GETTYIMAGES.COM

JANE DOE V. EMS

Viewing EMS under the legal microscope

By Walt Stoy, PhD, & Richard Gergel

Author's note: For the past decade I have served in the role of expert witness in a number of court cases involving EMS around the country. I have assisted both plaintiff and defense attorneys. Each case represents an opportunity to discover how our curricula, teaching and thinking should be altered regarding the care provided to patients presenting in the field setting. Unfortunately, more often than not, the EMS community is not able to gain knowledge from the experience due to legal aspects of the case barring the information from disclosure.

This case is different. Richard Mark Gergel of Gergel, Nickles and Solomon P.A., Attorneys at Law, recognized the benefit of disclosing the information from this case in hopes that these egregious errors will not be repeated. At the close of this case, Mr. Gergel contacted the family and requested permission for this information to be shared with the EMS community as a teaching tool. The family agreed. Mr. Gergel and I invite you to read and learn. ***—Walt Stoy, PhD***

Letter from the Victim's Sister

Dear Dr. Stoy,

Thank you for taking the time to assist my family and me in such a devastating experience. Your deposition was so heartfelt; in reading it one would think you were present during the morning of my sister's death. The experience of this terrible tragedy will forever be in my memory. ... I hope [that] telling this tragic story ... will save the life of someone and help other families and communities avoid a similar terrible loss. ...

Sincerely,
Vera Holmes

County of Beaufort, Vera E. Holmes as the Personal Representative of the Estate of Vermell Lula Jefferson; Emily Rose Jefferson & Vera E. Holmes v. EMS

Note to the reader: Most of this article has been excerpted directly from legal depositions, so it may sound awkward in places. We have edited the excerpts—primarily for punctuation and spelling—where we felt it necessary for clarification, and placed sections that were paraphrased in italics.

Trip sheet perspective

This transcript is excerpted from the patient care report completed by the EMS crew.

1. The narrative

EMS was called to the home of a 39-year-old female. The patient was conscious, sitting on the floor and combative. The patient history was that of hypertension and asthma. Lung sounds = air exchange in all fields, no rhonchi. Patient refused oxygen. Family stated that the patient had a vomiting episode prior to respiratory distress. Patient weighed approximately 120 kg [265 lbs.].

Several attempts to coach-lift the patient were unsuccessful. Patient lifted to bed. Vital signs attempted unsuccessfully. Patient is now unconscious. Patient is moved to the stair-chair, transported to unit. Placed onto stretcher/on folding cot. Once aboard quick look = asystole, CPR, airway, suctioned, #7.0 tube on second attempt, lungs full, en route IV established right A/C 20 gauge; Epi, atropine, medical control established. Request/administer 50 meq. Bi-carb; pacing attempted cap/no pulse. Atropine, Epi 10 mg, naloxone 2 mg, V-fib, 1 countershock, PEA, Pacing—no pulse. Atropine 2 mg. IV left A/C 18 gauge. Normal saline KVO. V-fib at ER. Countershock 360. Patient transferred (V-fib prior to arrival countershock 300–360).

2. Vital signs documented

Time 5:34 a.m.
Pulse = 126 Regular;
Respirations = 32 Regular;
Level of Consciousness = A/V [alert and verbalizing]
[No additional vitals were ever recorded.]

3. Medication administration times

First medication was given at 6:05 [a.m.]. A total of seven doses were administered. The last medication was given at 6:18.

4. Advanced procedures documented [see below]

	Skill or Monitor Activity	Rhythm/Watt Sec (WS)	Time
1	EKG Monitored	Rhythm–Asystole	0554
2	Intubation	ETI–7.0	0600
3	First Defibrillation Post Defibrillation	200 WS V-fib	0612
4	Second Defibrillation Post Defibrillation	300 WS V-fib	0617
5	Third Defibrillation Post Defibrillation	360 WS V-fib	0618
6	External Pacing		Not recorded by crew
7	IV started	20 gauge KVO NS 500 mL	Not recorded by crew
8	IV started	18 gauge KVO NS 500 mL Total IV attempts x 3	Not recorded by crew

Sister's perspective

The patient's sister was next door visiting their mother when the emergency occurred, but she was in the house when EMS arrived. The evening before, she had spent time with her sister. They ate and talked. No alcohol was consumed.

