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Legal Issues in EMS

Advanced Care Paramedicine

Module: 01

Section: 04

Lecture Outline

- Universal Health Care
- Legal Duties and Ethical Responsibilities.
- The Legal System.
- Laws Affecting EMS and the Paramedic.
- Legal Accountability of the Paramedic.
- Paramedic-Patient Relationships.
- Resuscitation Issues.
- Crime and Accident Scenes.
- Documentation.
- Regulations

Universal Health Care

- Federal legislation originally introduced in 1958 by Tommy Douglas
- Ensures that comprehensive health care is universally available to all residents of Canada
  - Accessible without income barriers
  - Portable within the country
  - Publicly funded
- Now ensured by the Canada Health Act
- Forms the foundation of health care provision in Canada

Canadian Health Act

- Five principles of the CHA are the cornerstone of the Canadian health care system
- Passed unanimously by Parliament in 1984
- The five criteria are:
  - Public administration
    - the administration of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority
  - Comprehensiveness
    - all medically necessary services provided by hospitals and doctors must be insured
  - Universality
    - all insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions
  - Portability
    - coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country
  - Accessibility
    - reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers

Legal Obligations

- Universal health care establishes the environment under which health care is to be administered
- Actual administration is the responsibility of the Provinces/Territories
- Governance for the paramedic varies from province to province but may include:
  - Civil or criminal law
  - Regulatory agencies
  - Employer
- Based on the overriding principle of “do no harm”

Best Protection

- Your best protection from liability is to perform systematic assessments, provide appropriate medical care, and maintain accurate and complete documentation.

Legal Duties and Ethical Responsibilities

- Promptly respond to the needs of every patient.
- Treat all patients and their families with respect.
- Maintain your skills and medical knowledge.
- Participate in continuing education.
- Critically review your performance, and constantly seek improvement.
- Report honestly and with respect for patient confidentiality.
- Work cooperatively and with respect for other emergency professionals

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PARAMEDICS, EMS, AND THE LAW

Legal System

- Each EMS response has the potential of involving EMS personnel in the legal system.

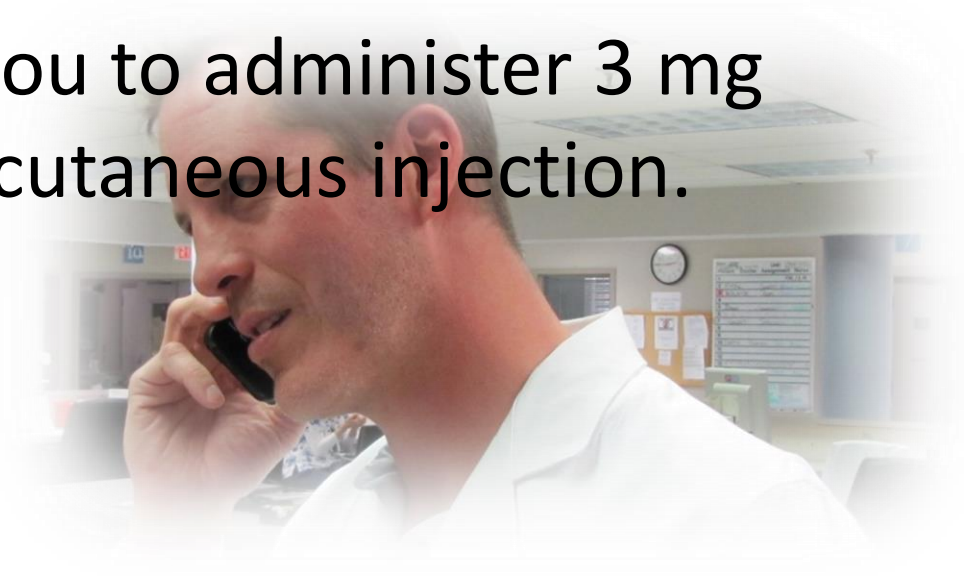
Scope of Practice

- Range of duties and skills that paramedics are allowed and expected to perform
- Typically (but not exclusively) determined by on-line and off-line medical direction

You may function as a paramedic only under the direct supervision of a licensed physician through a delegation of authority.

Case Scenario

- You are attending to a 3 year old male patient who is in mild distress with upper respiratory congestion and the occasional fine wheeze. You contact the delegating physician on-line about the efficacy of Ventolin for this child.
- The physician orders you to administer 3 mg of epinephrine by subcutaneous injection.
- What should you do?



Advocacy

- Your role as the patient advocate dictates that you will not respond to direction that:
  - You know is inappropriate
  - Outside of your scope of practice
  - You feel will unnecessarily harm the patient
- Medical control physicians will sometimes make mistakes too, if you catch an error you have a duty to inform & act as a “patient advocate”

Licensure and Certification

- Certification
- Licensure
- Reciprocity
- Agreement on Internal Trade

Motor Vehicle Laws

- Provincial jurisdiction
- Legislation may be covered in more than one act
  - In Ontario EMS vehicle legislation is covered in the Highway Traffic Act and the Ambulance Act
- Generally allow EMS vehicles to exceed speed limits and breach other laws (e.g. red lights) when it is safe and reasonable to do so

Mandatory Reporting Requirements

- Child abuse and neglect
- Spousal abuse and neglect
- Elder abuse and neglect
- Gunshot Wounds
- Fatalities
- Communicable Diseases

Mandatory Reporting Requirements: Cases

- You are taking care of a women who was badly beaten by her husband. She does not want to contact the police. What is your role?

Mandatory Reporting Requirements: Cases

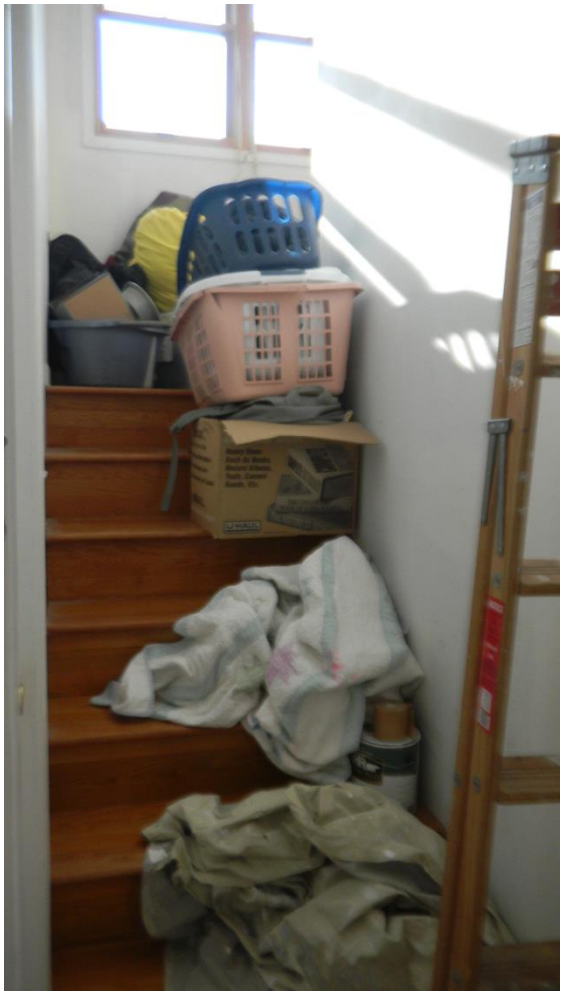
- You are caring for a patient who states their same sex partner has brutally raped them. What are your reporting duties?

Mandatory Reporting Requirements: Cases

- You are called to the home of a frail elderly woman who lives with her son. She has a history of dementia, and is too confused to provide a history but the neighbor who called 911 found her wandering in the neighborhood. The home is unkempt, there is no food in the fridge, and the patient is covered in bruises. Could this be elder abuse? If we suspect this can we report it?

