Medical-Legal Considerations in Prehospital Care

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IN THE PAST ten years, definitive emergency medical care has conceptually evolved from rigidly delineated inhospital care starting at the door of the emergency department to a less defined arena of activity commencing on the street. Inevitably, the latter is immeasurably more problematic, both in the legal and practical senses. Throughout the evolution of prehospital emergency care, there has been very little frank discussion of the role of the hospital in this changing situation and even less real-world candor about the *responsibility* of hospitals *and* physicians.

Some consideration must be given to the plethora of legal and ethical questions and the dearth of satisfactory answers. Who is ultimately responsible for the training of paramedical personnel? Is that same agency responsible for the paramedics' subsequent actions in the field? If not the training agency, then who should take responsibility: the municipal or county agency who pays the salaries, or the medi-

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cal authority providing the specific medical control? Are the paramedics accountable to the same authority when treating a patient as they are between calls? What happens if they are named defendants in a civil lawsuit? After a decade of disparate and multifaceted growth, this field of medicine requires the formalization of some foundational legal structures to meet the crises which are inevitable, given the prevalent impulse to litigation.

There is a common feeling among hospital administrators and physicians that the paramedics originate in some mysteriously nebulous region, beyond the confines of the hospital, and thus are of no concern to the medical staff until they enter the door with a patient. Is it still possible for the physician and the hospital to get off that easily?

There are an estimated 10,000 paramedics now functioning throughout the United States, many of them actually employed by fire departments or other public safety agencies. Only a small minority of them are employed directly by hospitals. Is it reasonable to expect the hospital to assume responsibility for the actions of persons not employed by them? How can responsibility be assumed without commensurate control? The quality of emergency care in the field is dependent not only on the skills of the paramedics, but on any number of elements in which the hospital has no commerce whatsoever, e.g., staffing patterns, equipment purchase and maintenance and continuing education. How much control is necessary before the hospital can assume responsibility for medical care delivered in the field?

HISTORICAL PRECEDENT

There is no legal precedent with which to answer these questions, mainly because they have not been litigated. Prehospital advanced life support has enjoyed a relative hiatus in medical-legal activity to date. A survey of the past several years reveals approximately 40 lawsuits involving the paramedical level of prehospital care, at least half of which occurred in Los Angeles County.

Even without actual legal precedent, some general and traditional legal concepts can be applied to these questions in projecting legal risks and preventing legal incidents. For example, today's paramedic can be equated to the "borrowed servant" of medieval England, the source for our legal system. In those days, land barons occasionally would loan a servant to a neighboring land baron for a special job, such as harvesting crops. When the borrowed servant was negligent and caused injury to a third party, the question of responsibility occurred. The lender of the servant had relinquished control and thus could not be held accountable for the servant's behavior. The servant was penniless and thus not capable of paying compensation. But the borrower of the servant had every opportunity to control the servant during the period of service. Thus, the courts tended to rule that the person who borrowed the servant should be accountable for any negligent acts.

An analogy for this ancient legal principle can be applied to the relationship between hospital and paramedic. It may reasonably be concluded that the paramedic, regardless of actual employment, is

a "borrowed servant" at all times he is engaged in prehospital advanced life support as an outreach function of the hospital. This legal conclusion is fortified by the direction of the national emergency medical services initiative authorized by the Congress and directed by HEW.

Physicians, hospital administrators or trustees are frequently dismayed by such a pronouncement. However, medical responsibility does not entail negotiating contracts with unions, budgeting for salaries and fringe benefits, arranging work schedules to assure coverage, or purchasing ambulances or rescue vehicles. It *does* entail assuring that paramedical personnel are adequately trained, that their skills are maintained, that they comply with protocols for patient care, that they obtain competent medical advice in handling patients, and that a medical professional on the hospital staff be fully responsible for the paramedical performance.

HOSPITAL RESPONSIBILITY

Conceptualized and labelled, the hospital's responsibilities for prehospital care are contained in the phrase *medical control.* It is the heart of a hospital outreach program of advanced life support. It is much more than a room full of radios.

Who should be responsible for the qualifications of paramedical personnel when they graduate from the paramedic training course? To whom does the community look as the guardian of health care quality? The fire chief? The police chief? A private ambulance operator? Or the hospital and its complement of medical resources? It is obvious that the hospital has the greatest opportunity and resources to evaluate and ensure standards of quality in patient care, and to spread the cost of that protection across the entire community.

