Chapter 3

Medical, Legal, and Ethical Issues

Unit Summary

After students complete this chapter and the related course work, they will understand the ethical responsibilities and medicolegal directives and guidelines pertinent to the EMT. The EMT’s approach to patient care relating to confidentiality, consent to treat, refusal of care, and advance directives is explained. Organ donor systems and policies, evidence preservation, and end-of-life issues are also discussed.

National EMS Education Standard Competencies

Preparatory

Applies fundamental knowledge of the emergency medical services (EMS) system, safety/well-being of the emergency medical technician (EMT), medical/legal, and ethical issues to the provision of emergency care.

Medical/Legal and Ethics

• Consent/refusal of care (pp 86–90)

• Confidentiality (p 91)

• Advance directives (pp 93–95)

• Tort and criminal actions (pp 101–103)

• Evidence preservation (p 105)

• Statutory responsibilities (pp 103–104)

• Mandatory reporting (pp 104–105)

• Ethical principles/moral obligations (pp 106–107)

• End-of-life issues (pp 95–97)

Knowledge Objectives

1. Define consent and how it relates to decision making. (p 86)

2. Compare expressed consent, implied consent, and involuntary consent. (pp 87–88)

3. Discuss consent by minors for treatment or transport. (p 88)

4. Describe local EMS system protocols for using forcible restraint. (p 89–90)

5. Discuss the EMT’s role and obligations if a patient refuses treatment or transport. (pp 90–91)

6. Describe the relationship between patient communications, confidentiality, and the Health Insurance Portability and Accountability Act (HIPAA). (pp 91–92)

7. Discuss the importance of do not resuscitate (DNR) orders and local protocols as they relate to the EMS environment. (pp 93–95)

8. Describe the physical, presumptive, and definitive signs of death. (pp 95–96)

9. Explain how to manage patients who are identified as organ donors. (p 97)

10. Recognize the importance of medical identification devices in treating the patient. (p 97)

11. Discuss the scope of practice and standards of care. (pp 98–100)

12. Describe the EMT’s legal duty to act. (p 100)

13. Discuss the issues of negligence, abandonment, assault and battery, and kidnapping and their implications for the EMT. (pp 101–103)

14. Explain the reporting requirements for special situations, including abuse, drug- or felony-related injuries, childbirth, and crime scenes. (pp 104–105)

15. Define ethics and morality, and discuss their implications for the EMT. (pp 106–107)

16. Describe the roles and responsibilities of the EMT in court. (pp 107–109)

Skills Objectives

There are no skills objectives in this chapter.

Readings and Preparation

Review all instructional materials including ***Emergency Care and Transportation of the Sick and Injured***, **Twelfth Edition**, Chapter 3, and all related presentation support materials.

• Review any related legal documents, such as statutes and regulations, that pertain to prehospital care services and personnel.

• Review any recent case studies or legal proceedings that may provide updated information on medicolegal issues. The local law librarian is a good reference source who can assist in gathering this type of information.

Support Materials

• Lecture PowerPoint presentation

• Case Study PowerPoint presentation

• Local/state statutes, regulations, or policies related to prehospital care:

– EMT scope of practice

– DNR orders

– Policies for reporting suspected child/elderly abuse, rape, and other crimes

– Refusal of care policies

– Use of restraints

Enhancements

• Direct students to visit Navigate.

• Contact a local human organ donation coordinator for handout materials on the human organ donation process.

• Contact a local hospital, EMS system administrator, or medical association for handout materials or guest lecturers on issues related to medical ethics.

• Contact a local legal bar association for guest lecturers on issues related to medicolegal policies, procedures, and guidelines.

• **Content connections:** Emphasize to students that the courts consider the following two general rules regarding reports and records:

* If an action or procedure is not recorded on the written report, it was not performed.
* An incomplete or untidy report is evidence of incomplete or inexpert emergency medical care.

Chapter 4, “Communications and Documentation,” discusses the importance of accurate, thorough, and legible reporting. Remind students that the information in the report may be used in court and may help to prove that they have provided a standard of care. In some instances, it may show they have properly handled unusual or uncommon situations.