Mandatory Reporting Requirements: Cases

- 911 is called by a 5 y/o M who called because his little brother fell down the stairs and is hurt. When you arrive on scene, there are no adults available, the house is untidy, there is drug paraphernalia and empty liquor bottles present but no food. Could this constitute child abuse? What are your reporting obligations?



Mandatory Reporting Requirements

- Child abuse and neglect
  - Provincial Legislation places obligation on paramedic
    - NS – Child and Family Services Act (CFSA), Section 23 (1)
    - NB – Family Services Act (FSA), Section 30 (1)
  - Identifies four kinds of child abuse:
    - Physical
      - The intentional use of force on any part of a child's body that results in injury.
    - Emotional
      - Anything that causes serious mental or emotional harm to a child, which the parent does not attempt to prevent or address.
    - Sexual
      - The improper exposure of a child to sexual contact, activity or behaviour.
    - Neglect
      - Any lack of care that may cause significant harm to a child's development or endangers the child in any way.

Mandatory Reporting Requirements

- Adult abuse and neglect
  - Provincial Legislation varies
    - For example no requirements currently exist in NB but they do in NS
      - NB Adult Victims of Abuse Protection Protocols
      - NS Adult Protection Act, Section 16 (1)

Mandatory Reporting Requirements: Cases

- You are transporting a 19 y/o M who has been shot – must this be reported to police?
- What about a patient who has been stabbed?
- Do you have to report animal bites?
- Are there infectious diseases that mandate reporting?

Mandatory Reporting Requirements

- Gunshots
  - Gunshot Wounds Mandatory Reporting Act
    - If EMS treats an individual for a gunshot wound it shall disclosed to the local police service that the service has been provided

Legal Protection for the Paramedic

- Immunity
  - Exemption from liability granted to government agencies
- Good Samaritan Laws
  - Provides immunity to certain individuals who assist at an emergency scene
- Bill C-217 Blood Samples Act
  - Federal Bill that has passed first reading
  - Allows for notification and testing when health care providers are potentially exposed
  - Similar provincial legislation (e.g. Alberta Blood Samples Act)
- Local laws and regulations

Good Samaritan Laws

- Provincial jurisdiction
  - BC, NB, NS, Ont, Alberta, Nfld, PEI, Sask have Good Samaritan laws or versions of them
  - Yukon and Nunavut do not have Good Samaritan laws or anything similar
  - Quebec is considered a civil law jurisdiction and notes that every citizen is obligated to stop and help in Quebec
- Off-duty medics are held to the same standard as the general public
- Does not apply to those on-duty

Legal Protection for the Paramedic

- Insurance coverage such as
  - Errors and Omissions insurance
  - Liability insurance
- May be provided by the employer or be required to be purchased by the paramedic personally

Other Provincial and Federal Acts

- As a practitioner you may be held accountable under the following Provincial or Federal Acts:
  - Motor Vehicle Act
  - OHS Act
  - Mental Health Act
  - Paramedics Act
  - Pharmacy Act
  - Controlled Drugs and Substances Act
  - Fatality Investigations

Medical Legal Aspects of Prehospital Care

LEGAL ACCOUNTABILITY OF THE PARAMEDIC

Negligence

- Deviation from accepted standards of care recognized by law for the protection of others against the unreasonable risk of harm.
- Neglect can be intentional or unintentional.

Always exercise the degree of care, skill, and judgment expected under like circumstances by a similarly trained, reasonable paramedic in the same community.

Components of a Negligence Claim

- Duty to act.
- Breach of duty.
- Actual damages.
- Proximate cause.

Duty

- Duty to Act
  - Formal contractual or informal legal obligation to provide care.
- Breach of Duty
  - An action or inaction that violates the standard of care expected from a paramedic.

Breaches of Duty

- Malfeasance
  - Performance of a wrongful or unlawful act by a paramedic.
- Misfeasance
  - Performance of a legal act in a harmful or injurious manner.
- Nonfeasance
  - Failure to perform a required act or duty.

Actual Damages

- Refers to compensable physical, psychological, or financial harm.
  - Acts of omission
    - the failure to perform an act
  - Acts of commission
    - performing an act that results in some harm
  - Acts of demission
    - Withdrawing a treatment

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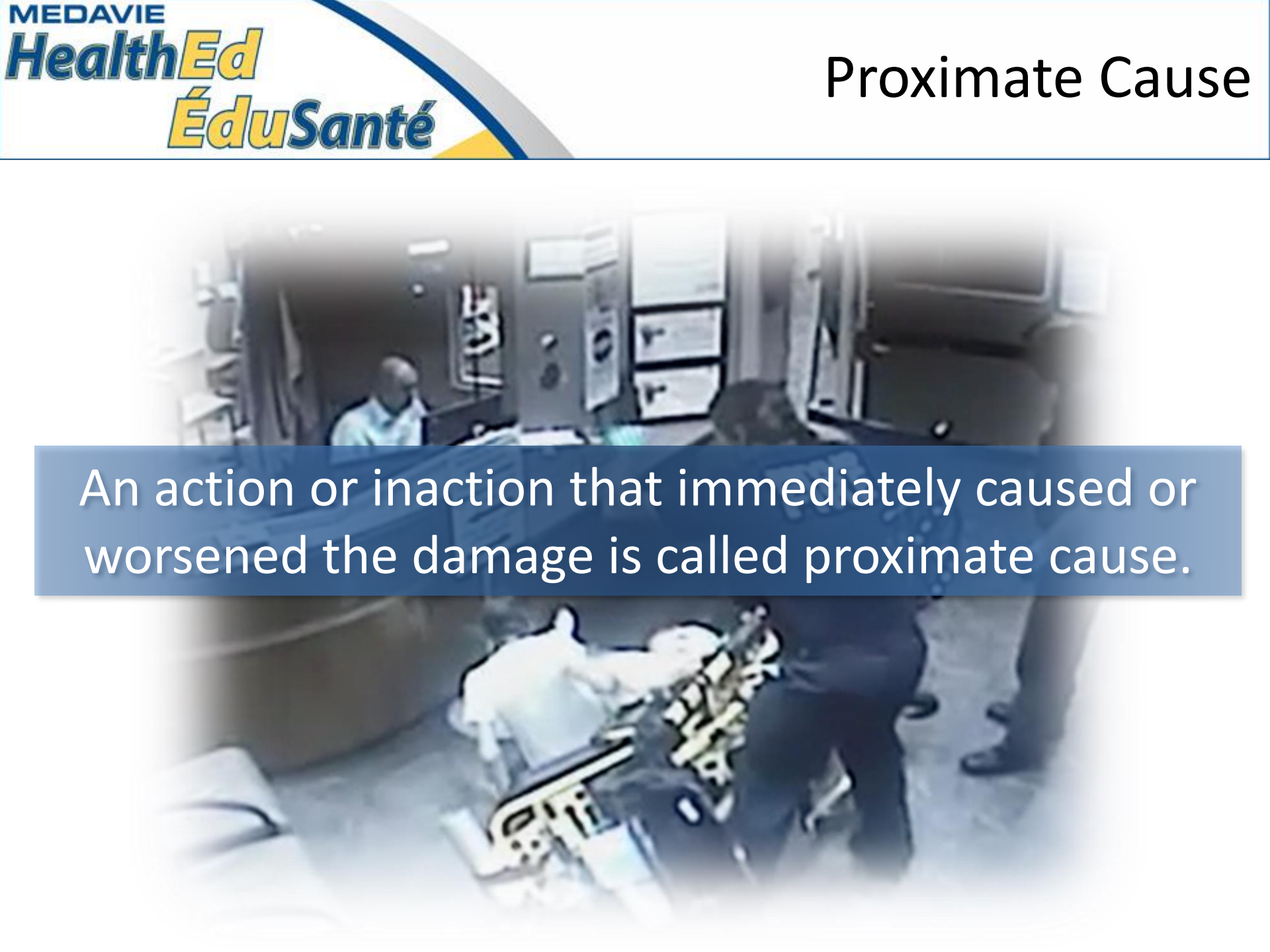
Proximate Cause



An action or inaction that immediately caused or worsened the damage is called proximate cause.

