Focus On: Emergency Medical Services

Increasingly complex clinical and operational environments, combined with funding and other challenges, may add to liability risks associated with emergency medical service providers.

While emergency medical services (EMS) agencies vary greatly in size and composition, the average provider has approximately 40 trained responders and a small support staff. Services may be offered by a private for-profit organization or by non-profit operations like municipalities or fire departments. With more than 36 million responses in the US in 2009, according to the 2011 National EMS Assessment, it’s clear that communities rely on EMS to respond in times of need. Less certain is whether communities recognize the challenges facing today’s EMS organizations and how they will respond.

Funding lags other first responders

EMS organizations are not consistently recognized among federal, state and local governments as a public good despite being a first line of defense in the nation’s disaster preparedness efforts and critical to community emergency response. Funding is typically low compared to police and firefighters. For example, only four percent of the Department of Homeland Security’s US$ 2.4bn first responder funding in 2002 and 2003 was allocated to EMS operations despite comparable numbers of EMS providers. Lacking a federal grant program and resources to secure state and local grants, municipal EMS must work within the confines of dwindling budgets and donations. Just three states in the 2011 National EMS Assessment reported that EMTs who work full-time with one employer can earn a reasonable living. The survey noted EMTs earned a median yearly income of about US$ 25k – US$ 29k compared to US$ 38k for paramedics and US$ 45k for firefighters. The comparatively low salaries make it difficult to attract and retain employees.

A shrinking volunteer base has caused some EMS agencies to close and increased demands on those remaining. And while new standards and training requirements seek to improve EMS care and operations, training may be left unfunded, shifting the financial burden to the EMS volunteers or employees themselves. This, combined with training requirements that many departments consider too burdensome, create obstacles to maintaining an adequate number of volunteers.
New risks introduced

More recently, crisis-level shortages of some commonly-used drugs have left emergency responders to do without, use expired drugs, or substitute alternatives. As a result, technicians may have extra steps and new dosage protocols to incorporate into emergency situations.

In addition, language and cultural barriers posed by an increasingly culturally diverse population can make it more difficult to obtain complete and accurate information from or about patients, putting both the patient and EMS provider at risk if complications should arise.

Greater demand for services

EMS providers face a growing demand for services. Unemployed or uninsured people may avoid seeking treatment from primary care medical channels and, instead, resort to EMS at a more serious stage of illness. Likewise, EMS agencies in rural areas may act as first line health care providers to residents who are underserved by primary care providers.

Health and demographic trends have also impacted EMS. Rising obesity rates among Americans lead to more serious health problems or exacerbate existing ones and place greater demands on EMS. In addition, EMS agencies must retrofit ambulances or purchase additional costly equipment to prevent injuries to both patients and EMS technicians.

An aging population is also expected to impact demand for EMS. A study conducted by researchers at the University of North Carolina at Chapel Hill concluded that emergency department transports increase steadily with age and predicted that, by 2030, older patients will account for approximately half of EMS transports in the state. Researchers suggested national trends are likely to mirror those of the study and highlight the need to emphasize geriatric care training.

Liability risks are complex

EMS providers face significant professional liability issues related to medical mismanagement, patient refusal, equipment maintenance, and training and supervision, among others. They may also face civil action for abandonment or improper termination of care, assault or battery, delayed response, false imprisonment (detaining a person against his or her wishes) or breach of confidential medical information.

The majority of EMS lawsuits are related to:

Ambulance accidents – According to EMS insurer VFIS, vehicle accidents accounted for 61% of lawsuits filed against its EMS insureds from 2002 through 2011. Further, ambulance crashes cause twice as many injuries per crash as the national average, according to the National EMS Culture of Safety. Vehicle performance standards, improper maintenance, excessive speed, variable operator training, and improper safety restraint use have been noted as contributing factors in these crashes. Intersections and overuse of warning lights or sirens are other common denominators.

Patient drops – Patient drops per year according to VFIS and the EMS industry. Patient drops are the premise hazards are the primary causes of an average of 42,000 patient drops per year according to VFIS and the EMS industry. Furthermore, patient drops are the most common cause of disability for EMS providers under the age of 45.

Improper treatment – A VFIS study found that 26% of lawsuits filed against its insured EMS providers from 2002 through 2011 were related to wrongful or improper treatment. While the percentage may be low compared to other types of lawsuits, the severity of such cases is typically high.

