patient Transport*”.
  - Use limited to ***emergency response & transport only***.
  - Based on standardized protocols established by medical directors participating in development of policies governing the emergency response.

# THE STANDARDIZATION OF EMS

- *NHTSA-Guide for Interfacility Patient Transfer (2003).*
  - Key national authorities convened to identify
    - National EMS priority issues.
    - Establish “**consensus-based guidelines**”.
    - Promote consistent **high-quality patient care**.
    - Systematic Processes for “**optimal delivery of care**”.

# THE STANDARDIZATION OF EMS

- AAA POSITION PAPERS
  - BEST PRACTICES FOR EMS FLU VACCINATION.
  - BEST PRACTICES FOR OPERATION OF EMERGENCY MEDICAL SERVICES VEHICLES.
  - POSITION STATEMENT ON EMS DRIVING

# THE STANDARDIZATION OF EMS

- Liability Exposure:
  - Uncertainty about Accepted practice=Uncertainty about Expected Practice.
    - » EXAMPLE: Pulse oximetry.
  - Accepted Practice=Expected Practice.
    - » EXAMPLE: EVOC Training.

# THE STANDARDIZATION OF EMS

- MORE CONSENSUS BASED GUIDELINES IN EMS.
- CONSENSUS LEADING TO DEVELOPMENT OF A BODY OF STANDARDS.
- STANDARDIZATION OF EMS INCREASES EXPOSURE FOR LIABILITY.

# RASING THE BAR IN EMS

- LEGAL STANDARD OF CARE: *What a “reasonable” EMS provider (EMT, Paramedic, Agency, etc) would do under similar circumstances.*
- **EMS Industry** has been consistently raising bar in all areas of pre-hospital care.
- Net Effect: EMS is consistently re-defining and raising the legal standard of care.

# RASING THE BAR

- Example No. 1:
  - Emergency Vehicle Operation: MCL 257.603(3) provides:
    - The driver of an authorized emergency vehicle may do any of the following:
      - (b) Proceed past a red or stop signal or stop sign, but only after **slowing down** as may be necessary for safe operation...and proceeding with *due regard* for the safety of others.

# RAISING THE BAR

- LEGAL STANDARD: “reasonable” ambulance driver.
- Standard of Care: Proceed past a red signal or stop sign only after coming to a **full and complete stop**.
  - EVOC
  - CEVO
  - Industry Practice.

# RAISING THE BAR

- EXAMPLE NO.2: Confirming proper ETT Placement.  
“Gold Standard”: Not any more!
  - 1. Visualization of the tube passing vocal cords (“Gold Standard”).
  - 2. Visualization of chest rise and fall upon ventilation of the patient via BVM.
  - 3. Presence of good lung sounds on auscultation.
  - 4. Absence of epigastric (belly) sounds on auscultation.
  - 5. Continued monitoring of all of the above; especially after any movement of patient.

**“Gold Standard”? NOT ANY MORE!**

# RAISING THE BAR

- STANDARD OF CARE: Use of Adjunct Devices to confirm ETT placement.
  - **END-TIDAL CO2 MONITORING DEVICE.**
  - **ESOPHAGEAL DETECTION DEVICE.**
  - **PULSE OXIMETRY.**

# RAISING THE BAR

- EXAMPLE NO.3: Contractual Standard of Care.
  - Response Time Standards.
  - 12 Lead EKG's.
  - Lights & Sirens outside 911 response.

# RAISING THE BAR

- **Conclusions & Recommendations:**
  1. Standard of Care in EMS today is constantly changing and not limited by the “legal” standard of care.
  2. Standard of Care today is increasingly influenced by:
    - a. Industry Data.
    - b. EMS Educational Materials.
    - c. Industry Practices, Policies and Procedures.
    - d. Legal Case Precedent.

# RAISING THE BAR

- Conclusions & Recommendations:
  3. Risk Management in EMS today requires constant education and training beyond basic clinical and operational guidelines.
  4. “Reasonable” EMS provider is increasingly being held to a higher standard of care based on industry best practices, industry data and educational materials.
  5. Contractual obligations require close and constant monitoring for adherence to the adopted standard.

# SPECIALTY CARE TRANSPORTS

- INTERFACILITY TRANSPORT.
- CRITICAL CARE TRANSPORT.
- BARIATRIC TRANSPORT.
- PEDIATRIC & NEONATAL TRANSPORT.
- PSYCHIATRIC TRANSPORT.
- VENTILATOR TRANSPORT.

# SPECIALTY CARE TRANSPORTS

- DEMAND FOR SPECIALTY TRANSFERS IS EXPANDING RAPIDLY
  - Interfacility Transports:
    - Development of Integrated Health Systems
    - Tertiary Care
    - Regional Referral
    - Specialty Hospitals.

