Dear Mr. Hockenberry 10-3-88

Enclosed is a copy of the booklet used in our recent one day legal lecture for paramedics.

Now that we have given it a test drive so to speak. There are some things we wish to change.

If you have the time I would appreciate any comments you have on section XV pages 25 and 26. dealing with Durable power of attorney.

I want to thank you again for the time you spent back in June when you explained this subject over the phone.

James Green
648-3380
LEGAL ISSUES CONFRONTING
THE PRE-HOSPITAL CARE WORKER

July 1, 1988

This Report Was Researched And
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Without The Expressed Consent Of The Author:

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I  INTRODUCTION

The intention of this report is to acquaint the pre-hospital care worker with the broad spectrum of legal issues that are confronting you. It is hoped that this report will give you a better understanding of the law and thus minimize your fears, frustrations and uncertainties. This information should also allow you to avoid some common pitfalls.

For many of us the law is seen as a kind of Sword of Damocles, perched precariously over our heads. Held in place by a tiny thread called "legal technicality", it waits to fall on a hardworking, sincere pre-hospital care worker, with devastating results.

Hopefully this report will put some of the terrible stories you've heard into perspective and minimize the feeling that you are at the mercy of courts and lawyers whose actions and methods may seem harsh, contradictory, and unintelligible.

CRIMINAL LAW, TORT LAW

Within the field of law there are two broad areas where a pre-hospital care worker can find themselves in trouble, Criminal law and Tort law.

Criminal law is that area of the law concerned with serious crimes that are prosecuted by state or federal government rather than an individual seeking some sort of compensation. Usually of an intentional nature they involve violence and they are violations of Penal Law. Penal laws deal with those crimes that are punishable by imprisonment.

We won't deal much with criminal offenses involving pre-hospital care workers because it is not a statistically significant issue. About the only time a criminal issue is raised is in cases of larceny. Larceny is the legal term for theft, and there are only occasional instances when patients or their families make the claim that rings, watches, wallets or other personal material is stolen; and these charges are hard to prove.

This idea of "to prove" is important and should be borne in mind at all times. It is easy to be accused of doing something, but you're innocent until proven guilty. Therefore, the accusing party must prove the accusation beyond any reasonable doubt before you can be found guilty. That is not easy to do, so if someone does accuse you of something don't panic.

TORT LAW (defined as a "wrongful act") is that area of law that most affects pre-hospital care workers. It deals with lawsuits and issues of negligence and liability for injuries suffered by the patient. It is the area of law where we make the person who is found responsible for a wrongful act compensate that person who is injured in order to "make them whole again."

Perhaps the easiest way to explain tort law is to describe how it came to be.
HISTORY OF TORT LAW

To some degree you could say that all our laws have their beginnings with Greek and Roman law. However we are concerned with English common law.

The best way to think of common law is in comparison to modern statutory law. Common law was based on a longstanding recognition, by the Kings Courts, of the common principles, customs and rules of conduct already existing among the populous. Statutory law by contrast - which came into existence in the United States with the advent of the Constitution - is written law which derives its authority over people not by custom but from the Legislature which enacted it.

The forces in English society that molded common law were at their height during the medieval period.

The medieval period was a feudal world. Everything revolved around the possession of land. Title to land established your relationship to king and country. With it you were someone, without it you were nothing.

As a result two important forces came to bear on the infant institution called the law. One force demanded ways to protect the precious titles to land and the other demanded ways to punish crimes related to the land.

Of the latter, one of the first laws was "breach of close." Close was the name for a piece of property marked off by fences made of stone or hedge. This was how property boundaries were marked out in those days. If someone entered onto the property of another, usually to commit some other crime such as theft, they were guilty of breach of close and severely punished.

By the 13th Century, breach of close became known legally as trespass. The law had evolved to the point where the category of trespass included almost any intentional wrongful act (a tort). It must be stressed that the word "trespass" represented not one specific crime, that of entering without permission, but was used as a general class heading encompassing many different but related crimes. It also had a distinct criminal quality which accounted for the often harsh punishments. For example, in cases where trespass occurred in order to commit a battery on someone the punishment was death. This had an interesting consequence.

Crimes against people - such as serious bodily harm or murder - were seen as crimes against the King. This was because English common law subscribed to the Felony - Merger Rule. It said that if someone was guilty of both a tort (trespass to property) and a felony (injuring one of the King's subjects) the tort was merged into the felony. Since felonies were crimes against the King not only was a person severely punished but he had to forfeit all his property and possessions to the King. As a result, injured people were never able to bring a claim against the wrongdoer or his estate for compensation.

As time passed landowners became aware that "trespass" did not address injuries associated with property when they were done unintentionally. For example, if someone cut down some trees they might accidentally fall on your land or someone's cattle might accidentally stray into your wheat fields.
At that time the idea of liability was already well established, albeit harsh. Liability was embodied in the legal dictum, "a man acts at his own peril." It was a form of absolute liability where a man was liable for whatever results followed either from his acts or omissions. Carried one step further it meant that if a man was responsible for his acts, he was responsible to the people his acts affected. It is here that we see the first weak glimmer of the element of duty to others, which we'll discuss in modern tort law.

So in order to address the issue of unintentional wrongs a new category of legal action was created: "Trespass on the Case." Trespass on the case was based on the idea that even though a wrongful act against property was unintentional someone should still be liable, and they should be made to compensate the injured party. It is important to note that unlike trespass, trespass on the case did not carry the presumption that an injury existed. Therefore, it became an important element of trespass on the case that you prove a physical injury existed. That requirement still exists today as part of modern tort law.

Unfortunately while trespass and trespass on the case were adequate in the beginning they did not keep pace with changing society. Both were basically formal lists that enumerated recognized offenses or wrongful acts and the punishment that went with them. If you had a grievance or cause of action it had to be fitted into one of the pre-existing forms of trespass or trespass on the case, otherwise you were out of luck. Trespass was based on injury that was a result of some direct act while trespass on the case was based on injury as a result of some indirect act. Neither idea lent itself to a clear theory that could be used by the courts to justifiably expand the range of wrongful acts they could pass judgment on.

Through the end of the medieval period and into the Renaissance (1400 A.D. to 1800 A.D.) trespass and trespass on the case developed, but separately.

Trespass was changed greatly when in 1700 it lost its criminal qualities, such as imprisonment. However, it continued to cover those acts that we usually think of as purely criminal acts, such as assault, battery, false imprisonment and the like. It also retained the characteristic of being an intentional act which did not require an injury to result from the act but required only that the act be done without privilege. Combining absolute liability with intentional act produced a new way of looking at certain injuries. It was felt that if a person intentionally commits a wrongful act it was reasonable to say that they should be able to "foresee" all the possible injurious results.

In contrast to the idea of "foreseeability" that was developing around trespass, trespass on the case clearly dealt with unforeseeable wrongful acts that occurred by accident. However a person was still liable for his acts.

How then could the courts judge the degree of responsibility, if any, one should bear for a wrongful act that happened by accident? They developed the concept that if people had used reasonable care, they should be able to avoid accidents that cause injuries to others. So for trespass on the case an important
element became the question of whether a reasonable standard of care was used. If they failed to exercise reasonable care, they were said to be negligent, from which we derive the general title negligence. By the 1800's trespass and trespass on the case had merged into one, to be known there after as "case for negligence." Foreseeability and reasonable standard of care became important elements of tort law along with the concepts of duty, negligence and proof of injury. Today tort law is also known by such terms as liability and personal injury. While it still follows the basic common law tenants it is statutory now and defined as a "civil wrong giving rise to a cause for action."
Tort law today encompasses three broad areas.
Violation of a right (or rights) of any man.
A breach of a duty, which is imposed by law, that is owed by one person to another person.
A breach of some duty that is owed by one person to the public at large.

II THE COURTS

Courts from their very inception, whether simple tribal affairs or today's Supreme Court, have been forums for the just, economical and efficient resolution of disputes, in order to keep the peace and promote order.
In the early days of English common law, disputes were taken before the king. But as the population grew, commerce expanded and the importance of land titles and inheritance increased the crown became overwhelmed with petitions for redress. The most expedient method for solving the problem was for the King to delegate to the noblemen and trusted advisors of his court the power to adjudicate disputes.
With the passage of time these advisors, or "courtiers" as they were known, became a regularly assembled "bench" whose job it was to act in the interest of the crown while resolving disputes and punishing crimes.
Eventually it became clear to the crown that in order to protect its own interests as well as insure consistent judgments it would have to establish a written law that would be followed by all the courtiers. So began the first attempts at written law and the procedures to be followed when asking the Kings court to resolve a dispute. One of the results of formalizing the procedures used when applying to the King's courts for help was the instigation of attorneys. In their earliest form they were not really concerned with the law per se. Rather their job was to guide the public through the intricacies of the procedures used by the King's court. To better understand today's courts we have to look at their underlying principle. Today, in the United States, we say that our form of justice is based on the "adversary system."
The adversary system means that the responsibility for beginning a lawsuit, shaping the issues and for producing the
evidence rests completely with the parties involved in the controversy.

There are many good rationales for choosing this system. First of all, it's felt that a truer decision is reached by a contest that is direct by the effected parties. Next it is felt that those effected parties, not the public, should bear the burden of time and energy required to bring about a resolution of the dispute. And lastly it is recognized that while resorting to law has replaced resorting to force of arms there is still an instinct to do battle. Therefore the methodology of law should be such that each party feels they have personal control over their case.

The court then, takes no active role, it does not do its own investigating, nor does it ask questions. Its job is to rule on issues that arise as to the meaning and proper interpretation of the applicable law and to enforce proper court room civil procedure.

