BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

In the Matter of the Emergency Medical Technician-Paramedic License Held by: LYNN THOMPSON-NORTHEY, License No. P22489 Respondent.	Case No. 08-0200 OAH No. 2010060536

PROPOSED DECISION

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on October 10, 2011, and January 12, 2012, in San Diego, California.

Cynthia L. Curry, Senior Staff Counsel, Emergency Medical Services Authority, represented complainant Nancy Steiner, Chief, EMS Personnel Division, Emergency Medical Services Authority, Health and Human Services Agency, State of California.

Phillip Hack, Attorney at Law, Farmer, Case and Hack, represented respondent Lynn Thompson-Northey (Northey or respondent), who was present throughout the administrative hearing.

Oral and documentary evidence was received and the matter was submitted on January 12, 2012.

FACTUAL FINDINGS

Jurisdictional Matters

1. On September 30, 2009, complainant Nancy Steiner, Chief, EMS Personnel Division, Emergency Medical Services Authority, Health and Human Services Agency, State of California (EMSA), signed the accusation in her official capacity. The accusation alleged that in 2008 respondent functioned outside the supervision of medical control and violated regulations during her care and treatment of one patient.

Respondent timely filed a notice of defense after being served with the required jurisdictional documents.

Respondent's California License Status

2. On June 29, 2005, EMSA issued Emergency Medical Technician-Paramedic License No. P22489 to respondent. That license is current and will expire on June 30, 2013, unless renewed or revoked.

There is no history of any disciplinary action having been imposed against Emergency Medical Technician-Paramedic License No. P22489.

Respondent's Background and Training

3. Respondent was employed by American Medical Response (AMR) from 2000 until 2010, when she left due to a back injury. Respondent was originally employed at AMR as an EMT. While working as an EMT, she attended and graduated from a paramedic school in 2004, after which she began working as an AMR paramedic. In 2006, Respondent was approached by the administrator from the paramedic college who asked her to be a preceptor based upon respondent's knowledge, training and experience. Respondent agreed and began preceptoring paramedic students who interned at AMR. On the date of this incident, respondent had been a preceptor for two years and the intern with her on the call at issue in this proceeding was the fifth student she had trained.

The April 1, 2008, Incident

4. On April 1, 2008, respondent, then an employee of AMR, was dispatched to the home of patient M.T., a 16-year-old asthmatic. On board the AMR ambulance were respondent, her partner, and a paramedic intern. The County of San Bernardino Fire Department (County Fire) paramedics[1] also responded to the emergency call pursuant to a mutual aid agreement. The County fire paramedics were the first to arrive on the scene. The County fire paramedics administered medications, placed M.T. on oxygen and awaited AMR's arrival. After AMR arrived, M.T. was loaded on the AMR ambulance for transport to the local hospital. While en route, M.T. suffered a respiratory and cardiac arrest. She died several days later at the hospital.

The Documentation of the April 1, 2008, Incident

5. The April 1, 2008, incident was documented in reports by County Fire, AMR, and in hospital emergency room records. While there are some inconsistent details in the documentation, the incident is generally as described in Factual Finding 4.

---

[1] The County Fire paramedics were from the Hesperia Fire Department.

Testimony Regarding the April 1, 2008, Incident

6. Respondent testified that she and her crew were in Victorville when they received a call to assist County Fire at M.T.'s home in Hesperia, a town approximately eight to 12 miles away. It was a mutual aid call which was precipitated because there were no other available units and AMR was required to provide backup. The response was not in AMR's primary call area.

Respondent testified that the call was a "breathing problems call," that respondent's partner drove the unit and backed it into the driveway, after which the student intern hopped out of the back and grabbed the gurney. County Fire was already on the scene. Respondent testified that her team only grabbed their gurney because County Fire equipment was already on scene as they were an Advanced Life Support (ALS) level provider.

When the AMR unit arrived at the home, M.T.'s grandfather was at the door. The AMR crew had to rearrange the furniture to get the gurney into the home, which was cluttered. Respondent and her intern proceeded to M.T.'s bedroom, leaving the gurney in the foyer because it would not fit down the hallway. There was an oxygen tank on the gurney and there was house oxygen in the ambulance which allowed AMR personnel to attach an airway adjunct to the gurney or the ambulance oxygen tank.