• **Cultural considerations:** Culture is not restricted to individuals of different nationalities, but also includes people of different ages. Discuss the concept of emancipated minorswith students. Ask students to look up your state laws concerning the issues surrounding emancipation and discuss them.

• **Current controversies:** The legal analysis relevant to the question of a minor’s ability to consent to medical care can be complicated and involves not only state common law and statutes, but also federal statutes. However, if emergency providers apply common sense and treat minors with the respect and care they would want for their own child, the law will almost invariably support their decisions.

Teaching Tips

• Explain to your students the local protocols regarding confidentiality, consent, refusal of care, advance directives, and other issues in this chapter that may be subject to local variations.

• Be sensitive to possible emotional reactions to violent crime scenes from your students.

• Provide an opportunity for private discussion if necessary.

• Role-playing can be helpful in allowing students to practice some situations involving refusal of care and consent to treatment and to explore their feelings and reactions.

Unit Activities

**Writing assignments:** Assign students a research paper on the topic of lawsuits against EMS. Ask them to explain what could have been done differently to minimize the potential for litigation.

**Student presentations:** Ask students to give a presentation to the class on a recent lawsuit that has been settled against EMTs in regard to negligence.

**Group activities:** Ask students to create scenarios that present difficult situations regarding consent as well as end-of-life issues.

**Medical terminology review:** Instructors should present definitions of important terms found in this chapter, asking students to choose the correct term to go with the definition.

Pre-Lecture

### You Are the Provider

“You Are the Provider” is a progressive case study that encourages critical thinking skills.

### Instructor Directions

**1.** Direct students to read the “You Are the Provider” scenario found throughout Chapter 3.

**2.** You may wish to assign students to a partner or a group. Direct them to review the discussion questions at the end of the scenario and prepare a response to each question. Facilitate a class dialogue centered on the discussion questions and the Patient Care Report.

**3.** You may also use this as an individual activity and ask students to turn in their comments on a separate piece of paper.

Lecture

I. Introduction

A. A basic principle of emergency care is to do no further harm.

B. Providing competent emergency medical care that does not exceed your scope of practice and conforms with the standard of care taught to you will help you avoid civil and criminal actions.

C. Even when emergency medical care is properly rendered, sometimes you may be sued by a patient seeking monetary compensation.

II. Consent

A. Consent is permission to render care.

B. A person must give consent for treatment.

C. If the patient is conscious and rational, and capable of making informed decisions, he or she has the legal right to refuse care.

D. The foundation of consent is decision-making capacity.

1. The patient can understand and process the information provided.

2. The patient can make an informed choice regarding medical care.

E. Patient autonomy is the patient’s right to make decisions about his or her health.

F. In determining a patient’s decision-making capacity, consider these factors:

1. Is the patient’s intellectual capacity impaired by mental limitation or dementia?

2. Is the patient of legal age?

3. Is the patient impaired by alcohol, drugs, serious injury, or illness?

4. Does the patient appear to be experiencing significant pain?

5. Does the patient have a significant injury that could distract him from a more serious injury?

6. Are there any apparent hearing or visual problems?

7. Is there a language barrier?

8. Does the patient appear to understand what you are saying? Does the patient ask rational questions that demonstrate an understanding of the information you are trying to share?

G. Expressed consent

1. The patient acknowledges he or she wants you to provide care or transport.

2. To be valid, the consent that the patient provides must be informed consent, which means that you explained the nature of the treatment being offered, along with the potential risks, benefits, and alternatives to treatment, as well as potential consequences of refusing treatment.

H. Implied consent

1. Applies to patients who are:

a. Unconscious

b. Otherwise incapable of making a rational, informed decision about care

2. Implied consent applies only when a serious medical condition exists and should never be used unless there is a threat to life or limb.

3. The principle of implied consent is known as the emergency doctrine.

4. Try to get consent from a spouse or relative before treating based on implied consent.

I. Involuntary consent

1. Applies to patients who are:

a. Mentally ill

b. In a behavioral (psychological) crisis

c. Developmentally delayed

2. Obtain consent from the guardian or conservator

a. It is not always possible to obtain such consent.

b. Many states have protective custody statutes that allow these individuals to be taken, under law enforcement authority, to a medical facility.