Between 5:00 and 5:10 a.m. EMS was contacted because the patient wasn't feeling well. She had gone to the bathroom and vomited a couple of times. She was sitting on the floor with her back against the bed and she was very weak. It took 20 minutes or more for EMS to arrive on scene after being called twice—about eight minutes apart.

Fire department arrived prior to EMS. One of the men listened to her lungs. Told us her lungs were clear. EMS was pulling up to the house at this time.

What did EMS do upon arrival on the scene? They asked us what was wrong. Told them of the history of hypertension and asthma. They took a mask and put it over her face. She was acting as if she was confused and agitated. She appeared to have a little blood coming from her nose. At this point they said, "Let's get her on the bed." They did not want to treat her on the floor.

> **'My sister was not a criminal. She was a dying patient.' —*Vera Holmes***

They tried to pick her up twice and failed. I said, "She is too weak." But after two attempts, [the paramedic] grabbed her in the chest and said, "What's your name?" We answered for her. We said, "Her name is Lula." He said, "Lula, damn it, if you don't cooperate with us, we're going to call the cops, and guess what? They're going to come and get you." After that there was nothing but chaos. Lula kept saying that he was hurting her.

They finally were able to get Lula on the bed. Then he had his foot on her shoulder. His boot was either on her shoulder or her arm. He yelled and cursed at her. I told him he was scaring her. The medic told me that he is not usually like that, that he's a pretty nice guy, but that my sister was making him mad—you know, made him mean.

My sister was not a criminal. She was a dying patient. This emergency team that came in to take care of her—never in my lifetime, not even on television, have I seen anything like that before. I graduated from a nursing assistant program and never learned anything like what took place here.

They were finally able to get her into the bed. Three or four minutes later she had what you would call a convulsion. At that point she was in a deep sleep; she was snoring very hard, and on the third one she stopped. The medic yelled and said, "Lula," and then said, "Oh, my god. Lula!" He was very—like he—it's almost like he went into shock himself and …

He took a flashlight and trie[d] to lift up her eyelids. Then he said, "Oh, my god. We got to go to the truck and start some serious resuscitation." She was placed in a rolling chair and taken out of the house. Her head was down. She was unconscious. They took the mask off of her. They took her out of the house in the rolling chair. In the yard they took her off the rolling chair and put her on the stretcher. Then they put her in the back of the truck. I would say that all took about 10 minutes.

There appeared to be enough help. EMS and firemen were there. Was not able to tell fire people from EMS people. They all look alike.

Mother's perspective

What did you hear the medic say to your daughter? When she was not able to help get on the bed, he said, "I'm going to call the cops, and you know he'll take you. He'll arrest you." Later I heard him say, "Damn it, Lula. Get up."

Once she was unresponsive in the bed, and her breathing stopped. I believed she had already passed. They took her out of the house with her face covered. I went home as they drove away.

That morning of the call, EMS was inappropriate. I observed his language and his treatment. He wasn't treating her right. The fire people did a better job of treating her. I saw him put his foot on her. There were three of them in the room with her. They were not taking care of her. They did not try to calm her down.

EMS did not offer her any care before she was unresponsive in the bed. There was a lot of time just trying to move her.

Provider's perspective

Background: *He has been an EMT since 1989. In 1991, he obtained his EMT-intermediate certification. In 1994 he obtained paramedic certification. No history of reprimands, lawsuits or other problems prior to this event. No criminal history. Five years of military service. Also, he was a firefighter. The highest educational level he obtained was high school.*

Equipment paramedic reported available the morning of the call: *BP set, EKG monitor, oxygen; he can't recall if there was a pulse oximeter.*

Description of the incident: *Dispatched to a code 47 (respiratory distress) and code 05 (vomiting). She had some distress and an accelerated respiratory rate. Her rate that morning was 32. He did not conclude that she was in respiratory distress, but noted only that she had an accelerated respiratory rate. It's not surprising to see patients with a rate of 32 being combative due to the low oxygen levels. They might also fight [you] putting on the oxygen mask.*

In the report the paramedic said that she refused oxygen; she was combative and would not tolerate it. That would have been for any number of reasons, one of which could have been possibly due to the respiratory distress.