When respondent entered the bedroom, two members of County Fire were present. The bed was full of clothing and there was a small spot where the patient was lying so County Fire could attend to her. One member of County Fire gave respondent the turnover report, advising that M.T. woke up that morning, had several breathing treatments, was coughing, and then called 911. M.T. was sitting forward in a tripod position, which indicated M.T. was having difficulty breathing. M.T. had accessory muscle use, which occurs when patients use their chest muscles to breathe and which indicates that a patient is breathing hard and is experiencing breathing difficulty. M.T. also had distended jugular veins (JVD), another indication of breathing difficulty.

An IV had not been started and the medical treatment being administered was an Albuterol mask for a breathing treatment. Respondent assessed M.T., listened to her lungs, heard audible wheezes, but heard nothing in the lower lobes, which indicated that M.T. was not moving air in her lower lobes. Respondent tried to ask M.T. questions, but M.T. was so short of breath that respondent did not pursue questioning because she did not want M.T. to unnecessarily expend energy to respond to her questions. Respondent gathered information from County Fire while she continued to assess M.T. Respondent told her partner to get the gurney ready, that they would be carrying M.T. out, describing it as a "load and go" and "scoop and haul." Respondent did not want to waste any time trying to start an IV. Respondent was in M.T.'s bedroom for less than three or four minutes.

M.T. was carried out in a two-point position with the oxygen cylinder between her legs. The oxygen was switched to the AMR gurney oxygen. M.T. was extremely agitated and she had to be buckled for transport. M.T. was not diaphoretic in her bedroom, but she

became so once placed on the gurney. While placing M.T. on the gurney, respondent reassessed M.T. and tried to decrease M.T.'s anxiety. Respondent and her partner were talking to M.T. as M.T. was wheeled out the door and into the back of the ambulance. When M.T. was on board, the intern switched M.T. back to house oxygen and then took off the monitors and retrieved the IV equipment. M.T.'s family was instructed not to follow the ambulance too closely because they would be going with "lights and sirens." Respondent's partner drove the ambulance while respondent and the intern remained in the back with M.T., rendering care.

Respondent set up the bag valve mask (BVM) which squeezed oxygen in and out of M.T.'s lungs. The intern was looking for a vein to start an IV, but M.T. was very agitated, thrashing about with her arms. M.T. was flailing, climbing onto the intern and the apparatus, and pulling things from the cabinets inside the ambulance. Respondent had a hard time holding M.T.'s head in position to perform the BVM bagging. Respondent wanted to establish an IV once M.T. was in the ambulance, but M.T. was shunting, venous access was very poor, and establishing access was not reasonably possible. Respondent continued to "bag Albuterol." Respondent considered performing a nasotracheal intubation as soon as M.T. was loaded into the ambulance and she had taken possession of the equipment required to conduct the procedure, but she did not initiate the procedure because M.T. was conscious and was highly anxious. Respondent feared that attempting the procedure would cause M.T. to experience more trauma. As the ambulance approached the hospital, M.T. coded. Once M.T. coded, respondent and the intern were able to place an intraosseous (IO) in her leg.

M.T. coded about one block from the hospital. Respondent told her partner to advise the hospital of the code. She and her intern administered CPR and they placed tabs on M.T. in the event they needed to shock her. Respondent and the intern provided bagging and compressions and the intern placed the IO as the ambulance arrived at the hospital. Hospital staff assisted in removing M.T. from the ambulance. Respondent gave a verbal report to the ER physician and staff.

Respondent admitted on cross-examination that "traditional ALS" treatment includes inserting an IV; however, owing to M.T.'s flat veins, respondent said she was unable to get an IV started. Respondent did not perform an intra-jugular IV because of M.T.'s distended neck veins. An intra-jugular IV posed several risks including pulmonary embolism, and the procedure would have required M.T. to be flat on her back, thereby decreasing her ability to breathe. The attempts to start an IV were unsuccessful. Respondent considered and rejected inserting an IO on M.T. when M.T. was conscious because that would have increased M.T.'s agitation. Moreover, the protocols only require the emergency personnel to "consider" IV/IO, and respondent considered the procedure. As respondent explained, "It is not that I did not want to do it, it's that I knew the outcome if I tried to do it."