As long as laws are written with words there will always be a need for a final interpretation as to what the law really means and how it may be applied.

Civil Procedure is the name given to the basic rules that govern the court. They outline the way lawyers must deal with court. In a sense they outline how the court does business.

When talking about the legal system and the courts one question that frequently arises is whether the courts, simply apply the laws, interpret the laws or in fact create laws. The simple answer is that they do all three.

Generally they apply and interpret laws that pertain to the issues raised in a lawsuit.

However, especially in the field of tort or personal injury law, where an injured party is seeking a remedy, the courts will sometimes try very hard to find a legal means to compensate him or her.

In doing so the court can appear to be creating law where the legislature intended none. Other times, especially in the Supreme Court, for example, legal technicalities or new interpretations will be used to further social policy that the court feels is proper. For example, by re-interpreting the doctrine of "separate but equal" they made segregation illegal, or by deciding that a woman had a right of control over her own body free from governmental interference they opened the way for legal abortions.

III THE LAWYER

While historically it is true that lawyers began more as guides for the "procedural" maze of the king's court rather than advocates for their clients, today civil procedure is but one small part of a lawyer's professional knowledge.

Today the study of law takes from three to four years and covers all the different aspects of law.

Law students study the law of all the states since in general the laws are similar. Students study "cases", which are summaries of actual court cases. They detail the history, the legal issues, arguments and legal precedence as well as black letter law used by
the court in making its judgment. Sometimes the textbooks present cases that represent the prevailing legal precedent, used by all courts. As often as not though, cases are unclear, occasionally contradictory and demonstrate that rulings are based on complex technicalities and interpretations.

Law students learn that one of the essential elements of law, which distinguishes it from other occupations or for that matter common experience is that it is not concerned with finding the right or wrong answer to a question. There simply may not be one. Rather, they learn that every problem, if it is to be resolved by legal recourse must be distilled down into issues that the law recognizes.

Once the issues have been identified, then applicable rules of law must be found. In most cases, the chosen rule of law will not in fact conclusively answer the specific issues that arise out of your problem. Rather, the rule of law is used as a legal basis to support your arguments. Your arguments in turn are what you use to convince the judge or jury to decide the issue in your favor.

A student must also learn to anticipate the opposing party’s arguments, to understand them and be able to refute them.

In effect a future lawyer learns to see each issue from both sides of the fence. Ultimately, for a lawyer the issue is not which side is right or wrong but which side can develop the most persuasive arguments in behalf of their client.

Due in large part to the media, and in particular television, the image of the modern lawyer creates a fair amount of confusion and anxiety in the mind of the public. Too often the public perception of a lawyer is someone who has no moral or ethical commitment to the truth or to justice. They are seen as playing sophist games at taxpayers’ expense, trying to prevent the admission of significant evidence by raising obscure issues of privacy and generally searching for minute technicalities that “will get their client off.”

What must be remembered is that a lawyer’s job is to protect his client as well as advocate for them.

Part of protecting the client’s rights demands that the defense question every step of the trial. In doing so, the prosecutor or plaintiff is constantly under pressure to prove beyond doubt that the facts demonstrate the guilt of the accused.

Our system of legal justice is not a perfect one. Accordingly, there are many safeguards built into it. It is the lawyer’s job to protect his client from abuse as well as to see to it that he takes advantage of all the appropriate safeguards.

IV A LAWSUIT

When we have a legal dispute or a personal injury that we wish to resolve or remedy the first thing we must do before walking into a courtroom is to contact a lawyer.

Before a lawyer will accept a case or file the necessary papers with the court in order to start a lawsuit several questions must be considered.

The lawyer must first find out what the facts are. Then he
must decide what the legal issues are based on those facts. Then
he must decide: if there are laws that apply to our particular

grievance; can we bring the opposing party into court; will it be

possible to collect the necessary evidence to support our

arguments; will our story be believed; will the opposing party be

able to mount a reasonable defense that refutes our claim and

lastly will what we win in damages (in legal terms damages means

the amount of monetary compensation you receive) be worth all our

efforts.

If the lawyer decides we have a good case the next thing to be
decided is how will we pay. There will be filing fees, research

fees, deposition costs, evidence collection costs, expert witness
fees and a whole host of other things, not to mention the actual
time the lawyer himself will spend working on your case.

Frequently the method used is to enter into a contract with
the lawyer whereby you get his services in exchange for a
"contingency fee." This means that instead of paying the lawyer a
straight fee for every hour he works, he will do the work in
exchange for a fixed percentage of either the settlement (if both
parties agree to acceptable compensation before going to court it
is called a settlement) or the final judgment (final judgment is
the compensation awarded by a jury at the end of a trial).

Typically a lawyer gets 25\% of a settlement or 33\% of a final
judgment.

When people think about some of today’s sensational trials
where millions of dollars in damages are awarded they find it hard
to understand what possible justification there is for a lawyer
getting 33\% of the injured person’s money. Well, it is true that
occasionally a lawyer will strike it rich but it must be kept in
mind that the lawyer advances all the up-front costs. If he wins
and also gets an adequate jury award (sometimes juries give far
less than the party is asking for) fine, but if his client loses he
usually gets nothing at all. It’s a gamble.

Perhaps the most important thing to keep in mind is that today
the price of justice is high. Most people simply don’t have the
financial resources to obtain good legal counsel or to pursue
lengthy lawsuits which are often the only means available to
achieve just compensation.

Once the lawyer decides to pursue the case he must choose the
proper court.

We have two major judicial bodies. The state court system and
the federal court system. Both are divided into 3 levels. In the
state system, we have Trial Courts, State Appellate Courts and the
State Supreme Court. Similarly the federal system has U.S.
District Courts, U.S. Courts of Appeal and finally the U.S. Supreme
Court.

Generally a lawsuit will be tried in a state court where the
injury occurred.

In some cases a lawsuit will be tried in a federal court if
circumstances warrant it. It is important to realize though that
the federal court uses the same laws as the state in which it sits.

Each state has statutes (laws enacted by the legislature) that
determine which trial court your lawsuit belongs in. In most cases
the monetary value of the damages you seek determines which court
you use. If you are seeking damages less than $25,000 you go to Municipal Court; greater than $25,000 you go to Superior Court.

While we’re on the subject of courts and their different levels this is a good time to mention "appeals." We hear a lot about "appeals to a higher court" when someone loses their case. You can not appeal issues of fact. Once the jury decides a matter it’s decided. But you can appeal issues of law. For example, if you feel that the law you’re charged under is unconstitutional, or you can challenge a judge’s instructions to the jury, or you can challenge the legality or sufficiency of certain evidence, etc.

There are many things which can be appealed. If you win an appeal it does not mean however you get what you want, or if you’re charged with a crime that you will go free. It means in most cases you are granted a new trial.

A final note on appeals. Cases started in the state court system can go as far as the State Supreme Court and that is where they stop. Whether or not your case is reviewed by the U.S. Supreme Court is entirely up to the discretion of that court. So it is not entirely accurate when a lawyer says "We’ll take this all the way to the Supreme Court." In truth many appeal but very few are ever reviewed.

So our injured party has a lawyer and knows what court they belong in. Now they must put together a case that proves malpractice or some form of negligence for which there is a legal remedy.

For health care workers this means you can be sued for committing "intentional torts" such as battery or false imprisonment (these will be discussed separately later) or you can be accused of treating someone in a way that is below an accepted standard of medical care. That is called malpractice.

The most encompassing definition of malpractice is, "the failure of a professional to exercise that degree of skill, care, and diligence exercised by members of the same profession practicing in the same or similar locality in light of the present state of scientific knowledge in that profession."

In effect this means that if a question arises as to whether or not you medically treated someone correctly the judicial system will look to the profession as a whole to see what is the generally accepted standard of care. Then they will compare what you did against that standard. If you’re found lacking in your performance and an injury resulted from it, then you have a legal responsibility to compensate the injured party.

As with most things in law it is not quite that simple. The tort (wrongful act) of malpractice has several elements that must be met before a jury can find someone guilty and assess a damage award.

There are four basic elements.

First, the plaintiff (the party bringing a lawsuit) must prove that some sort of legal duty was owed to them by the defendant (the party accused of wrongdoing). Under the law no one has a duty to aid or attempt to rescue another person. It is the responsibility of the plaintiff to prove a legal relationship existed which created a duty. For example, if you advertise emergency medical care, either by putting up a sign on your hospital to that effect
or by providing a 911 emergency number whereby an injured party can get an ambulance, you effectively establish a duty to help those people who then avail themselves of your service. In legal terms they say that by offering a service which induces people in need to come to you, you have undertaken a duty. This is one way to establish duty.

Second, the plaintiff must prove that the care given by the defendant was substandard. If the care is found to be substandard then legally they say there was a breach of the duty owed to use a reasonable standard of care.

To know what is substandard, you must first establish what the standard is. This is what expert witnesses are frequently for. Their job is to testify as to what is a reasonable standard of care for the particular situation.

For a surgeon performing an operation a lawyer will bring in another surgeon to establish what would normally be done and what results could reasonably be expected. For a Paramedic who extricated someone from a serious car wreck the lawyer may bring in another paramedic who has a lot of experience with auto accidents or the lawyer might choose instead to bring in a trauma surgeon. In either instance their testimony will establish how an extrication should properly be done and what results can reasonably be expected.

Once the standard of care is established, the defendants actions are measured against it. For accuracy sake it should be borne in mind that a breach of duty may be committed either by an act of commission, doing something a reasonably prudent person of equal training would not do; or by an act of omission, failing to do something a reasonably prudent person of equal training would have done.