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Defenses to Charges of Negligence

- Good Samaritan laws
- Governmental immunity
- Statute of limitations
- Contributory or comparative negligence

Medical Legal Aspects of Prehospital Care

SPECIAL LIABILITY CONCERNS

Medical Direction

- A paramedic's medical director and on-line physician may be sued if:
  - Medically incorrect orders were given to the paramedic;
  - There was a refusal to authorize the administration of a necessary medication;
- A paramedic's medical director and on-line physician may be sued if:
  - The paramedic was directed to take the patient to an inappropriate facility;
  - Negligent supervision of a paramedic is proven.

Borrowed Servant Doctrine

- As a paramedic you may find yourself supervising other:
  - Emergency care providers (EMR, PCP, ACP)
  - Students on practicum
- Your responsibility is to ensure that these providers perform their duties in a professional and medically appropriate manner

Civil Rights

- If medical care is withheld due to any discriminatory reason, a paramedic may be sued.
  - Race
  - Creed
  - Colour
  - Gender
  - National origin
- Patients should be provided care regardless of:
  - Status
  - Condition
  - Disease (including HIV/AIDS, tuberculosis and other communicable diseases)

Off-Duty Paramedics

- The authorization to practice is typically reserved for the on-duty paramedic
- Performing procedures that require delegation from a physician while off-duty may constitute practicing medicine without a license.
- Not obligated to provide care

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Medical Legal Aspects of Prehospital Care

PARAMEDIC-PATIENT RELATIONSHIPS

Confidentiality

- All records relating to the emergency care rendered to a patient must be kept strictly confidential
- Any medical or personal information about a patient may not be released

Acts

- Federal
  - Privacy Act (Canada) - 1983
    - The act sets out rules for how institutions of the federal government must deal with personal information of individuals.
- Provincial
  - Freedom of Information and Protection of Privacy Act (May also be listed as Privacy Act or Personal Information Protection Act)

Confidentiality

- Right to confidentiality belongs to the patient
- Under special circumstances it may be breached:
  - Patient consent
  - Other medical providers have the need to know, they are in the “circle of care”.
  - Required by law (ie mandatory reporting cases)
  - Third party billing requirements

Definitions

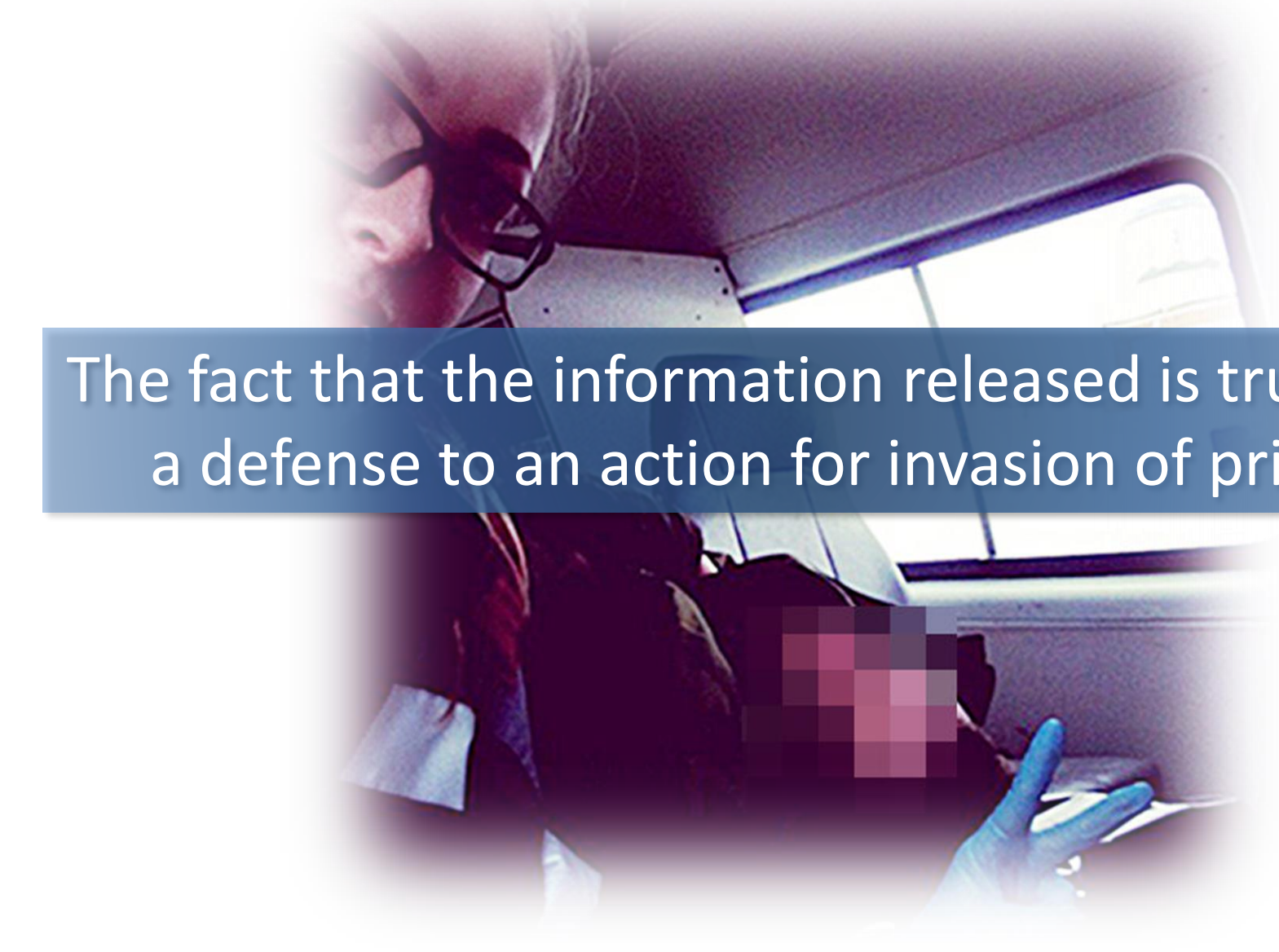
- Defamation
  - An intentional false communication that injures another person's reputation or good name.
  - Libel (written)
    - The act of injuring a person's character, name, or reputation by false statements made in writing or through the mass media with malicious intent or reckless disregard for the falsity of those statements
  - Slander (spoken)
    - The act of injuring a person's character, name, or reputation by false or malicious statements spoken with malicious intent or reckless disregard for the falsity of those statements

Defamation

- Many cases of defamation arise out of statements and notations that are written as expressions of humour

Invasion of Privacy

- A paramedic may be accused of invasion of privacy for the release of confidential information, without legal justification, regarding a patient's private life, which might reasonably expose the patient to ridicule, notoriety, or embarrassment.



The fact that the information released is true is not a defense to an action for invasion of privacy.

Consent

- The granting of permission to treat a patient.
- You must have consent before treating a patient.
- Patient must have “decision making capacity” to give or withhold informed consent.

