So You Want to Get Sued? Unique and Not-So-Unique Case Studies and Lessons Learned

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TEXAS EMS CONFERENCE

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The Six Best Ways to Get Sued in EMS

1) Ignore Patient Privacy
2) Let Burned Out EMTs and Medics Treat Patients
3) Disregard Fundamental Patient Rights
4) Document Poorly
5) Let Patients Refuse Care Without Explaining Risks
6) Don't Take Action When You Should

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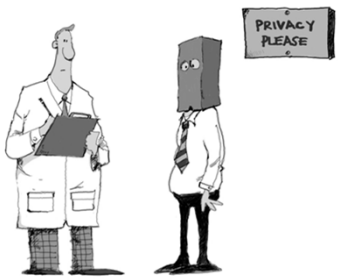
1. Ignore Patient Privacy



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Hereford v. Norton Healthcare, Inc.

Kentucky Court of Appeals
July 21, 2017

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Facts

- Dianna Hereford was employed by Norton Healthcare as a nurse
- Prior to assisting a physician with a procedure, she warned him that he should wear gloves because the patient had Hepatitis C

5

Facts

- The patient filed a complaint with the hospital alleging that Hereford improperly disclosed PHI because her voice was loud enough to be heard by other patients and medical personnel
- Her employer investigated and terminated her for violating HIPAA

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Facts

- Hereford sued her employer for wrongful termination, claiming that:
  - She was following HIPAA
  - HIPAA permits "incidental disclosures"

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Court's Ruling

- Trial Court granted Summary Judgment in favor of the hospital
- Upheld Hereford's termination

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"A physician should not require being told that a patient has an infectious disease as a reminder to wear personal protective equipment…"

Court's Decision, p. 4

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The Liability of Ignoring Patient Privacy

- Difference between disclosures that are strictly for the provider's benefit and those that are related to patient care

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The Liability of Ignoring Patient Privacy

Contrast these Statements:

- *"Glove up! This dude has HIV"*
- *"Pt has past medical history of pneumonia and liver failure, pt is HIV positive and has had prior abdominal surgery…"*

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This is About Your *People…*

And the concepts of *ethics, integrity, respect* and *human decency!*

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Upholding Patient Privacy

- This is both a *legal* and *ethical* obligation
  - Your agency needs a robust HIPAA compliance program
  - Initial and periodic privacy and security training
  - Proper use and management of portable devices
  - Fostering a culture that respects patient privacy

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2. Let Burned Out EMTs and Medics Treat Patients

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Estate of Kerry R. Butler, Jr. vs. Joseph Stracke, et al.
Circuit Court for Baltimore City
October 1, 2018

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Facts

- Early morning of March 2, 2011, Kerry Butler, a 28 y/o male, awoke with severe chest pains
- Told his wife Crystal he thought he was having a heart attack and asked her to call 911
- Crystal reported her husband was conscious but having chest pains and difficulty breathing

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Facts

- After she completed the 911 call, Crystal observed her husband lying on the bed with his legs "balled up" and holding his chest
- City EMS was dispatched for a chest pain patient, a "Level 1" priority call
- Paramedics Joseph Stracke and Stephanie Cisneros responded emergently to the call

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Facts

- Crystal testified that Paramedic Stracke came to the door without a medic bag and in a very loud voice yelled *"what seems to be the problem? What seems to be the problem?"*
- Crystal responded: "He's having a heart attack!"

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Facts

- Medics had Kerry walk unassisted to the ambulance
- While walking to the ambulance, Kerry held his neck and said his throat was "burning" and that "his chest hurt"
- During assessment, Paramedic Cisneros learned that Mr. Butler had eaten a spicy chicken sandwich from Wendy's, Oreo cookies and Hawaiian Punch before going to bed

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Facts

- Pt transported to Harbor Hospital with no EMS interventions
- Upon arrival, medics obtained a wheelchair and walked pt from the ambulance to the wheelchair
- Medics told the hospital staff the pt had "burning in his throat" and documented ***"heartburn"*** as the reason for transport

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Facts

- Kerry waited in the ER about 10 minutes, holding his chest and complaining of chest pains
- Became unconscious and slid from the wheelchair
- Paramedic Cisneros called out for help
- Kerry coded in ED and was pronounced dead
- Cause of death: Myocardial Infarction (MI)

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The Trial

- Case was tried before a jury from February 23 to March 10, 2016
- Jury returned a verdict of $3,707,000 in favor of Mr. Butler's estate
  - Verdict subsequently vacated on appeal

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Paramedic Cisneros' Own Deposition Testimony:

"If you're complaining about chest pain, you're going to get nitroglycerine. You're going to get oxygen, in fact, if necessary. You're going to get an IV, you know? Those are just givens. That's it."