7. Jade Morgan is a licensed paramedic who is employed by the San Bernardino County Fire Department. She was part of the County Fire first responders on the call at M.T.'s home. Morgan testified that County Fire took all of their equipment with them into M.T.'s home when they arrived including an airway bag and equipment, nebulizer

equipment, an endotracheal kit, nasogastric tubes, medications, narcotics, blood pressure cuffs, IV equipment, needles, cardiac monitor, pulse oximetry equipment, and other devices.

Morgan testified that there were access problems going down the hallway and that it was difficult to get into M.T.'s room, which was small and dark. M.T. was having difficulty breathing and Morgan was told that M.T. had taken multiple breathing treatments that day. When County Fire arrived, M.T. was already on a nasal cannula that the family owned. Morgan left that cannula in place when she used the nebulizer. M.T.'s oxygen levels increased after she was given the nebulizer. Morgan sat M.T. up and administered Albuterol and Atrovent via nebulizer.

When AMR arrived on scene, it was difficult for them to get the gurney to M.T.'s room, so the responders decided to carry M.T. to the gurney at the front of the house. Morgan recalled that when M.T was placed on the gurney, her oxygen was switched over to the oxygen that AMR carried on their gurney. M.T. was conscious and Morgan gave a turnover report to AMR personnel.

Morgan characterized the 17 minutes it took from the time County Fire arrived on scene until M.T. departed in the AMR ambulance as being "really fast for transport time." Morgan did not observe any violations of ICEMA protocols and she was not critical of AMR's care and treatment of M.T.

8. Martha Lujan had been employed by AMR since 1989. She was respondent's partner on this call and she drove the ambulance. The call area was not part of AMR's usual response area.

Lujan testified that after they arrived at the scene, M.T. was very anxious and complained that she could not breathe. Lujan recalled that the caregivers were at the side of the gurney talking to M.T., trying to get her to calm down. When M.T. was loaded in the ambulance, her anxiety had "come down a hair." Lujan characterized the seven minutes from AMR's arrival at the scene to their departure as being "pretty quick." Lujan testified that respondent and the intern were "very busy in the back of the ambulance" during the drive to the hospital. Approximately one block from the hospital, respondent yelled from the back that M.T. had coded. Lujan immediately radioed that information to the hospital.

Lujan admitted that she told respondent to document this case very well based on a conversation Lujan overheard between M.T.'s mother and the ER physician. Lujan observed respondent entering information on a computer at the hospital and then handwriting a supplemental report which respondent turned in with all of her other paperwork. Lujan acknowledged that reports are written after the fact and that notes are not taken while emergent care is being rendered. Reports are recreated from the paramedic's memory after delivering patients to the hospital.

Complainant's Evidence

9. The only witness called by complainant was Kymberly Mitchell. Based upon her investigation, Mitchell concluded that respondent failed to follow Protocol 1001, BLS Interventions steps 2b, 3b, and 3c, in that respondent did not obtain airway control and did not assemble the necessary equipment to perform IV/IO or endotracheal intubation. Mitchell also testified that respondent failed to follow the ALS Interventions, steps 3, 4 and 5 in that respondent did not augment the BLS treatment with advanced treatments, respondent did not initiate airway control and respondent did not initiate vascular access.

10. Mitchell began working in 2008 as an EMSA retired annuitant special investigator. Mitchell's duties include receiving complaints, performing investigations, preparing reports, and submitting reports for follow-up. Before she began working for EMSA, Mitchell was employed by CHP for 28 1/2 years, during which time she became an EMT, attended paramedic school, and served as a liaison for the state EMT program. On cross-examination, Mitchell admitted that in her career she probably encountered no more than 16 to 20 asthmatics, treated two in her capacity as an EMT, and had never performed nasotracheal intubation on an actual patient.