J. Minors and consent

1. The parent or legal guardian gives consent.

2. In some states, a minor can give consent.

a. Emancipated minor: an individual under the legal age who is legally considered an adult

b. Many states consider minors to be emancipated if they are married, if they are members of the armed services, if they are parents, or if living away from home and no longer relying on parents for support.

3. Teachers and school officials may act in place of parents (in loco parentis) and provide consent for treatment of injuries that occur in a school or camp setting.

4. If a true emergency exists and no consent is available, treat the patient under implied consent.

K. Forcible restraint

1. Necessary for patients who are in need of medical treatment and transportation but are combative and present a risk of danger to themselves or others

2. Forcible restraint is legally permissible.

a. Consult medical control for authorization and utilize law enforcement on the scene.

b. Restraint without legal authority exposes you to potential civil and criminal penalties.

c. Make sure you know the local laws and protocols regarding forcible restraint.

d. Once applied, do not remove restraints en route unless they pose a risk to the patient.

e. Consider calling ALS backup to provide chemical pharmacologic restraint.

III. The Right to Refuse Treatment

A. Adults who are conscious, alert, and appear to have decision-making capacity:

1. Have the right to refuse treatment, even if the result is death or serious injury

2. Can withdraw from treatment at any time, even if the result is death or serious injury

B. Calls involving refusal of treatment are commonly litigated in EMS and require adherence to local protocols and policies.

C. Involve online medical control and document this consultation.

D. A patient’s, parent’s, or caregiver’s decision to accept or refuse treatment should be based on information that you provide:

1. Your assessment of what might be wrong

2. A description of the treatment you believe is necessary

3. Any possible risks of treatment

4. The availability of alternative treatments

5. The possible consequences of refusing treatment

E. When treatment is refused, you must assess and document the patient’s ability to make an informed decision:

1. Ask and repeat questions.

2. Assess the patient’s answers.

3. Observe the patient’s behavior.

F. If the patient appears confused, delusional, or suicidal, you cannot assume that the decision to refuse is an informed refusal.

G. When in doubt, providing treatment is a much more defensible position than failing to treat a patient.

1. Do not endanger yourself to provide care.

H. Before leaving the scene where a patient, parent, or caregiver has refused care, you should again encourage the patient, parent, or caregiver to permit treatment.

1. Advise patients, parents, or guardians that they can call 9-1-1 back if they change their mind.

2. Advise the patient, parent, or caregiver to contact his or her physician as soon as possible.

3. Ask the patient, parent, or caregiver to sign a refusal of treatment form.

4. A witness should be present.

5. Thoroughly document all refusals.

IV. Confidentiality

A. Communication between you and the patient is considered confidential.

B. Confidential information includes:

1. Patient history

2. Assessment findings

3. Treatment provided

C. If you inappropriately release information, you may be liable for breach of confidentiality, which is the disclosure of information without proper authorization.

D. In most states, records may be released only if:

1. The patient signs a release.

2. A legal subpoena is presented.

3. It is needed by billing personnel.

E. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

1. HIPAA contains a section on patient privacy that strengthens privacy laws.

2. HIPAA provides guidance on:

a. Which types of information are protected

b. The responsibility of health care providers regarding that protection

c. Penalties for breaching that protection

3. HIPAA considers all patient information you obtain in the course of providing medical treatment to a patient to be protected health information (PHI).

a. PHI includes medical information and any other information that can be used to identify the patient.

4. Failure to abide by the provisions of HIPAA laws can result in civil and/or criminal action against you and your agency.

5. The general public is often permitted by law to record identifying and protected patient information and images.

F. Social Media

1. Unless you are operating as an official spokesperson for your agency avoid logos, uniforms, vehicles, or other markings that associate you with your agency while off duty.

2. Conduct yourself with the same professionalism that you do while on duty.

3. Respect your patients, their friends and family, bystanders, colleagues, and the organization for which you work both in person and online.