Informed Consent

- Conscious competent patients have the right to decide what medical care to accept
- Generally this includes the following:
  - Nature of illness or injury
  - Nature of recommended treatments
  - Risks, dangers and benefits of those treatments
  - Alternative possibilities
  - Dangers of refusing treatment including transport

Informed Consent

- Must be obtained before treatment may be initiated
- A process not an event
  - Patients have the right to change their mind
- Generally patients must be 18 years of age or older (varies)
- Parents must give consent for the treatment of children

Expressed Consent

- Verbal, non-verbal, or written communication by a patient who wishes to receive treatment.
- The act of calling for EMS is generally considered an expression of the desire to receive treatment.
- You must obtain consent for each treatment provided.

Implied Consent

- Consent for treatment that is presumed for a patient who is mentally, physically, or emotionally unable to give consent.
- It is assumed that a patient would want life-saving treatment if able to give consent.
- Also called emergency doctrine.

Involuntary Consent

- Consent for treatment granted by a court order.
- Most commonly encountered with patients who must be held for mental-health evaluation or as directed by law enforcement personnel who have the patient under arrest.
- May be used on patients whose disease threatens a community at large.

Case

- 911 called for 88 y/o F who lives alone and fell down the stairs, neighbors heard a scream and thump. On arrival, the patient is covered in blood from a large scalp laceration, she has a large goose egg on her head, and is unable to ambulate. She is argumentative, confused, and refusing care. She is yelling at you to leave.
- How do you approach this?
- She is refusing to “consent” to treatment.
- Can you leave her there?

Special Consent Situations

- Minors
  - Usually a person under 18 years of age.
  - Consent must be obtained from a parent or legal guardian.
- Mentally incompetent adult
  - Consent must be obtained from the legal guardian
- If a parent or legal guardian cannot be found, treatment may be rendered under the doctrine of implied consent.

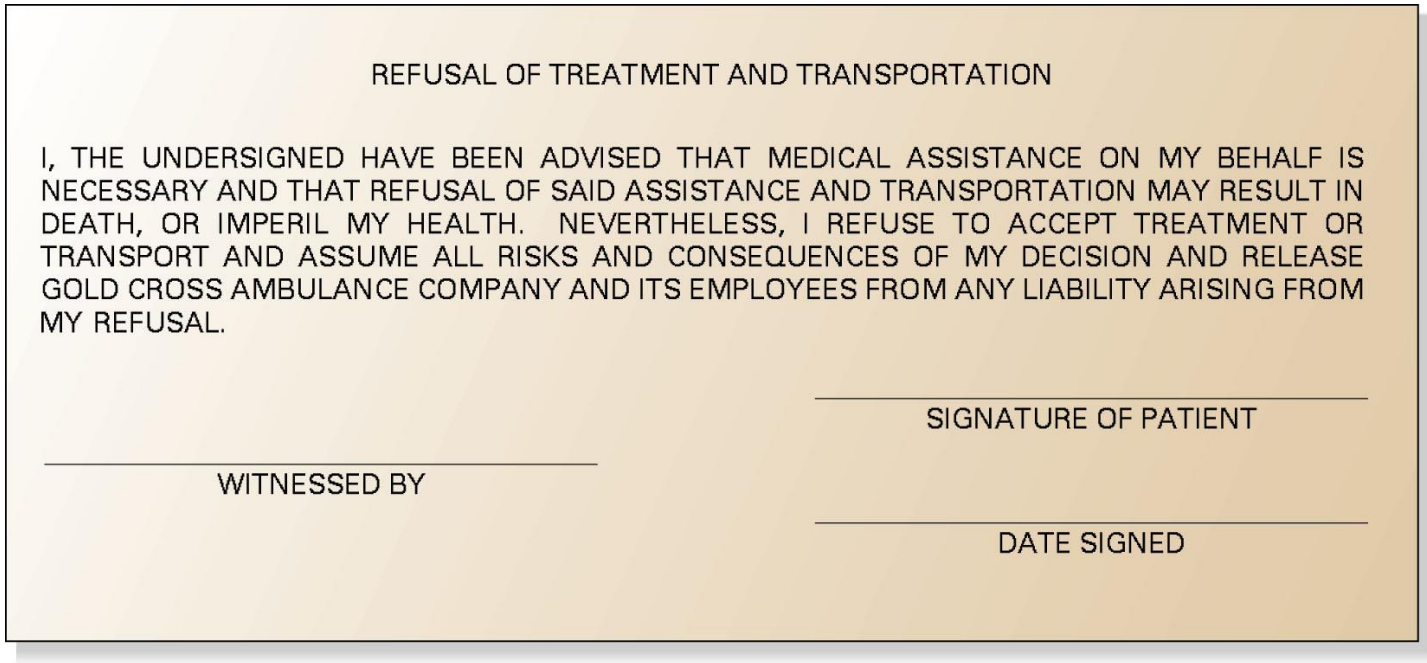
Emancipated Minors

- Person under 18 years of age who is:
  - Married
  - Pregnant
  - A parent
  - A member of the armed forces
  - Financially independent living away from home
- Emancipated minors may give informed consent.

Withdrawal of Consent

- A patient may withdraw consent for treatment at any time, but it must be an informed refusal of treatment.

An example of a "release-from-liability form."



REFUSAL OF TREATMENT AND TRANSPORTATION

I, THE UNDERSIGNED HAVE BEEN ADVISED THAT MEDICAL ASSISTANCE ON MY BEHALF IS NECESSARY AND THAT REFUSAL OF SAID ASSISTANCE AND TRANSPORTATION MAY RESULT IN DEATH, OR IMPERIL MY HEALTH. NEVERTHELESS, I REFUSE TO ACCEPT TREATMENT OR TRANSPORT AND ASSUME ALL RISKS AND CONSEQUENCES OF MY DECISION AND RELEASE GOLD CROSS AMBULANCE COMPANY AND ITS EMPLOYEES FROM ANY LIABILITY ARISING FROM MY REFUSAL.

SIGNATURE OF PATIENT

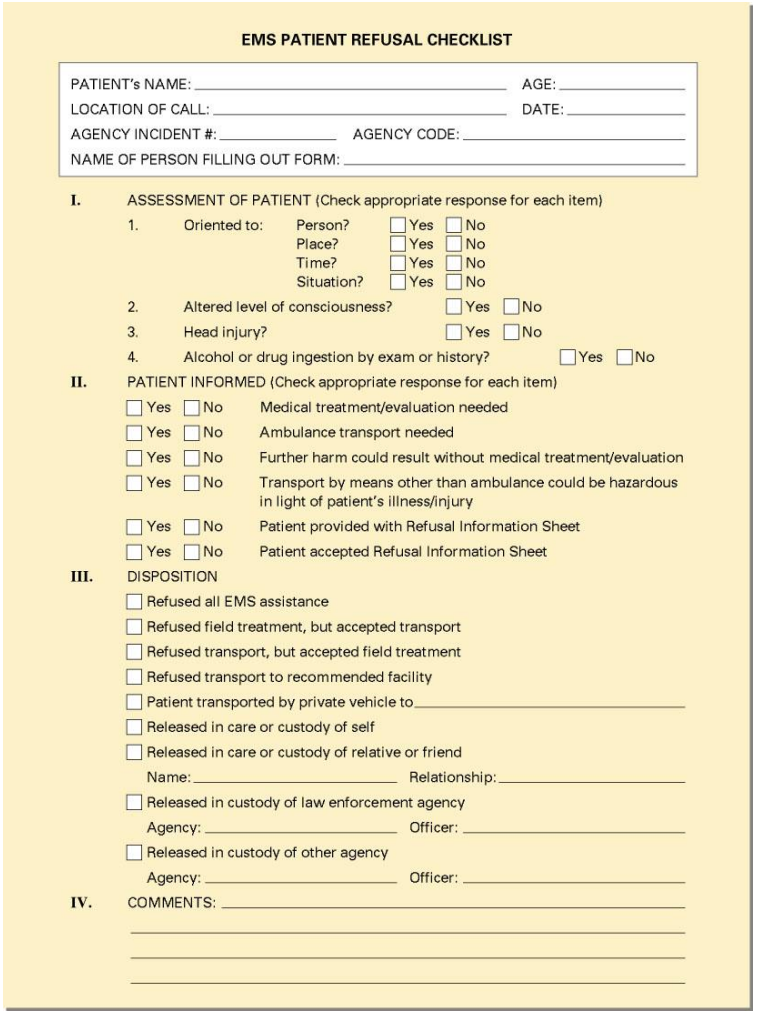
WITNESSED BY

DATE SIGNED

- It is worth noting that this on its own is grossly inadequate for legal coverage.
- This wouldn't actually "release" you from liability at all.
- It is very common for ambulance services to use such a form without fully understanding this.