# SPECIALTY CARE TRANSPORTS

- Specialty Care Transports present unique clinical challenges.
- Specialty Care Transports also present unique Risk Management issues:
  - Who are we transporting?
  - Why are we transporting?
  - What do we really know about the patient?
  - Scope of Practice issues?
  - Protocols?
  - Training & Education?

# SPECIALTY CARE TRANSPORTS

- **Case Study No.1: Ventilator Patient.**

- 78 yr. old male; DX: Respiratory Insufficiency.
- Hospitalized 10 days; Traech.& Vent Dependent.
- Transferred to Specialty Care Facility(65miles).
- Dispatch: **Vent, insulin drip, monitor.**
- Priority: Non-Emergency.

# SPECIALTY CARE TRANSPORTS

## VENTILATOR PATIENT (Cont'd):

### Hospital Contact:

- Spontaneous Respirations (6/min/).
- PEEP Setting: 8 (high positive pressure).
- No pulmonology consult before transfer.
- Pavulon (chemical paralytic) administered for transport.
- No Resp. Tech & No Nurse.

# SPECIALTY CARE TRANSPORT

VENTILATOR PATIENT(Cont'd):

Transport:

- > Depart Hospital: 15:20
- > Vitals: BP -112/53; O<sub>2</sub> Sat-96%
- > Bradycardia: 15:45
- > Asystole: 15:46
- > ER: 15:53 (Divert)

Result: Brain Damage. Patient Dies 4 days later.

# SPECIALTY CARE TRANSPORTS

- THE LITIGATION:
  - Vent Failure.
  - Trach Failure.
  - Failure to Bag.
  - No CPR.
  - Poor Airway Management.
  - Anoxic Encephalopathy ( Death Certificate).
  - No Autopsy.

# SPECIALTY CARE TRANSPORTS

- THE LITIGATION (Cont'd):
  - Key Witness: Daughter/Nurse following ambulance who administered care with DNR.
  - CT Scan: Stroke just before or during transport. Primary etiology?
  - Hospital/Physicians: Not Named.
  - Proximate Cause Expert? No Problem, just ask attending pulmonologist who signed death certificate without seeing patient or records.

# SPECIALTY CARE TRANSPORTS

- THE LITIGATION (Cont'd):
  - Standard of care: State Model Protocols (never adopted by local MCA).
    - Training in CCT Curriculum.
    - Paramedic should decline transport outside scope of practice.
    - Ventilator Patient Training 4 hours.
    - Ventilator Equipment Training 1 hour.

# SPECIALTY CARE TRANSPORTS

- **CONCLUSIONS & RECOMMENDATIONS**
  1. Transport of Critical Care Patients requires special attention. There is no such thing as a “routine” critical care transport.
  2. Identify “red flag” Criteria: Vent Patients, imminent labor, psychiatric patients.
  3. Assign Supervisor or other Trained personnel to oversee critical care transports.
  4. Identify applicable Protocol and Scope of Practice BEFORE accepting transport.
  5. Equipment Check & Verification.
  6. Training and Education of Transporting Staff.
  7. Refuse unstable patients ( the sending physician will not back EMS if unstable patient deteriorates).

# CONTRACTED LIGHTS & SIRENS

- Catheterization Lab Transport.
- Nursing Home Response.
- Urgent Care Response.
- Non- 911 Response.

# CONTRACTED LIGHTS & SIRENS

- **LIABILITY EXPOSURE:**
  - Running Lights & Siren dramatically increases risk of accident.
  - Violation of State Vehicle Code for authorized emergency vehicle operation (response to emergency only) may forfeit exemptions.
  - State EMSA immunities may be forfeited.
  - Local MCA Protocol Violation may result in licensure action.

# CONTRACTED LIGHTS & SIRENS

- National Standards:
  - National Association of Emergency Medical Services Physicians (NAEMSP) and National Association of State EMS Directors (NASEMSD)
    - **POSITION PAPER:** "Use of Warning Lights and Siren in Emergency Medical Vehicle Response and Patient Transport"
      - » Utilization of emergency warning L&S should be limited to emergency response and emergency transport situations only.

# CONTRACTED LIGHTS & SIRENS

- CONCLUSIONS & RECOMMENDATIONS
  1. Contracted “*hot*” responses not only increase chance of accident, but may violate state statutes and local protocols.
  2. Will not meet national standards criteria.
  3. May forfeit EMSA Immunity protection.
  4. Business Partner liability (i.e. urgent care).
  5. No system oversight.