

## CHAPTER 16

# Legal issues

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### Introduction

Medical oversight in prehospital care is distinctly different from any other supervisory activity performed by a physician. Although it is acknowledged as an integral element of an EMS system, medical oversight has been a bit of a mystery to the law, the public, and the medical community [1]. Despite their immense responsibilities in providing medical oversight, medical directors were rarely defendants in litigation during the first 30 years of EMS. Although weakening, this trend continues.

There have been obvious improvements in the sophistication of EMS systems since the early days of "invalid coaches" staffed by "ambulance drivers," and a continued appreciation for "the speed with which the ambulances reach the sick and injured, bringing help that literally wrest the sufferer from the jaws of death, as the last flickering spark of life is leaving the body" [2]. However, prehospital medical care is often misunderstood, and consequently the role of the medical director is often not understood by lawyers, citizens, bureaucrats, and even some physicians. As recently as 1989 an appellate court judge referred to an ambulance as a "medical taxicab" rather than a mobile intensive care unit [3].

Ignorance and misperceptions affect medical directors. They face confusion, misconceptions and uncertainty in the day-to-day events of medical oversight and in the legal crises that may erupt from those duties. The medical profession has had decades to develop standards and predictability in legal rulings involving medical malpractice. However, only recently has a patchwork of legal decisions involving EMS activities solidified sufficiently to provide some predictability. In a few states, trends are evolving about liability issues that help define responsibilities of systems or prehospital care providers and interpret immunity statutes governing prehospital care. Medical directors may benefit from the few legal precedents established by other participants in this unique and developing area of medical care. However, any medical director, whether a novice or an expert, must keep in mind that there are many unresolved issues surrounding medical oversight.

In most states, the birth of EMS preceded the enactment of enabling legislation authorizing this unique delivery of medical care [4]. When federal highway grant funds were offered, every state eventually enacted EMS legislation to qualify; however, intense physician supervision was not necessarily mandated in these early statutes, many of which remain in effect more than three decades later [5].

During the development of EMS systems, immunity from liability for the rescuer gradually became a focus of many state legislatures. It was assumed that immunity was a prerequisite for volunteer (uncompensated), provider involvement in emergency response, although there was, and still is, no good evidence to substantiate this proposition [6]. In a 1978 appellate court ruling absolving from liability rescuers who failed to oxygenate a patient in cardiac arrest, the court reasoned that immunity laws were essential because of the difficulty in obtaining insurance and because unlimited liability could "be enough to drive many providers of ambulance service out of business and greatly discourage others from entering" [7]. Immunity for the prehospital care provider became common and remains rooted in EMS law.

Eventually laws were passed to protect the trained rescuer and professional paid responder, as well as the "Good Samaritan." Governmental immunity also became a strong shield from liability for the public agencies. Immunity for the Good Samaritan physician became commonplace, and immunity for the supervising physician was seen as early as 1976.

Medical oversight as a necessary component of a system has not been recognized with uniform enthusiasm in legislation. Although physician participation (often side by side with paramedic personnel) existed in the early mobile cardiac care units, legislative mandates for physician involvement varied tremendously from state to state. Physician involvement commenced only at the hospital door for the majority of volunteer basic life support units that covered the expanse of highways and hillsides across the country. Even as EMS entered the 21st century, medical directors still were not required to supervise the medical care of many non-paramedic services, particularly in rural, nontransporting EMS services. ♦

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Despite the years of muted development of medical oversight, the silence of the courts regarding the role of the prehospital medical director has begun to change. Medical oversight will become increasingly recognized in the legal arena as a fundamental component of quality prehospital care, especially as medical directors become more active and more informed, and the level of care delivered by EMS providers becomes more complex. Potential liability is the inevitable corollary that shadows the development of responsibilities in medical oversight.

With EMS becoming the sixth subspecialty of emergency medicine in September of 2010, awareness of the EMS medical director's role is becoming more high profile. The responsibilities of EMS medical directors are being taken seriously by both the medical and legal professions. A recent health law publication recognized the medical legal position of the EMS medical director and its importance [8]. The role of the EMS physician as an expert witness in legal proceedings has been recently outlined in a position paper by NAEMSP [9].

### **The legal framework of the physician/EMT relationship**

We have all heard that the relationship between the EMS medical director and the EMT is one in which the EMT is the "eyes, ears and hands of the physician" and that the EMT practices "under the license" of the physician. Although these phrases still find their way into texts and sometimes court rulings, they do not describe the legal relationship [10]. The legal relationship is one of supervision rather than agency. An "agent" is "a person authorized by another to act for him" [11]. In a supervisory relationship, the physician has the responsibility to properly oversee the practice of another health care provider, whereas in an agency relationship the health care provider is an employee or representative of a company or governmental department which is responsible for what its employee does under the legal principle of respondeat superior ("let the master answer") and the agency is liable for the actions of its agent. Although EMTs are agents of the EMS institution that employs them, they are not the agents of the EMS medical director.

Agency relationships in the law began with the relationship between master and servant, with the master being liable for any harm caused by the servant. Also known as "vicarious liability," this is not the relationship between the medical director and EMT, because the medical director does not employ the EMT or otherwise function in a manner that would implicate the physician for errors made by the EMT.

The term "delegated practice" had been widely used to describe the relationship between the physician and the EMT. However, in most states, there are no statutes that authorize a physician to "delegate" skills within his or her practice to another health care provider. Texas is a notable exception to this general rule [12].

Emergency medical technicians are either licensed or certified by the state or county in which they practice. The terms "license" and "certification" have been muddled and cause a great deal of confusion in EMS. A license is "permission from a competent authority to do an act which, without such permission, [would] be illegal" [10]. Certification is "the formal assertion of some fact" [10]. Therefore, even when it is called certification, EMTs who are permitted to practice by states and counties are actually licensed. They do not practice "under the license" of the physician, but instead under the physician's supervision, with the permission of the governing body. The notion of "practicing under a physician's license" actually grew out of the fact that EMS developed quickly, and the legal system took some time to catch up to the existence of this completely new health care provider. Although paramedics began practicing in the 1970s, many states did not have enabling EMS legislation until the mid-1980s [10].

The EMS medical director has responsibilities that, in and of themselves, may open him or her to liability for negligently training, supervising, or retaining an EMT. Similarly, the EMS medical director has the responsibility to develop and update protocols so that they are in step with current EMS practice, the medical standard of care, and the law. The EMS physician who simply signs off on an EMT's competency without being intimately involved with medical oversight activities is opening himself to the scrutiny of the courts if an EMT under his supervision commits medical error.

### **Sources of accountability**

The role of the medical director encompasses multiple and diverse responsibilities. Aspects of administration, medical care, personnel management, and education occupy the daily activities of the medical director in the oversight of an EMS system. Consequently, liability concerns are also multifaceted. As with any form of medical practice, physician conduct must conform to accepted standards of care. Sources that define those standards are discussed here.

### **Federal law and regulations**

Although EMS is almost exclusively under state and local law as a health and safety concern, medical directors need to be aware of several areas of federal law. If medical directors are part of the employment hierarchy, their actions may allow them to be named in lawsuits based on employment disputes. The number of such lawsuits is increasing yearly.

Medical directors should recognize the newer definition of sexual harassment. Formerly, overt inappropriate action was required. Now, the creation or perpetuation of "an oppressive or hostile work environment" can constitute harassment [13].

There is continued tightening of safeguards against Medicare and Medicaid fraud and abuse. One of the areas being closely watched is the use of ambulance services, especially for transport.

Physicians have been warned against easy certification of medical necessity for the use of ambulances when other avenues of transportation are available. Merely signing the medical necessity form stating the patient needs transport by ambulance could subject a physician to fines, damages, and civil monetary penalties under the False Claims Act and Medicare fraud and abuse regulations, which have been targeted by government investigators, including FBI task forces, in recent years [14,15]. New regulations for ambulance reimbursement have been drafted that state acceptable reimbursement levels for ambulances based on the condition of the patient [16]. Generally, the patient must demonstrate a need for ALS, such as abnormal vital signs or a need for medications, in order to qualify for ALS reimbursement. Additionally, final rules from the Department of Health and Human Services clarify "medical necessity," provide minimum staffing levels for ambulances, and revise rules for physician certification of the need for ambulance transfer of patients [17].

Federal rules promulgated as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require the protection of any information collected, in electronic or paper form, by a health care provider that may "relate to the past, present, or future physical or mental health or condition of an individual; [describes] the provision of health care to an individual;" or "identifies the individual; or ... can be used to identify the individual" [18]. In response to these regulations, EMS services had to examine their record-keeping and consent procedures as well as those of the entities with which they commonly share information.

### Civil rights

A federal civil rights statute, 42 U.S.C. §1983, provides that "every person who . . . subjects, or causes to be subjected, any citizen . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law" [19]. The effect of this brief passage is significant. Any individual who believes that another has acted against him/her in violation of any law may choose to sue in federal court for a civil rights violation.

Civil rights claims usually include claims of due process and equal protection violations as well. The Fourteenth Amendment of the U.S. Constitution states, "No person shall be deprived of life, liberty, and the pursuit of happiness, without due process of law." This has been interpreted to provide a right for fundamental fairness requiring, at the minimum, "notice" and "an opportunity to be heard" before some right, such as a license, is taken away. Equal protection is the constitutional requirement that similarly situated individuals are treated similarly – this is why discrimination lawsuits are civil rights questions as well.