Here is where we get into the idea of negligence. Where someone either acts or fails to act using a reasonable standard of care and they knew or should have foreseen the possible injuries that would result from their act or omission, we say they acted negligently.

It’s important to realize though, that just because the patient receives a poor result, that is not proof of negligence in and of itself. Just because a triple by-pass patient dies on the operating table does not automatically mean the doctor made an error. The patient may have died simply because after years of abuse, his heart just gave out.

The third important element is called proximate cause. Proximate cause in its simplest form just means that cause without which the injury complained of could not have happened. The plaintiff must show that there is a direct cause and effect relationship between the injury they claim to have suffered and some act or omission by the defendant.

Here again expert witnesses are used to explain how the injury could have resulted from the defendants actions.

The fourth and last element is proof that an injury actually exists. No matter how bad you may think someone treated you if no actual injury resulted you have no "cause of action".

A few final points.
It should be clear that it is the responsibility of the
injured party (the plaintiff) to prove that the defendant is guilty as charged. That is in keeping with our philosophy of innocent until proven guilty.

You can also see that since expert witnesses play an important part for the plaintiff they also play an important part for the defense. In order to refute one expert witness you must get one of your own. The inevitable result is that winning or losing a case can rest on the credibility of the experts who testify as well as the skill of the lawyer.

Lastly, no matter how obvious or cut and dried a case may be, never underestimate the sympathy of the jury. If someone is seriously injured or disabled, the jury may feel sorry for them and want to help them financially. If the plaintiff’s lawyer can create a reasonable doubt in the jury’s mind as to your performance, then that may be enough of an excuse for the jury to find you liable and award damages.

One way that the court system tries to inhibit sympathy judgments is to make information about how much liability insurance coverage the defendant has inadmissible in court.

V DAMAGES

If the plaintiff who started the suit can convince the jury that the defendant was negligent and that as a result they caused an injury, what sort of damages (monetary compensation) can the plaintiff expect to receive?

There are three basic forms of damages.

"Nominal" damages are very small sums. Since they can be as low as one dollar their real purpose is to make a verdict, or judgment as it’s sometime called, a matter of formal record. It vindicates the rights of the plaintiff.

"Compensatory" damages is the most important category. It covers all of the areas effected by the injury. Compensatory damages are given with the intention that they will return the injured party to the condition they were in before the injury occurred. Within this category the jury considers and awards money as is appropriate for, past physical and mental pain, future physical and mental pain, past and future medical costs, loss of past and future earnings and permanent disability and disfigurement.

This is another area where trials and lawyers can gain great notoriety. Melvin Belli is a good example. He pioneered the use of "demonstrative evidence". In order to get the most money for his clients he would bring in films taken of the plaintiff showing the tortuous and miserable existence they have since being injured. The sympathy value of this evidence during the damages phase of the trial could sometimes add hundreds of thousands of dollars to a damage award. These sorts of strategies gained Mr. Belli the often heard title, "King of Torts."

"Punitive" damages are the last category. As the word implies this is more than compensation, it is designed to punish the negligent defendant. The jury uses this when it wants to make an example of him and to deter others from doing the same thing.
However the courts will only allow punitive damages in cases where there was gross negligence or willful or malicious conduct. The distinction between simple negligence, gross negligence, and wanton, reckless or willful misconduct is one of degree.

Simple negligence may be as basic as failing to check that your defibrillator batteries are adequately charged. A reasonable standard of care dictates that you check them on a timely basis and every one is aware of that.

Gross negligence would be knowing that the batteries are in fact dead but deciding to do nothing because you hardly ever defibrillate anyone.

Wanton, reckless, or willful misconduct would be along the lines of defibrillating, at low wattage, a healthy but belligerent drunk with the intent to scare him; but who, as luck would have it, goes into V-fib and dies, thus ruining his whole day.

VI EXCESSIVE VERDICTS

Sometimes a damage award will seem excessive, or on occasion too little. In either event the judge presiding can not alter the jury’s verdict but he can completely set it aside, effectively throwing the whole case out.

What this means is that the judge, concluding that some sort of undue prejudice exists on the part of the jury for or against the plaintiff, will order a whole new trial.

From the plaintiff’s point of view there is an incentive to settle for a lesser more realistic sum rather than absorb the expense of a new trial which they might lose the second time around. From the defendant’s point of view it is an incentive to increase their settlement offer so as to also avoid the cost of a whole new trial.

VII STATUTE OF LIMITATIONS

In California, as in all other states there are statutory limits of time after which someone who is injured can no longer file a lawsuit.

Historically the time limit, usually 1 year, began at the time the injury was committed. However many medically related injuries do not appear till much later. For this reason in 1961 California adopted the "discovery" rule.

Incorporated into the California Code of Civil Procedure, it says that in actions against health care workers for death or injury the action must be filed within three years of the date the injury occurred or one year after discovering the injury.

One of the main reasons statutes of limitations are important is to limit the time one is liable. However, since one may not discover an injury until many years later insurance companies charge enormous sums of money for their policies in order to cover what people do today but may have to pay for years down the road.
VIII VICARIOUS LIABILITY

The last issue we need to discuss in our general overview of the law which concerns pre-hospital care workers is that of "Vicarious Liability".

Vicarious Liability is a descendent of the legal principle "Respondeat Superior". Both terms mean that the law holds the employer responsible for injuries caused by his employees while they are acting within the scope of their employment.

The idea of vicarious liability became established in English law during the 17th century. At that time the master craftsman was held liable for the acts of his apprentices which he commanded or which he expressly assented to.

Many rationales have been put forward to justify carrying this idea into the 20th century. When an enterprise (which is owned by the employer) creates risks to society, the employer should be required to bear the burden. The employer, in furtherance of society, is often the best able to spread the costs of injuries to third parties, over all those who benefit from his service or product.

A more cynical explanation of vicarious liability would be to say that in hard fact the reason behind employer liability is that he has the financial resources (deep pocket) from which damages can be taken. Employees on the other hand may not have sufficient financial resources to compensate someone adequately.

One last note. It should be kept in mind that while vicarious liability means that the employer will cover the costs of a compensatory damage award, it is not liable for the costs of a punitive award. Since punitive damages are awarded to punish the wrongdoer the individual employee must absorb those costs.

XIX CONTRACTUAL LIMITS TO LIABILITY, LIABILITY RELEASES

Now that we have discussed the basic components of a lawsuit, let's address an often asked question.

"Why can't we just have the patient sign a contract relieving us from liability? After all, we make contracts for almost everything else."

California, as well as most states, looks very carefully and with great skepticism at any attempts to contractually limit liability. As far back as 1872, California enacted legislation (Civil Code Section 1668) which said that contracts to limit personal injury liability arising out of negligence were against public policy.

Unfortunately, this statute was pretty general and was open to problems so finally in 1963 the California Supreme Court decided to review the case of Tunkl vs. Regents of University of California in order to settle the matter (60 Cal.2d 92; 32 Cal.Rptr. 33).

The Tunkl case was about a man who underwent surgery at U.C. Medical Center and who signed a contract releasing the hospital from liability. Mr. Tunkl later sued the hospital for damages. When the case came to trial the hospital defended itself on the basis that Mr. Tunkl relinquished his right to sue when he signed
the liability release.

The court ruled that it was legal to contractually limit liability for simple negligence so long as no general public interest was involved. However, if a public interest was involved then the contract was invalid. The court then went on to list six criteria for determining if a service qualified as being a public interest:

(1) The party or business had to be publicly regulated or suitable for regulation, (2) the party or business had to be of great importance to the public, (3) the party or business offers its services to the public at large, (4) the party or business, because the service it offers is important, has a bargaining advantage over the public, (5) because of the superior bargaining position of the party or business, it can offer what amounts to a take it or leave it contract to the public which limits its liability, (6) and lastly, the public by accepting the service offered gives up a significant degree of personal control, even if only for a short time.

The State Supreme Court held that all hospitals, not just U.C., were of great public interest. They also had a great bargaining advantage over patients who sought their service. Therefore, they could not contract away their liability.

Ambulances, because of their great public importance, are treated like hospitals. As a result, contracts to limit liability are held to be invalid in California.

(It is important to remember that when your patient signs the refusal form on the pre-hospital care chart they are not signing a liability release, they are simply exercising their right to refuse treatment.)

(B) GENERAL LEGAL PRINCIPLES EFFECTING PRE-HOSPITAL CARE WORKERS

I  RESCUE/DUTY TO ACT

Common law historically held, and statutory law holds the same today that a mere bystander incurs no liability where he fails to take any action to rescue someone in need. In short, you don't normally have a legal obligation to help or render aid to anyone.

A mere bystander can be thought of as anyone who has no relationship to the injured party. They are someone who has no statutory duty, nor are they in any way responsible, through act or omission, for causing the injured party to be imperilled. For example, a paramedic who is "off duty" has no duty to stop and aid someone that they see is injured. However, there are many ways that a duty to aid can be established.

For example, statutes say that if you injure someone, you must stop and render aid in a reasonably affirmative way. This may mean controlling bleeding or it may be as simple as calling 911.

Another way to create a duty is to voluntarily begin to aid someone. Once you start, the law will impose a duty where none existed before. The law also says that once you voluntarily undertake a duty to aid someone you must exercise reasonable care. This means that if a duty can be established, and it can be shown
that you acted negligently then a lawsuit could be won against you.
In the case of public pre-hospital care workers, where does their duty to act come from?

Their duty, depending on the job they perform, is governed by statute and sometimes by Department policy. Non-profit, public
ambulances, have a statutory duty to respond to all calls for
assistance, where as for-profit ambulance companies, with the exception of those locally designated EMSA providers, are not duty
bound. Every public entity has by nature some implied duty to the
public at large.