This is at least better. Refusal Checklist

- Some EMS systems have checklists for procedures to follow when a patient refuses care.



EMS PATIENT REFUSAL CHECKLIST

PATIENT's NAME: _____ AGE: _____
LOCATION OF CALL: _____ DATE: _____
AGENCY INCIDENT #: _____ AGENCY CODE: _____
NAME OF PERSON FILLING OUT FORM: _____

I. ASSESSMENT OF PATIENT (Check appropriate response for each item)

1. Oriented to: Person? ☐ Yes ☐ No
   Place? ☐ Yes ☐ No
   Time? ☐ Yes ☐ No
   Situation? ☐ Yes ☐ No
2. Altered level of consciousness? ☐ Yes ☐ No
3. Head injury? ☐ Yes ☐ No
4. Alcohol or drug ingestion by exam or history? ☐ Yes ☐ No

II. PATIENT INFORMED (Check appropriate response for each item)

- ☐ Yes ☐ No Medical treatment/evaluation needed
- ☐ Yes ☐ No Ambulance transport needed
- ☐ Yes ☐ No Further harm could result without medical treatment/evaluation
- ☐ Yes ☐ No Transport by means other than ambulance could be hazardous in light of patient's illness/injury
- ☐ Yes ☐ No Patient provided with Refusal Information Sheet
- ☐ Yes ☐ No Patient accepted Refusal Information Sheet

III. DISPOSITION

- ☐ Refused all EMS assistance
- ☐ Refused field treatment, but accepted transport
- ☐ Refused transport, but accepted field treatment
- ☐ Refused transport to recommended facility
- ☐ Patient transported by private vehicle to _____
- ☐ Released in care or custody of self
- ☐ Released in care or custody of relative or friend
  Name: _____ Relationship: _____
- ☐ Released in custody of law enforcement agency
  Agency: _____ Officer: _____
- ☐ Released in custody of other agency
  Agency: _____ Officer: _____

IV. COMMENTS: _____

Clinical Context…

- Patients refuse care/transport all the time.
- Forcing a patient to be transported without their consent = “kidnapping”!
- Leaving a patient at home to suffer a poor outcome you knew was foreseeable = “negligence”
- Is it ever ok for a patient to refuse transport?

Case 1

- 74 y/o F calls EMS with chest pain, it sounds like cardiac pain, there are some EKG abnormalities, but the patient is now refusing to go to hospital.
- Reason: her husband went to hospital with chest pain and never came back.
- She has some mild dementia.
- Can she stay home?
- How do you determine this?

Case 2

- 45 y/o M falls down a flight of stairs, he has a goose egg on his head and is a bit unsteady on his feet. He does not wish to go to hospital.
- He tells you he's not the one who called 911 and he didn't want you there in the first place and asks you to leave.
- Can you leave him there?
- How do you decide?

Case 3

- 38 y/o M has a known seizure disorder, his wife called EMS today because he seized again and it lasted longer than usual.
- He is refusing transport.
- He states because “the ED doesn’t do anything except send me home in an hour”, this has happened many times.
- How do you assess whether he can decide to stay home?

- All of these cases you will see regularly, refusals are common.
- They all require a careful assessment of the patient's "decision making capacity".
- DMC is a critical component of the informed refusal process.

Informed Refusal?

- This is a really important concept
- DMC is an important part of this…

Decision Making Capacity:

- “A persons ability to make and express a reasoned choice”.
- There is no such thing as “global capacity”, rather it varies from decision to decision, and it may vary over time.
- It is a “decision specific” assessment.
- “High stakes” decision: requires high degree of demonstrated capacity.

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Decision Making Capacity: 3 Elements

- What are the options (ie transport or not?)
- What are the possible consequences?
- Is the decision made within a “stable set of values”?
- How do we assess this?

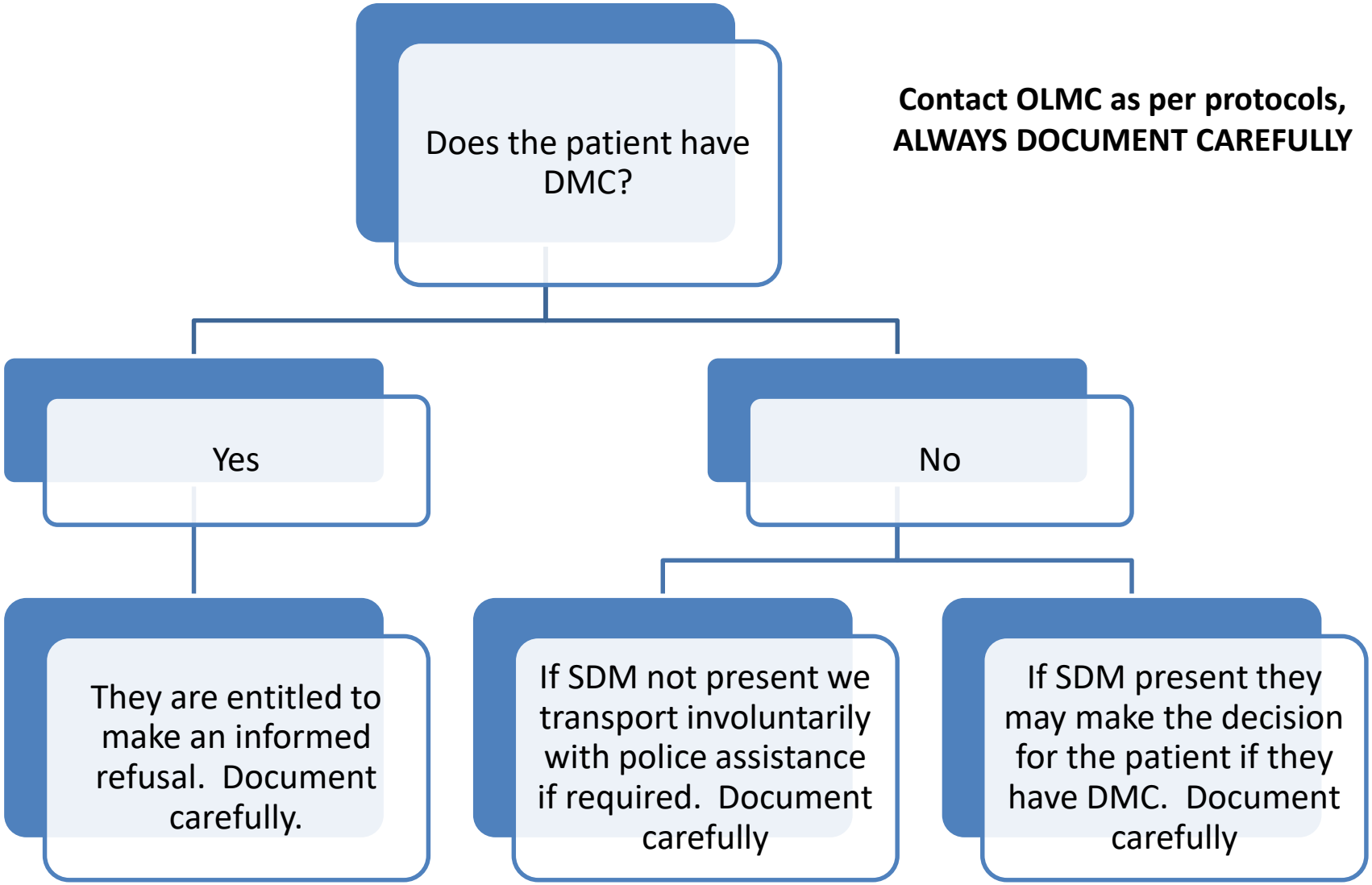
Capacity Assessment When Patient Is Refusing Transport:

- H&P…
- Impression:
  - What are the possible risks? High stakes?
- Explain:
  - Options.
  - Possible consequences.
- Explore:
  - Understanding/ judgment (how?)
  - Stable set of values (how?)