These claims are significant for a number of reasons. State immunity statutes do not affect the ability of the plaintiff to sue and seek damages in federal court, and there are no absolute federal immunities that apply to these types of cases (though there are qualified immunities). State damage caps, which may affect the maximum recovery in malpractice actions, do not

apply. The successful plaintiff may recover punitive damages and attorney's fees. Often the individual charged does not have proper insurance coverage to indemnify him/her against the costs of the lawsuit, much less a damage award. A few examples demonstrate why these "1983 actions" can be significant in pre-hospital care.

The decision of *Doe v. Borough of Barrington*, rendered in 1990 [20], ruled that a city violated a citizen's rights because it failed to train police officers about AIDS and the need to keep confidential the identity of a person infected with HIV. Reasonably extrapolated to EMS agencies, failure to train public employee prehospital care providers about the transmission of AIDS and patient confidentiality may result in liability if medical treatment and confidentiality are not managed correctly because of ignorance on the part of the prehospital care providers. New HIPAA requirements directly address these issues.

In *Wideman v. Shallowford Community Hospital, Inc.* [21], an obstetric patient argued that she had a constitutional right to direct a county ambulance to the hospital of her choice. The patient contended that when an ambulance transported her to a county hospital that was the direct medical oversight facility for the ambulance service, she was deprived of her "constitutional right to essential medical treatment." However, the appellate court held that there is no constitutional right to prehospital treatment and transport to a facility of patient choice.

Medical directors may face constitutional issues when a pre-hospital care provider contests termination from employment based on due process. Grievance procedures that involve the qualifications of personnel may involve the medical director. Understanding due process may prevent unnecessary review proceedings. For example, in *Baxter v. Fulton-DeKalb Hospital Authority*, a federal court ruled on the due process claim of a paramedic who had been cleared of misconduct in a hospital investigation of field performance [22]. The medical director, who was employed by the hospital and supervised the paramedic who was employed by a public hospital, refused to reinstate the paramedic, even though the paramedic had been cleared of misconduct. The court ruled that the paramedic's claim against the hospital should not be dismissed because the hospital deprived the paramedic of due process by acquiescing to the decision of the medical director without holding a hearing.

A New Mexico physician was charged with federal civil rights violations after he withdrew medical oversight from two providers who were suing him for medical malpractice [23]. The providers claimed that they had a "right" to medical oversight just by virtue of being EMTs, and sued for civil rights violations. A significant problem for this physician was the fact that his malpractice insurance did not indemnify him for civil rights lawsuits.

A Kentucky physician was named as a defendant in a state lawsuit alleging violation of rights under the Family Medical Leave Act as well as for civil rights violations, because he withheld medical oversight for a paramedic in a delegated practice

state [23,24]. The physician refused to extend medical oversight to the paramedic after the paramedic tried to return to work after treatment for alcoholism and depression; the medical director had a long list of prior complaints against this individual, unrelated to his illness, and was in the process of bringing them to the attention of the state licensing authority. Again, the physician's insurance did not clearly cover the costs of his defense. This case is somewhat interesting because the plaintiff chose to bring it in state, rather than federal, court. A federal district court had already dismissed a related case brought by the same paramedic against an ambulance service, citing that the plaintiff had not proven his case under the Americans with Disabilities Act (ADA) [25–27]. Individuals such as medical directors are not subject to the ADA unless they are employers.

### State statutes and regulations

Although the role of the medical director is complex, the statutory provisions that directly address the role are often brief. Each state statute has supplemental regulations concerning the responsibilities of medical directors to the EMS personnel they supervise or the EMS system in which they function. There are different regulatory structures and varying degrees of specificity in different jurisdictions [28]. For example, some state laws provide little more than a short definition of the medical director as a licensed physician responsible for the supervision and training of EMS personnel. Some regulations only state the responsibilities of the medical director in general terms, and it is assumed that the medical director will engage in certain supervisory activities. In other states, regulations identify the responsibilities of the medical director in detail. The Florida statute requires, for example, that the medical director “establish a quality assurance committee to provide for quality assurance review of all EMTs and paramedics under his supervision” [29]. Medical directors are encouraged to ride with the ambulance services in Oregon [30]. In Washington, rules expressly provide that the “medical program director” is certified by the EMS regulatory authority and can be terminated for failure to perform the duties of the position [31]. Clearly, trends are emerging in the regulatory arena to abolish the “paper doc” and mandate quality supervision and involvement.

Increasingly, states are attaching qualifications to the role of medical director beyond mere state licensure to practice medicine. In Oregon, the Board of Medical Examiners must review and approve an application for the position of prehospital medical director [32]. Board certification in emergency medicine, family practice, internal medicine, or surgery or certification in both advanced cardiac life support (ACLS) and advanced trauma life support (ATLS) is required in Missouri [33]. Now that medical director training is available at the national level, certain states now require their medical directors to be certified. New Mexico requires that new medical directors complete, within 2 years after appointment, either a nationally recognized EMS medical director course, a state-approved course, or local orientation provided by a regional or state medical director [34].

State regulations also cover the scope of practice, licensure or certification, and training of prehospital personnel. Licensure differs from certification in that certification by a state only recognizes that an EMS provider has achieved a certain level of training, but does not confer any right to practice based on that training [35]. Licensure by a state conveys a property interest, which requires due process in any proceeding to take away that license. These are both different from the “verification” given by training such as Advanced Hazmat Life Support and ATLS, which simply state a person has completed the education, but makes no representations about his or her ability to use the new skill. It is important to mention that some states use the term “certification” inappropriately, such as when the provider is actually licensed – it is important to look at the underlying rights associated with the position.

At least one federal court has stated that state protocols, not the training of the EMT, dictate his duty [36]. In this case, a basic EMT who had ACLS training was faulted for not intubating a patient. Although he had been trained to do so in his ACLS class, intubation was not within his scope of practice and therefore he did not have a legal duty to intubate.

State law determines the link between the medical director and the provider. The medical director must ensure that protocols articulate medical functions consistent with each prehospital care provider's certification and training. On more than one occasion an unwary medical director has conceded to a provider's request to perform a medical act not legally authorized by statute nor covered by that individual's training. Some skills are subject to extra reporting requirements. In addition, specific testing or training requirements may exist for registered nurses who function in the prehospital setting, such as flight nurses who are often required to have significant critical care experience. The medical director should keep abreast of these regulatory provisions.

Another common regulatory provision is the pre-requisite that the medical director provide written authorization for a provider to qualify for certification. Quite often the medical director signs a form, often the provider's license application, making a statement such as, “I understand that I am legally and professionally responsible for the directed medical actions of this EMT-paramedic.” This language is quite explicit and may impose significant legal responsibilities on the medical director. The medical director who makes a commitment on paper must ensure that the prehospital care provider is capable and can practice with reasonable skill and safety. Available evaluation or risk management tools should be used. At the very least, documentation of proficiency or capability from reliable sources such as training institutions or employers should be provided.

Medical directors must be aware of the regulatory constraints that define and affect their role. They should not rely on an apparent lack of enforcement by the state regulatory authority to justify ignoring legally imposed responsibilities. A shortage of prehospital care providers in a community should never be justification for authorizing practice by a person with serious



deficiencies in skills or poor judgment. New medical directors are wise to contact state and local EMS offices early in their tenure to be sure that they are compliant with these matters. Veteran directors should have maintained communication channels that enable them to use regulatory agencies as a reliable resource.

In addition, the physician remains accountable to the state licensing board for his medical oversight functions. A recent Arizona case held that a physician medical director for an insurance company who was engaged in making "medical decisions which could affect the health and safety of a patient or the public" was subject to the jurisdiction of the Board of Medical Examiners even though he had no direct physician-patient relationships [37]. Several state legislatures have attempted to put this responsibility into statute.

### Local ordinances

The medical director will encounter additional layers of codifications in county and municipal government. City ordinances and county resolutions often target activities not addressed by state regulations. Such provisions can be very stringent and sometimes quite outdated. Although the sanctions imposed on ambulance services for violations are sometimes insignificant fines, misconduct may lead to revocation of an ambulance service permit to operate in the jurisdiction. These provisions may require proof of protocols, insurance, and proper staffing and may restrict the response activities of the ambulance service. Medical directors who give orders that conflict with local laws set their services up for trouble with city administrators. Local government politics can be a major source of consternation, and seemingly minor infractions can seriously complicate community relationships.

County attorneys and plaintiff lawyers scrutinize the "black letter law" of these various codifications and hold the physician accountable to the "letter of the law" and the "spirit of the law" as circumstances warrant. The medical director must know and operate within these legal statutes, regulations, and codes. Sound legal advice should be sought if there is a question of interpretation or application, preferably before a legal conflict has materialized. Competent private counsel, city and county attorneys, and state regulatory boards can provide valuable guidance in medical director decision making.

### Immunity laws

Some states have statutes that provide immunity from liability for acts performed by medical directors as long as they act in good faith or in a non-reckless manner [38]. The medical director immunity laws may therefore give a medical director a sense of comfort that the courts will forgive some misjudgments in medical oversight activities. These statutes have not yet been the subject of review at the appellate court level. However, the responsibilities of the medical director remain unchanged. Only the payment of damages is avoided; the medical director may still be responsible for attorney fees and court costs. Immunity laws are also venue specific: state immunity is good only in state

courts. If the complaint involves a federal question, there is no immunity in the federal court system. There may be an ongoing tendency for courts to limit sovereign immunity [39].

Immunity statutes for EMS providers have successfully shielded providers from liability for simple negligent conduct, but providers typically still remain accountable for "grossly negligent or reckless" conduct [40]. For example, Washington paramedics were sued when a patient died after arrival at a hospital with an esophageal intubation [41]. They received immunity under Washington law, however, because "there [wa]s absolutely no evidence in the record to suggest that the paramedics acted without good faith."