Once a duty has been undertaken, or effort made, to rescue or
render aid, may it be terminated?
This is an area fraught with danger. In general you can
terminate a rescue so long as you do not leave the person in the
same or worse danger. You must be very careful that you do not
increase the danger to them. You must be sure that by having
helped them you have not deprived them of the opportunity to seek
other aid. You must be sure you have not induced them to forgo
seeking aid based on their belief that you will help them or that
you have permanently and medically resolved their problem.

About the only accepted defense to a charge of improperly
terminating aid to someone is "self-preservation." It is a valid
excuse to terminate aid, if for example, continuance would put the
rescuer's life in danger. For example, leaving someone in a
burning building where the flames have driven you out, or breaking
off an attempted water rescue because the currents were too strong.

The best way to avoid problems is to remember that a duty to
act, once established, continues until the injured party is turned
over to someone responsible who has the same or greater level of
medical competency.

II ABANDONMENT

Technically abandonment is an issue only between a doctor and
his patient. It requires that there be an established
relationship. That the doctor ended the relationship without the
patient's consent. That while the patient still needed medical
attention the doctor ended the relationship in such a way as to
deprive the patient of obtaining other medical aid. And lastly
that injury or death resulted.

The issue of abandonment for the pre-hospital care worker
arises during transfer of authority for a patient at the hospital
or when a pre-hospital care worker leaves a patient at the scene.

More than once an ambulance crew has arrived at a hospital
with a critically ill patient, failed to transfer custody of the
patient to a designated responsible party (triage nurse, etc.) and
then left. If any injury results, they are liable under
abandonment. The easiest way to avoid this problem is to find out
who the designated receiving person is at the hospital. Physically
turn custody of the patient over to that person and then give an
accounting of the patient's history and condition. This sort of
thing is glaringly obvious to most people. Leaving people at the
scene is more complex.
When someone calls for help the municipality is duty bound to respond. Once the ambulance arrives and patient contact is made the crew members have established a duty. If they leave a patient, who they "know or should have known" requires medical aid, that is a "breach of their duty to aid." If any injury results proximate (as a result of or shortly thereafter) to their leaving they are actually liable under the usual application of negligence. But since the whole issue revolves around leaving someone at the scene it has been customary, though not technically correct, to refer to this as abandonment.

The reasons for leaving a patient at the scene vary from the drunk waiting for M.A.P. to the automobile accident victim who is going to see his own doctor.

What is the best way to reduce your exposure to the charge of abandonment?

The best avenue of defense to this type of "abandonment" is to have every person with whom you have contacted sign the refusal form on the pre-hospital patient care chart. Regardless of whether they appear injured or not at the time it is to your benefit to have them sign because the law recognizes that every mentally competent person has a right to refuse medical treatment (we will discuss refusal separately later).

As will be seen when we discuss "consent" you can not treat or transport someone against their will. This occasionally causes a dilemma for the pre-hospital care worker when confronting a patient who clearly needs medical care but refuses. You can not leave him for fear of breach of duty or abandonment but you cannot take him because without consent you can be charged with false imprisonment or kidnapping (to be discussed later). The only way to protect yourself against a charge of abandonment in these cases is to involve the police. The police cannot force someone to go with the ambulance crew unless they are in police custody. But as often as not their presence will help to convince the patient of the wisdom of seeking medical attention.

If in the end the patient still refuses to go, has signed the refusal and the police can not justify a 5150 detention then you are basically off the hook since you've done everything a reasonable person in the same situation would do.

III CONSENT

The Constitution gives everyone certain rights. In order not to violate those rights in the process of rendering aid to someone you must get their informed consent. Without consent you may be guilty of "Assault" when you tell someone you're going to start an I.V. with an 18 gauge needle. You may be guilty of "Battery" if you touch the person. You may be guilty of "False Imprisonment" if you place them in the ambulance. You may be guilty of "Kidnapping" if you transport them in the ambulance to the hospital.

It may help to review the distinction, made in the historical introduction, between intentional torts (trespass) and unintentional torts (trespass on the case).

Unintentional torts, such as malpractice, require as an
essential element of liability that a person suffer an injury as a result of the treatment they received.

Intentional torts on the other hand, such as assault, battery, false imprisonment and kidnapping have no such requirement. No injury need be proved, only that you acted without consent or permission.

As a result, even if the treatment given is flawless, and even if it in fact saves their life you may still be liable for damages and the fact that your treatment was non-negligent is no defense.

There are several accepted forms of consent.

The most common form is "expressed" or voluntary consent. You ask the person if you can do something and they say yes. The elements that must be met for there to be informed consent are: the patient must be a legal adult, they must be conscious, they must be mentally competent, and they must be informed of what will be done in a manner which they can understand.

The law presumes that a person is mentally competent until sufficient evidence is produced to refute the presumption.

However, it does not hurt to include facts in the patient’s chart that shows they were oriented as to person, place and time; that they could give a good historical account of what preceded their illness or injury; and that their oral responses to questions were consistent with the nature and severity of their problem.

"Involuntary consent" exists usually in cases where someone is in police custody. Up to certain limits the person in custody must accept treatment. To treat beyond those limits requires a court hearing and a formal court order authorizing treatment.

The other time where you may run across involuntary consent is concerning an injured minor. A minor, except in certain cases, cannot give consent without parental approval. On the other hand if a parent is authorizing medical care for a minor child, that child cannot refuse.

The final form of consent is "implied consent." Technically speaking implied consent exists only in the case of an unconscious person, suffering a life-threatening injury. "Unconscious," for legal purposes, means a state in which the person is unable to maintain protective reflexes.

In practice implied consent gets stretched a bit and anyone who is marginally unconscious or even just suffering some degree of altered mental status and has a potentially serious injury can be taken to a hospital. The key to using Implied Consent is determining whether or not the patient is mentally competent enough to make decisions for themselves; if not, then Implied Consent applies. The underlying theory is that everyone wants to live. So we presume in those cases where the injured party can’t tell us as much, that in fact they want to be treated in order to continue living.

IV REFUSAL

The flip side of consent, as a requirement before treatment, is the patient’s legal right to refuse treatment.

A conscious, mentally competent adult who understands the
situation, its seriousness, and the likely consequences of refusing medical treatment may in fact refuse, even if doing so may result in their death.

Historically the only way that the medical profession could force someone to undergo medical treatment was by resorting to a court order. The court order was based on one or more "states interests" that would be better served by forcing the patient to undergo treatment (i.e., maintaining the ethical standards of the medical community, preserving life, preventing suicide, protecting innocent 3rd parties).

While this issue is still in doubt on a state by state basis, California has adopted the 1986 Bouvia v. Superior Court (179 Cal.App.3d 1127) case as precedent concerning patients' rights.

The court said in part, "The right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both State and Federal Constitutions....Its exercise requires no one's approval. It is not merely one vote subject to being overridden by medical opinion."

In order for a refusal to be valid it must be written. The signature must be authentic and legible. It should always be witnessed whenever possible and dated.

The signed refusal can be looked at as a defense against negligence if the patient later decides to sue.

In effect the signed refusal says that the patient clearly understood the seriousness of the situation but instead of accepting treatment chose to assume the risk of aggravating any existing injuries and go about their business.

In order for assumption of risk to be used as an effective defense you must prove by information in your narrative that the patient understood the risks and then voluntarily proceeded in the face of those risks.

V FALSE IMPRISONMENT

False Imprisonment occurs when, without the patient's consent, you unlawfully confine them by the use of physical barriers, physical force, the threat of force or by assertion of authority which results in submission.

In practical terms this means physically restraining someone, or handcuffing someone, or confining someone inside the ambulance. You may also be guilty of false imprisonment if someone, seeing your uniform, thinks that you have official power over them and they submit to you when they would not otherwise do so. For example, they think you are a police officer and they fear you will arrest them if they fail to comply with your demands.

It is especially important that anytime you handcuff someone you put in your report that the patient, who by voluntary or implied consent was legally in your charge became violent and was a threat to you and themselves. You therefore were obligated to restrain them in order to protect them from injuring themselves.
VI KIDNAPPING

If you have falsely imprisoned someone and then transport them to a hospital you are guilty of kidnapping. If there is ever any question explain in your report that the patient voluntarily agreed to go to the hospital, and have them sign the Pre-Hospital Care Chart.

(C) SELECTED LAWS REGULATING AND EFFECTING PRE-HOSPITAL CARE WORKERS

I HISTORICAL REVIEW

Wedworth-Townsend

The California legislature in the early 1970’s enacted the Wedworth-Townsend Act. This was a pilot program that allowed only L.A. County to establish a paramedic program. As the success of the program became apparent the Wedworth-Townsend Act was amended to allow all the counties to participate.

S.B. 125 (Senate Bill)

In 1980 the state legislature superceded the Wedworth-Townsend Act with S.B. 125. It established Division 2.5 as a new part of the State Health and Safety Code. Division 2.5 is called, "Emergency Medical Services System and the Pre-Hospital Emergency Care Personnel Act."

S.B. 125 established the broad general laws that govern the certification, actions and responsibilities of MICN’s and Paramedics as well as establishing the statewide regulating authority in Sacramento.

Title 22

S.B. 125 included a provision that once the state authority was in place it must create specific regulations for pre-hospital care workers. These regulations, governing training, certification, scope of practice, etc. are what is known as Title 22. Title 22 is a large body of regulations found in the California Administrative Code. Those specifically dealing with pre-hospital care workers are found in Division 9.

Therefore, when questions arise the pre-hospital care worker must consult both the Health and Safety Code as well as Title 22, Division 9.