Patient refusal – More than half of EMS lawsuits stem from incidents in which patients refuse medical treatment and/or transport and later experience medical distress. EMS organizations recommend that EMS providers complete thorough assessments of patients and situations and detailed prehospital care reports to reduce liability. They also caution against relying on patient refusal forms as protection against liability.

Emerging Issues

Social media – Used properly, social media can provide cash-strapped EMS agencies with an efficient way to share best practices, disseminate safety information, enhance recruiting efforts and improve community relations. It also poses substantial risks when information is released that violates privacy rights or portrays the organization in a negative light. Given a relatively young and technically savvy EMS workforce, exposures related to social media could be substantial.

Incidents of EMS technicians posting photos of accident victims on social media sites, for example, have resulted in lawsuits. Likewise, grievances aired on social media sites and instances of compromised investigations or divulged confidential patient information have also prompted legal action. Clear and concise social media guidelines that stipulate prohibited actions are essential to mitigate social media exposures.
Paramedicine – The role of EMS is expanding in rural areas where the ratio of primary care physicians to patients is relatively low. As more EMS agencies are required to provide primary healthcare such as diabetes management, cardiac patient monitoring and wound care in these areas, agencies need to ensure that proper resources, equipment, training and protocols are in place to manage the added risks.

Weak liability protections

Many states have discarded or weakened the protections provided by traditional governmental immunity. And while all 50 states have some form of Good Samaritan law, they do not typically protect healthcare professionals from acts of gross negligence, reckless disregard and willful or wanton misconduct. Volunteer and paid EMS workers are therefore left with a variety of inconsistent protections.

According to the 2011 National EMS Assessment, only 15 states have a law or statute that provides liability protection to EMS agencies, systems or health care professionals. Of those, 12 offer protections to EMS personnel during disaster-related events. Only seven provide protection to EMS professionals associated with a 9-1-1 event.

Under state immunity statutes, plaintiffs must prove the defendant’s misconduct exceeded the standard thresholds for negligence, but they do not bar an individual from filing a suit. When lawsuits arise, state directors of EMS agencies are encouraged to consult with their Attorney General’s Office in each situation to clarify how much protection, if any, is granted under state law.

Risk management is improving

The EMS Culture of Safety Project is one example of recent focus on safety and risk management activities in the EMS community. The project has identified six key elements to reduce risks to patients and EMS personnel, including: encouraging individuals to report mistakes as a step toward prevention, coordinating resources, establishing a national EMS responder and patient database, and developing EMS educational initiatives, standards and requirements for reporting and investigation.
Exposure Checklist

Commercial auto

- Is there a documented policy that strictly limits the use of communication devices by the driver while the vehicle is in motion, except in emergencies?
- Are rules established and enforced concerning complete stops at intersections and traffic signals and limiting use of warning lights and sirens to calls requiring immediate life- or limb-threatening medical intervention?
- Does the agency adjust drivers’ work schedules to limit fatigue and provide for the safe operation of vehicles?
- Is there an incentive program that rewards safe driving?
- Are company vehicles properly maintained and are maintenance records kept?
- Are company vehicles locked to prevent drug thefts?
- Are drivers required to inspect vehicles before operation?
- Do employees use their own vehicles for business purposes and is the condition of employee-owned vehicles considered in the scope of the operation?

Commercial general liability

- Is liability of the ambulance service limited by governmental immunity, Good Samaritan laws, or other statutes?
- Is the work of lesser-skilled EMS personnel supervised to ensure that they do not exceed their scope of care?
- Is there a full-time medical director on staff at the agency? If not, do EMS personnel have access to competent medical instruction?
- Are thorough patient assessments conducted and documented prior to treatment?
- Is consent for emergency care obtained and documented from competent patients before treatment begins?
- Are providers effectively trained in lifting techniques and in proper equipment use?
- Are persons who refuse treatment or transport required to sign waivers of liability?
- Are waivers available in multiple languages?
- Does the agency maintain records of all emergency care provided?
- Does the agency have procedures in place for dealing with drug supply shortages including: contacting local hospitals to purchase needed medications, extending expiration dates, developing “just-in-time” protocols or explore the possibility of obtaining compound medications?
- Are stocks of controlled substances kept in locked cabinets and is a complete physical inventory of medical supplies and equipment taken at least yearly?
- Are there established procedures for reporting the internal theft or loss of controlled substances to the Drug Enforcement Administration (DEA), as required by the Controlled Substances Act?
- Is there a social media policy in place for all employees/volunteers?
- Does the EMS agency have a wellness program for its employees?
- Is the agency involved in providing paramedicine services to the community? If so, have the paramedics received advanced training in order to perform these additional duties?