An Ohio court recently upheld immunity for EMS providers when a bariatric patient fell from a stretcher as she was carried down some steps. The court found no "willful and wanton" misconduct even in the face of a protocol deviation regarding the use of specialized bariatric stretchers [42]. However, the existence of such immunity statutes can be a blessing as well as a curse. Medical directors should not be complacent in relying on the existence of immunity statutes to shield providers from liability for negligent acts.

### Sovereign immunity

Many EMS services are run by a governmental subdivision such as a county or municipality. These generally benefit from sovereign immunity, which greatly limits actions for which governmental (that is, sovereign) agencies may be sued. Lawsuits generally require gross or willful negligence, although in some states, specific instrumentalities of the alleged negligence, such as the use of an automobile, may allow lawsuit. For example, a county and city ambulance service was sued by a patient who was allegedly rendered quadriplegic during a difficult extrication from a canyon [43]. All of the defendants were found to be immune from lawsuit under a sovereign immunity statute.

Although the statute stated that immunity did not apply to the negligent use of "equipment," the court determined that this did not include the equipment used in this rescue. Similarly, sovereign immunity has shielded municipalities from lawsuits for crashes involving ambulances [44]. A Tennessee court found that prehospital care providers were "health care practitioners" because they were licensed under state law, and as such were specifically exempted from the state tort claims act, which read, "No claim may be brought against an employee or judgment entered against an employee for damages for which the immunity of the governmental entity is removed by this chapter unless the claim is one for medical malpractice brought against a health care practitioner ..." [44,45].

### Contracts

The role of the medical director is complex and demanding. The days of volunteer medical directors working without contractual agreements are gone. A contract sets out the framework of your relationship with the EMS agency. The physician newly recruited as a medical director can benefit from predecessors

and peers. Accepting a position of responsibility for an EMS system and all patient care rendered within that system should be preceded by a frank and detailed discussion of everyone's roles and responsibilities. The job is more manageable if medical directors have clear and unequivocal authority to accomplish the tasks with which they are charged. A contract in which the medical director's responsibilities and authority are delineated and agreed on is not an unreasonable formality; it is an important source of the medical director's legal authority. It is critical that medical directors have the authority to carry out their responsibilities. It is simply sound business practice.

Beware of the service that approaches a physician for medical direction because its previous medical director left the position precipitously and it needs services immediately. These agencies will hand over a contract drafted by its own attorneys and ask for your immediate signature to remedy the situation. Be certain to take your time with the contract and have it reviewed by competent counsel – and find out exactly why the prior medical director left.

Medical directors must acknowledge the fact that they are accountable regardless of how much time they devote to medical oversight and regardless of the number of field personnel they supervise. Medical directors must also realize the risks, the means, and the goals of the position and not hesitate to address these factors before accepting the position. Moreover, accepting the responsibility without any authority is an invitation for frustration, as well as risk. It is important to also recognize limitations that exist in the EMS system and negotiate the means and resources necessary to meet the goals of the job. For example, medical directors may insist that the fire department assume certain responsibilities in training and documentation and that practice restrictions invoked by the medical director be honored. They might insist that a coordinator position be established or equipment upgrades be made. If a private ambulance service has a contract with a city and has promised certain response times or other guarantees, potential medical directors must evaluate whether they can accept the constraints of that performance contract before they become the medical director for the ambulance service.

It is likely that the medical director has implied authority to impose certain restrictions and standards despite the absence of a formal written contract. He or she may accomplish some goals by using written protocols or establishing a quality improvement program with performance standards. The case of *County of Hennepin v. Hennepin County Association of Paramedics and Emergency Medical Technicians* was the first to address the relationship between an EMS medical director and a paramedic in the context of a collective bargaining agreement. A state court ruled it is a matter of medical judgment for medical directors to determine who they would supervise. The employer or the paramedic union could not force the medical director to accept a paramedic the medical director felt was incapable of practicing with reasonable skill and safety [46].

Although many physicians have malpractice insurance coverage that may extend to certain of their activities as a medical director, they are unlikely to have coverage for all potential liabilities. Many of the insurance companies that provide insurance to ambulance services have begun offering secondary insurance policies that cover a physician for potential liabilities that may arise from his duties as a medical director. Secondary insurance policies step in only when the primary insurance, usually malpractice, does not cover an event or when the policy limits of the primary policy have been exhausted. This is in the interest of the insurance companies who know that having a medical director will improve the quality of the service rendered by the ambulance service and therefore reduce insurance claims. If this is not available, the medical director needs to find a source that will protect him or her for these duties, which are often classified as administrative rather than the usual patient care duties.

There is no standard contract, but there are certain minimum issues any contractual arrangement should address (Box 16.1). Prospective medical directors should carefully scrutinize the EMS agency's strengths and weaknesses, the political tone and community support for EMS, and other factors that may affect achievement of their goals. The detail and complexity of the contract will differ if it is an understanding between the medical director and each EMS provider rather than between the medical director and the county commissioners or a municipality.

The substance of the contract may differ, depending on the agencies, the patient populations, the training and staffing of the prehospital care providers, and the different needs for

#### Box 16.1 Minimum provisions of contracts.

- 1 Responsibilities of both parties must be delineated clearly. For example, the medical director likely will be responsible for creating protocols, and the service agency is responsible for distribution of protocols to all prehospital care providers.
- 2 The authority to fulfill the responsibilities must be provided. For example, the medical director should be allowed to impose education requirements and practice restrictions on any EMS provider who demonstrates inadequate performance. His or her position in the chain of command must be made clear – the medical director is in charge of anything that affects patient care.
- 3 The medical director should have a clear understanding of the person or entity to whom he or she is responsible. At the same time, it must be understood that the medical director is at all times a patient advocate.
- 4 The terms of payment, duration of the contractual arrangement, and the recourse for non-performance by either party should be delineated.
- 5 The details of insurance coverage for the medical director should be provided.
- 6 The medical director must have the authority to participate in all aspects of the EMS system that affect patient care, including dispatch, information about all patient complaints, equipment selection, and review of all contracts that may affect the medical director's responsibilities.

immediate and long-range goals for quality improvement measures. The medical director's role must be formalized, because many systems consist of multiple management heads with decision-making authority spread among fire chiefs, company owners, city managers, and medical directors. Medical directors must identify the correct party or parties with whom they must negotiate. A contract with the city health department may be meaningless if the city fire department chief has unbridled discretion regarding who is hired, what level of providers are dispatched to certain medical emergencies, and whether attendance at continuing education sessions is mandatory.

The sovereign immunity of the US government is controlled by the Federal Tort Claims Act, which, on its face, seems to allow federal employees to be sued on the same basis as private individuals [47]. Federal employees do have further protection, however. An additional section of federal law [48] exempts "any claim based upon an act or omission of an employee of the Government, exercising due care, in the execution of a statute or regulation, whether or not such statute or regulation be valid, or based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty on the part of a federal agency or an employee of the Government." The boundaries of the Federal Tort Claims Act were examined in a recent California case in which the National Park Service and two of its providers were sued for failure to have neither the proper equipment nor training for proper c-spine immobilization and CPR [49]. The court determined that any decision as to the training level of providers and what equipment they were provided was a discretionary function and therefore immune from lawsuit. On the other hand, the proper delivery of care at this scene was not a discretionary function and could be heard at trial.

Although medical directors have yet to specifically benefit from sovereign immunity, lawsuits against EMS providers have been dismissed based on it. Without liability of providers, it would be impossible to derive liability against their medical oversight physician.

### Good Samaritan statutes

Good Samaritan statutes are another possible source of immunity for the medical director, though they are more likely to be of benefit in limiting his direct liability from actions at a scene than by preventing vicarious liability by giving immunity to the providers. These statutes vary from state to state, so no blanket statements are possible [50]. In general, however, Good Samaritan statutes usually are written to protect physicians, although others are sometimes included. California, for example, protects nurses, prehospital care providers, firefighters, and anyone attempting to aid a choking victim at a restaurant. Good Samaritan statutes usually apply to actions rendered "at the scene of an emergency," which has been limited to the roadside in some jurisdictions and expanded to hospital rooms in others [51,52]. They usually require that the care rendered is gratuitous and delivered in "good faith." The statutes vary in

their protection, some offer complete immunity, whereas others excuse ordinary negligence [53,54]. A medical director should understand the limitations of his or her state's Good Samaritan statute and how it might apply to medical oversight activities. The American College of Emergency Physicians has published a policy statement supporting Good Samaritan legislation [55].

A Maryland decision temporarily extracted Baltimore firefighter/paramedics from the state's Good Samaritan statute because the city billed for their services and allowed a suit against a paramedic for an alleged esophageal intubation [56]. This decision was overturned on appeal. The appeals court based the decision on another specific fire company immunity act and did not specifically address the Good Samaritan issue [57].

The Aviation Medical Assistance Act of 1998, a limited federal Good Samaritan law, immunizes qualified individuals from liability in state or federal court unless they are guilty of "gross negligence or willful misconduct" in their response to an in-flight medical emergency [58].

### Court decisions

Case law is a source of law in which a written decision by a judge, or a panel of judges, interprets statutes or the applicability of legal principles to a case. Often referred to as "common law," these rulings can determine the merit of a plaintiff's negligence claim or interpret a statute. For example, in recent years, interpretations of the working of immunity statutes and what conduct constitutes "gross negligence" have abounded. However, because of varying facts from case to case, varying interpretations from state to state, and passing years between the date of the incident and a court ruling, case law is sometimes an ineffective educator. Often, though, it is all we have.

