Medico-Legal

EMS Continuing Education
Technician through Tech-AP

Consistent with the
National Occupational Competency Profiles
as developed by
Paramedic Association of Canada
and
"An Alternate Route to Maintenance of Licensure"
as developed by Manitoba Health

Originally Evaluated for content by:
Cal Friesen, B.A., M.A., LL.B.

Developed by:
Educational Subcommittee – Paramedic Association of Manitoba

Revised July 2011

Disclaimer

These documents were developed for improved accessibility to standardized continuing education for all paramedics in Manitoba.

This training package is consistent with the National Occupational Competency Profiles and the core competency requirements (both mandatory and optional) as identified in "An Alternative Route to Maintenance of Licensure" (ARML). It is not the intent that this package be used as a stand-alone teaching tool. It is understood that the user has prior learning in this subject area, and that this document is strictly for supplemental continuing medical education. To this end, the Paramedic Association of Manitoba assumes no responsibility for the completeness of information contained within this package.

It is neither the intent of this package to supersede local or provincial protocols, nor to assume responsibility for patient care issues pertaining to the information found herein. Always follow local or provincial guidelines in the care and treatment of any patient.

This package can be used in conjunction with accepted models for education delivery and assessment as outlined in "An Alternative Route to Maintenance of Licensure". Any individual paramedics wishing to use these continuing education packages to augment their ARML program should contact their local EMS Director.

This document was designed to encompass all licensed training levels in the province (Technician, Technician – Paramedic, Technician – Advanced Paramedic.). Paramedics are encouraged to read beyond their training levels. However, it is suggested that the accompanying written test only be administered at the paramedic's current level of practice.

This package has been reviewed by the Paramedic Association of Manitoba's Educational Subcommittee and is subject to review by physician(s) or expert(s) in the field for content.

As the industry of EMS is as dynamic as individual patient care, the profession is constantly evolving to deliver enhanced patient care through education and standards. The Paramedic Association of Manitoba would like to thank those practitioners instrumental in the creation, distribution, and maintenance of these packages. Through your efforts, our patient care improves.

This document will be amended in as timely a manner as possible to reflect changes to the National Occupational Competency Profiles, provincial protocols/Emergency Treatment Guidelines, or the Cognitive Elements outlined in the Alternate Route document.

Any comments, suggestions, errors, omissions, or questions regarding this document may be referred to info@paramedicsofmanitoba.ca , attention Director of Education and Standards.

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Conventions Used in this Manual

The cognitive elements contained in this training module apply to all EMS licensure levels. Therefore no conventions have been used to differentiate between Technician, Technician – Paramedic, Technician – Advanced Paramedic.

Introduction

Emergency care has changed a lot since its early days. One improvement has been in the quality of EMS training. People have come to expect a competent paramedic, one who understands and accepts his or her responsibilities to patients and to the public. Legal issues are also an important concern to the paramedic. As a paramedic, you will interact with the legal system frequently, and you must be familiar with all its components. In addition, you must be familiar with all laws affecting prehospital care.

Legal Duties

Each province defines a paramedic's scope of practice (actions that are legally allowed). All paramedics are to provide for the well being of their patients as outlined in the scope of practice. Your local medical director enhances provincial law. In fact, your legal right to act as a paramedic depends on medical control.

When providing medical care, you should do the following:

- Follow standing orders and protocols as approved by medical direction
- Consult a medical director via phone or radio any time there is a question about the scope of care
- Communicate clearly and completely with the medical director
- Follow the orders the medical director gives

Ethical Responsibilities

A code of ethics is a list of the rules for ideal conduct. Basically, if you place the welfare of a patient above all else during emergency care, you rarely will do anything unethical. Manitoba Emergency treatment guidelines outline the code of ethics for EMS personnel as follows:

- Have the fundamental responsibility to conserve life, to alleviate suffering and to promote health
- Must provide services based on human need, with respect for human dignity, unrestricted by consideration of nationality, race, creed, color or status
- Should respect and hold in confidence all information obtained in the course of professional work unless required by law to divulge such information
- Understand and uphold the laws of the land, and work with other citizens and health professionals to meet the health needs of the public
- Maintain professional competence
- Participate in defining and upholding standards of professional practice and education