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The Liability of Burnout

- Sometimes we worry about retention *too* much
- Retention is not always a virtue, and turnover is not always a vice!

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The Liability of Burnout

- EMS leaders must recognize signs of burnout in the clinical care provided – or not provided – by their people
- Robust QA programs should spot this
- Engaged supervisors should too!

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3. Disregard Fundamental Patient Rights

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Susan Ross Green as Executrix of the Estate of Walter Green v. City of New York, Paul Giblin and St. Luke's-Roosevelt Hospital Center

2nd Circuit Court of Appeals
October 5, 2006

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Facts

- Walter Green had ALS (Lou Gehrig's Disease) and was vent-dependent
- March 19, 2000, had respiratory episode; caregiver began performing mouth-to-trach
- Pt's daughter arrived and found him unconscious, eyes rolled back, "green skin" and cold to touch
  - 911 called at 2:40 p.m.

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Facts

- Daughter told the dispatcher her father's vent was not working and "we need help"
- A few minutes later, her mother (Susan) arrived and began using an ambu-bag and suction
- Walter regained consciousness

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Facts

- St Luke's EMS personnel and police then arrived on scene
- Walter blinked "no" when asked if he wanted to go to the hospital and typed out "no, because I fine" on his computer, which spoke the words for him

30

Facts

- The FD arrived, and Lt. Giblin announced that he was in command and told Susan "we are taking him in" while the words "no hosp" appeared on Walter's computer screen *(Court's opinion, p. 7)*

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Facts

- "Susan begged Giblin to ask Walter questions, so that he could observe his answers, but Giblin refused to look at Walter." *(Court's opinion, p. 7)*
- "Giblin could not tell whether Walter was oriented to time, place and person, and did not assess his decisional capacity" *(Court's opinion, p. 9)*

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Facts

- Susan called her family attorney, who came to the scene while EMS was present
- Attorney determined Walter to be competent and told Lt. Giblin that
- Attorney asked: "if Walter could talk and say no, he didn't want to go, would you still take him?"
- Giblin replied that he would not

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Facts

- By this time, the daughter erected a makeshift barrier of furniture to prevent the EMS personnel from moving Walter
- Officers and EMS began to move Walter for transport, and in the process Susan was knocked down

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"We are going to the hospital whether you like it or not."

-Lt Giblin

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Facts

- Susan then asked if Walter could be taken to Columbia Presbyterian since it had a unit for the treatment of Lou Gehrig's Disease
- Giblin responded "no we are going to St. Luke's Roosevelt"
- Susan asked: "Why?

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"Because I said so."

-Lt Giblin

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Walter's Deposition

- "How to express in words the depth of pain I experienced that day. It was by far the worst physical pain I've ever endured. I cried in my wife's arms for an hour. For 40 years I have protected my family…I watched my wife get knocked to the floor…I saw my daughter manhandled by large men who claimed to be helping. My home was violated, my self-respect crushed…I couldn't look at my wife and children. I felt ashamed, and for the first time an utterly helpless man, worthless."

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Appeals Court Decision

- Found that the EMS personnel violated Walter's rights under the Americans With Disabilities Act (ADA) and state anti-discrimination law

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The Liability of Disregarding Fundamental Patient Rights

- A competent patient who understands the risks and benefits has a right to elect not to receive EMS care/transportation – even if potentially lifesaving
- Competent patients can express their refusal in both verbal and non-verbal ways

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The Liability of Disregarding Fundamental Patient Rights

- The decision on a patient's competence must be made by assessing the patient – not merely the "chaotic" circumstances or "crisis atmosphere"
- Severe physical disability does not equate to decisional incapacity

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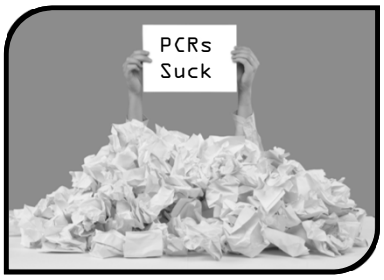
4. Document Poorly



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De Tarquino v. Jersey City EMS
Superior Court of New Jersey
June 28, 2002