They arrived on scene at 5:32 and arrived at the patient at 5:34. At that time, the patient had a pulse of 126 and respirations of 32. The paramedic was not able to get a blood pressure due to the patient's movements. Patient was "A" alert and "V" verbalizing.

They knew the patient was in asystole at 5:45 but are not sure of all the times.

Paramedic's statement: It took a while because she was unconscious on the bed. And the stair chair was in the retracted position, being it was in the form of a chair, so we had to get her body, herself, into the chair while she was in a laying position. It would be fair to say that it took three to five minutes. Then there is the time to move her through the house. That would be another two to three minutes. A minute or less to get her on the stretcher. We retracted the wheels so it would lay flat. We then put on the "fast patch" [monitor pads] for a quick look. About

another minute would be fair to add to the overall time so far.

The scope was asystole. So it took about seven to 10 minutes to determine the rhythm of the patient. As for the oxygen during this time, once she became unconscious, we placed her on oxygen. She was still breathing, still had a pulse. She was on oxygen until we moved her from the room. Remember, she weighed about 120 kg so it was hard to move her. The chair is narrow. And the oxygen was hampering the bottle. The bottle was a problem. [*It was reportedly in the crew's way as they moved the patient so they disconnected the oxygen tank and took the mask off of her to try to get her out of the house. He doesn't recall when they put her back on the oxygen.*]

Once she was unconscious he knew that she should be intubated. He doesn't recall what her respiratory rate was when she went unconscious. He does know that she was breathing. He knew he just wanted to get her out of the house and into the truck. "It did not take but a second or two for us to use the BVM prior to intubation." *He saw asystole at 5:54 and the intubation was at 6:00, so it was six minutes. He was not going to say that she was oxygen-starved. He believes they did everything they could.*

They assessed her respiratory status, meaning that they checked it. They assessed her to make sure she was still breathing. As far as taking a specific number, he may or may not have taken a specific number. The key is that they were just focused on the breathing, as they—he—tried to provide oxygen for her several times, and she wouldn't take it, so he couldn't provide oxygen for her until she was unconscious.

He knew the patient appeared to be in some kind of distress. He did not want to delay getting out of the house. He would not stop this [movement to get her out] to get vitals. That's not what his focus was—vitals are a broad thing. There are more vital signs than blood pressure, pulse and respirations. And as a matter of fact, he assessed—made an attempt to assess—pupils when she went unconscious, which is a vital sign.

He said she was breathing at 5:39. However, he can't tell you the rate or rhythm. Her blood pressure was greater than 80 systolic, because she had a radial pulse.

As for the abnormal respirations, obviously it's not written there, but that's not to say it wasn't done [recognized]. He knows that he did not write it down; however, he knows it was done [recognized].

He stated that he did not threaten her. He did make reference to calling the sheriff's department. She was combative and refusing care. To take a patient against their wishes or take restraint on a patient, you must have police backup. He was using it as a tool to coax her to calm down enough to take care of her. He did have recollection of saying that he would have to call the sheriff's department.

He didn't recall using any profanity. He also didn't recall saying, "Damn it."… He didn't have any specific recollection. He was willing to say he didn't recall it. He doesn't make it a point to use profanity when dealing with patients. He was not in [a] position to deny it. He just didn't recall it.

He said he gave the family reassurance that while they were dealing with the patient, trying to coach her and lift her, that they were not being malicious toward her. The crew was trying to get her to help them.

He has no recollection of saying, "I am usually a nice guy, but

she's making me mad." He claimed he never placed his foot on the patient, either.

He knows the question of medications was asked of the patient. He was aware that the patient had a prescribed inhaler available. There was no attempt to offer it to the patient. She wouldn't tolerate an oxygen mask. She most certainly wouldn't tolerate an inhaler or anything on her face.

While moving the patient from the house to the vehicle, her head may have fallen down once or twice, but efforts were made to keep her head up, which would facilitate maintaining her airway.

They brought the EKG into the house. However, because of her combativeness, they were not able to use it. He was not sure if they brought the intubation equipment into the house. But at the time she went unconscious, she was still breathing and still had a pulse, which would be indicative of an intact gag reflex, and intubation is not something he would have done. And she was in the house, and there was not enough room. The room she was in would not provide an easy means of egress should she have digressed to the point where she needed advanced care. Intubation's not something you just do right now. You have to provide pre-oxygenation, which she received when she was being bagged. He needed to set up the equipment. His first intubation attempt was unsuccessful. He was successful on his second attempt. He thinks six minutes is a fair number to get a patient intubated in the back of the ambulance.