- Adhere to standards of personal ethics that reflect credit upon the profession
- Do not lend professional status to advertising, promotion or sales
- Have an obligation to protect the public by not delegating to a person less qualified any service which requires the professional competence of an EMS personnel
- Works harmoniously with his or her associates and other members of the health care team
- Refuse to participate in unethical procedures, and assumes the responsibility to expose incompetence or unethical conduct in others to the appropriate authority

A paramedic is expected to practice the same level of care as any other competent paramedic in the community who has equivalent training. As a rule, you are expected to perform as any other "prudent person" would in a similar situation. Any deviation from this standard might open you to allegations of negligence. *Negligence* is defined as a deviation from an accepted standard of care. It is synonymous with malpractice in the context of medical care. *Abandonment* is defined as the termination of a health care provider-patient relationship, without assurance that an equal or greater level of care will continue. To establish negligence, the court must decide that all four of the following are true:

- The paramedic had a duty to act. The concept known as duty to act refers to your contractual or legal obligation to provide care, that is, while you are on duty, you must care for a patient who needs it and consents to it.
- There was a breach of duty. A breach of duty exists when a paramedic either fails to act or fails to act appropriately, that is, the paramedic violated the standard of care reasonably expected of a paramedic with similar background and training.
- The patient was injured physically or psychologically
- The paramedic caused the injury. It must be proven that the paramedic breach of duty is what caused or contributed to the patient's injury.

There are several types of assault named in the Criminal Code of Canada: common assault, assault causing bodily harm, assault with a weapon and aggravated assault are just four. Common assault is the most likely of the assault charges a paramedic might face in relation to patients who claim they were mishandled or did not want to be touched. This criminal charge may be hard to prove, since it is unlikely that a plaintiff could prove the paramedic had intent to injure the patient. The paramedic should still remain cautious in light of the possibility of civil litigation. Obtain consent before touching a patient's clothing or body.

By law, you must get a patient's consent, or permission, before you can provide emergency care. In order for that consent to be valid, the patient must be competent and the consent must be informed. It is your responsibility, therefore, to fully explain the care you plan to give as well as the related risks. Generally, consider an adult incompetent if he or she

- is under the influence of alcohol or drugs;
- has an altered mental status;
- has a serious illness or injury that could affect judgment; or

- is mentally ill or mentally challenged.

There are generally 4 types of consent.

Informed consent: consent obtained only after the patient has had the risks and benefits of treatment explained in a manner, which the patient understands.

Expressed consent: consent may consist of oral consent, a nod, or an affirming gesture from a competent adult. Expressed consent is the most common form of consent. Often, the act of the patient requesting an ambulance is considered an expression of a desire to be treated.

Implied consent: in an emergency when an unconscious patient is at risk of death, disability, or deterioration of condition, the law assumes that he or she would agree to care. Implied consent also applies to a patient who refuses care but who then becomes unconscious and to a patient who is not competent to refuse care.

Minor consent: depending on provincial law, a minor usually is any person under the age of 18 years. A minor may give consent to their own treatment providing it is an informed consent and they are competent enough to give their consent. A parent or legal guardian may override any consent or refusal of treatment by a minor. In the case of a mentally incompetent adult a parent or legal guardian must give consent prior to treatment. However, if a life-threatening condition exists and neither the parent nor guardian is available, provide emergency care under the principle of implied consent. Note that the above comes from the Manitoba Medical Association in regards to treatment of minor children. There is nothing in law in Manitoba that states anything about minor children and emergency medical care.

Health Care Directives

In Manitoba, The Health Care Directives Act acknowledges and respects that people have the right to accept or refuse medical treatment. A health care directive, sometimes referred to as a living will, allows people to make choices about their future medical care. To be valid, a health care directive must be in writing, signed and dated. There are several forms that may be used for this purpose but a valid directive may be written on anything. The person making the directive must be 16 years of age and able to understand the consequences of his or her decision. The directive can be changed at any time. A health care directive only comes into effect should the patient not be able to communicate their wishes to the appropriate health care provider. EMS must be able to access the advance directive. Just being told that the directive exists is not acceptable. If a proxy has been named the proxy has the final decision in regards to treatment. For example, a person may have written in their directive that they do not want CPR in the event of a cardiac arrest but the proxy may override that wish. If a proxy is not present or able to be contacted, EMS staff must follow the direction in a health care directive. EMS is under no obligation to seek out an advance directive, but must abide by the wishes of the person making the directive or the proxy once they have seen the directive. In

Manitoba many people have an ERIC kit on their fridge which contains a health care directive.