Special Note: Some of the following statutes carry misdemeanor penalties. While custodial policies differ somewhat from department to department, generally a misdemeanor is a citeable offense. The only time someone is actually arrested and taken into custody is if they have no valid identification, they are likely to continue the offense for which they are being charged or if they have outstanding warrants.
II   DISCIPLINARY ACTION

1798.200 H & S

The medical director of the local E.M.S. agency may place on probation, suspend or revoke any certificate (EMT-1, EMT-P, MICN). To justify such action the medical director must find that some sort of dangerous or improper behavior is or has taken place which constitutes a threat to the public health and safety. (Find means to conclude based on some kind of evidence. The quality and quantity of the evidence is not expressly defined but guidance and certain specific offenses are listed.)

1798.204 H & S

If the medical director does decide to suspend, revoke, etc. they must do so in accordance with proper procedures established by the E.M.S. authority. (At present only interim guidelines are available through the local E.M.S. office. Statewide regulations are presently undergoing final review.)

III   MISREPRESENTATION OF PARAMEDIC STATUS

1797.177 H & S

It is a misdemeanor to represent yourself as a paramedic in a county where you have not been certified by the Emergency Medical Services Agency and been issued a valid number.

IV   SUPERVISION OF FIELD CARE

1798.102 H & S

The base hospital is responsible for supervising pre-hospital medical treatment. They are responsible for seeing that paramedics follow the protocols and policies. They do this by reviewing tapes and charts. They also review any unusual occurrence reports or incident reports pertaining to the performance of pre-hospital care workers.

No disciplinary powers are mentioned.

V   PATIENT CHART REQUIREMENT

Title 22, Section 100163(a)(b)

Every time that a pre-hospital care worker has contact with a patient, they must prepare a completed patient chart. A patient is defined as someone obviously injured, someone asking for help, or someone with a high probability of some sort of
injury, regardless of whether or not they are going to be transported.

VI    LIMITS ON PROFESSIONAL LIABILITY

California Vehicle Code 17004

A public employee is not liable for civil damages arising out of accidents which occur while responding to an emergency. The use of the word emergency would indicate this statute means Code three response only.

California Vehicle Code 165(.5)

"No act or omission of any rescue team operating in conjunction with an authorized emergency vehicle...while attempting to resuscitate any person who is in immediate danger of loss of life shall impose any liability upon the rescue teams...if good faith is exercised."

This applies more to sheriff's rescue units that are often staffed by volunteers. The good faith clause leaves them liable for intentional or willful misconduct.

Good Samaritan Laws

In 1959 California became the first state in the nation to enact a "Good Samaritan" law. The reason was to encourage doctors in particular, but the public in general to stop and help injured people without fear of civil liability.

The original act was basically a blanket immunity from civil liability.

1799.102 H & S

This is the basic Good Samaritan statute which says if you are off duty, not asking for monetary compensation, and assisting at the scene of a medical emergency you are not liable for any civil damages resulting from any act or omission.

However, when they tried to extend the Good Samaritan law to on-duty emergency personnel they amended it to include liability for gross negligence and acts or omissions not performed in good faith.

1799.106 H & S

This describes the liability of a working paramedic performing within their scope of practice.

The result is that the statute does not offer any real protection from being sued, but it does offer some liability protection. The only real effect is to make it harder for the injured party to prove their accusation before a jury because gross negligence is tougher to prove than ordinary negligence.

The best example of this is the 1988 City of Santa Cruz v.
Superior Court case in which EMT-life guards were sued for negligence because it took them 20 minutes to respond to the scene of a water accident. The delayed response was due to the fact that the accident took place in a remote, unincorporated area where signs were posted stating no swimming was allowed and no life guard services were available.

The judge dismissed the suit saying there was no evidence to demonstrate "gross negligence" and the Good Samaritan Act of California precluded liability for any other form of negligence.

**Doctor/Nurse/Paramedic Liability For Orders**

*1799.104 H & S*

Section (a) of this statute says the doctor or M.I.C.N. who gives a paramedic an order is not liable to the patient for any injury so long as the order was given in good faith. Section (b) of this statute is supposed to protect a paramedic who follows the orders given by a doctor or M.I.C.N in the event that those orders cause injury. However, you must follow those orders in a non-negligent manner, while working within your scope of practice.

This is a relatively uncharted area. A paramedic may "just be following orders" but since they are the ones who actually administer the treatment they may end up bearing some or all of the liability for any resulting injuries.

If the paramedic receives an unusual order they must question it, and document it so that once performed they can show that the doctor is responsible. However, because you administer the treatment, you have the last clear chance to protect the patient and the courts may therefore find you liable for the patient’s injuries.

The question will come down to whether you were negligent in accepting the doctor’s orders.

It is not our intent to frustrate you with this review of the immunity statutes. But it is important to appreciate that in a working status you have no blanket immunity from liability for injuries resulting from your acts or omissions.

**VII SCOPE OF PRACTICE**

*1797.172 H & S*

This section established what might be called a general or generic scope of practice. It listed what a paramedic may do in general and in certain specific situations (such as, radio failure which will be discussed later).

This section also specified that this scope of practice was to be used in the interim until the E.M.S. Authority could establish detailed regulations (Title 22).

Title 22 section 100141 now lists the paramedic’s basic and optional scope of practice.
VIII RADIO FAILURE

Title 22, Div. 9, Section 100141, Subsection (c)

This section says that in the event you try to make contact with the base hospital and cannot, a paramedic may (1) use any treatment in the scope of practice, (2) that they have been trained to do, and which (3) is included in the local county protocols that address radio communication failure.

S.F. County Protocol, Reference No. 1007, Lines 2 and 3

This protocol says in effect that if radio failure occurs you are permitted to (1) fully assess the patient (2) document their condition and (3) use the appropriate treatment protocol approved for that specific medical emergency.

IX A.L.S. TREATMENT PRIOR TO BASE CONTACT

Title 22, Div. 9, Section 100141, Subsection (d)

This section tells the paramedic that if they feel it would jeopardize the patient’s life to take the time to call the hospital they may do only the following things:
(1) Give I.V. solutions
(2) Intubate
(3) Use M.A.S.T.
(4) Defibrillate
(5) Cardiovert
(6) Use the laryngoscope to clear the airway
You must make a written report within 24 hours.
There is one condition and that is that county protocols may narrow this list.
You will notice that until new protocols or the statewide scope of practice is changed you are not permitted to administer narcan to an apneic patient without orders, or until after you have established that you have a radio communication failure and then follow county protocol.

X 72 HOUR IN VOLUNTARY HOLD

5150, Welfare and Institutions Code

A lot of confusion surrounds the 5150 statute and how it may be used.
The statute empowers a Police Officer or a Doctor or a certified Mental Health Care worker to physically hold someone against their will for a maximum of 72 hours in an appropriate psychiatric care facility.
A 5150 hold is only appropriate for those persons who because of a mental disorder are a danger to themselves, to others, or are in some way gravely disabled.
A "danger to one's self" usually is interpreted to mean that the person is taking some sort of affirmative or direct action towards hurting themselves. Suicide is the best example. Simply neglecting one's self or a medical condition that warrants attention does not qualify.

"Gravely disabled" means the person is unable to provide food, clothing, and shelter for themselves. It must be emphasized that for a 5150 to apply the patient's failure to thrive must be due to an underlying mental disorder.

A 5150 hold may not be used as a method of forcing needed medical treatment on a recalcitrant patient. Every mentally competent patient has the right to refuse treatment. And don't think that just because someone needs medical care and refuses it, that you have sufficient proof that they are suffering from a mental disorder. That is a form of circular reasoning that the courts don't accept. A 5150 should always be viewed as an instrument only for the evaluation and treatment of persons suffering from a mental disorder and not simply as a convenient excuse to force someone to go to the hospital.

If the pre-hospital care worker finds herself confronted by a 5150 candidate the Police should be called.

Do not accept 5150 orders over the phone or telemetry. This is because the person signing the form must have probable cause to believe that the patient is a danger to themselves by reason of a mental disorder. This is interpreted to mean that they must have actual first hand contact with the patient.

XI AUTHORITY AT THE SCENE

1798.6(a) H & S

At all medical emergencies the person with the highest medical qualifications relating to emergency medicine is in charge of patient care. In effect that usually means the paramedic.

MICN's (unless certified as "Field MICN's") have no authority outside the radio telemetry setting and few, if any, doctors will agree to accompany the patient to the hospital as per protocol. This important section distinguishes between the overall emergency scene and patient care. Authority for the scene is vested in the appropriate public safety agency having primary investigative power, but they must consult with the paramedics as to the management of injured persons.

XII INTERFERENCE AT THE SCENE

California Penal Code Section 148.2

Anyone at the scene of an emergency who interferes, delays or obstructs an E.M.T. in the proper discharge of their duty is guilty of a misdemeanor punishable by not more than $1,000.00 and/or not more than one year in county jail.
XIII ASSAULT/BATTERY ON PRE-HOSPITAL CARE WORKER

California Penal Code Section 241(a)

(Assault is the unlawful attempt, coupled with a present ability, to commit a violent injury on the person of another.) When assault is committed on an EMT-P, outside the hospital, by someone who knows or should reasonably know that the EMT-P is in the performance of their duty the fine shall be not more than $2,000.00 and/or not more than one year in county jail.

California Penal Code Section 243(b)

(Battery is any willful and unlawful use of force or violence upon the person of another) -- the penalty is the same as for assault.

XIV SELF-DEFENSE AND THE USE OF FORCE

California Penal Code Sections 692, 693, 694

"Lawful resistance to the commission of a public offense may be made: (1) by the party about to be injured, (2) by other parties."