The IV was established after the intubation. The IV was established en route, and medications were given. The IV was not established in the house. According to the report, she received epinephrine at 6:05. So it took 11 minutes to get the first medication to her.

Expert's perspective

The expert presented his opinion as to the aspects of care provided.

If I may, I would like to break it down into two areas: first, the evaluation of the patient while on the floor and prior to becoming unconscious. Then I would like to address the issues of care provided following the patient being placed on the bed and becoming unconscious.

First and foremost, [the EMS crew] failed to properly assess this patient and continuously assess this patient from the very beginning. [The second care issue is] the lack of vital signs continuously being monitored; this would include pulse, respirations and blood pressure—at a minimum. Third, not using a pulse oximeter on the patient, even though it is listed as equipment available for use by this system. Fourth, was their failure to take the necessary equipment into the home in order to properly treat the patient. Fifth, was their failure to provide oxygen to the patient in a timely manner. Sixth, was their decision to not treat the patient with her nebulizer or their nebulizer. Last, was their failure to use proper therapeutic communications to comfort the patient. All of the above were the errors in care while initially treating the patient.

Following this, the patient was placed on the bed, and the following errors took place. The patient became unresponsive; however, [she] was not properly reassessed. The airway was not appropriately managed; ventilation of the patient did not take place. Rather than intubate and start the IV in the home, EMS opted to move the patient to the unit for transportation. The unconscious patient was placed on a stair chair for removal from her

home. This resulted in a compromise of her airway as well as the oxygen being removed during this time. Medications were not provided in a timely manner.

It took a total of six minutes to intubate the patient. There was no documentation of asystole in more than one lead. Overall, the documentation of the call lacked detailed information regarding the care of this patient. There was no demonstration of an appropriate assessment and failure to document SAMPLE history of the patient.

Summary

This indeed was an unfortunate situation. The patient was conscious and in severe respiratory distress. EMS was called to assess and care for this patient. While in the hands of EMS, the patient became unconscious and ultimately died. The manner in which EMS operated lacked professionalism. Their inability to meet the standard of care was a contributing factor in the death of this patient. This case was settled and never went to trial. EMS paid the family for the errors.

One bright spot was the willingness of the family and their attorney to recognize that this regrettable situation could serve as a teaching device. This case should serve as a warning to others.

It is of utmost importance that all EMS providers remember the reason they entered the profession: to care for patients in their time of need. The patient is the person in need of assessment, treatment and a loving hand. In addition, family, friends or even bystanders in the area may also need help coping with the situation.

The role of EMS is to adapt, modify and overcome obstacles presented in every situation in order to ensure the safe treatment and transfer of patients to the appropriate medical facility. Think about the needs of the entire medical situation, and be willing to use all resources available in a reasonable time frame in order to properly handle the situation.

This is a litigious time. Errors in EMS will result in legal implications that will cost the EMS system time and money. Ensuring that care and kindness are factors in treating every patient can decrease the occurrence of legal cases. Clinical competency is not enough. You need to genuinely care or, perhaps, consider a role in another profession. JEMS

Walt Alan Stoy, PhD, is professor and program director of the Emergency Medicine Program, School of Health and Rehabilitation Sciences, University of Pittsburgh and director of the Office of Education and International Emergency Medicine at the Center for Emergency Medicine. Stoy has more than 25 years' experience in EMS and has served as principal investigator for the revision of the EMT-Basic: National Standard Curriculum (NSC) *and as project director for the revision of the* First Responder: NSC, *the* EMT-I: NSC *and the* Paramedic: NSC. *He has authored numerous texts and ancillary products for EMS education, served as a paramedic for the city of Pittsburgh, served as a flight paramedic and worked with numerous volunteer EMS/fire service organizations. Contact him via e-mail at stoywa@msx.upmc.edu.*

Richard Gergel is senior partner of Gergel, Nickles and Solomon P.A. in Columbia, S.C. He is a graduate of Duke University School of Law and has practiced law for nearly 25 years. He specializes in the areas of medical malpractice, products liability and other complex litigation.