Court decisions in one state are not binding on any other state; however, discussions of issues in state case law reveal the success or failure of legal theories proposed by plaintiffs, thereby highlighting the kinds of conduct that attract the attention of judges and juries. Courts also often look to see how other jurisdictions have handled new legal theories and are sometimes persuaded by their reasoning. An awareness of the legal arguments by plaintiffs seeking recovery from EMS agencies and prehospital care providers can guide the medical director in areas where acceptable protocols and negligent conduct have not been well defined. Specific areas of EMS case law important to the medical director are discussed further below. In areas where there is little law directly on point, analogous situations serve to show current legal reasoning.

Remarkably, few legal decisions have discussed medical oversight or implicated medical directors in allegations of providers' misconduct. One of the few negligence actions that addressed the role of the medical director resulted in a ruling adverse to the medical director. In Florida, an appellate court upheld a jury verdict against a medical center, because the EMS medical director failed to properly supervise, train, and instruct the paramedics [59]. After assessing a 5-year-old girl at her home,



paramedics decided no emergency medical care was needed. The young patient died hours later of congestive heart failure. The EMS medical director admitted there was no written protocol for "how to take a history or how to distinguish between an emergency and non-emergency situation" or for taking pediatric vital signs. Instead, the medical director depended on the paramedics' schooling and experience to provide the necessary guidance. The jury concurred with the plaintiff's contention that the medical director was responsible for developing procedures "and deviated from the standard of care by not having established such written procedures" [60]. Protocols addressing, or simply forbidding, non-transport might have protected the system and the medical director.

## Areas of liability

The medical director's duties require that potential liabilities be separated into two general categories: professional and administrative. The professional role encompasses most of what is thought of as the traditional role of the medical director (e.g. delivering and supervising patient care). The liabilities for the medical director in the professional role center on negligence, and common professional liability insurance often provides protection. The administrative role is less clearly defined. Because medical oversight is necessary for employment of a prehospital care provider, decisions on the part of the medical director about withholding medical oversight effectively become employment decisions. Often, disgruntled former employees will find ways to blame the medical director for these decisions. Additionally, a medical oversight physician may be placed in a position where he or she deals with reimbursement issues for the service. This may expose the physician to liabilities for false claims/fraud issues. The significant feature of administrative liability is that traditional professional liability insurance does not apply in these areas. Most of the subsequent discussion will address medical director liabilities in the professional role, which are usually associated with actions/inactions of prehospital care providers.

Without judicial interpretation of the duties for proper medical oversight, the legal claims against medical directors that will prove successful for a plaintiff attorney can only be surmised. The relationship of the medical director and the prehospital care provider is unique, although there are similarities to the relationships between nurses and physicians and physicians' assistants and physicians [61]. Extrapolating from these medical professional relationships and from general medicolegal principles, a few theories are worth noting. These legal theories are some of the pathways by which a medical director can be linked to liability. No doubt there will be other theories proposed by inventive plaintiffs' attorneys.

## Failure to perform responsibilities

The clearest source of liability is a negligent act committed by the medical director. This could be a simple malpractice action for treatment rendered at the scene of an accident by a medical

director who rides along with the ambulance, but it is more commonly a failure in other areas. Through statute and regulation, medical directors are obligated to perform certain tasks, such as providing direct medical oversight, establishing protocols, and auditing the performance of field personnel. Despite many variations among EMS systems and state laws, standards of conduct in medical oversight have taken shape. When litigation arises, expert testimony by other medical directors is usually necessary to give substance and shape to the professional duties of colleagues. A malpractice action against a medical director could be a valid cause of action if the plaintiff can establish the requisite elements of malpractice including duty, breach, proximate cause, and damages. This was successfully argued in the case of Tallahassee, discussed previously.

## Negligent supervision

A claim of negligent supervision requires proof of a duty to supervise and a failure to do so that causes harm to another person. Negligent supervision might be argued if the medical director failed to take action to correct deficiencies in scenarios such as these: (1) the medical director observes a paramedic with poor intubation technique; (2) the supervisor of an ambulance service reports a series of patient care incidents involving a paramedic who verbally abused patients; or (3) the medical director fails to establish medication protocols consistent with current standards of medical practice, thereby letting the paramedic exercise unfettered discretion in the field. If a physician fails to act on knowledge, whether acquired from direct observation, field audits, patient complaints, or other sources, that a provider is lacking in skills or is practicing in a dangerous manner, the physician is duty-bound to remove, restrict, or otherwise prevent the prehospital care provider from continuing to render substandard care. This responsibility would likely be shared (although not necessarily equally) with the provider's direct employer. This duty to supervise arises from the statutory role of medical directors, as well as by virtue of the medical director's delegation of medical practice. It may be clarified in the medical director's contract. A jury would likely view medical directors, with their superior training and their authority to have taken corrective action, to be culpable because of failure to exercise their lawful authority. Although errors in judgment regarding the capabilities of a particular prehospital care provider can still occur, negligence claims against medical directors are less likely to materialize if the physician is active, informed, and involved.

Until recently, no court in the country had held a private physician liable for injuries sustained by a person the physician has never treated, never met, and never agreed to treat [62]. This has changed. North Carolina has found a non-traditional physician-patient duty formed between a physician and a patient seen only by residents the physician had contracted to supervise [63]. Although the reasoning in this case has been criticized, its extension to medical director liability for patients seen by EMS providers he contractually supervises is a possible expansion of



this legal theory [64]. There are several recent cases that follow the same theory. A Missouri surgeon agreed to be on-call for the emergency department (ED) at the same time he was attending a medical conference out of town. A patient was injured in a motor vehicle collision and the delay in obtaining surgical treatment for her due to the absence of the surgeon led to complications. A Missouri Court of Appeals determined that even in the absence of a traditional physician-patient relationship, public policy and the foreseeability of harm to patients supported finding a duty on the part of the on-call surgeon [65]. An Arizona Court of Appeals has recently determined that a physician had a duty to a patient he had never seen nor treated just by providing an informal, or "curbside," consultation about an ECG [66]. The court determined that the consultant physician was in the best position to prevent future harm to the patient by giving correct advice, no matter how informal the request. Again, extending this reasoning to creating a duty on the part of a medical oversight physician is not difficult.

Medical directors usually do not have control over the employment or membership of a prehospital care provider in an EMS agency. However, although active involvement in the personnel aspects of an EMS service is important because the skills and judgment of prehospital care providers directly affect the quality of patient care, the physician should not become an "employer." The authority of medical directors to determine who they will supervise was the focus of *County of Hennepin v. Hennepin County Association of Paramedics and Emergency Medical Technicians* [67]. A county paramedic who was a member of a union had been terminated by the county because of patient care-related conduct. After a hearing for reinstatement, an arbitrator ruled that the paramedic should be reinstated. The case was appealed and the testimony of the medical director was important because he had stated that he could neither trust the paramedic nor be certain that the paramedic would perform safely and appropriately even if on probation. The appellate court ruled that the medical director could not be forced to supervise a particular paramedic he did not believe was competent. The unique relationship of medical directors to the paramedic could "impose potential tort and disciplinary liability on the medical director for actions of unfit paramedics." Therefore the medical director may exercise "medical judgment" to decide who should or should not work as a paramedic, according to the Hennepin County decisions. It is important to note that this court decision relied on the doctrine of delegated practice, which is not the way the law is structured in most states. The court noted that the paramedic could have been assigned to a position not involving direct patient contact.

A more recent case in Pennsylvania outlines a situation in which a medical director's authority was undermined by additional layers of administrative appeals [68]. An EMS medical director and the service he provided medical direction for challenged the Department of Health's finding that he had failed to present adequate evidence to support the withdrawal of medical control. The court found that the Department of Health could

hold a hearing to review determinations regarding a paramedic's medical authorization. The case illustrates the importance of understanding what authority a medical director actually has in a given practice situation before engaging in medical oversight for a given service.

The case of *Rinehart v. City of Greenfield* illustrates the increasingly frequent scenario of EMS medical directors being sued after withdrawal of medical supervision results in an adverse employment action against an EMT [69]. In that case, the EMS medical director withdrew medical supervision from a firefighter/paramedic and reported his action to the fire chief and the government licensing agency. In response, the fire chief placed the paramedic in an administrative position and subsequently terminated her. She filed suit against the city, the fire chief, and the physician. Interestingly, the court stated in a footnote that "It is not clear as a legal matter whether Dr. Rutherford actually had the authority to take this action, but the chief and other parties have assumed that he did." Subsequently, the court noted that the physician's contract provided that the fire department would terminate an individual paramedic's responsibility for advance life support upon receipt of written notice that the paramedic had failed to exhibit satisfactory performance, indicating that it was "troubled" by the interpretation of this portion of the agreement.

As recently as 2012, suits continued to be filed in situations where a paramedic felt that employment consequences resulted from the actions of a medical director who restricted his or her practice. A paramedic was deemed no longer qualified for her job as a result of the suspension of her medical direction and a suit resulted [70].

If an employer such as a fire department fails or refuses to impose restrictions requested by a medical director, the medical director's ability to invoke conditions on the scope of practice of a prehospital care provider may seem complicated. Medical directors are not forced to continue extending their supervision to a prehospital care provider employed by an uncooperative agency, whether in a paid or volunteer service, if that provider has demonstrated incompetence in patient care. It is hoped that the employer would be persuaded to follow the medical director's recommendations for remediation. Such scenarios can be quite divisive and are best averted by being addressed before they occur, such as at the time of contract negotiation. The contract could state, for example, that he or she may, after reasonable investigation, limit, suspend, or withdraw medical oversight from any EMT.

