Help me understand....

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Please don't share this with anyone but truth be told, I love paramedics. I sometimes thought I had it bad (I really didn't think that, but it makes the story better if I sound tragic) treating the myriad disenfranchised in an inner city ED until I talked with the paramedic who wrestled the feces-covered, bath salts and meth-using, naked, combative maniac who was my patient the previous night. (The patient had an upper GI bleed, was septic and hypotensive and, actually, the meth he took probably helped him maintain his blood pressure — you can't make this up!). All in all, I have it easy compared to those on the actual scene who were tasked with treating this antithesis of Darwinism.

Despite my admiration for paramedics, like the rest of us, they sometimes do things that make me shudder. Take this case report from a physician in Arizona:

I had a strange thing happen in the urgent care on Saturday night, I wanted to get your opinion. This 57 y/o female came in with her daughter and son-in-law. She presented shaking, having paranoia and some mild hallucinations. She is a chronic pain patient secondary to back pain and took some "medical grade marijuana" given to her by a friend she trusts. On exam vitals were stable except BP 156/84, heart rate slightly elevated, pupils were constricted and breathing quickly. EKG showed sinus tach. I called EMS and just before they arrived she complained that she couldn't swallow well and that she had some chest pressure. I gave her some SL nitro. When EMS arrived, I gave report. I asked if they needed anything else from me, and they said, "no." I left the room to see other patients. Upon leaving the next room the MA said, "They left." At first I thought she was telling me they had left with the patient. As it turns out, they left without the patient. They told them she was having an expected reaction to marijuana and that she should just go home and sleep it off. Of course, I was not happy. It WAS most likely a marijuana reaction, but she was tachycardic and who knows what else she could have been taking that was not disclosed or if the THC was laced with another illicit substance. Her children and I discussed I felt she needed to be in the ED and that they should take her there.

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Are you kidding me!!?? Sadly, and somewhat remarkably, this happens all the time. Occasionally, I see paramedics bring a patient in who is in full arrest. Typically when this particular set of facts happens, it is around 6:30 AM. For some reason I sense there is more to the story and almost always, on further questioning, they admit to being called to the patient's home a few hours earlier, evaluating him/her and then talking the patient out of being transported to the hospital.

Now, with the patient responding only to gravity, the paramedics seem to sense the gravity (pun intended) of their mistake. Now, the paramedics never say it quite so honestly; they usually say, "We evaluated the patient who decided they actually did not want to go to the hospital and signed a refusal." Sometimes, if a patient does not ultimately die, he/she says that the medics *strongly* encouraged not being transported and that it was "ok" to wait or see a PCP. Odds are that the medics are almost always correct, but when they aren't correct, a patient suffers. Even with a lot more information, I am often uncomfortable sending a patient home. Sometimes, "tincture of time" is all that is needed to determine which way a patient ultimately turns. For paramedics on the scene, the tincture of

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time is only a few minutes and the information is generally only a fraction of what is needed to a make a truly informed decision and give truly informed consent.

I often ask myself why on earth a paramedic would take on that risk or responsibility. Arizona, like most states, gives medics and other government employees wide immunity for services performed while they are on duty.

The statutory provision below provides qualified immunity and is generally drafted like Arizona's Statute A.R.S. § 9-500.02(A) which, in relevant part, protects City employees providing emergency medical aid absent gross negligence.

> A city or town or its officers and employees, a private fire or ambulance company whose services are procured by a city or town or its officers and employees, a property owner or its officers or employees, a tenant or a licensed health care provider or an emergency medical technician certified who performs emergency medical aid, when rendering emergency medical aid provided by an emergency medical technician, an intermediate emergency medical technician or a paramedic who is certified by the director of the department of health services is not liable for civil or other damages to the recipient of the emergency medical aid as the result of any act or omission in rendering such aid or as the result of any act or failure to act to provide or arrange for further medical treatment or care for the sick or injured person. This subsection does not apply if the person providing emergency medical aid is guilty of gross negligence or intentional misconduct.

If the patient in the scenario above suffered an adverse outcome, he/she would have argued that the paramedics' conduct was grossly negligent or that the statute does not provide immunity for negligently providing informed consent because the act of giving consent is not rendering care and thus not covered under the statute.

So why is this information relevant for urgent care providers? It is relevant because if a patient suffers an adverse outcome because of paramedics' refusal to transport, the urgent care provider and the center will likely be left holding the bag. Therefore, the best way to mitigate this risk is by being proactive.

If you decide that a patient needs to be transported to the hospital, make the decision collaboratively with the patient – explain the need for an ambulance as opposed to simply driving or being driven. When appropriate, give the patient the choice between a 911 call and a non-emergent transport. A patient with a shoulder dislocation that cannot be reduced in the urgent care center cannot drive him or herself to the hospital but probably does not need emergent transportation. Someone with a posterior knee dislocation, however, does need emergent transport.

Once the paramedics arrive, I would stay in the room and say something like this: "As we discussed, these paramedics are here to take you to the hospital. They will do a great job monitoring you and making sure you suffer no untoward events on the way to the hospital." I would then address the paramedics in front of the patient. "We called you because this patient is complaining of XX. Given her history, her exam and her constellation of findings (they will have no idea to what you are referring), she needs to be taken to the emergency department. We called ahead and they are expecting her."

Given that introduction and admonition, no one will attempt to talk the patient out of being transported. I usually stick around to "help load" to ensure that the patient is actually loaded on the stretcher.

If, for some reason, the medics still manage to talk the patient out of being transported, I would immediately call their supervisor and consider calling the body responsible for licensing ambulances.

At the end of the day, an urgent care provider is ultimately responsible for the patient and his or her disposition. If somehow the medics do "talk the patient out of transport," the urgent care provider remains responsible for the appropriate disposition of the patient. ■

Take-home points

1. Be proactive by giving the patient informed consent about the reasons for transport.
2. Accompany the medics into the room with the patient.
3. Overstate the reasons for the transport.
4. If able, call ahead to the ED and tell the medics that the ED is expecting the patient.