11. This investigation was initiated as a result of a complaint received from M.T.'s family.[2] Mitchell reviewed the complaint, obtained the patient care records and other documents, reviewed ICEMA protocols, and interviewed witnesses. Mitchell testified that this was an abnormal case in that the first responders at the scene normally transport the patient to the hospital. Mitchell testified that a review of the records indicated that M.T. was extremely ill, that M.T. had difficulty breathing, that M.T. was sweating profusely, and that M.T. was in the late stages of hypoxia with poor blood flow. Mitchell acknowledged that there were items in the narrative reports that did not coincide with the timelines, so it was difficult to determine when actual care was rendered. Much of Mitchell's testimony was based upon an assumption that the computer generated AMR record was accurate, although respondent testified that AMR report had the patient's condition in reverse order because of respondent's difficulty using the new computer system. It was suggested that those discrepancies may have contributed to Mitchell's confusion.

12. Mitchell testified that County protocols are a set of policies and procedures that are established in the field for paramedics to work under because paramedics are not allowed to work independently and must work under a medical physician's license. Mitchell testified that respondent was required to follow the protocols and the steps set forth in the protocols. Mitchell testified that BLS, basic life support, permits trained individuals, such as EMTs, to perform certain procedures in pre-hospital settings. ALS, advanced life support, is reserved for those individuals who have been specifically trained to perform life support, which includes paramedics.

---

[2] Mitchell assumed that the complaining party was M.T.'s mother, but she has since learned that the complaining party was M.T.'s care provider and not the mother.

Evidence Regarding the Alleged Violation of Protocol Reference 1001[3]

13. Protocol Reference 1001, General Patient Care Guidelines, contains both Basic Life Support (BLS) Interventions and Advanced Life Support (ALS) Interventions. The BLS interventions contain the following four parts:

1. Obtain a thorough assessment of the following:
   a. Airway, breathing and circulatory status
   b. Subjective assessment of the patient's physical condition and environment
   c. Objective assessment of the patient's physical condition and environment
   d. Vital signs
   e. Prior medical history and current medications
   f. Any known medication allergies or adverse reactions.
2. Initiate care using the following tools as clinically indicated or available
   a. Axial spinal immobilization
   b. Airway control with appropriate BLS airway adjunct
   c. Oxygen
   d. Assist the patient into physical position that achieves the best medical benefit at maximum comfort
   e. Automated external defibrillator
   f. Consider the benefits of early transport and/or intercept with ALS personnel if clinically indicated

3. Assemble the necessary equipment for ALS procedures under direction of EMT-P
   a. Cardiac monitoring
   b. IV/IO
   c. Endotracheal intubation
   d. Pulse oximetry

4. Under EMT-P supervision, assemble pre-load medications as directed, excluding controlled substances.

The ALS Interventions state as follows:

1. Evaluation and continuation of all BLS care initiated
2. Augment BLS assessment with an advanced assessment including but not limited to the following:
   a. Qualitative lung assessment

---

[3] All references are to Inland Counties Emergency Medical Agency's (ICEMA) protocols, unless otherwise specified

b. Cardiac monitor
c. Blood glucose monitoring

3. Augment BLS treatment with advanced treatments as indicated or available
4. Initiate airway control as needed with the appropriate ALS adjunct
5. Initiate vascular access as clinically indicated

Based on Mitchell's testimony and other evidence, complainant argued that respondent functioned outside the supervision of medical control and violated the regulations, policies and provisions pertaining to pre-hospital personnel and violated Protocol 1001 in that respondent entered the patient's home with no equipment, failed to establish an advanced airway, failed to establish IV/IO access, failed to provide fluids to the patient, failed to administer epinephrine, and failed to establish advanced life-support routes to administer life-saving medications. Complainant asserted that Protocol 1001 required that respondent to assemble the necessary equipment for ALS procedures, including cardiac monitoring equipment, IV/IO equipment, endotracheal intubation equipment and pulse oximetry equipment, and that respondent failed to meet those responsibilities. Complainant argued that the protocol required respondent to evaluate and continue all BLS care, which respondent did not establish when she took over patient care nor did she start any BLS interventions. Additionally, complainant asserted that respondent failed to perform a qualitative lung assessment, failed to provide cardiac monitoring and blood glucose monitoring, failed to initiate airway control and failed to initiate access as required by Protocol 1001.