The medical director should remember that EMS is fundamentally the provision of health care. At least one jurisdiction has determined that following a protocol is "following the instructions of the physician" [71]. Medical oversight should be just that – responsible oversight of patient care. No medical director should allow individuals to function under his or her oversight without the ability to completely supervise and, if necessary, limit their action. This oversight extends to direct medical oversight contact with prehospital care providers. Every

radio contact between physician and provider is a potential source of liability. Failure to treat these interactions seriously and appropriately document them may result in problems.

## System concerns

By definition, EMS is a network of resources; therefore, medical directors must construe their role and responsibilities jointly and cooperatively with the other components and players in the EMS system.

Modern EMS is often tainted with antiquated principles that define structures by political boundaries rather than patient needs. Medical directors rarely have an opportunity to implement the system of their choice; they are usually saddled with a machine that is in terrible need of repair, functioning suboptimally, and probably not up to code. Nonetheless, medical directors' responsibilities cannot be shirked; certainly they are no less accountable and perhaps over time even more so, if they acquiesce to unabated problems in their system.

System problems such as regionalization, patient destination, and the use of paramedics or air medical transport can cause a damaging ripple effect in an EMS system. Competing agencies can compromise patient care if coordination and cooperation are not promoted by the medical director, who often has to remind everyone that appropriate patient care, rather than turf and egos, is the important factor. These politico-legal battles are among the most vociferous and most costly. Often, problems are the result of parochialism, competition for patients, or simply ignorance. Medical directors can be instrumental in correcting the errant habits and customs of a system, although it may take years of patience, debate, and befriending; if they do not make the effort, both they and the system are destined to fail.

Entire EMS systems, not just individual providers, are increasingly under legal scrutiny. Although medical directors usually are not identified as the negligent defendants in these cases, they are not simply unwitting appendages to the system. They should be the quarterbacks for all EMS resources. Medical directors should have their positions in the system command structure defined by contract and implemented in standard operating procedures (SOPs). Interactions with, for example, fire department personnel who are used to using chains of command is facilitated by this definition. There should be no hesitation when the medical director appropriately assumes medical oversight of a scene. The following system concerns can become less daunting when addressed with protocols and policies founded on and driven by the principle of optimal patient care.

## Dispatch

Structured and prioritized emergency medical dispatch (EMD) has become the standard of care in most areas. The widespread use of commercial EMD products has fueled this expansion.

Although dispatchers are often not EMTs, they are providing medical information and services as part of an EMS system, and

they usually are required to have medical oversight. Their actions may implicate a medical director. The medical director bears the responsibility to ensure that the dispatch protocols and procedures are reviewed and updated at least as often as patient care protocols. This is especially true if protocols are obtained "off the shelf" from a commercial source – they should be reviewed and modified to ensure compliance with local protocols as well as provision of proper patient care.

Lawsuits have occurred over the issue of dispatch. Although none has yet implicated medical directors, they are worth reviewing. The suits have generally been based on dispatchers sending ambulances to the wrong address, delays in dispatch, or not sending one when needed [72,73]. The results of these cases have been mixed, but usually the dispatch agency has escaped liability. There are two reasons for this. The first is sovereign immunity, which was discussed earlier.

The second theory blocking these lawsuits is somewhat more complex and has to do with the concept of duty. Governments, and their agents such as dispatchers, have a general duty to provide basic, or "essential," public services such as police, fire, and EMS to their citizens. This duty is owed to the population as a whole, not to specific individuals. Unless a court can find that a public service has established a "special duty" toward a specific individual, that individual may not sue for negligence. The key to finding a special duty is finding that a "special relationship" has formed that includes the open assumption by the municipality to act on behalf of an injured party, knowledge on the part of the municipality's agents that inaction could lead to harm, direct contact between the agents and injured party, and the injured party's justifiable reliance on the municipality's help [74]. For example, a call to a dispatcher by someone with a headache who was advised to try aspirin and was later found to have a stroke was not sufficient to establish a special duty, where a series of two phone calls to another dispatcher was [75,76]. Special duty has not been clarified in all states, and is more likely than other theories to vary between jurisdictions. New York and the District of Columbia, for example, have a series of cases discussing special duty, whereas in New Mexico the public duty/special duty distinction has been eliminated by the courts [77].

A lawsuit from Chicago addressed both of these issues [78]. A patient dialed 9-1-1 to request assistance for an asthma attack. The dispatcher indicated help was on the way, but did not keep the patient on the phone until the providers arrived. When the providers arrived, no one answered the door. The EMS personnel made no attempt to enter the apartment. The patient was found dead in the apartment the following morning. The city was sued for failing to keep the caller on the phone until help arrived, and for failure to either attempt to open the apartment or to use force to enter it. An appeals court initially found that the city had sovereign immunity from lawsuit as well as a defense under the special duty exemption, but this was overturned on appeal [79]. The court specifically noted that conduct that is beyond the level of a paramedic's training is not immunized, whereas

conduct that merely deviates from a paramedic's training and constitutes negligence is subject to immunity unless it is willful and wanton. In the present circumstance, the court noted that the paramedics' failure to attempt to open the unlocked door may have been a gross violation of the department's "Try Before You Pry" policy.

In *Ma v. City and County of San Francisco*, the family of a patient who died from an asthma attack while EMS crews attempted to locate her after receiving incomplete directions sued for damages resulting from her death [80]. The court directly addressed the inter-play between duty and immunity, concluding that a duty of care was owed not with regard to the design or structure of the 9-1-1 dispatch system, but as to the manner in which the 9-1-1 emergency service procedures were implemented. The California Supreme Court ultimately found that San Francisco did not enjoy immunity from suit. A year later, the same court addressed *Eastburn v. Regional Fire Protection Authority*, a case in which a plaintiff alleged injury to her minor child resulting from a dispatch error and delayed 9-1-1 response [81]. The court found that no statute imposed direct liability on public entities in such situations and that vicarious liability is limited to cases involving gross negligence or bad faith, overruling portions of its previous decision in *Ma*.

Dispatch recordings that contain protected health information as defined in HIPAA must be handled as medical records, with confidential information protected. These are not public record and should not be distributed to news media or others without appropriate medical release documents in place [82].

Interestingly, many municipalities routinely make forced entrances at homes to which they are called, preferring to pay for a broken window or door, rather than face criticism for not finding a patient *in extremis*.

On the other hand, in late 1999, a Florida paramedic was shot in the chest as he attempted to enter a locked apartment, where he thought he would find a disabled woman who had dialed 9-1-1. He had inadvertently entered the wrong apartment.

Special duty has also been addressed in federal court. In Virginia, a federal district court determined that a municipality had no "special relationship" with plaintiffs in a case that would support a claim brought under 42 U.S.C. §1983 [83]. The court specifically noted that "not every death that results from the state's failure to act is a deprivation under the Fourteenth Amendment. Before an omission that leads to a death is actionable under the Fourteenth Amendment and §1983, the Constitution must recognize an underlying duty on the part of the state to act [84].

## Response

How a fire department staffs rescue units or uses medical personnel to respond to a medical emergency is as much a medical decision as is the choice of intravenous solution. Optimal patient care is sacrificed by the poor placement of ambulances, the lack of coordination of tiered responses, and many other political, emotional, and business factors. Medical directors must study

objectively the components and agencies within their systems; the goal of quality patient care must dictate system management decisions.

Ambulance response should be timely. A Honolulu jury awarded nearly \$2 million against the city for a 2-hour delay in ambulance arrival [85]. It is important to recognize, however, that even when the ambulance response is appropriate, patients often perceive that it took too long [86].

The type of response needed is worth exploring. It is imperative that the service, with the help of the medical director, develop clear and appropriate guidelines for the use of lights and sirens in emergency responses and transfers. Crashes involving emergency vehicles represent more than half the claims paid by insurers of EMS systems [87]. Some providers do not even have an adequate knowledge of ambulance traffic laws [88]. Insurers often recommend special training for drivers of emergency vehicles, to protect both EMS personnel and their patients; medical directors are in a unique position to support this training.

An example of a system failure is *Brooks v. Herndon Ambulance Service, Inc.* The care of a patient was compromised when an EMT unit responded to a call. The patient, a student in a gym class, began seizing and then arrested [89]. The ambulance that received the call had difficulty finding the address, equipment malfunctioned on-scene, and finally the ambulance broke down en route to the hospital with the patient. Ten minutes from the school was a fire department with a paramedic unit that was never notified. Modern EMS will not tolerate such provincialism and uncooperative practices.

Volunteer systems are not immune to attack. Many communities depend on the willingness of individual, uncompensated volunteers to respond to emergencies. However, such EMS services still must meet the same minimum standards as paid services. The volunteer spirit and contribution must not compromise patient care. A promise to provide EMS through the formation of a fire department or fire protection district supported by public funds creates obligations irrespective of the uncompensated status of the responders or the absence of charges to the patient. The duty for these providers to act reasonably is not altered by their gratuitous services. For example, a volunteer fire department with so few providers that there are no adequately staffed ambulances to respond to a call may invite liability if the delay in response was avoidable. This issue was raised in a Virginia case where a volunteer rescue service repeatedly had a shortage of personnel during early morning hours. The dispatcher was not notified of this problem and as a result did not request the assistance of a neighboring agency until the local rescue service failed to acknowledge the requests [90]. Unless medical directors are actively involved in these aspects of an agency, the care rendered in the field may be less than optimal, thus inviting legal complications. A volunteer service should not hold itself out to the community as having a level of care that it cannot promise 24 hours a day, 7 days a week. Medical directors must show prehospital personnel how such

operations endanger or compromise patient care. They can encourage other options to be considered by the service and perhaps lead efforts for systemwide improvement that had not yet been recognized as necessary by the community. Mutual aid arrangements and insistence that only qualified personnel accept patient care responsibilities are examples of the input the medical director may offer to minimize legal risk.