4. Recognize that free speech does not mean everyone has a right to say anything under any circumstances and without repercussions.

V. Advance Directives

A. You may respond to a call where a patient is dying from an illness. When you arrive at the scene, family members may not want you to resuscitate the patient.

B. A do not resuscitate (DNR) order gives permission to withhold resuscitation.

1. “Do not resuscitate” does not mean “do not treat.” Even in the presence of a DNR order, you are still obligated to provide supportive measures (oxygen, pain relief, and comfort) to a patient who is not in cardiac arrest, whenever possible.

2. Each ambulance service should have a protocol to follow in these circumstances.

C. Advance directives

1. A written document specifying medical treatment for a competent patient should he or she become unable to make decisions

2. Most commonly used when a patient becomes comatose

3. Often referred to as a living will or health care directive

D. In general, a valid DNR order must meet the following requirements:

1. Clear statement of the patient’s medical problem(s)

2. Signature of the patient or legal guardian

3. Signature of one or more physicians or other licensed health care providers

4. DNR orders with expiration dates must be dated in the preceding 12 months to be valid.

E. You may encounter physician orders for life-sustaining treatment (POLST) and medical orders for life-sustaining treatment (MOLST) forms when caring for patients with terminal illnesses.

1. These medical orders explicitly describe acceptable interventions for the patient.

2. They must be signed by an authorized medical provider to be valid.

3. If you encounter these documents, contact medical control for guidance.

F. Some patients may have named surrogates to make decisions for them when they can no longer make their own.

1. Durable powers of attorney for health care

2. Also known as health care proxies

VI. Physical Signs of Death

A. Determination of the cause of death is the medical responsibility of a physician.

B. Presumptive signs of death:

1. Unresponsiveness to painful stimuli

2. Lack of a carotid pulse or heartbeat

3. Absence of chest rise and fall

4. No deep tendon or corneal reflexes

5. Absence of pupillary reactivity

6. No systolic blood pressure

7. Profound cyanosis

8. Lowered or decreased body temperature

C. Definitive signs of death:

1. Obvious mortal injury such as decapitation

2. Dependent lividity

a. Blood settling to the lowest point of the body, causing discoloration of the skin

3. Rigor mortis

a. Stiffening of body muscles caused by chemical changes within muscle tissue

b. Occurs between 2 and 12 hours after death

4. Algor mortis

a. Cooling of the body until it matches the ambient environment

5. Putrefaction (or decomposition) of body tissues

a. Depending on temperature conditions, occurs between 40 and 96 hours after death

D. Medical examiner cases

1. Involvement of the medical examiner depends on the nature and scene of the death.

2. In most states, the medical examiner, or the coroner in some states, must be notified in the following cases:

a. The patient is dead on arrival (DOA; sometimes called dead on scene [DOS])

b. Death without previous medical care, or when the physician is unable to state the cause of death

c. Suicide

d. Violent death

e. Known or suspected poisoning

f. Death from accidents

g. Suspicion of a criminal act

h. Infant and child deaths

3. Make every attempt to limit your disturbance of a scene involving a death.

4. If emergency medical care has been initiated, be sure to carefully document what was done or found on scene.

VII. Special Situations

A. Organ donors

1. Organ donors have expressed a wish to donate their organs.

2. Consent is evidenced by information on a donor card or driver’s license.

3. Treat potential organ donors the same as any other patient.

a. Your priority is to save the patient’s life.

b. Remember that organs need oxygen.

B. Medical identification insignia

1. Bracelet, necklace, keychain, or card indicating DNR order, allergies, or other serious medical condition that may be helpful in assessing and treating the patient

2. Some patients wear medical bracelets containing a USB flash drive.

a. Often stored as a PDF file that can be read on most computers

VIII. Scope of Practice

A. Outlines the care you are able to provide

B. Usually defined by state law

C. The medical director further defines the scope of practice by developing protocols or standing orders.

D. Authorization to provide care is given by medical director via:

1. Telephone or radio (online)

2. Standing orders or protocols (off-line)

E. Exceeding your scope of practice may be considered negligence.

IX. Standards of Care

A. The manner in which you must act or behave is called a standard of care.

B. It is defined as how a person with similar training would act under similar circumstances.

C. The standard of care is established in many ways:

1. Standards imposed by local custom

a. How a reasonably prudent person with similar training and experience would act under similar circumstances, with similar equipment, and in the same or similar place.