Where a “Do not resuscitate” order has been issued by a physician the paramedic must have a copy of the order and it must be signed, dated and legible.

When attending a call and a Health Care Directive form is presented the paramedic must:

- ensure the form and the information provided clearly identifies the person to whom the Health Care Directive applies
- ensure the patient is the person referred to in the Health Care Directive
- identify what, if any, procedures are authorized or prohibited by the patient in the Health Care Directive
- follow the instructions outlined in the Health Care Directive including the discontinuation of resuscitation if required
- certain procedures that are permitted under the Health Care Directive should be initiated, if appropriate
- document who provided the Health Care Directive or the information on the Health Care Directive and their relationship to the patient
- document the circumstances fully, including patient assessments, vital signs and any treatments initiated
- assist the patient’s representative to contact the appropriate local authorities
- provide emotional support
- A copy of the health care directive or do not resuscitate order should be attached to the PCR if it has been a factor in the treatment or non treatment of a patient.

Refusal of Care

The non-transport of patients because of refusal of care is a common occurrence in prehospital care. The EMS personnel must attempt to obtain a thorough a history and patient assessment as possible so that the patient who refuses medical evaluation and treatment has an opportunity to make an informed decision on refusing care. Careful documentation is required whenever care is refused.

While patients have the right to refuse medical evaluation and treatment it is incumbent on the EMS personnel to first attempt to ensure the following:

- the patient must be oriented to person, place, and time
- there are no signs of significant impairment due to alcohol, drugs, or mental or organic illness
- vital signs must be within normal limits
- patient must have a reasonable understanding of the provisional diagnosis and the risks of refusing treatment

EMS personnel must take care to ensure that the instructions given to the patient and the family member or friend present who is willing to assume responsibility for the patient's care are clearly understood. This information must include:

- a reasonable plan of action should the patient's condition deteriorate and
- how to activate the EMS system if the patient wishes to seek medical evaluation and transport
- The patient should be encouraged to seek medical follow-up.

The following information must be documented on the patient care report:

- date, time, and location where patient found
- presenting complaint
- history and physical examination, including vital signs
- mental status examination
- patient not under influence of alcohol, drugs, other substances, or injuries that may impair ability to make decisions
- patient is clearly not a risk to self or others
- reason(s) for refusal
- consequences of refusal of care reviewed with the patient
- information on how to contact EMS if patient changes mind about seeking medical care and transport
- other advice given to the patient
- identification of police on scene (if applicable)
- name of family member or other adult present as witnesses
- record name of person(s) present with patient at disposition

A copy of the refusal of care form must be completed and attached to the patient care report.

If the patient does not meet the above criteria and subsequent to the EMS personnel's evaluation and assessment of the patient that, in the EMS personnel's judgement, the patient should received medical assessment, then the following actions should be considered:

- responsible family members or friends who are present should be enlisted to encourage the patient to accept transportation
- if this fails, the Regional EMS Medical Director or physician designate should be contacted to discuss the situation
- if required, direct communication between the physician and the patient could be conducted to ensure the patient clearly understands the consequences of their decision to refuse care and to assist in convincing the patient to accept transport for medical assessment

If these measures fail and the EMS personnel have concerns about the patient's capacity to decide and ability to make an informed decision to refuse care and transport, the police should be contacted for assistance.