The issue of several appellate court decisions has been the inappropriate use of personnel and equipment; liability has generally been defeated only because of the protections of immunity laws. For example, in *Malcolm v. City of East Detroit*, firefighters trained only in first aid were dispatched to care for a man complaining of chest pain, while available EMT firefighters stayed at the station [91]. The patient arrested and the firefighters attempted to ventilate with a bag-valve-mask, although the patient was aspirating. The jury decided the city's action was willful and wanton, and therefore immunity protections did not apply. However, the judgment of \$500,000 was vacated by the state Supreme Court, which gave an expansive interpretation to the governmental immunity statute [92]. The message is that although the law may excuse substandard care from monetary damages, scrutiny and evaluation of EMS resources must still be pursued by the medical director of the system.

### Scene handling

Besides the delivery of medical care, there are other scene issues the medical director should consider. These include the use of incident command (IC), and scene safety. Although neither of these is directly a medical concern, they have an effect on the efficient delivery of patient care.

Mass casualty incidents are a scene of confusion. There needs to be a command and control structure in place to ensure that appropriate use of resources is accomplished. A New Mexico lawsuit charged municipal, county, and private EMS agencies with negligence in failing to discover the body of a driver who had been thrown 200 feet from a crash scene [93]. Plaintiffs alleged that the agencies had failed to implement a proper incident command structure (allegedly required in their SOPs), which might have required a search; the court disagreed, finding for the defendants. There are federal requirements for the use of IC in all hazardous materials incidents [94]. NFPA 1500 requires fire departments to establish written procedures for IC [94,95].

Scene safety should be a concern for the medical director. Texas paramedics began applying a back-board and c-collar in the middle of an intersection to a patient who had been ambulatory for 10 to 15 minutes after an accident. They were forced to abandon the patient, still strapped to the board, when a vehicle careened into the intersection, ultimately running over the patient. The appeals court found that sovereign immunity did not apply [96]. The paramedics' attention to their own, as well as their patient's safety, would have prevented this tragic error. The US Fire Administration has recognized that scene

management is of primary importance in decreasing injuries for all types of emergency personnel [97].

### Destination

The wrath of the courts has surfaced in decisions addressing the destination policies of EMS systems. When transport of a patient is not dictated by medical concerns and the patient's best interests, or is hindered due to non-medical reasons, juries have been harsh in their verdicts. In *Hospital Authority of Gwinnett County v. Jones*, the plaintiff convinced a jury that the transport of a patient who had sustained serious burn injuries was dictated by consideration of potential economic gains for the receiving hospital. The jury awarded punitive damages against the hospital in the amount of \$1.3 million, and \$5,000 against the ambulance service. A burn facility was approximately 15–20 minutes away by helicopter, and the defendant hospital was closer by ground. Rather than transporting the patient directly to the burn facility by the helicopter already en route to the scene, the patient was brought to the defendant hospital by ambulance, thereby necessitating another transfer of the patient to the burn facility. Arrangements for this second transport caused further delay. When lifting off from the hospital en route to the burn facility, the helicopter crashed, killing the pilot and crew but sparing the patient. The helicopter landing area had been used for years but was not approved by the Federal Aviation Administration. The jury returned its verdict with an additional powerful message: "We the jury find that there should be more stringent regulations of the ground and air ambulance services in the state of Georgia" [98].

The authority of the patient to direct the ambulance to a specific hospital poses troubling issues. A state court found no liability against a direct medical oversight physician who advised EMTs to comply with a patient's preference to be transported to a Level II hospital [99]. The providers had assessed the patient's injuries and felt that transport to a Level I facility was more appropriate. However, the patient's stated preference was honored, consistent with a protocol approved by the regional EMS authority. The patient died from a ruptured aneurysm while awaiting treatment at the Level II facility. The father's claims against the physician and hospital providing direct medical oversight were dismissed because the father failed to produce evidence that the patient would have survived the injury at the Level I facility. This state court ruling emphasizes the need for protocols that reflect sound medical principles; these are defensible even when patient outcome may not be optimal.

Another case illustrates the importance of clear direction and consistency in protocols for transport to specialty care hospitals. Stroke centers and STEMI centers have joined the trauma designation system to mandate EMS transport to the hospital best able to care for the patient despite family request for transport to a different facility. In *Entrican v. Ming, et al.* the mother of a young pregnant woman involved in a motor vehicle accident sued after EMS transported her to a hospital that was not capable of managing multisystem trauma. The court found a conflict in



protocols titled "Choosing a Hospital" and another titled "Emergencies." EMS had reasoned that the smaller hospital could have given blood to stabilize the patient, which it unfortunately failed to do. EMS providers need to be assured that their medical director will back up a decision to bypass a smaller hospital to get to a more specialized center [100].

The issue of hospitals placing themselves on diversion or bypass has begun to be addressed by the courts, which should influence how service protocols deal with the issue. In an early federal case, a hospital on bypass was found to have established a duty to a patient in an ambulance when it established radio contact with the ambulance to tell them to divert [101]. The hospital escaped liability for simple negligence under an immunity statute. A related case from Maryland, however, supports bypass, stating that hospitals have no duty to accept persons when they are unable to treat them [102].

There is a potential complication for hospital-owned ambulances. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to provide a medical screening exam for any individual presenting to the emergency department, and, if an "emergency medical condition" is found, to stabilize the condition before transfer. "Coming to the emergency department," the action that triggers EMTALA, includes reaching hospital property or simply being in a hospital-owned ambulance [103]. EMTALA does allow hospitals to refuse patients after radio communication if they are formally on diversion, but this applies only to ambulances not owned by the hospital, unless local EMS protocols dictate otherwise. In a Hawai'i federal court case, the court considered "coming to the emergency department" to apply to an ambulance in radio contact with the hospital heading toward the hospital, but this decision has not been followed by other courts [104]. A recent opinion from the Center for Medicare/Medicaid Services has further made it clear that the practice of ambulance "parking" that has developed in recent years probably violates EMTALA, and that leaving patients on ambulance stretchers for extended periods of time is not a solution to ED overcrowding problems [105].

### Failure to transport – "no loads"

Emergency responses in which the patient is not transported can seem like wasted effort. In some systems, these ambulance encounters consume time and resources; they constitute a significant patient population the medical director never sees, yet for whom he or she may still be responsible [106].<sup>1</sup> These calls are a medicolegal quagmire involving issues of patient autonomy, consent, medical assessment, and ill-defined legal duties. Patients denied transport or convinced by field personnel to forego ambulance transport have been a source of numerous claims and case law [107].

Research indicates that a significant number of individuals who refuse transport are eventually seen by physicians, and a high number of patients who are refused transport by EMS personnel are eventually admitted to the hospital [108,109].

This area of liability is becoming more visible because some ambulance services are attempting to institute policies for alternative means of transport [110].<sup>1</sup> Under this practice, paramedics determine if a patient needs ambulance transfer to an emergency facility or if an alternative form of transportation, such as a medical taxi, may be used. However, attempts by EMS agencies to identify "alternative means" of transport for EMS patients have largely failed. Research has shown that EMS seriously undertriaged patients who later had critical events, even when paramedics received specialized training and protocols in field triage [111–114].

When field personnel are called to a scene and do not transport a patient because they discover no medical reason for the patient to be taken by ambulance to the hospital, questions of liability are raised quickly if the patient suffers deterioration or demise. If the patient refuses the transport despite apparent medical need, the questions focus on whether patient refusal was "informed." The medical profession requires that refusal of treatment be informed refusal [115]. Informed refusal requires that the patient have decisional capacity, and be informed of his or her diagnosis, the recommended treatment and alternatives, and what is likely to happen if treatment is refused. Claims of liability in either case depend on the following two factors: (1) the thoroughness or accuracy of the prehospital field assessment, and (2) the adequacy of the prehospital communication with the patient about the findings of the assessment and the need for medical treatment.

In *Lemann v. City of Baton Rouge EMS*, the EMS agency responded to a call for a fight in a bar parking lot. They found a 21-year-old man and treated him for a cut hand. He refused transport and the police took him home. Two hours later, EMS received another call for a "man down" and the patient was found unconscious at the top of a flight of stairs. He later died of a fractured skull and subdural hematoma [116]. In *Holt v. City of Memphis*, a man called 9-1-1 on behalf of his mother, who was having trouble breathing. She refused transport, and the son signed the refusal form at his mother's request, only to testify later that he was coerced to sign it. The same EMS crew was called back 3 hours later, and the mother went into cardiac arrest and died during transport. The court found that EMS had performed an incomplete patient assessment, and found their documentation to be extremely deficient [117].

At least one court, however, has upheld a refusal of transport by a patient with decisional capacity even when the patient declined transport after EMS evaluation. In *Kyser v. Metro Ambulance*, the court refused to find abandonment when a 52-year-old man with abnormal vital signs and neurological deficits suffered a severe stroke after refusing EMS transport. The court ruled in favor of the paramedics because they had followed their protocol, had contacted medical oversight, documented the patient's mental capacity, and made persistent attempts to explain the risks and encourage transport. In deposition, a family member admitted that the paramedics had tried repeatedly to convince the patient to be transported [118].