Patient Is Refusing Transport

- If the patient has demonstrated DMC, they are entitled to make an informed refusal, just document carefully!!!!
- If they do not have DMC, they are unable to make an informed refusal.
- If a substitute decision maker (SDM) is present, you assess their DMC.
- If no SDM, we act in the pts best interest and embark on involuntary transport, typically with the assistance of police.
- In many systems, ALL high risk cases are discussed with an on-line MD first.
- In all cases, document very carefully.

Patient Is Refusing Transport



Contact OLMC as per protocols, ALWAYS DOCUMENT CAREFULLY

Capacity assessment and substitute decision makers…

- The Personal Directives Act in NS (April 2010):
  - Help individuals who lack capacity for making health care decisions.
- PDA Hierarchy for substitute decision makers:
  - Court appointed Guardian
  - Nearest adult relative:
    - Spouse
    - Child
    - Parent
    - In loco parentis
    - Sibling
    - Grandparent
    - Grandchild
    - Aunt or uncle
    - Niece or nephew
    - Other relative
  - Public trustee
- Stipulations…

Medical Legal Aspects of Prehospital Care

WHAT ABOUT ASSESSING PATIENT "COMPETENCE"?

Competence

- Throw out the term! Never use it!
- This is a broad-based legal term.
- “Right to determine ones own affairs, begins at age 18, revocable only by a court”.
- You will never be assessing this!!!
- DMC however, you will assess daily.

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Why do we care about non-transported patients?

- What are the medical-legal concerns?
- Could biases impact non-transport rates?
- Some local examples of high risk NOBIs

Why talk about NOBIs?

- Non-transports 90% EMS-related litigation in US.
- Non-transport rates as high as 20 - 35% in many systems.
- NOBIs in NS roughly:
  - 25% in central, 12% rest of province.
- Some notable NS NOBIs:
  - 6d old with a “spell”.
  - 4 week old dropped on head in domestic…
  - Calf cramp…
  - Highway speed roll over MCV

Why talk about NOBIs?

- Increasing call load, overcrowding, offload delays, morale, 911 abuse may contribute.
- Patient vs. medic initiated?
- Do medics really understand DMC?
- Role of the medic in “initiation” of non-transport…is this endorsed? What does the evidence say? This is risky.

A Case: NOBI and Seizure…

- Called for 55 y/o M w seizure.
- +PMHx seizure d/o.
- Sustained his typical tonic-clonic generalized seizure, witnessed by wife.
- On dilantin, compliant, no recent changes.
- No recent illness/drug/EtOH use.

Seizure pt…

- VS normal. Patient is post-ictal, but now easily rousable, protecting airway, generally improving in his LOC such that he is speaking but he is still altered.
- He is refusing transport to hospital.
- Can he refuse transport?
- How do you assess this?

Seizure pt…

- Pt does not convincingly demonstrate decision making capacity.
- His wife is present, and she is also refusing transport on his behalf. “They don’t do anything when we go to the ED”.
- Approach?

Seizure pt

- Estimate the risk for the seizure+NOBI
- Non-transport based on informed refusal by spouse.
- Document carefully.
- What happens to NOBI seizure patients?
- Literature review…

Mechem et al., 2001

- "Short term outcomes of seizure patients who refuse transport after out-of-hospital evaluation".
  - Prospective study.
  - Seizure pts with hx seizures, refusing transport.
  - "Back to baseline", +DMC, +OLMC
  - 72h telephone f/u.
  - 3/52 pts had another sz, 1 admitted.
  - No deaths.
  - 20 contacted their GP.
  - Authors conclude most do ok, importance of +DMC.

What the literature says about NOBI's and informed refusal/DMC

- Schmidt et al., 1998: Telephone f/u to assess recall & understanding of information given during refusal of transport.
  - 256 pt followed up.
  - Only 22% recall explanation of risks.
  - 18% would now agree to transport.

- Documentation becomes very important…

Documentation with Non-transport

- What to include in record?
  - Reasons explained to pt why transport was felt to be warranted.
  - Risks of non-transport, specifically what risks?
  - Reason the patient doesn't want to go.
  - Document that the pt demonstrated DMC.
  - Document the things they were told to watch for/reasons to call back.

Refusal of Service

- Not every EMS run results in the transportation of the patient to the hospital.
- Emergency care must always be offered to the patient, no matter how minor the injury or illness.
- Patients can absolutely refuse service.

BUT!!!!!

- It MUST be an informed refusal.
- Decision making capacity MUST be demonstrated.

Problem Patients

- Violent
- Victim of drug overdose
- Intoxicated
- Ill or injured minor with no adult to provide consent for treatment

Problem Patients

- Attempt to develop trust and some rapport with patient.
- Regardless of type of problem patient, always document the encounter in detail.

Medical Legal Aspects of Prehospital Care

LEGAL COMPLICATIONS RELATED TO CONSENT

Legal Complications Related to Consent

- Abandonment
- Assault and Battery
- False imprisonment

Abandonment

- The termination of the paramedic-patient relationship without assurance that an equal or greater level of care will continue.
- May involve something as simple as leaving a patient unattended

Assault and Battery

- Assault
  - An act of unlawfully placing a person in apprehension of immediate bodily harm without his or her consent.
- Battery
  - The unlawful touching of another person without his or her consent.
  - Not a term used in Canadian law, both assault and battery come under the general criminal heading of assault

False Imprisonment

- The intentional and unjustifiable detention of a person without his or her consent or other legal authority.
- Often a consideration in the treatment of psychiatric patients
- May be averted by having a police officer accompany patient

Reasonable Force

- The minimal amount of force necessary to ensure that an unruly or violent person does not cause injury to himself, herself, or others.
- Use of restraints generally requires the involvement of law enforcement officials
- Maintain your own safety at all times.
- Sometimes this requires transport to ED by police.

Patient Transportation

- Maintain the same level of care as was initiated at the scene.
- A common error observed is having a PCP partner attend *en route* with a patient who requires, or is predicted to require ACP level care.
- Know the closest, most appropriate facility, or local trip destination policies.

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Medical Legal Aspects of Prehospital Care

RESUSCITATION ISSUES

Advance Directives

- A document created to ensure that certain treatment choices are honored when a patient is unconscious or otherwise unable to express his or her choice of treatment.

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Advance Directives

- Living will
- Durable powers of attorney for health care
- DNR orders
- Organ donor cards

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Living Wills

- A Living Will allows a person to specify what kinds of medical treatment he or she should receive.

LIVING WILL

I, _____ _____, make the following **Living Will** declaration to my family, physicians, hospitals, and other health-care providers and any Court or Judge:

After thoughtful consideration and while I am of sound mind, I make this statement as an expression of my settled and firm wishes if the time comes when I can no longer take part in decisions about my own future health.