2. Standards imposed by law

a. Standards of emergency medical care may be imposed by statutes, ordinances, administrative regulation, or case law.

b. Become familiar with the particular legal standards in your state.

3. Professional or institutional standards

a. Recommendations published by organizations and societies that are involved in emergency medical care—for example, the American Heart Association’s standard for BLS and CPR

b. Specific rules and procedures of your EMS agency

4. Standards imposed by textbooks

a. Almost all textbooks follow the standards established by the National Highway Traffic Safety Administration (NHTSA) and contribute to the EMT’s standard of care.

b. Local protocols may differ. Always follow local protocols.

5. Standards imposed by states

a. Medical Practices Act

i. In some states, the EMT is exempt from the licensure requirements of the Medical Practices Act.

b. Certification and licensure

i. Credentialing is an established process to determine the qualifications necessary to be allowed to practice a particular profession, or to function as an organization.

ii. EMTs may be licensed or certified.

X. Duty to Act

A. Duty to act is an individual’s responsibility to provide patient care.

B. Once your ambulance responds to a call or treatment is begun, you have a legal duty to act.

C. In most cases, if you are off duty and come upon a crash, you are not legally obligated to stop and assist patients. Know your local laws and policies pertaining to your duty to act.

XI. Negligence

A. Negligence is the failure to provide the same care that a person with similar training would provide in the same or similar situation.

B. All four of the following factors must be present for the legal doctrine of negligence to apply:

1. Duty

a. The obligation to provide care and to do so in a manner that is consistent with the standard of care established by training and local protocols

2. Breach of duty

a. The EMT did not act within an expected and reasonable standard of care.

3. Damages

a. A patient is physically or psychologically harmed in some noticeable way.

4. Causation

a. A cause-and-effect relationship exists between a breach of duty and the damages suffered by the patient.

C. Res ipsa loquitur

1. An EMT can he held liable under this theory if it can be shown that an injury occurred, that the cause of the injury was in the control of the EMT, and that such injuries generally do not occur unless there is negligence.

D. Negligence per se

1. A theory that can be used when the conduct of the person being sued is alleged to have occurred in clear violation of a statute

a. Example: An EMT performs an ALS skill that resulted in injury to the patient

E. Torts

1. Civil wrongs

a. Not within the jurisdiction of US criminal courts

b. Examples include defamation of character and invasion of privacy.

XII. Abandonment

A. Abandonment is the unilateral termination of care by the EMT without the patient’s consent and without making any provisions for care to be continued by a medical professional who is competent to provide care for the patient.

B. Once care is started, you have assumed a duty to act that must continue until an equally competent medical provider assumes responsibility.

C. Abandonment may take place at the scene or in the emergency department where you are dropping off your patient.

1. Obtain a signature on the patient care record from the person accepting transfer of care at the hospital.

XIII. Assault and Battery, and Kidnapping

A. Assault: unlawfully placing a person in fear of immediate bodily harm

1. Includes threatening to restrain a patient who does not want to be transported

B. Battery: unlawfully touching a person

1. Includes providing emergency care without consent

C. Kidnapping: seizing, confining, abducting, or carrying away by force

1. Could include a situation where a patient is transported against his or her will

2. False imprisonment is the unauthorized confinement of a person.

D. Potential legal problems may arise in situations in which a patient has not given or rescinds consent for treatment and/or transport.

XIV. Defamation

A. Defamation is the communication of false information that damages a person’s reputation.

1. Libel: written, such as a false statement on a patient care report

2. Slander: spoken, such as inappropriate comments made during “station house” conversation

B. All statements on your run report should be accurate, relevant, and factual.

XV. Good Samaritan Laws and Immunity

A. Good Samaritan laws are based on the common law principle that when you reasonably help another person, you should not be held liable for errors or omissions that are made in giving good-faith care.