The courts have always held that self-preservation is the first law of nature. While it may be the better part of valor and good common sense to back away from a fight, if you are attacked the law imposes no duty on you to retreat.

Accordingly, an innocent person is justified in using non-deadly force which reasonably seems necessary to prevent or terminate a physical attack upon their person.

A person may act in defense of another person, and they may act in defense of their own real or personal property.

A person may use deadly force if it appears reasonably necessary to prevent or terminate a deadly attack upon themselves. They are not justified in using deadly force against a non-deadly attack.

Deadly force may also be used, if necessary, in defense of others. However, deadly force is never justified in defense of real or personal property except in the instance where someone is breaking into your house with the intent to harm you.

The term "self-defense" besides describing your physical actions, is also used as a legal defense to the charge that you acted improperly (i.e., you intentionally and without excuse injured someone, etc.). In order to support your claim of self-defense you must prove you reasonably believed you needed to use force and that the force you used was not excessive but was commensurate with the attack.
In California a competent adult has the right to choose for himself or herself what manner of health care he or she will accept or reject.

In order to protect that right in the event that he or she becomes incapacitated and can no longer express his or her wishes, California has enacted Civil Code Section 2432; known as the "Durable Power of Attorney for Health Care."

This written document is intended to do three things: First, it is designed to insure that a person's wishes, regarding health care, are respected. Second, it offers real legal protection, to the health care provider, from criminal prosecution, civil liability and professional disciplinary action. Third, it names a specific person (known as the attorney-in-fact) who has legally recognized authority to make health care decisions for the patient. (Special note: The attorney-in-fact need not be a licensed attorney but may be a family member, friend or trusted associate).

A Durable Power of Attorney for Health Care should not be confused with a "Living Will" or a "Directive to a Physician."

A "Living Will," which expresses a patient's desire not to have their life prolonged by artificial means, is not recognized in California as having any legal validity.

A "Directive to a Physician," is a legally recognized document and was created by the California Natural Death Act of 1976. This document does give legal protection to health care workers who abide by the wishes expressed therein. However, it can only be executed by the patient once death has become imminent.

If a health care worker is confronted with an incapacitated patient and another person who claims to be the attorney-in-fact, as specified in a Durable Power of Attorney, the health care worker should follow their instructions after doing the following.

The attorney-in-fact must be able to show you the actual document. The document must have a date showing when it was executed by the patient. A document older than seven years is invalid.

The document must state the patient's name and who the attorney-in-fact is.

The document must be signed by two witnesses who are not related to the patient by blood, marriage or adoption. The witnesses cannot be the patient's doctor, or the attorney-in-fact or a member of a health care facility where the patient may be living.

Lastly, the document must be signed by the patient and it must be notarized.

Once the health care worker is satisfied as to the authenticity of the document, the attorney-in-fact must be able to prove they are who they say they are; a driver's license being the most common way.

Before the health care worker follows any instructions they must attempt to learn what the patient's wishes are. If the patient can communicate, by whatever means, their wishes are the controlling factor and they may revoke the Power of Attorney at any time.
If the patient cannot communicate and there are no written instructions, then you must follow the instructions of the attorney-in-fact.

Two final important points.

First, a Durable Power of Attorney for Health Care does not empower the attorney-in-fact to command any affirmative act that may lead to the patient’s death except for the withholding of treatment or the withdrawal of treatment (Civil Code Section 2443).

Second, a health care worker who refuses to withdraw any existing form of ongoing treatment from the patient is protected from criminal, civil, and professional liability (Civil Code Section 2438 2(c)).

(To most people withholding treatment or withdrawing treatment from a critically ill patient seems like an affirmative act of murder.

However, in California withholding or withdrawing treatment, at the request of the patient (directly or by attorney-in-fact), is not considered an affirmative act. Rather, it is an admission that the patient is already dying and that they have a right not to have their existence uselessly prolonged.

As a consequence of this position, the issues of murder, criminal neglect or suicide do not arise.)

(D) THE PRE-HOSPITAL CARE REPORT NARRATIVE

I INTRODUCTION

The narrative is a story that sets the stage for the E.R. personnel or anyone else who reads the patient’s chart later. It gives a picture of what brought the patient to the hospital in the first place. It gives clues as to the nature of the emergency and perhaps helps the doctor formulate a plan of treatment. It is a historical record of what happened, how it happened, what injuries resulted and what treatment was given before the patient reached the hospital.

It is part of a medical document.

It is part of a legal document.

When people think in terms of medicine they are usually pretty comfortable with their writing skills. They get a little nervous though when they start questioning whether or not their writing can stand up under legal scrutiny.

From a purely practical standpoint one of the simplest rules to remember is that a chart which is well-written medically is well-written legally. It is not necessary and may even be counterproductive to try and write a chart as if looking through the eyes of a lawyer.

Let’s review the factors that make for a well-written narrative.

There are three major categories to be covered: (1) What was going on prior to the emergency, (2) What you found upon your arrival, (3) Special circumstances.
At first glance there seems to be a glaring omission. There is no category for what you did to the patient. Generally there are other places on a patient chart for treatment and patient response. For that reason it is not necessary to repeat the information in the body of the narrative. Space for the narrative is notoriously limited so save it for those things which have no other place.

II WHAT WAS GOING ON PRIOR TO THE EMERGENCY

First of all, for our purposes "emergency" just means the reason the patient called the ambulance. There are three factors to this first part; setting the stage, the basic mechanism of injury, and pertinent facts or conditions. "Setting the stage" just amounts to briefly explaining what the person was doing. Were they driving a car? Were they a pedestrian in the crosswalk? Were they a secretary at their desk working, etc? The idea is to describe the environment since that may help the E.R. doctor. The "basic mechanism of injury," while it may imply trauma, is just meant to be a description of the obvious or most likely cause of the presenting problem. In the case of trauma it amounts to describing whether there was a car accident, or industrial accident, or a criminal assault, or an accidental fall, etc. In the case of a medical emergency it amounts to describing whether there was a CVA, or a heart attack, or acute abdominal pain, or whether there is an underlying disease such as cancer, etc.

"Pertinent facts or conditions" are simply those added pieces of information that clarify or modify your view of the patient. These include such things as, was the car driver wearing a seat belt, was the motorcyclist wearing a helmet, was the person resting or exercising before the onset of his angina pain, does the CHF patient sleep lying flat or propped up with pillows, did the person have witnessed LOC, etc.

III WHAT YOU FOUND UPON ARRIVAL AT THE SCENE

This part of the narrative can be broken down into five parts; what was the patient doing physically, what did you observe from your primary and secondary survey, what is the chief complaint, what did the witnesses tell you and what information did you get from the scene. Describing what the patient was doing at the scene gives a base line. Are they out of their car and walking or unconscious in their seat, is the person standing up or laying on the bed immobilized with abdominal pain, are they talking or unconscious, etc. This information is important when combined with the mechanism of injury. It keeps things in perspective when trying to judge the severity of the problem.

The primary-secondary survey gives very important information about the patient’s condition. Often this information can be placed in specially designed boxes somewhere else on the chart. In
any case it is important that the narrative or the boxes clearly indicate that you thoroughly examined the patient. The chief complaint is usually something they tell you and is usually what hurts them the most. In the event that they are unconscious it would be that problem that appears to you to be the main problem.

Bystanders or witnesses can often give important information such as speed, was there any LOC, did the person initially act normal while you now find them disoriented, etc.

Information that you get from the scene is just simple observations that enhance your knowledge about the patient or increase your suspicions. For example, a bent steering wheel, fractured windshield, the patient’s medications, did the person fall on a carpeted floor or a tiled floor, etc.

IV SPECIAL CIRCUMSTANCES

This last part of the narrative should briefly cover anything unusual you did to the patient. Along with what you did, some sort of facts should be included to justify your actions.

For example; if you turned the patient over to MAP or the PD the narrative should include information that clearly shows that the patient was medically stable, in no need of hospital care, requesting some alternative service (i.e., MAP) and that they were left to wait in a safe and secure environment.

Another example would be a patient who you restrained with handcuffs. If they are a 5150 patient that should be so noted. You must also describe the patient’s behavior that necessitated the restraint. You should explain it in such a way as to indicate you acted in the best interest of the patient; to keep them from hurting themselves or others.

One last example is that of a refusal by a patient. You should explain that they were informed of their condition in a manner that they could understand. That you offered to take them to the hospital. That they adamantly refused to go and if you can, quote how they said they would take care of the problem. Be sure if you contact the base hospital to make an AMA report that you record their tape log number.

If after reading all this it seems like a lot to include in a small space, hopefully the following examples will show it can be done easily and effectively.

The thing to keep in mind as you write your narrative is that you want to include enough facts to justify your actions or treatment.
V SOME EXAMPLES

CAR ACCIDENT:

Patient was driver, no seat belt, struck parked car, speed 10 mph.
Patient presented out of car, ambulatory, alert x4, good Hx'n (about the events preceding the accident), denies LOC, denies head, neck or back pain. C/O soreness in L shoulder from striking the door. Fracture lines on windshield. Patient has hematoma on R forehead.
Patient refused treatment. I explained that head injuries should be checked by doctor. Patient said he would see his own doctor.

RESTRAINED PATIENT:

Patient was riding a skate board, jumped off, fell, striking head on concrete.
Patient presented awake, thrashing around, combative, did not respond to questions. No palpable Fx's. Moving all extremities. Witnesses say patient had 60 second LOC. C/O large laceration to L forehead with 300 cc blood loss.
Patient was handcuffed and tied to gurney with sheets in order to immobilize and protect from further injury. P.D. on scene assisted.