14. Reza Vaezazizi, M.D., received his medical degree from the Chicago School of Medicine in 1997, completed his emergency medicine residency at Loma Linda University in 2000, and has been a practicing emergency room physician since then. He is board certified in emergency medicine.

Since November 2006, Dr. Vaezazizi has been the medical director of the Inland Counties Emergency Medical Agency (ICEMA), the local EMS agency serving San Bernardino, Inyo and Mono counties. ICEMA is charged with overseeing the functions of the emergency services provided to those three counties. Dr. Vaezazizi's duties as the medical director include the oversight of medical protocols, the development and review of those protocols, continuing education, participating in multiple committees and overseeing the Quality Improvement Program (QIP).

Dr. Vaezazizi performs call reviews to determine compliance with the protocols; he explained that the protocols are basic detailed plans of care used by emergency medical personnel in conjunction with their clinical judgment and training. Dr. Vaezazizi testified that the protocols are fairly detailed plans that attempt to provide guidance for the typical patient encountered, and set forth a detailed plan to care for that patient. However, he testified that patient care requires significant training and emergency medical personnel judgment; the exercise of sound clinical judgment is expected. Dr. Vaezazizi explained that the protocols are not laws or regulations that must be followed, nor are they guidelines

because emergency medical personnel are not independently licensed practitioners and must operate under the medical director's license.

15. ICEMA has a Quality Improvement Plan (Exhibit 14) and ICEMA constantly reviews and reevaluates its system and components to improve patient care.

In August 2008, Dr. Vaezazizi conducted a telephonic review with all of the emergency medical personnel who handled M.T.'s call. During that telephonic review, Dr. Vaezazizi had the Summary of QI Call (Summary) (Exhibit 15) that he conducted on July 17, 2008, at M.T.'s family's request.[4] In that Summary Dr. Vaezazizi noted that the County Fire captain advised that when they arrived at the home, they found M.T. in a tripod position, on home oxygen, in acute respiratory distress. M.T.'s mother stated that M.T. had used her breathing treatments approximately eight times that day. While the County Fire paramedic was assessing the patient, the captain went back to the engine to retrieve additional equipment. He stated that egress and ingress were difficult and slow due to clutter present in the hallway and inside M.T.'s room. The County Fire paramedic provided patient care from the time of arrival until AMR arrived on the scene. Care included the initial assessment, measuring vital signs, placing M.T. on a cardiac monitor and supplemental oxygen, as well as giving her additional breathing treatments. M.T.'s oxygen saturation level improved from 91 to 97 percent; however, she continued to remain in severe respiratory distress with increased work of breathing.

AMR arrived on the scene and found M.T. to be cyanotic with capillary refill of greater than two seconds. M.T. was given additional breathing treatment with Albuterol and was continued on supplemental oxygen. The patient was en route to the hospital within minutes and subsequently went into respiratory failure, after which she was ventilated by BVM with a continuous breathing treatment. Shortly afterwards, she became pulseless with PEA (pulseless electrical activity) on the monitor, CPR was started and continued until arrival at the hospital.

Dr. Vaezazizi noted that departure from the scene to the hospital was approximately 12 minutes.[5]

M.T. became apneic approximately four minutes after initiating transport and CPR was started approximately one minute later. Although M.T. was initially resuscitated at the hospital, she ultimately succumbed to her illness.

---

[4] Dr. Vaezazizi admitted on cross examination that he is not sure if he had the protocols in front of him when he conducted the telephone call, but testified that this did not mean he was not familiar with them during the telephone call.

[5] This calculation assumes scene departure at 13:57 and arrival at the hospital at 14:09.

