FIRE/EMS Medical Director
Risk/Liability

A Case Report

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Where do you transport acute stroke patients?

In December 2003, the AZ EMS Regional Council decided that acute stroke patients would be transported to the closest primary stroke center*

* If the patient could be delivered to the stroke center within 2 hours or less from symptom onset. (There were 6 PSCs in our region at the time.)

Fire/EMS agencies and hospitals in the east valley decide to ignore the AZ EMS stroke triage guideline because most acute stroke patients are not eligible for intravenous TPA and no PSCs were located nearby.

In early 2005, this decision is not re-evaluated despite the addition of a primary stroke center only 10 miles away.

AHA ACLS Provider Manual 2001 Chapter on –Acute Ischemic Stroke

Unacceptable Actions by ACLS Providers in the Prehospital Setting: Perils and Pitfalls

Transporting a potential stroke victim to an ED not capable of treating acute ischemic stroke patients with fibrinolytic therapy.

Stroke-- An Educational Program for Pre-Hospital Personnel

Hospitals should notify community EMS services whether they have the equipment and personnel to manage patients with acute ischemic stroke.

Developed by the EMS Committee of Operation Stroke
American Stroke Assoc. Phoenix, AZ July 2003.

The Case (Oct. 2005)

26 y.o. male was playing wiffle ball with his friends. He threw the ball and then fell down.

When he got up, his speech was slurred and he started stumbling on his feet. 911 was called. The local Fire/EMS paramedic arrived at 4:44 pm. He found that the patient was A & O x 4, but had slurred speech and right sided weakness. After a courtesy notification to the local community hospital, the patient was transported there by private ambulance. He arrived at the E.D at 5:09.

The local community hospital

The E.D. physician confirmed the neuro. exam deficits and sent the patient for a head CT scan. The patient worsened after the CT was completed and required intubation. (NIHSS scale 22-23) The E.D. physician Dx'd "Locked In" Syndrome. The head CT was read as negative. At 7:15pm the E.D doc then arranged for transfer to a tertiary neuro. hospital (because there were no neurologists on the community hospital staff).

The tertiary neuro. hospital

The receiving hospital E.D. physician agreed to accept the patient, but 5 min. later the E.D. charge nurse at the neuro. hospital called back and refused the patient, stating “we have no beds, we are on diversion. Try another hospital.”

The Primary Stroke Center

The closest (less than 10 miles) primary stroke center was also on E.D. diversion and refused the patient. The next closest PSC accepted the patient but did not have an ICU bed until 8:30pm. The patient was flown to that facility/arrived at 8:40pm.

The Primary Stroke Center

The patient has an MRI/MRA and is found to have a left vertebral artery dissection with clot extending into the basilar artery (brainstem). It is decided to transfer the patient to the tertiary neuro. hospital for either intra-arterial TPA or the MERCI clot removal procedure, since it is too late for intravenous TPA.

The tertiary neuro. hospital

The neuro-interventionalist accepts the patient who arrived there at 04:30am. Because of the length of the clot, it is felt that intra-arterial TPA will not be effective, so the MERCI clot removal procedure is done and is completed by 09:15am. The patient's prognosis was listed as grave, despite some minor improvement in his paralysis. He could communicate only by moving his eyes. He was unable to swallow or talk.

The Patient

After extensive rehab:

K.C. is alert and is able to talk, but not well.

He communicates mostly by email/computer.

He cannot walk but is able to feed himself.

He has painful spasticity of his legs.

He requires bowel and bladder care 24/7.

The Lawsuit

In Dec. 2006—K.C. and his lawyers file a claim against the east valley Fire/EMS agency for $20 million. They allege that the fire captain /paramedic was grossly negligent for sending the patient to the local community hospital rather than the closest Primary Stroke Center.

The plaintiff's expert

He is a neurologist and is "the founder of the Stroke Center" as well as Director of the Stroke Research Program at the tertiary neuro. hospital in Phoenix. He reviewed the medical records of K.C. in order to form his opinion.

The plaintiff's expert

His opinion stated "If K.C. had been taken to a Primary Stroke Center, instead of the local community hospital, he would have received appropriate medical intervention for his stroke and to a reasonable degree of medical probability (51%), he would have been substantially better than he is." (Affidavit dated Mar. 2007)

In April 2007

The east valley Fire/EMS agency changes its triage protocol for acute stroke patients and begins transporting them to Primary Stroke Centers (despite requests from the local community hospitals to continue transporting stroke patients to their facilities).

The City Attorney

The city attorney for the Fire/EMS agency blames the community hospital and their E.D. doctors for encouraging the prehospital providers to bring them acute stroke patients that they were unable or unwilling to treat with TPA.

The plaintiff's lawyer

Adds the following defendants:

The Fire/EMS Medical Director (and his wife)
The emergency physician (and his wife)
The community hospital/hospital corporation
The private ambulance company

(lawyers call this looking for deep pockets!)

The plaintiff's expert

At his deposition in April, 2009—the stroke neurologist admits under oath that the E.D. physician at his own facility should have called the stroke team and they would have accepted this patient, even though the E.D. was on diversion. He also admits that the charge nurse did not have the authority to refuse this patient. She should have notified the stroke team.

2 yr. statute of limitations

Unfortunately for the patient K.C., the statute of limitations had run out in Oct. 2007, so the tertiary neuro. hospital could no longer be added to the lawsuit.

The settlement

- Due to perceived risks of going to trial, a settlement was reached in July 2009.

The settlement

- Private ambulance $50,000
- City Fire/EMS agency $500,000
- Fire/EMS Med. Director $750,000
- E.D. doc/community hospital $1,500,000(?)

The settlement

The actual amount was confidential but was reportedly between $2.5-$3 million.

5 Points to Remember

- Check your malpractice insurance coverage
- It should specifically cover your EMS activity
- Review your EMS standing orders and triage protocols frequently (at least annually)
- Ensure that they meet the standard of care
- Lawsuits have nothing to do with who is right or wrong (it is only about the money!)

References

- Kelly Corliss has his own website--google Kelly Corliss stroke.
- Article in Glamour Magazine by his wife, Britt Magnuson on his rehab./recovery process. (March 2, 2009)

The

End

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