M.A.P. (Mobile Assistance Patrol) PATIENT:

Patient is street person, has been drinking today.
Patient presented alert, oriented, ETOH on breath, able to walk unassisted. No medical complaints. Has nowhere to sleep tonight.
M.A.P. called, patient stated he will stay at this address and wait.

VI WHY ARE THE "BOXES" AND THE "NARRATIVE" IMPORTANT?

If you are accused of negligent behavior your defense will be that (1) you performed your mandatory duties, (2) using the facts that you discovered you made a reasonable determination as to what the problem was and, (3) based on your determination of the problem you chose a reasonable course of treatment and correctly carried it out.
The proof that you performed these steps is found in the appropriately marked boxes and in your narrative.
The following are two actual examples where paramedics lost negligence cases because of sloppiness.
EXAMPLE ONE

A 50 year old male with pre-existing degenerative bone disease fell in his bathroom. The paramedics were called. Paramedics found the patient on the floor complaining of posterior lower neck pain, mild SOB, lacerated chin, numbness in the lower extremities, and numbness and tingling in the arms. Patient had apparently had a syncopal episode and as he fell he struck his chin on the sink and snapped his head back. The patient was rapidly transported to the hospital and was diagnosed as having several fractured vertebrae and permanent paralysis from the chest down.

The patient sued the City claiming the paramedics were negligent in their treatment thus causing permanent paralysis. The patient won.

Why? The paramedics insist they did everything right. However, they failed to mention anywhere on their chart that they put on a C-Collar or that they immobilized the patient to a back board. The triage nurse could not remember the patient or how he arrived and the patient himself said that the paramedics carried him in their hands.

EXAMPLE TWO

An elderly male with a history of five previous M.I.’s called the paramedics to his house because he had left shoulder pain. After a thorough exam including an EKG the paramedics found nothing but offered to take him to the hospital. The patient refused and the crew left.

The patient was found dead the next morning. The family sued the City claiming the paramedics were negligent in their treatment. They won.

Why? The paramedics failed to have the patient sign the refusal and instead of taping a copy of the EKG to the chart they threw it away in a garbage can in the patient’s house. Their chart also omitted to include any reference, in the appropriate box, as to what they saw on the monitor.

As an aside to this story the second crew that arrived to confirm the death found the first crew’s EKG but it was deemed to be inadmissible evidence because the chain of evidence had been broken.

On the subject of the narrative consider the following example of how a well-written narrative can be used as an effective defense.

The ambulance crew arrives and evaluates the patient and tells him or her that they should go the hospital. The patient refuses, so they document the call and have the patient sign and date the refusal. The crew is sued later for negligence because the patient did not get treated and suffered some permanent injury.

The patient’s attorney will claim that it was negligent for the crew to leave the patient.

The crew’s response will be that they knew the patient
needed medical care and that a statement in their chart proves that they informed the patient of this. Next, they will point out a second statement in the chart which shows that they offered to take the patient but he or she refused. Next, they will turn to the back of the chart and show the patient’s signature indicating that he or she refused treatment.

The attorney may then counter by saying that while it is true a person has a right to refuse treatment that is only valid if the person is mentally competent at the time, and his client was injured and not mentally competent.

The crew’s response to this will be to point out the information in the narrative that clearly shows that the patient was alert and in a clear mental state, that they were not in a state of great physical suffering or under the influence of someone or something. The facts will demonstrate the person was a competent adult whose signature is valid.

(E) SUGGESTED RESPONSE TO INVESTIGATIVE INQUIRIES BY SUPERIORS

It is not the intent of these guidelines to suggest a person under investigation should not cooperate. Rather, the intent is to give some basic guidelines that protect against self-incrimination and insure that due process will be respected.

The first rule is "keep a simple problem simple." If an answer is appropriate and it will settle the issue then and there, go ahead.

If you have reason to be concerned, avoid being rude, defiant or antagonistic. Be firm as to what you will and will not do. Then you must seek some sort of impartial council.

The best protection is to be familiar with the rules, regulations and policies that cover investigation of complaints in your department or company.

Suggested Guidelines

1) Treat an investigation as formal; don’t buddy-buddy up to the person asking questions.
2) Ask what the specific questions are.
3) Listen to the questions carefully.
4) Don’t ramble, think about the question, think about your answer, then speak.
5) Answer the question as simply as possible.
6) Don’t make the other sides case for them by giving more information than is requested.
7) If you think the situation is serious or just wish to protect yourself further:
   a) Request the complaint or accusation in writing.
   b) Don’t answer the questions until you get them in writing. However, sometimes inquiries are made in order to find out if there is merit to a complaint or if the parties accused are the right ones. Since it may be insubordination to flatly refuse to answer any
questions use your judgment as to whether and to what extent you should cooperate. If you do decide to talk ask that all questions and answers be recorded.

c) When answering a written question address your answers to the specific questions, don’t get wordy and don’t go off on tangents. Keep your answers short, simple and to the point.

d) Always keep copies of everything received or sent. Remember, you are innocent until proven guilty. Guilt is proven with evidence. So don’t get angry or belligerent; all that does is leave a bad impression which hurts your case.
APPENDIX A

LEGAL QUESTIONS SUBMITTED BY PARAMEDICS

DISPATCH RELATED QUESTIONS

1. Q) WHAT IS THE CREW LIABILITY IF THE AMBULANCE IS REROUTED BEFORE PATIENT CONTACT?
   A) None.

2. Q) WHAT IF THE AMBULANCE HAS ARRIVED BUT THERE IS NO PATIENT CONTACT?
   A) None.

3. Q) WHAT IF DISPATCH ASKS YOU TO LEAVE A MINOR MEDICAL PROBLEM FOR A MORE SERIOUS ONE?
   A) Once you have made patient contact you have a duty to act unbehalf of your patient. You can not simply leave them. We recommend that you explain the situation and get their permission to leave. If they still have need of medical assistance then dispatch is obligated to send another ambulance as soon as possible. If the patient refuses to permit you to go then you must stay.

4. Q) DOES A DISPATCHER INCUR LIABILITY FOR REROUTING AN AMBULANCE?
   A) The dispatcher is in the best position to know the severity of each of the calls and therefore it is appropriate for them to send an ambulance where it is most needed. Division policy makes it a requirement to dispatch on a priority basis and not a first come first serve basis.

5. Q) IF ALL THE AMBULANCES ARE BUSY AND YOU GET A SERIOUS CALL WHAT IS YOUR DUTY TO THE CALLER?
   A) Explain that there are no ambulances available. Tell them one will be sent as soon possible. Depending on the severity of the problem you may wish to stay on the line with them.

6. Q) WHAT IS THE DISPATCHERS LIABILITY FOR MEDICAL INFORMATION OR INSTRUCTIONS GIVEN OVER THE PHONE?
   A) Presently no statute exists that specifically addresses dispatchers. An argument can be made that because they are paramedics (at least in San Francisco) they get some protection from H&S 1799.106.

This whole issue is clouded over by several different factors. First, it is becoming the standard across the nation for Emergency Dispatch Centers to aid the public by giving out essential information over the phone. Once a trend like this becomes the accepted norm it will be impossible to turn back the clock. Therefore as time goes by everyone will become tacitly obligated to follow the trend.

This means then, that in the near future a dispatcher will no longer be able to voluntarily limit their own liability by simply choosing not to give out information.

Second, paramedic dispatchers are employees of the Department of Public Health but work under contract for the E.M.S. Agency. In the event of a law suit it is unclear who would bear ultimate financial responsibility for the dispatchers.
Lastly, the E.M.S. Authority is presently trying to pass legislation to limit the liability for Poison Control Center personnel. If they are successful they will then turn their attention to the problem of dispatchers.

7. Q) WHAT DO YOU DO IF SOMEONE CALLS TO REPORT A SICK RELATIVE WHO DOESN'T ANSWER THEIR PHONE?
A) Only the Police, while performing a well being check, may break into a dwelling without getting into trouble, so long as they have probable cause. Only if you are on the scene and actually see someone who is dieing and needs immediate medical care may you also be justified in breaking in.

8. Q) WHAT IF THE ABOVE CALL COMES FROM OUT OF STATE OR OUT OF COUNTY?
A) The Police Department requires that out of state or county residents first contact their local police and then that department must send a teletype to the S.F.P.D. Then they will go out and investigate.

9. Q) WHAT IF YOU GET A CITIZEN'S 911 CALL FROM A NEAR BY COUNTY REQUESTING AN EMERGENCY RESPONSE?
A) You must either tell them to call the proper authorities or keep them on the line and call for them.

LEAVING A PATIENT FOR M.A.P. OR P.D.

10. Q) CAN YOU LEAVE A PATIENT BEFORE MAP OR PD ARRIVES?
A) Yes because if you are leaving them at all it means they are not in medical need and the ambulance is not the proper mode of assistance. Your report must show that they were physically OK to be left alone.

11. Q) WHAT IF YOU THINK THAT YOU SHOULD STAY WITH THE PATIENT UNTIL PD OR MAP ARRIVES BUT THE DISPATCHER TELLS YOU THERE IS A SERIOUS CALL WHICH YOU MUST TAKE?
A) If you feel someone may be in jeopardy then you should stay with them even though they may not be in medical need. Your priority is always the patient with whom you have made contact. If there is any question in your mind and the dispatcher is adamant then you must cancel MAP or PD and transport the patient to the nearest medical facility.

CONSENT, REFUSAL, AND 5150 HOLD

12. Q) HOW SERIOUS MUST THE PATIENT BE BEFORE IMPLIED CONSENT CAN BE USED?
A) Technically they must be unconscious but any time a significant injury affects their mental faculties it is appropriate to assume that they want treatment.