B. To be protected by provisions of Good Samaritan law, several conditions must generally be met:

1. You acted in good faith in rendering care.

2. You rendered care without expectation of compensation.

3. You did not exceed your scope of practice.

4. You did not act in a grossly negligent manner.

C. Gross negligence is defined as conduct that constitutes a willful or reckless disregard for a duty or standard of care.

D. Immunity statutes apply to EMS systems that are considered governmental agencies.

1. Sovereign immunity provides limitations on liability and immunity is not complete.

XVI. Records and Reports

A. Your agency should maintain a complete and accurate record of all incidents involving sick or injured patients.

1. Such records are an important safeguard against legal complications.

B. The courts’ perception of records and reports:

1. If an action or procedure was not recorded on the written report, it was not performed.

2. Incomplete or untidy reports are evidence of incomplete or inexpert emergency medical care.

C. National EMS Information System (NEMSIS)

1. Provides the ability to collect, store, and share standardized EMS data throughout the United States

XVII. Special Mandatory Reporting Requirements

A. Most states have a reporting obligation for health care providers and emergency responders, including EMTs.

B. Special mandatory reporting requirements may vary from state to state:

1. Child abuse, abuse of an older person, abuse of other “at-risk” adults

2. Injury during commission of a felony

3. Drug-related injuries

4. Childbirth

5. Attempted suicides

6. Dog bites

7. Certain communicable diseases

8. Assaults

9. Domestic violence

10. Sexual assault or rape

11. Exposures to infectious disease

12. Transport of patients in restraints

13. Scene of a crime

14. The deceased

XVIII. Ethical Responsibilities

A. In addition to legal duties, EMTs have certain ethical responsibilities to themselves, their coworkers, the public, and the patient.

B. Ethics is the philosophy of right and wrong, moral duties, and of ideal professional behavior.

C. Morality is the code of conduct affecting character, conduct, and conscience.

D. Bioethics specifically addresses ethical issues that arise in the practice of health care.

E. You will encounter ethical dilemmas that will require you to evaluate and apply ethical standards.

1. Your own

2. Those of the profession

F. Applied ethics is the manner in which principles of ethics are incorporated into professional conduct.

G. Allow rules, laws, and policies to guide your decision making (Table 3-2).

XIX. The EMT in Court

A. You can end up in court as a witness or a defendant.

B. The case may be either civil or criminal.

C. When subpoenaed to testify in any court proceeding, you should immediately notify your service director and legal counsel.

D. As a witness:

1. Remain neutral during your testimony.

2. Review the run report before your court appearance.

E. As a defendant, an attorney is required.

1. The attorney is generally supplied by your service in a civil suit.

F. Potential defenses

1. Statute of limitations: the time within which a case must be commenced.

2. Governmental immunity: generally applied to municipalities or other governmental entities. If your service is covered by immunity, it may mean that you cannot be sued at all or that the amount of monetary judgment that can be recovered is limited.

3. Contributory negligence: a legal defense that may be raised when the defendant believes that the conduct of the plaintiff somehow contributed to injuries or damages sustained by the plaintiff.

G. Discovery

1. An opportunity for both sides to obtain more information to reach a better understanding of the case

2. Discovery includes:

a. Interrogatories (written requests or questions)

b. Depositions (oral requests or questions)

H. Trial

1. Most cases are settled following the discovery phase and do not go to trial.

2. For those that go to trial, several types of damages may be awarded:

a. Compensatory damages are intended to compensate the plaintiff for injuries he or she sustained.

b. Punitive damages are intended to deter the defendant from repeating the behavior and are reserved for cases where the defendant has acted intentionally or with a reckless disregard for the safety of the public. These damages are not commonly awarded in negligence cases.

3. In most cases, if a judgment is rendered against you, your service or its insurance carrier will pay the judgment.

4. Any EMT charged with a criminal offense should secure the services of a highly experienced criminal attorney immediately.

Post-Lecture

## Assessment in Action

A. Assessment in Action is available in the Navigate course.