There is no way to avoid the legal reality that paramedics are agents of the hospital and physician whenever they are engaged in patient assessment or care, regardless of any employer/employee relationship.

IDENTIFYING THE RESPONSIBLE HOSPITAL

Many prehospital care systems are so structured that the paramedics cannot consistently identify with a specific hospital and physician but communicate with a number of hospitals for medical guidance in handling emergencies. In many communities, more than one local hospital is equipped with radio and electrocardiogram telemetry equipment. One group of paramedics may communicate with more than one hospital during a duty shift. Which hospital is responsible ultimately? This is a good question for which there are no good answers.

The problem is exacerbated when there is *no* medical control. Frequently, no single medical professional has the responsibility for training paramedics or maintaining their proficiency. It is significant that one such nonsystem in Los Angeles has produced at least half the lawsuits involving prehospital advanced life support thus far. In those lawsuits, hospitals and physicians have been named as defendants nonetheless. The issue of medical control for paramedic performance has been

avoided, but the ultimate responsibility has not.

A prototypical model system currently extant in the suburbs of Chicago may provide a solution. In that system, one hospital, known as the resource hospital, has the primary responsibility for training, maintenance of skills and monitoring paramedic performance throughout the region. Several other hospitals, known as associate hospitals, routinely communicate with paramedic units in the region and direct their performance in managing medical emergencies.

If the paramedics find the medical guidance from an associate hospital less than adequate, they have authority to request an "override." In such an event, the resource hospital, which monitors the regional radio system continuously, assumes management of the case. Similarly, the resource hospital can override a case of its own volition if an associate hospital is unresponsive to a paramedic unit or is providing guidance that is clearly contraindicated by the paramedic's description of the case.

SETTING UP A SYSTEM

Given the unavoidable realities of prehospital care medical-legal risk, it would seem reasonable and prudent to acknowledge the responsibility that is rooted in logic and the law, and undertake the *management* of the risk through medical control. The first step should be placing responsibility for the program in the hands of a thoroughly competent physician with a full-time commitment to emergency medicine. If a hospital cannot provide that resource, it should relinquish management to another hospital that can. In addition, serious consideration should be given to the liability exposure of an emergency department that does not guarantee optimum levels of medical competence at all times.

The project medical director should have significant and ratified authority. The director must mandate competence from every member of the emergency medical services team, prehospital as well as inhospital. Where competence is marginal, the director must have the clear-cut *responsibility* to develop and conduct training programs. Where incompetence is beyond remedy, he should have *authority* to remove people from both inhospital and prehospital service. The project medical director must have awesome responsibility and should have the authority that is commensurate with it.

The hospital should also play a major role in training the prehospital care personnel for their new positions and patient care responsibilities. When assuming legal responsibility for paramedic performance, the institution personnel must insist on knowing the paramedics well before allowing them to represent the institution. Systems that import paramedics from distant training programs or community colleges do not know enough about them, and could subject the system administration to some serious unexpected consequences and significant legal risks.

Not only should the project medical director have primary responsibility for the training program, but also for the termina-

tion of trainees who fail to develop adequate skill, knowledge, techniques and attitudes. The authority must extend to continuing education programs and the termination of paramedics who develop performance or attitude problems at a later date. Obviously, there is a need for a project medical director with courage, integrity and rare talents. But there also is a need for contractual linkages between the resource hospital and the employers of the paramedics. Recently, the Advanced Coronary Treatment (ACT) Foundation developed such a contract document for the city of Pittsburgh, and it is anticipated that a model contract document will be published in the near future.

As might be imagined, this profile of medical control can generate confrontations between hospitals and medical personalities. By design, every incident of override requires a meeting of the involved individuals and representatives of the institutions within 24 hours. When more than one hospital has asserted medical control over paramedics, a problem arises. This is a potentially formidable stumbling block to the system, and further investigation, as yet unpublished, is ongoing. Quite clearly, a solution must be found.

From a legal point of view, *someone* must be responsible for the medical aspects of the program. Is it better to let everyone pretend to be in charge and share the burden when the ineluctable lawsuit arrives? Or is it preferable to accept the responsibility fully, and have the opportunity to manage and minimize risk? From a legal and medical point of view, the latter is the only choice.

SUMMARY

Prehospital advanced life support in the United States has been in use for more than ten years. The legal experience of this phenomenon has been watched very closely. It is a conservative estimate that five million patients have been treated by paramedics during this period. Yet, the author is not aware of a single loss by either judgment or settlement by any hospital, physician or insuror when that system has built true medical control into its structure. The experience speaks for itself.