The principle of consent is well known to the practicing physician. Adults of sound mind have the right to refuse medical treatment, even if the refusal of treatment may result in death [119]. Refusal of transport is complicated by the fact that there are indications in EMS that there is no constitutional right for a patient to be transported to the hospital by a governmental EMS agency [120]. In addition to outright refusal, there is some indication that the patient may insist on transport to a hospital less qualified to provide necessary emergency care [121].

Several issues make "no-transport calls" or "no loads" troublesome. To minimize the risk in these situations, short of transporting every patient, the medical director must understand the legal pitfalls inherent in the protocols or absence of protocols for these calls. First, although it is repeatedly impressed on EMS providers that they cannot "diagnose" illness, they are often directed by protocol to determine whether a patient is mentally "competent," a determination which is both a diagnosis and arguably a legal conclusion [122]. In fact, what EMS actually does is to evaluate a patient's decision-making capacity. Second, prehospital care providers have only basic training in assessing mental capacity or lucidity to evaluate a patient's ability to refuse treatment. Typically, they are instructed to ask only simplistic, routine questions about orientation such as "awake, alert, and oriented times three." This training is insufficient for evaluating mental status and providing information to patients for purposes of informed refusals. Third, there is no clear standard of the validity of mental status evaluations made outside the clinic or hospital environment [123]. These cases are further complicated by the lack of established legal standards regarding what constitutes informed refusal in the prehospital environment, to what extent consent is warranted for transport, and to what extent the duty to establish consent or refusal can be delegated by the medical director. Medical directors should make certain that their protocols are based on sound medical, rather than economic, grounds.

Another important issue is the scope of informed consent in the prehospital environment. Decades of case law in medical malpractice regarding the principle of consent involve patients seen in doctor's offices and hospitals, but the field environment is different. It may therefore be unrealistic to assume that the physician's duty to obtain informed consent or informed refusal applies to the prehospital care provider, particularly given the dearth of training in EMS for this task, and EMT's current poor record of informed consent practices [124].

Similarly, there have been no judicial interpretations of the relationship between a patient contacted in the field and a prehospital care provider or the medical director. Although arguably a physician-patient relationship is created in both cases, several cases suggest that direct contact between a physician and patient is necessary for this to occur. A telephone call, for example, is not usually sufficient [125]. Similarly, there is no judicial statement that the prehospital care provider must contact the base station to terminate the patient relationship in a no-transport situation. However, sound medical oversight

#### Box 16.2 Management of calls resulting in no transport

- 1 The medical director must understand that non-transport calls are potentially the area of greatest exposure and liability for a service and the medical director.
- 2 The medical director should have an accurate understanding of local and state laws regarding patient rights, and the circumstances, if any, under which a physician may authorize or direct treatment and transport without the consent of the patient.
- 3 The medical director must ensure adequate training is provided to prehospital care providers on specific techniques for evaluating a patient's mental status in the field.
- 4 Protocols should be guided by optimum patient care, rather than economic benefit to any entity.
- 5 Protocols must be appropriate for the prehospital care providers' respective skill and experience levels and should be reviewed periodically by the medical director and altered as needed.
- 6 Contact with direct medical oversight, if not required, should be encouraged in all cases in which a patient is not transported. Moreover, contact with direct medical oversight should not be an empty formality; it should be a true consultation.
- 7 Ongoing review and audit of radio reports, patient care reports, and follow-up patient contact to evaluate the quality of field releases and patient refusals are imperative.
- 8 All use of restraints and any transport against a patient's will should be reviewed by the medical director.
- 9 A review by competent legal counsel of the release form is recommended, and if the release form used by the EMS agency is of questionable legal merit, then the medical director should prohibit its use.

dictates that the medical director consider direct medical oversight essential, or that very clear and precise protocols be in place if the patient-prehospital care provider relationship can be terminated without such supervision.

Factually, legal cases involving non-transport often involve glaring deficiencies in the assessment performed by the EMS providers; often, they reflect lack of discipline by the providers in adherence to protocols [126]. Liability can befall prehospital care providers who leave the patient in the field without thorough and adequate assessment; medical directors may be responsible if they fail to provide sufficient protocols that detail the circumstances under which patients may be left in the field (Box 16.2).

#### Denial of ambulance transport

*Wright v. City of Los Angeles* expounded on the paramedic's duty to assess in a costly incident of failure to transport [127]. Police summoned EMS personnel for a man found lying on the sidewalk. He appeared to have been involved in an altercation. The paramedic did only a cursory assessment and decided ambulance transport was not necessary; he advised the police officers that the patient could be checked by a physician before booking. In fact, the patient was in sickle cell crisis. The court held that if the paramedic had conducted an examination consistent with the standard of care, he should have been able to determine that the patient was in need of immediate treatment.

There was no contact with the direct medical oversight physician for approval of the nontransport; the paramedic testified that he "saw no symptoms indicating such a call was necessary" [127]. Minutes after the paramedic left the scene, the patient arrested and died. The paramedic thought the patient was simply intoxicated. The court found that the failure of the paramedic to provide "even a scant amount of care" was an "extreme departure from the standard of care for a paramedic in such a situation." Governmental immunity therefore did not shield the defendant from liability in this state court ruling, because the conduct was deemed grossly negligent. Although the medical director was not implicated, the case exemplifies how direct medical oversight might have averted a death and a costly lawsuit.

The medical director should evaluate the substance of the prehospital care provider's radio report when any request is made for a nontransport disposition. Although the prehospital care provider has the best direct view of the patient's situation, the direct medical oversight physician may have the medical expertise to evaluate the complications or implications of the patient's signs and symptoms; therefore, the need for consultation and careful supervision is certainly warranted. The medical director should also carefully monitor radio contacts and ensure that all physicians providing direct medical oversight know the protocols for nontransport situations.

An example is provided in *Green v. City of Dallas*, which involved paramedics who failed to transport a 35-year-old man complaining of chest pain [128]. Because of the patient's age, the fact that he was on no medications, and the observation that he was exhausted from playing basketball, the paramedics reasoned that the pain was not cardiac in nature. Five minutes after the crew departed, the man arrested. The ambulance was sent back to the scene, but the man could not be resuscitated. The city avoided liability only through sovereign immunity.

The decision in *Hialeah v. Weatherford* demonstrates that the time between the EMS contact with the patient and patient demise need not be brief to establish proximate cause [129]. In this case, the patient died 24 hours after the ambulance crew left. The patient's wife had called for assistance; the prehospital care providers observed her husband lying naked and stuporous when the ambulance arrived. The ambulance crew refused to transport the man, despite his wife's requests. The patient was transported 24 hours later when his wife again called for an ambulance; he died shortly afterward. The court held that there was sufficient evidence of proximate cause between the failure of the first crew to transport and his death more than 24 hours later, notwithstanding the wife's delay in requesting an ambulance the second time.

Prolonged scene times have also fared poorly under judicial scrutiny. In a case from Louisiana [130], a delay of transport due to prolonged scene time (20 minutes for someone with chest pain) was determined to be a cause of loss of a decedent's chance of survival and resulted in a jury award of damages against the paramedics involved.

## Patient refusal

Sometimes a patient adamantly refuses transport, although the EMS crew feels transport is necessary. These cases are troubling for prehospital care providers when they feel it is in the patient's best interest to receive medical care. In addition, some prehospital care providers have been instructed by medical directors who would rather take the risk of forced transport than leave an injured patient. The rationale is that transport should be accomplished so a physician can evaluate the patient and establish informed refusal in the controlled setting of the ED. It can be argued that transport is warranted because the patient is unable to give informed refusal if, for example, circumstances or injuries appear to impair his or her ability to comprehend the risks and consequences of refusal. On the other hand, an adult of "sound mind" is allowed to refuse medical treatment. Patients have the right to make medical treatment decisions that may result in deterioration and even death [131].

In some cases, a friend or relative has summoned the ambulance and wants the patient transported. Liability claims may still be argued against the EMS agency. In *St. George v. City of Deerfield Beach* an ambulance was summoned by a visitor of a man found bleeding extensively from a tooth extraction [132]. The paramedics failed to transport the man who was "obviously drunk and bleeding, but he absolutely and continually refused examination or treatment." The visitor called 9-1-1 a second time about 20 minutes later, but the dispatcher refused to send an ambulance. The appellate court rejected the defendant's motion to dismiss, ruling that sovereign immunity did not apply. Additionally, the court determined that the service owed a "special duty" toward the patient based on the repeated phone calls.

An interesting area of patient refusal arises in the context of children. Some states possess specific statutes that allow consent for medical treatment, and therefore refusal, to individuals as young as 14, but they often pose a dilemma [133]. Frequently, ambulances are dispatched for a minor driver involved in a motor vehicle accident who does not need, nor want, transport. It is important to have protocols in place to deal with this situation. EMS medical directors should be familiar with their states' laws on emancipated minors and should educate EMS providers on issues involving minors and consent.

## Transport against will

Transport against the patient's express desires, particularly if restraints are used, may constitute false imprisonment. It may also have Fourth Amendment implications for government EMS services. The pivotal issue is whether the detention of the patient is justified under the circumstances [134]. There is some legal authority for a physician to forcibly restrain a person in need of treatment by virtue of a qualified privilege [135]. The *Shine v. Vega* case (429 Mass. 456, 709 N.E.2d 58) involved the involuntary restraint and treatment of an asthma patient in a hospital emergency room and resulted in the court cautioning physicians against imposing their will on patients with



decisional capacity. Deprivation of a person's liberty is always a serious and risky matter.