My Wishes. If at any time I have a terminal condition, and in the opinion of my attending or treating physician there is no reasonable probability that I will recover and the condition can be expected to cause my death within a relatively short time if medical procedures which serve only to prolong the process of dying are not used, or if I am in a persistent vegetative state in which I have no voluntary action or cognitive behavior and cannot communicate or interact purposefully and which is a permanent and irreversible condition of unconsciousness, **I request that I be allowed to die naturally and not be kept alive by artificial means.** I ask that all life-prolonging procedures, including medical assistance to eat and drink when it is highly unlikely that I will regain the capacity to eat and drink without medical assistance, be withheld or withdrawn in such a situation.

Resuscitation. It is my further wish that no cardiopulmonary resuscitation shall thereafter be administered to me if I sustain a cardiac or respiratory arrest. In those circumstances I consent to an order not to resuscitate, and direct that such an order be placed in my medical record.

I direct that these decisions shall be carried into effect even if I am unable to personally reconfirm or communicate them, without seeking judicial approval or authority.

I recognize that there may be instances besides those described above for which life-sustaining treatment should be withheld or withdrawn and this instrument shall not be construed as an exclusive enumeration of these circumstances.

Revocation and Responsibility. This instrument and its instructions may be revoked by me at any time and in any manner. However, no physician, hospital, or other health-care provider who withholds or withdraws life-sustaining treatment in reliance upon this Living Will or upon my personally communicated instructions shall have any liability or responsibility to me, my estate, or any other persons for having withheld or withdrawn treatment.

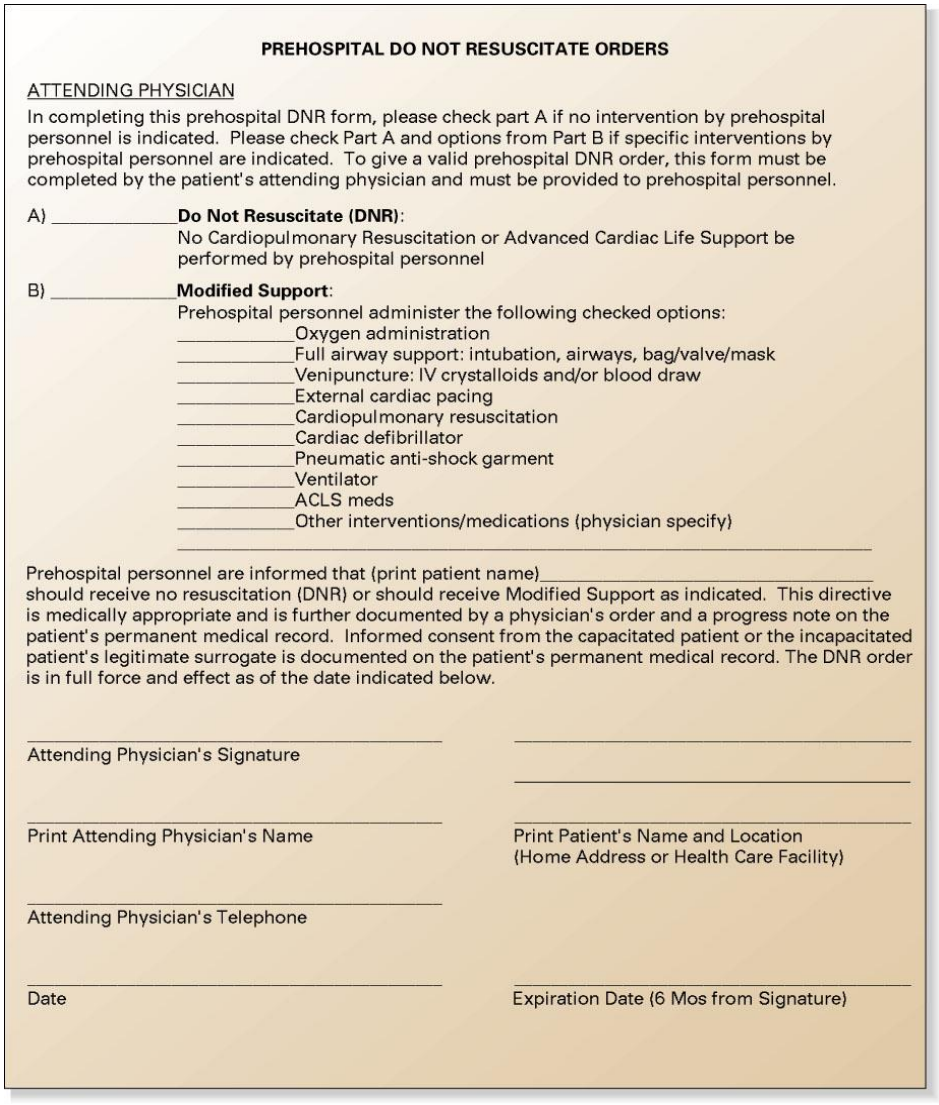
I intend this declaration be accepted in the circumstances described as an exercise of my legal right to refuse medical treatment even if I am unable to personally reconfirm or communicate that. It is made in the presence of the witnesses who have signed below in my presence.

Signed on (date): _____ Witness: _____

Signature: _____ Witness: _____

DNR

- Do Not Resuscitate Order (DNR) indicates which, if any, life-sustaining measures should be taken when the patient's heart and respiratory functions have ceased.



PREHOSPITAL DO NOT RESUSCITATE ORDERS

ATTENDING PHYSICIAN

In completing this prehospital DNR form, please check part A if no intervention by prehospital personnel is indicated. Please check Part A and options from Part B if specific interventions by prehospital personnel are indicated. To give a valid prehospital DNR order, this form must be completed by the patient's attending physician and must be provided to prehospital personnel.

A) _____ **Do Not Resuscitate (DNR)**:
No Cardiopulmonary Resuscitation or Advanced Cardiac Life Support be performed by prehospital personnel

B) _____ **Modified Support**:
Prehospital personnel administer the following checked options:
_____ Oxygen administration
_____ Full airway support: intubation, airways, bag/valve/mask
_____ Venipuncture: IV crystalloids and/or blood draw
_____ External cardiac pacing
_____ Cardiopulmonary resuscitation
_____ Cardiac defibrillator
_____ Pneumatic anti-shock garment
_____ Ventilator
_____ ACLS meds
_____ Other interventions/medications (physician specify)
_____

Prehospital personnel are informed that (print patient name)_____ should receive no resuscitation (DNR) or should receive Modified Support as indicated. This directive is medically appropriate and is further documented by a physician's order and a progress note on the patient's permanent medical record. Informed consent from the capacitated patient or the incapacitated patient's legitimate surrogate is documented on the patient's permanent medical record. The DNR order is in full force and effect as of the date indicated below.

_____ Attending Physician's Signature

_____ Print Attending Physician's Name

_____ Attending Physician's Telephone

_____ Date

_____ Print Patient's Name and Location (Home Address or Health Care Facility)

_____ Expiration Date (6 Mos from Signature)

DNR

- Keep in mind that a “DNR” is only applied to pulseless patients.
- A common error is to interpret a DNR directive as meaning comfort measures only in an emergency.
- Often patients will want varying levels of aggressive care despite having an active DNR.
- DNR orders only apply to dead ppl, they have no bearing on pts while they are living.

Crime Scenes

- If you believe a crime has been committed, involve law enforcement.
- Protect yourself and other EMS personnel.
- Initiate patient care only when the scene is safe.

Crime Scenes

- Don’t touch/move anything unless it interferes with patient care
- Preserve the scene as much as possible:
  - Observe and document anything moved;
  - Leave gunshot or stabbing holes intact if possible;
  - If something must be moved, notify investigating officers and document your actions.

Documentation

- Complete promptly after patient contact.
- Be thorough.
- Be objective.
- Be accurate.
- Maintain patient confidentiality.
- Never alter a patient care record.