If the decision is made that a patient requires medical assessment and is unable to make an informed decision, and the patient must be transported against their wishes, police must make this decision based on consultation with the on scene EMS personnel and the Regional EMS Medical Director or their physician designate

If a patient is identified as requiring transport to a health care facility and all attempts to persuade the patient are unsuccessful, then a decision must be made whether to restrain the patient during transport

If a patient requires transport to a health care facility and all attempts to calm the patient are unsuccessful, a decision must be made whether to restrain the patient during transport EMS personnel should request that the police restrain the patient. Restraining a patient is not an EMS function

Procedure for restraining a patient:

- explain restraining actions to the patient, family, and others at the scene
- use all reasonable precautions to safeguard the welfare of the patient and other
- apply only reasonable therapeutic force
- ensure the patient is not injured in the restraining process or by the restraints
- ensure the airway is maintained
- position the patient in the recovery position, if possible
- document the indication(s) for restraint and action(s) taken
- record serial examinations at regular, frequent intervals while the patient is restrained
- police assisting in patient restraint must accompany the patient in the ambulance in case the restraints need to be removed

A number of patients must be transported even if they meet all the criteria for discharge in the field, including:

- patients who are a danger to themselves or others
- the decision to transport is done in consultation with the police
- victims of child abuse if there is the potential for further abuse
- patients who are critically ill or injured
- critically ill patients may have an advance directive expressing a wish not to be treated or transported
- EMS personnel may refer to Do Not Resuscitate Protocol or Medicolegal Guideline for further information

The following information must be documented on the patient care report:

- date time and location where patient found

- presenting complaint
- history and physical examination, including vital signs
- mental status examination
- patient not under influence of alcohol, drugs, or other substances that may impair ability to make decisions
- patient is clearly not a risk to self or others
- reason(s) for refusal
- consequences of refusal of care reviewed with the patient
- information on how to contact EMS if patient changes mind about seeking medical care and transport
- other advice given to the patient
- name of family member or other adult present as witnesses
- identification of police on scene (if applicable)
- patient disposition
- record name of person(s) present with patient at disposition

A copy of the refusal of care form must be completed and attached to the patient care report.

In all but the most minor situations, the patient should be encouraged to accept transportation for medical evaluation.

If there are any doubts regarding transportation, then EMS personnel should err on the side of caution and safety and undertake transport of the patient, if possible.

Patients who are not transported should always be advised to seek further medical as indicated by their circumstances or to call for EMS if they wish transportation at a later time.

If the patient initially refuses transport but later changes their mind and requests transport the EMS personnel cannot refuse to transport the patient.

EMS personnel must not attempt to dissuade the patient from transport.

Whenever possible EMS personnel should attempt to obtain a signature from the patient, the patient's care giver, and the patient's proxy or responsible family member confirming refusal of care.

All patients who refuse care must sign a completed refusal of care form. EMS personnel must recognize that the form does not absolve them of the EMS system of medico-legal responsibility.

A person is determined to have the capacity to make health care decision if he or she is able to understand the information that is relevant to making a decision and is able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

EMS personnel may be required to use creativity and compromise to persuade patients to cooperate with further evaluation, management, and transportation.

There may be reluctance on the part of EMS personnel to contact the police to assist in the transport of a patient. The risk of legal action against EMS personnel for unlawful confinement or common assault must be balanced against the risk of malpractice and the fundamental needs of a patient who is unable to make an informed decision.

Despite of efforts to remain at a safe distance or to avoid becoming involved in a violent situation, there may be times when EMS personnel find themselves confronted by a violent non-competent patient while attending the patient. If necessary, EMS personnel should leave the scene until the police arrive. If they cannot leave the scene then protective actions should be taken. To protect themselves, the patient's family, friends, and the patient from harm it may be necessary for the EMS personnel to temporarily physically restrain the patient, though restraint of a non-competent patient is normally a police function, the police may be delayed or not immediately available to undertake the immediate restraint of the suddenly violent patient. EMS personnel should use only the minimum amount of physical restraint required to prevent injury to all involved

Confidentiality

Information related to a patient's history, assessment findings, and any treatment rendered generally is considered confidential information. The release of this information requires written permission from the patient or legal guardian. Personal health information is any information that is recorded in any form. Information that can be linked to an identifiable individual and relates to an individual's health, health history, genetic makeup, healthcare, personal health identification number or other identifying information collected in the course of providing health care. As a health care professional, The Personal Health Information Act affects EMS personnel. All EMS personnel must clarify their obligation to their employer, service, and RHA regarding the Personal Health Information Act. It is also the employer's responsibility to ensure all EMS personnel receive clear instruction on how to comply with the Act. Detailed information regarding the Act can be obtained from the Government of Manitoba's website and the Manitoba Emergency Treatment Guidelines Appendix 10.