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Facts

- Patient involved in altercation with police
- Pt taken to police station, then EMS was called
- Two EMT-Is arrived at the police station
- Patient vomited during the EMS treatment
  - Plaintiffs allege this was a sign of a serious head injury

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Facts

- Transported pt to a community hospital
- Crew provided copy of PCR to the hospital
- PCR did not document that the pt had vomited
  - In fact, the PCR indicated "-N/V"
  - Testimony later confirmed this mean "negative for nausea or vomiting"

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Facts

- The community hospital concluded that pt was not seriously injured
  - Released pt to police custody
- Six hours later, pt experienced seizures
- EMS called again
  - Transported pt to a trauma center

46

Facts

- Three days later, pt declared brain dead
- Cause of death: epidural hematoma

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The Lawsuit

- Plaintiff's lawsuit:
  - Ambulance crew negligently failed to record that the patient had been vomiting, which can be a sign of serious head injury

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Trial Court Decision

- Dismissed the lawsuit against the EMS crew
  - Found that NJ immunity statute protected them from liability
    - EMS providers immune for "an act or omission… committed while in training…or in the rendering of services in good faith"
    - Court found that *"the rendering of services includes the preparation of a report regarding those services and the EMT defendants were therefore entitled to immunity"*

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Question for the Appeals Court

- Does the immunity provision apply only to the direct rendering of patient care, or does it include the preparation of documentation describing that care?

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Appeals Court Decision

- Plaintiff's claim is ***not*** based on negligence in the performance of actual patient care
- Claim is based on alleged negligence in failing to properly document the patient's condition
- Immunity law does ***not*** protect the EMS providers from negligence in their ***documentation***

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The Liability of Poor Documentation

- Documentation may be "negligent" even when patient care is not
- There is a distinct standard of care applicable to patient care documentation
- Immunity statutes can't be relied on to protect EMS practitioners in all cases

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5. Let Patients Refuse Care Without Explaining Risks

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Browning v. West Calcasieu Cameron Hospital
Louisiana Court of Appeals
Nov. 12, 2003

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Facts

- Jewell and Billy Browning went out to see a movie
- Jewell complained of pain in her left arm and shoulder and told her husband "it's just bursitis"
- After the movie, they stopped to eat then went to visit their daughter and son-in-law and went for a walk with them

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Facts

- After their walk, Jewell said she was not feeling well and was "weak and hot"
  - Subsequently began vomiting
- Jewell's daughter called for an ambulance
- Ambulance from West Calcasieu Cameron Hospital (WCCH) arrived w/in 3 min with two paramedics

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PCR Narrative

- *"Upon arrival found 57 year-old female seated on couch. Noted vomitus on floor. Patient stated had eaten burger from Burger King approximately one hour prior to going for a walk. Patient denied any chest pain or any medical history. Patient stated that when she returned to the house, she became dizzy, light-headed, and nauseated. Skin cool and diaphoretic. AOX3. Pt stated she felt fine after vomiting. BP taken. Pt again stated felt fine and refused transport to hospital for evaluation."*

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Family Testimony

- Family stated in their depositions that they had also told the crew about her left arm pain, and daughter told medics her mother also said "she was having a hard time breathing"
  - No such documentation appeared in the PCR

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Crew Communications With Pt

- After completing assessment and medical history, the lead medic told Jewell she "probably suffered a heat related illness" and advised "ice chips and a tepid bath"
- Husband testified the lead medic repeatedly said "you're going to be all right, Mrs. Browning"
- Crew did not consult online medical command

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The Patient's Refusal

- Conflicting testimony about number of times and manner in which crew asked for permission to transport Jewell
  - But the court was convinced that "Mrs. Browning clearly refused any and all attempts made by the paramedics to transport her to the hospital"
  - Crew then asked Mrs. Browning to sign their refusal form

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The Refusal Form

- The WCCH refusal form contained this language:
  - *I admit that the above refusal is against the advice of the personnel of West Calcasieu Cameron Hospital Ambulance Service who have advised me of the dangers which may result from my refusal including, and not limited to the following:*

BLANK

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Second Call

- Less than 1 hour later, Mrs. Browning began shaking and gasping for breath
- Ambulance called again
- Pt found without pulse and monitor showed v fib
- CPR/defibrillation – restored cardiac rhythm and transported pt

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Outcome

- Pt pronounced dead at 0400 the following morning
- Cause of death: Myocardial Infarction (MI)

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Court's Ruling: The Refusal Form