A flurry of lawsuits has occurred in the area of the death of individuals who have been restrained. These "in-custody death" cases have mushroomed in recent years and are often coupled with civil rights claims. These will require services to closely scrutinize any restraint policies they may use and to insure that policies are updated to reflect the current state of medical knowledge about conditions such as excited delirium.

A few states have statutes that provide legal authority for peace officers to direct EMS personnel to take a person to a hospital if it reasonably appears that medical treatment is needed. Such statutes usually require the peace officer or transporting personnel to act in "good faith" to gain the protections of immunity [136]. In other states, the statute may allow EMS personnel this authority on their own. New Mexico allows transport upon a "good faith judgment" by the EMS provider that it is needed [137]. These types of statutes provide both authority and legal protection in the unwilling transport situation; however, medical oversight is no less important and may be evidence of "good faith." The medical director must understand the circumstances under which such laws may be used. Consultation with local law enforcement may be vital for the effective application of protective custody efforts. Immunity was not available for paramedics who forcibly took an allegedly suicidal patient to a Wyoming hospital against her will, although they were acting under the state's valid emergency detention statute [138].

The "reasonableness" of their actions, carrying the patient, naked, uncovered, and handcuffed, to the ambulance, was left for the jury to decide. In a similar circumstance, the city of Louisville was forced, after an unsuccessful appeal, to go to trial to determine if its actions of transporting a patient to the hospital and inserting an IV against her will constituted false imprisonment and battery [139].

Many EMS agencies and medical directors require that the provider contact direct medical oversight in every patient refusal encounter. This is useful only if the quality of the contact is not superficial. EMS providers must be thorough, accurate, and honest in their reports to physicians. The physician must be diligent in listening, questioning, and evaluating the soundness of the information. The medical director must tailor the protocol for patient refusals according to the EMS system and the prehospital care providers' skill and experience. Quality supervision by a medical director thereby diminishes claims of negligent failure to transport or patient abandonment.

### Documentation of the refusal

Careful patient assessment and instructions or advice regarding refusal of treatment must be documented. The documentation on the prehospital care report (PCR) should unequivocally demonstrate an assessment adequate for an informed decision regarding the need for transport. Liability might arise for the medical director who fails to review retrospectively cases of

nontransport or patient refusal to identify deficiencies in assessments or information provided to patients.

The use of releases, waivers, and other such documents that the patient signs in the field have limited legal merit for several reasons. First, courts frown on documents that attempt to deprive a person of recourse to the courts through such language as "release of liability." Therefore, as a matter of public policy, these documents are construed against the party placing them in use. Some state court rulings have rejected medical professionals' efforts to contract away potential liability for negligent medical treatment [140]. Release from liability for negligent care has also been rejected when the patient has little choice in where these services are obtained [141]. Many of these forms are written in nearly incomprehensible legalese, which further invalidates their use. Therefore, documents purporting to relieve the prehospital care provider from liability might be invalid. Second, "promise not to sue" language in these documents does not preclude the necessity to obtain an "informed refusal" of treatment and transport from the patient.

Obtaining a patient's signature may be beneficial for simply demonstrating the patient's physical and cognitive abilities. Such a document may be appropriate if used as a written acknowledgment by patients of their voluntary refusal of treatment. It may serve as a testimonial of the efforts made to educate and persuade the patient to be transported. However, such forms should be supplemented with appropriate documentation of the patient's physical and mental condition as assessed by the prehospital care provider. The document should reflect attempts to warn the patient of the risks of delaying treatment and alert the patient that the prehospital care provider may not be aware of the full extent of the injuries [142]. The medical director should not permit a release form to be used until it has been evaluated by legal counsel. Well-reviewed forms may be available from the insurance agency that provides liability coverage for the ambulance service.

### Transfers

Interhospital transfers have evolved as one of the more lucrative profit centers for ambulance services. Transfers generally mean nonemergent use of ambulances. For many prehospital care providers, these patient contacts seem less exciting and less deserving of their medical skills. For example, these calls could include the "routine transfer" of a debilitated nursing home patient to and from a clinic appointment, a neonate in an incubator, or the cardiac patient with multiple intravenous lines infusing medications. Obviously, transfers can be as diverse and critical as 9-1-1 calls, and clearly require the attention of a medical director [143].

A variety of problems can arise in the management of transfers. For example, the "transfer car" may be staffed with less experienced personnel, which can create patient risk should the unexpected occur. In addition, research shows that physicians may fail to use the appropriate level of skill for the patient's medical condition and, more importantly, fail to stabilize patients adequately before transport [144]. Transfers are often initiated



by persons unfamiliar with EMS systems and ambulance service management. Transfer orders are often written by physicians who are unaware of the current scope of practice of the transporting personnel. This is evidenced by the requesting party directing the non-emergency response of the ambulance. It is also evident in the reimbursement problems that arise when the transport destination is based on physician convenience. Transfers can also be a source of liability for physicians and hospitals if a patient is unnecessarily put at risk because of the transfer. Efforts to decrease transport problems have led to the creation of patient transfer guidelines by certain critical care organizations. Medical directors should ensure that their protocols are consistent with these guidelines [145].

The case of *Morena v. South Hills Health System* involved the limited paramedic resources of the City of Pittsburgh [146]. One issue in the case was whether paramedics were negligent in not accepting an interhospital transfer of a gunshot victim. The paramedics had responded and transported the patient to the nearest hospital. The patient then required transport to another facility where a trauma surgeon awaited. At that time, the City of Pittsburgh had only four paramedic ambulances for emergencies; private ambulances handled non-emergency interhospital transports. A nurse asked the paramedics to handle the transfer, but she did not explain that the transfer was an emergency that the unit was authorized to accept. Consequently, according to the protocols the paramedics declined the transfer. The surgical treatment had to be delayed until the transfer was ultimately completed. "Due to this shortage of vehicles it was the policy of the service to not make inter-hospital transfers," the court noted. The court deferred to the policy and held that the duty of the emergency ambulance service was completed upon transporting the patient to the nearest facility; without knowledge that the transfer was of an emergency nature, there was no basis for negligence in the paramedics' refusal to accept the transfer. The message from this is that ambulances in an EMS system should not be used or viewed as an unlimited resource, and sound policies are defensible.

With the enactment of federal legislation that regulates interhospital transfer of patients in EMTALA, planning and preparation for transfers became serious business [147]. The law may actually protect prehospital care providers from being "dumped on," as well as create more paperwork for EDs. Although EMTALA does not directly regulate EMS, EMTALA pertains to the transfer of "unstable" patients and mandates that any transfer be "effected through qualified personnel and required transportation equipment" [148]. The law may also affect destination policies, because the patient must be transported to a qualified facility. The law can impose significant burdens on small ambulance services, which the medical director should attempt to limit. For example, in rural systems the need to transport an unstable patient to a higher level of care may be valid. However, the service may have only minimally trained personnel available and a limited number of ambulances. Nonetheless, "qualified personnel and transportation equipment" must accompany the

patient. It becomes imperative that the medical director educate hospital staff about the transport capabilities of the ambulance service for transfers. A 2010 case in which EMTs were asked to transfer a woman in labor resulted in which a baby was born apneic at 25 weeks gestation in the ambulance. EMS was found liable at trial in Volusia County, Florida, with a jury finding that the service was "negligent by accepting the transport task" and that the company showed "reckless disregard" in rendering its services. The award of \$10 million threatened to bankrupt the ambulance service [149].

The medical director should also be careful that "convenience transfers" do not misuse ambulance resources, exposing the rest of the EMS system to risk. A recent tendency for patients who feel that ED waits are lengthy to call EMS from a hospital ED waiting room requesting transport to a different facility should be carefully managed. Additionally, political and economic decisions should not dictate the movement of patients. One court considered it egregious to refuse ambulance service to a patient because of political interests. A hospital that refused to allow use of its ambulance unless the patient was brought to its facility (where the patient's attending physician did not have privileges) supported a verdict of outrageous conduct in *DeCicco v. Trinidad Area Health Association* [150].

The medical director must vigilantly ensure that an ambulance service accept transfers only if adequately trained crews are available, or if the transferring hospital provides appropriate personnel to accompany the patient in the ambulance. This may entail careful examination of individual skills and prospective identification of specific medications that the prehospital care provider may monitor. He or she must also keep the Medicare reimbursement regulations on staffing levels in mind. In addition, there may be need for cooperative arrangements between the hospital nursing staff who accompany the patient in the ambulance and the ambulance personnel. The respective responsibilities of nursing personnel and the EMS crew should be clarified before transports are initiated. There should be no question of responsibilities in the back of a moving ambulance with a critical patient dependent on the attendant caregivers assigned to the transfer.

Ambulance services have also come under increased scrutiny in recent years from government efforts to stem fraud and abuse. Many services have found themselves liable for large fines when they have submitted bills to Medicare for ambulance transfer of patients from home to dialysis centers when the patients were ambulatory and could have traveled by van or taxi. For example, in a recent case, the former owners of an ambulance company agreed to pay \$2.25 million in damages and penalties for fraudulent ambulance claims submitted to Medicare and Medicaid after they had been found guilty of fraud in earlier criminal proceedings [151].

## Documentation

Paperwork has been the bane of existence for many medical professionals otherwise skilled in the provision of patient care. Training in this critical area has been largely overlooked,