Crime and Accident Scene Considerations

When responding to a crime scene, if possible, it is best to be in direct radio communication with law enforcement personnel at the scene. This will provide the paramedic with information regarding scene safety and the number of patients. If police are not on the scene or if the EMS crew is the first to respond, contact with the dispatch center should be maintained so that appropriate information can be relayed to law

enforcement personnel. In addition to providing patient care, the paramedic should observe and document the overall scene and make an effort to protect potential evidence.

Responding to an accident scene requires the same commitment to personal safety and personal safety and preservation of possible evidence. In addition, accident scenes and crime scenes often require additional personnel and resources.

Your first concern should always be your own safety. Once the scene is safe, your priority is patient care. When on the scene, do not disturb any item that may be evidence. Basic guidelines include the following:

- Observe and document anything unusual at the scene.
- Touch only what you need to touch.
- Move only what you need to move to protect the patient and provide emergency care.
- Do not use the telephone, unless the police give you permission to do so. They may wish to find out who the last caller was.
- Move the patient only if he or she is in danger or must be moved in order for you to provide emergency care.
- If possible, do not cut through holes in the patient's clothing. They may have been caused by bullets or stabbing.
- Do not cut through any knot in a rope or tie. Knots are often used as evidence.
- If the crime is sexual assault, encourage the patient not to wash, to preserve evidence and explain the reason why. Ask him or her not the change clothing, use the bathroom, or take anything by mouth. Doing any of these things could destroy evidence.

In general, physicians must report suspected child, elderly, and spouse abuse. In Manitoba there is a legal duty for all persons who have knowledge of child abuse to report it. Related provincial laws often grant immunity from liability for libel, slander, or defamation of character, as long as the report is made in good faith.

EMS personnel should report an injury that may be the result of a crime. That includes gunshot wounds, knife wounds, and poisonings. Your province may also want you to report any injury that you suspect was caused by sexual assault.

In some areas, EMS workers must report all suspected infectious disease exposure. That includes exposure to TB, hepatitis B, and AIDS. Other situations to report may include use of restraints on a patient, attempted suicide, and dog bites. Learn your local and provincial requirements.

Documentation

In the legal professions, the general belief is that "if it was not written down, it was not done." The paramedic's documentation of an emergency call will be one of the first items reviewed in the case of a lawsuit for negligence or malpractice. Memory is fallible, and claims may not be filed until years after an event. As a result, EMS personnel may

be expected to testify to events years after they occurred. The paramedic will be allowed to refer to written reports to refresh his or her memory about details while testifying. Therefore thoroughness and attention to detail are absolutely essential in documentation. Characteristics of an effective PCR include the following:

- Completed promptly. It is a record made “in the course of business” not long after the event. Timely completion is essential to the PCR becoming part of the hospital record.
- Completed thoroughly. It should cover assessment, treatment, and other relevant facts and “paint” a complete, clear picture of the patient’s condition and the care provided.
- Completed objectively. The paramedic should make observations rather than assumptions or conclusions and should avoid the use of emotional and value-laden words or phrases.
- Completed accurately. Descriptions should be as precise as possible, and the Paramedic should avoid using abbreviations or jargon not commonly understood.
- Written with confidentiality maintained. The paramedic should follow established policy for release of patient information, and whenever possible, obtain patient consent before releasing information.

PCR’s must to be maintained in accordance with PHIA.

The general scope and function for EMS personnel is outlined in the legislation. EMS personnel must ensure they are current on legislation that can affect their actions. These Acts include but are not limited to:

- The Emergency Medical Response and Stretcher Transportation Act
- The Personal Health Information Act
- The Health Care Directives Act
- The Mental Health Act
- The Child and Family Services Act
- The Highway Traffic Act
- The Public Health Act
- The Fatality Inquiries Act
- The Midwifery and Consequential Amendments Act
- The Evidence Act
- The Protection for Persons in Care Act

References

"An Alternative Route to Maintenance of Licensure", Manitoba Health Emergency Services, Revised March 14, 2001

Brady Emergency Medical Responder A Skills Approach, Canadian Edition, Keith J. Karren, Brent Q. Hafen, Daniel Limmer, John Mackay, Michelle Mackay Prentice Hall, Inc., 2003