Forms of Documentation

- All forms of documentation should be held to the same standard
  - Personal notes
  - Patient care reports
  - Incident reports

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Medical Legal Aspects of Prehospital Care

PROFESSIONAL REGULATIONS

Funding

- EMS services in Canada are generally funded, at least in part, by the government of the province or territory in which they operate through the Ministry of Health or Health Department.
- However, paramedics and ambulance services are not mentioned in the Canada Health Act and are therefore not an insured service.
- Provinces may choose to subsidize some of the cost, usually just for patients with a valid provincial health card.
- Health insurance in Canada is universal and publicly funded, therefore the cost of emergency ambulance services is covered to some degree.
- The degree to which individual use of EMS is subsidized by provincial health insurance varies by province, and may be supplemented by either partial fees for service, or from the property tax revenues of local municipalities operating such services.

Paramedics must possess knowledge, skills, and attitudes consistent with the expectations of the public and the profession.

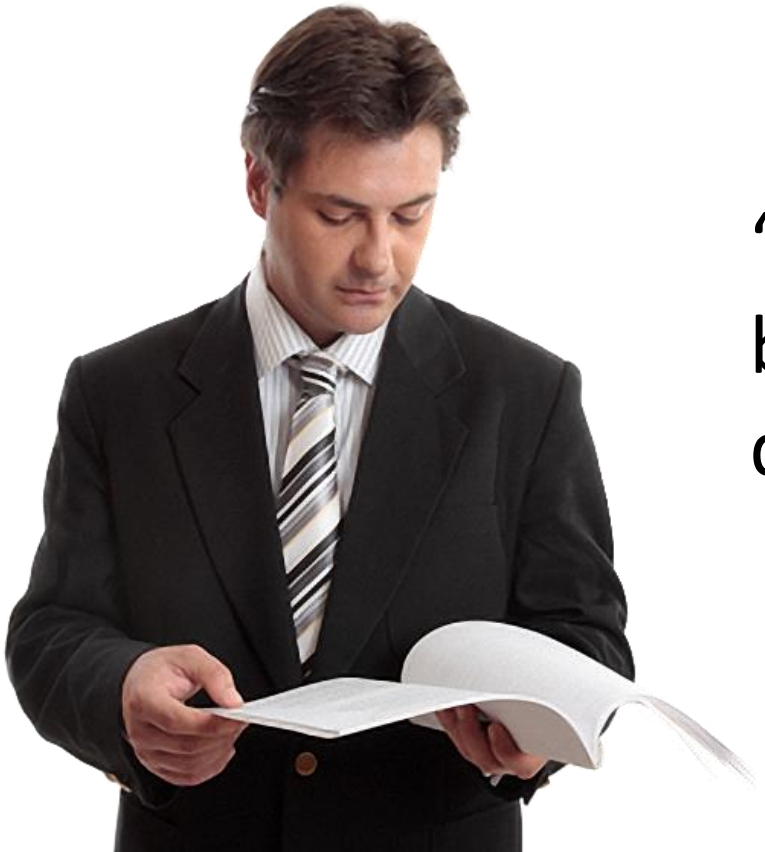
National Occupational Competency Profile (NOCP)

- Developed by the Paramedic Association of Canada (PAC)
- Sponsored by HRDC
- Agreement for Internal Trade (AIT)
- Established comprehensive framework for standardizing the paramedic profession
  - First challenge to agree on the names

NOCP

- Facilitates mobility of the professional
- Forms basis for accreditation of educational programs
  - Canadian Medical Association (CMA)
- Has become the blueprint for national registry exam
  - Coordinated by the Canadian Organization of Provincial Regulators (COPR)

www.paramedic.ca



"It is your responsibility to be familiar with this document"

Practitioner Levels

- As outlined in the NOCP document there are four practitioner levels in paramedicine:
  - Emergency Medical Responder (EMR)
  - Primary Care Paramedic (PCP)
  - Advanced Care Paramedic (ACP)
  - Critical Care Paramedic (CCP)

Emergency Medical Responder (EMR)

- Generally a first responder or entry level position
- Primary assessments, BLS interventions
- Occasionally provide transport
- Do not perform delegated acts

Primary Care Paramedic

- The PCP has successfully completed a recognized education program in paramedicine at the primary care paramedic level.
- PCPs may be volunteer or career paramedics associated with remote, rural, suburban, urban, industrial, air ambulance and military services. PCPs constitute the largest group of paramedics in Canada.
- Controlled or delegated medical acts in the PCP competency profile include intravenous cannulation and the administration of certain medications

(National Occupational Competency Profile for Paramedics, October 2011 – pg 8)

Advanced Care Paramedic

- The ACP has successfully completed a recognized education program in paramedicine at the advanced care paramedic level. An ACP education program may require prior certification at the PCP level (or equivalent).
- ACPs are often employed in rural, suburban, urban, industrial, and air ambulance services. ACP education builds upon the PCP competencies, and ACPs apply their added knowledge and skills to provide enhanced levels of assessment and care.
- Controlled or delegated medical acts in the ACP competency profile include advanced techniques to manage life-threatening problems affecting patient airway, breathing and circulation. ACPs may implement treatment measures that are invasive and/or pharmacological in nature.

(National Occupational Competency Profile for Paramedics, October 2011 – pg 9)

Critical Care Paramedic

- The CCP has successfully completed a recognized education program in paramedicine at the critical care paramedic level. This is currently the highest level of paramedic certification available.
- CCPs are often employed in suburban, urban, and air ambulance services. CCP education builds upon the ACP competencies, and CCPs apply their added knowledge and skills to provide enhanced levels of assessment and care.
- Controlled or delegated medical acts in the CCP competency profile include advanced techniques, including invasive hemodynamic monitoring devices to manage life-threatening problems affecting patient airway, breathing and circulation. CCPs may implement treatment measures that are invasive and/or pharmacological in nature.

(National Occupational Competency Profile for Paramedics, October 2011 – pg 9)

Provincial Variations

- We must appreciate the considerable degree of inter-provincial variation.
- NOCP provides a national consensus but each province retains ultimate authority in legislating the actual administration and delivery of EMS within its own region.
- Regulatory frameworks vary from province to province
  - Direct government regulation
  - Professional self-regulating bodies
- Paramedic is a generic description of a category of practitioners that also has provincial variability
  - Alberta uses EMT and Paramedic
  - Ontario uses A-EMCA and Paramedic

Definitions

- Certification
  - The process by which an agency or association grants recognition to an individual who has met its qualifications.
- Licensure
  - A process of occupational regulation.
- Reciprocity
  - The process by which an agency grants certification or licensure to an individual of comparable certification, licensure or registration from another agency

Agreement on Internal Trade Act

- As a paramedic practitioner registered in a Canadian province or Territory, you may submit an application for equivalency recognition and registration if you meet all the following criteria:
  - You have passed the registration examination in the Canadian province where you completed your program of study
  - You are current and fit to practise, and registered with a recognized provincial paramedicine regulator in another Canadian province
  - You meet all the registration requirements for that province or territory

College of Paramedics

- Some provinces have established a “College of Paramedics”
- Roles:
  - Self regulation
  - Regulatory body
  - Protect public interest
    - establishing, maintaining and enforcing standards for registration, competency and standards of practice for the profession.
    - setting the standards for approved paramedicine education programs.
    - ensuring registered practitioners provide safe and ethical front-line care.

Summary

- Universal Health Care
- Legal duties and ethical responsibilities.
- The legal system.
- Laws affecting EMS and the paramedic.
- Legal accountability of the paramedic.
- Paramedic-patient relationships.
- Resuscitation issues.
- Crime and accident scenes.
- Documentation.
- Regulations