13. Q) DOES SIGNING THE REFUSAL FORM ACTUALLY DO ANY GOOD?
A) Yes. It is a valid document and a mentally competent adult has a right to sign. It will in fact protect you, BUT your narrative must demonstrate with factual observations that the patient was in fact
competent when they signed and that they understood the consequences.

14.Q) CAN YOU TRANSPORT A MINOR IN NEED OF MEDICAL TREATMENT TO THE HOSPITAL AGAINST THEIR WILL?
   A) Yes, a minor in need falls under implied consent or Parens Patriae.
   Parens Patriae is a legal principle based on the notion that the state has a duty to protect certain classes of people who it feels can not properly protect themselves.Minors, the mentally retarded and imbeciles fall into this sort of class.

15.Q) IF MINOR IS TREATED FOR AN INSIGNIFICANT PROBLEM OR IF THEY ARE EXAMINED AND FOUND TO HAVE NO INJURIES AT ALL, MAY YOU RELEASE THE MINOR ON HIS OR HER OWN RECOGNIZANCE?
   A) No. A minor must be released to an adult person of authority. That person should ideally be a parent; however a Police Officer, a relative or an appropriate official such as a teacher is acceptable depending on the circumstances.
   The safest course of action is to transport any minor you come in contact with to a hospital. This applies even to so called "Latch Key Kids" who you may encounter even in their own homes.

16.Q) CAN A DOCTOR AT THE BASE ORDER A PARAMEDIC TO TRANSPORT A PATIENT WHO IS REFUSING TREATMENT?
   A) No. A competent adult has a constitutionally protected right to refuse treatment. A doctor may not order a paramedic to treat or transport that person against their will.
   It must be remembered that a doctors authority over a paramedic exists primarily in the realm of treatment modalities outline in the paramedic scope of practice. That authority does not carry over into the area of constitutionally protected rights. A doctor, no matter how superior in knowledge and skill may not over ride the expressed wishes of a competent adult.

17.Q) CAN A DOCTOR ORDER A 5150 OVER THE PHONE?
   A) No, they must be physically present to fill out the form and it must be done prior to actually moving the patient.

18.Q) IF THE POLICE REFUSE TO 5150 SOMEONE THAT YOU FEEL SHOULD GO TO THE HOSPITAL WHAT CAN YOU DO?
   A) If the Officer on the scene refuses to sign a 5150 then you should call the nearest mental health clinic for that part of town and arrange for a mental health care worker to come out the following day and evaluate the patient. The alternative is to call the Police Department's Psychiatric Unit which will send out a special team to evaluate the patient.

19.Q) IF THE PD DOES 5150 SOMEONE MUST THEY PHYSICALLY STAY WITH THE PATIENT IN THE AMBULANCE DURING TRANSPORT?
   A) Yes, technically the patient is in police custody and therefore should be guarded by an officer at all times.

20.Q) CAN YOU HAVE P.D. 5150 AN AIDS PATIENT WITH AIDS DEMENTIA WHO IS ADAMANTLY REFUSING TO GO THE HOSPITAL.
   A) If the patient is a danger to himself or is unable to care for himself as a result of the AIDS dementia then yes.
21.Q) IN REFERENCE TO THE PRVIOUS QUESTION CAN A FAMILLY MEMBER OR A LOVER DEMAND THAT YOU TAKE THE PATIENT TO THE HOSPITAL?  
A) No. No one has any power over a competent adult. The patient must be free to make their own decisions. If there is a question call PD.

22.Q) IF A WIFE WHO IS CARING FOR HER BED RIDDEN HUSBAND COMMITS SUICIDE AND YOU TRANSPORT HER TO THE HOSPITAL CAN YOU TAKE HIM ALSO AGAINST HIS WILL?  
A) Your first priority is the patient. If there is a problem with the husband you should call dispatch and request that they send a police unit to the house to evaluate the husband.

GENERAL QUESTIONS

23.Q) DOES THE PARAMEDIC INCUR ANY LIABILITY WHEN CONTRARY TO A PATIENT’S SPECIFIC REQUEST HE IS DEVIRTED TO ANOTHER HOSPITAL?  
A) No. The county is responsible for the deversion policy and as long as the paramedic is following Base Station orders in good faith no cause of action arises.

24.Q) IF YOU ARE TRANSPORTING AN UNSTABLE PATIENT ACROSS COUNTY LINES AND YOU HAVE NO COMMUNICATION WITH A BASE HOSPITAL, WHAT DO YOU DO IF THE PATIENT COLLAPSES?  
A) Title 13, section 1106, sub (b)2 says that the driver shall "transport emergency patients to the most accessible emergency medical facility prepared to administer care".

25.Q) IF A PERSON IS UNDER ARREST MUST THE POLICE OFFICER ACCOMPANY THEM IN THE AMBULANCE?  
A) Technically yes. If the patient is under arrest there should be an officer with them at all times.

26.Q) DOES CALLING IN AMA’S REDUCE YOUR LIABILITY?  
A) Not really. The patient pre-hospital tapes are all erased after one hundred days. Technically the States’ position at this time is that the tapes are not part of the patient’s record nor are they accessible by discovery.

27.Q) IF YOU TRANSPORT SOMEONE FROM AN AUTO ACCIDENT, AND AFTER YOU LEAVE, PROPERTY IS STOLEN FROM THE PATIENTS CAR ARE YOU LIABLE?  
A) No. Your responsibility is to the patient and not their property.

28.Q) DO YOU HAVE A DUTY TO IDENTIFY THE PARTIES TO AN ACCIDENT SO YOUR PATIENT CAN CONTACT THEIR INSURANCE COMPANIES?  
A) No. Your priority is to transport the patient. It is the job of the police to collect information.

29.Q) DOES OUR INADEQUATE C-SPINE EQUIPMENT LEAVE US OPEN TO LIABILITY?  
A) No. So long as the City issues the equipment and you use it correctly there is no liability.

30.Q) IS IT AGAINST THE LAW TO ACCEPT FREE COFFEE OR THE LIKE?
A) Technically no. However, section 70 of the Penal Code makes it a misdemeanor offense for a public employe to accept a gratuity if it is in exchange for an official act. Therefore it is a very bad idea to accept things from a patient, especially if it could be misconstrued later. As for store owners trying to be friendly, well, you're ok so long as it's not against Department Policy. The best way to cover yourself is to always leave a tip that is equal to what they gave you. In that way you can always say that you payed.

31.Q) IF SOMEONE AT THE SCENE OF AN 802 IS DISTURBING THE BODY OR THE SCENE MAY YOU TELL THEM TO STOP?
A) Yes.
California Government Code 27491.3(c) makes it a misdemeanor to search for or remove anything from a body or the residence where a death has occurred without the permission of the coroner. California Penal Code section 642 makes it a crime to take things from a dead body. Depending on the value of what is taken you may be charged with a misdemeanor or a felony. If after being told to stop a person continues to interfere then they will also be guilty of Penal Code section 148.(b), which is interfering with a paramedic.

32.Q) YOU ARRIVE AT THE SCENE OF AN 802(A DEAD BODY). THE BODY IS IN PUBLIC VIEW. BEFORE THE POLICE OR CORONERS DEPUTIES ARRIVE THE DISPATCHER TRIES TO SEND YOU ON AN EMERGENCY CALL; CAN YOU LEAVE THE SCENE?
A) E.M.S. Agency policy number 1024 section C(2) says that emergencies shall take precedence over staying at the scene to protect a body. In contrast, section 13 of the M.A.G. says that you will treat the body with the same respect that you show to a live person. This would imply that you should not leave. The City Coroner's Office takes the position that while there is no statutory requirement that Paramedics remain with an 802 in public view, they do expect them to wait until police arrive if it is a suspicious death or a homicide.

33.Q) IF THE DISPATCHER GIVES YOU AN EMERGENCY CALL AND YOU LEAVE THE HOSPITAL BEFORE YOU HAVE TURNED IN THE PRE-HOSPITAL PATIENT CHART ARE YOU GUILTY OF ABANDONMENT?
A) No. Once the pre-hospital care worker arrives at the hospital and; (1) identifies the proper person who is designated to receive custody of the patient, (2) physically turns the patient over to that person, and (3) gives a report describing the patient's condition they are free from any charge of abandonment.

34. IN A MASS CASUALTY INCIDENT IS IT "ABANDONMENT" IF I LEAVE PATIENTS BEHIND AT THE SCENE IN ORDER TO TRANSPORT A PRIORITY ONE PATIENT TO THE HOSPITAL?
A) No. As will be recalled the first ambulance in on a mass casualty incident is to establish a command center, casualty registration point and promptly triage all the injured people. It is the responsibility of the following units to do the transporting. As a consequence the first ambulance may be responsible for handling...
the refusal signitures for those persons not transported when every thing is mopped up.

Usually the issue of abandonment does not arise in the mass casualty situations but it does arise in smaller incidents such as a car accident with two or more injured people. For example, a car accident with a driver complaining of a dislocated shoulder and an unconscious passenger with a depressed skull fracture. Clearly you want to get the head trauma patient to the hospital immedeately. If you call for additional assistance, explain to the driver that additional help is on the way then you are probably safe in leaving. Ideally you would want to leave a police officer or a fireman with the driver to watch over them.

35.Q) DOES PARTICIPATION IN SAN FRANCISCO'S INTEGRATED RESPONSE PLAN OBLIGATE PRIVATE AMBULANCES TO ACCEPT CALLS?

A) The I.R.P. is a voluntary contractual arrangement which is designed to offer back up support to the municipal 911 first responder service. It is the terms set forth in the contract which determines the extent of a private ambulance company's obligation.