- Appeals court said Jewel's signing of the refusal form *did not* waive legal claims against WCCH because the paramedics failed to include required information in the refusal form about possible dangers and outcomes of refusing transport to the hospital

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Court's Ruling: The Refusal Form

- ***"The refusal form itself reveals crucial omissions which are at the heart of informed consent…and her signature on the form is not a waiver of claims against WCCH."***

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The Liability of Bad Refusals

- A signed refusal form will offer little or no legal protection if the pt is not fully informed of the underlying risks of refusal
- The disclosure of those risks to the pt or legal decisionmaker must be fully documented

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The Liability of Bad Refusals

- When a pt exhibits any symptoms or history that could indicate serious underlying condition, EMS practitioners should not reassure a pt that "everything will be all right" or attempt to ascribe a benign cause to the symptoms

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6. Failure To Act When You Should – or, "Forgetting Who We Work For"

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People of the State of Colorado v. Randy Roedema, Jason Rosenblatt, Nathan Woodyard, Jeremy Cooper, Peter Cichuniec
Colorado State Grand Jury Indictment
August 27, 2021

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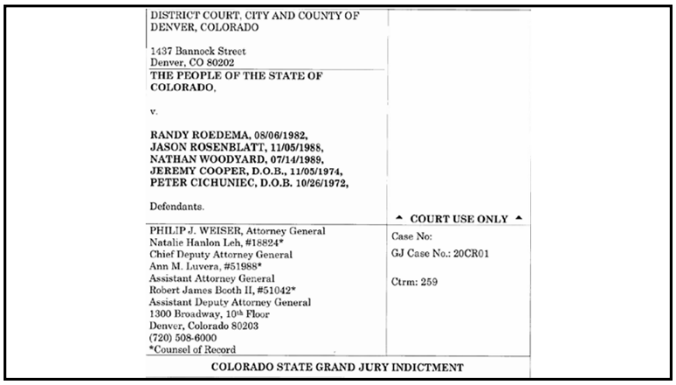

DISTRICT COURT, CITY AND COUNTY OF DENVER, COLORADO

1437 Bannock Street
Denver, CO 80202

THE PEOPLE OF THE STATE OF COLORADO,

v.

RANDY ROEDEMA, 08/06/1982,
JASON ROSENBLATT, 11/05/1988,
NATHAN WOODYARD, 07/14/1988,
JEREMY COOPER, D.O.B., 11/05/1974,
PETER CICHUNIEC, D.O.B. 10/26/1972,

Defendants.

▲ COURT USE ONLY ▲

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Case No:
GJ Case No.: 20CR01
Ctrm: 259

COLORADO STATE GRAND JURY INDICTMENT

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"Essential Facts"

- On August 24, 2019, Mr. McClain, was walking home from a convenience store and was approached by 3 Aurora police officers who had responded to a 911 call reporting a person wearing a ski mask and acting strangely
- The officers concluded that McClain was "suspicious" and very shortly after engaging him, acted to physically "take control" of McClain. One officer told the other officers that McClain had reached for "your gun," but the other officer stated that he did not feel any contact with his service weapon

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"Essential Facts"

- Officers applied pressure to McClain's carotid arteries using a "carotid control hold." Other restraint techniques were also used. McClain allegedly vomited into his ski mask during the interaction but was unable to remove the mask or clear his own airway in his position of restraint
- McClain lost consciousness and the officers released the carotid control hold but at no time checked McClain's pulse or breathing. At that time, officers called for Aurora Fire Rescue

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Essential Facts

- Two paramedics from Aurora Fire Rescue (a non-transporting ALS first responder unit) arrived and found McClain restrained and in handcuffs. EMS was informed that a carotid control hold had been applied to McClain and that he previously lost consciousness
- The 2 paramedic defendants deny having knowledge of the carotid maneuver. The indictment alleges that the two medics stood near McClain but did not speak to him or ask him questions

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Essential Facts

- The medics observed the restraint by policy and watched them forcibly push McClain to the ground
- One medic told police: *"We'll just leave him there until the ambulance gets here and we'll just put him down on the gurney"*

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Essential Facts

- One of the medics ordered ketamine from the ambulance that had arrived. The medic estimated McClain's weight to be 200 pounds and dosed the ketamine at 500 mg
- The correct dosage of 5 mg/kg would have been a dose of 453 mg. McClain actually weighed 143 pounds, an overestimation of 57 pounds. The correct dosage of ketamine should have been closer to 325 mg

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Essential Facts

- About two minutes after ketamine administration, McClain was placed on the ambulance gurney, unconscious and limp, with visible vomit on his face
- Shortly after loading McClain into the ambulance, medics determined he had no pulse or respirations. CPR and epinephrine were administered. McClain regained a pulse but was declared brain dead three days later

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The Charges

- Manslaughter – unlawfully, feloniously, and recklessly caused the death
- Criminally Negligent Homicide – unlawfully and feloniously caused the death by conduct amounting to criminal negligence

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The Charges

- Assault in the Third and Second Degree – unlawfully, feloniously, and recklessly caused serious bodily injury – for purpose other than lawful medical treatment intentionally caused stupor, unconsciousness, or other physical or mental impairment or injury by administering a drug capable of producing the intended harm without consent
- Crime of Violence – unlawfully caused seriously bodily injury or death; *unlawfully used a deadly weapon - ketamine*

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The Prosecution's Theories

- Determination of excited delirium "was an inaccurate diagnosis born of the paramedics' failure to adequately assess Mr. McClain's symptoms," and that in light of the "inaccurate diagnosis," ketamine should never have been administered
- If ketamine administration had been appropriate, the correct dosage would have been 325 mg, not 500 mg
- The medics "deviated from the standard protocols governing when to administer ketamine *such that the administration of Ketamine was unlawful*."

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"Unlawful Protocol Deviation"

- Improper assessment led to improper "diagnosis" of excited delirium
- Failed to reasonably estimate McClain's body weight, leading to a dosage of ketamine that was too high
- Failed to properly monitor McClain during/after ketamine administration, causing "multiple predictable complications"
- Lack of consent to administer ketamine, and no attempts to obtain consent

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Civil v. Criminal Conduct

- Ordinary Negligence – unintentional mistake
- Gross Negligence – more than a mistake - Indifference or reckless disregard
- Criminal Negligence – *willfully* and *purposely* acted recklessly with disregard to obvious risks to human life

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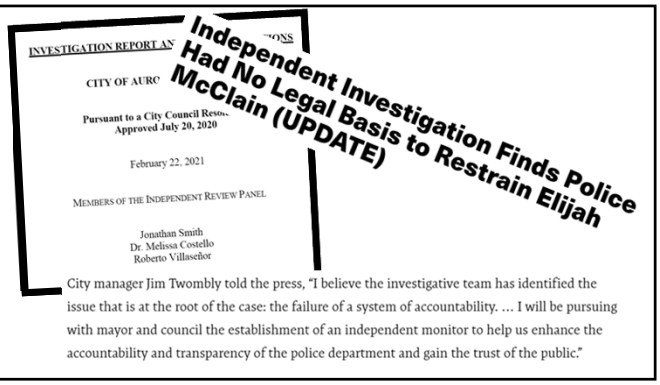

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Concerns About EMS Response

- Delays in a clear transfer of control from police to EMS
- Lack of clear communication and possible information loss between Aurora Police and Fire
- Delayed and incomplete assessment

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Concerns About EMS Response

- Failure to obtain appropriate equipment
- Inaccurate estimation of patient weight
- The role of "cognitive errors" in medical decision making

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Unconscious Bias in Healthcare

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We Have a *Legal*, *Moral* and *Professional* Duty to Act!

….duty to take proper actions to prevent harm to the patient

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Lessons Learned

- Legal, moral and professional duty to act – and access the patient
- Duty to prevent harm to the patient
- Always practice the 3 principles of the "professional caregiver"

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Three Essential Attributes of the "Professional EMS Practitioner"

- As health care professionals, we recognize that:
  - We have a duty to *question ourselves*,
  - We have duty to *question each other*
  - We have a duty to *accept responsibility* for our actions/inactions

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Lesson Learned

- Address the implicit biases that cloud decision-making
- EMS must accept and serve ALL patients
- Teach how to intervene in difficult situations
- EMS needs to act – and access the patient when necessary

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When Bystanders Remain Silent…

- "Normalizes" the bad behavior – the perpetrator feels its OK and others see that as acceptable conduct
- ***We can't be bystanders to bad behavior or when we see a patient who needs us!***

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Lessons Learned

- Need to collaborate with police *before* a stressful event
- Need to develop "role definition" and "handoff" procedures to ensure proper EMS involvement

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Lessons Learned

- Don't let *complacency* become *complicity*
- Always remember – First, Do No Harm!

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Our Prime Directive

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The National EMS Industry Law Firm℠

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