Dr. Vaezazizi testified that he performed a Call Quality Improvement (CQI) in response to M.T.'s mother's complaint that the emergency medical service provided to her daughter departed from the expected standard of care. The CQI process involved a careful review of all patient care records, as well as a telephone interview with the crew members involved. Following that review, Dr. Vaezazizi opined:

> The death of this patient is tragic and unexpected event. [sic] However, our careful review did not find any significant deviation from current ICEMA treatment protocols. We did note that the patient was not given any Epinephrine during this incident. Current ICEMA protocols call for administration of Epinephrine to patients in extreme respiratory distress who do not improve with standard breathing treatments and oxygen therapy. The patient met the criteria to receive epinephrine [sic] in the field. We also conclude that administration of epinephrine was unlikely to improve patient's respiratory status or the ultimate outcome of this case. After careful review of the timeline of events in this incident, we found that the assessment, treatment, and transportation of this patient was [sic] conducted in an expeditious manner without any evidence of unnecessary delays. We did not identify any additional steps that paramedics could have taken to prevent the tragic outcome of this incident.

Dr. Vaezazizi further wrote, "[A]s is true with all CQI reviews, this review identified the following areas that may benefit from additional training and education for continued improvement of ALS services." Dr. Vaezazizi identified the three areas as (1) using base hospital contact as a resource when the current treatment is not producing the desired response, (2) realization that although the majority of asthma patients improve with standard EMS treatment, and the crew here fully expected M.T. would improve, as well, a review of the pathophysiology of asthmatic disease process, the physiology of treatment modalities including the role of epinephrine, and related ICEMA protocols may improve crews' ability to better recognize patients who may be rapidly deteriorating despite adequate treatment, and (3) although not verified, the review indicated a possible delay in accessing 911 by the patient's family which may have been a contributory factor in the patient's poor outcome so public education may be needed to assure rapid access of the 911 service.

Dr. Vaezazizi testified that BLS intervention had been initiated by County Fire and AMR. M.T. was given a nasal cannula of oxygen and Albuterol and nothing additional was required at that juncture for her airway management. Dr. Vaezazizi explained that in the case of an extreme asthma attack, the physical problem lies within the lower lungs and emergency medical personnel are not permitted to perform any airway management of the lower lungs; they can do nothing more than administer Albuterol and an oxygen cannula. The functional deficit in an asthma patient is the inability to breathe out, the patient cannot exhale, which causes a buildup of toxic gases; asthma is not a failure of oxygenation, it is a failure of ventilation.

Dr. Vaezazizi testified that he was not critical that there were several unsuccessful attempts to establish an IV or that an IV was not attempted until M.T. was in the ambulance so long as there was there was a good rationale. Dr. Vaezazizi explained that EMTs must

rank priorities and often manage several issues at the same time. In this case, transporting M.T. was the highest priority and that task superseded establishing an IV that would not have been of much benefit to M.T.'s situation. Departing the scene in seven minutes was "well within the standard of what would be expected for this type of call" and was "quickly expeditious." Dr. Vaezazini testified that it is not uncommon for an IV not to be established, that the failure to do so does not violate the standard of care, and that not establishing an IV is not surprising with a critically ill patient. Dr. Vaezazizi testified that the protocols merely require that an IO line be considered; not that it is required.

Dr. Vaezazizi concluded that there was no violation of Protocol 1001. He was satisfied with respondent's airway management based on the techniques that were currently available to emergency personnel. Respondent did all she could do in this case to manage this patient's airway.

16. Christopher Heiser, a Division Chief with the Carlsbad Fire Department (a community in San Diego County), was retained by respondent as an expert witness. Chief Heiser is a certified paramedic and licensed registered nurse. Chief Heiser graduated from paramedic school in 1979 and has practiced continuously as a paramedic or EMT since then. He served in the military as a medic and he has taught at the paramedic college. Chief Heiser was a preceptor of interns for 10 years. He was a founding member of the STAR team, created in 1981 as an organization to provide an "all-risk type of paramedic" for certain calls during an era when firefighters were not paramedics. Currently, Chief Heiser oversees his department's emergency medical services, performs Quality Improvements, and makes referrals to EMSA when discipline is warranted.

Chief Heiser has never practiced under ICEMA protocols because his professional service has been limited to San Diego County. However, he explained that the protocols are similar and should be viewed as "a series of guidelines without any specific obligation" because paramedics are trained to utilize the protocols and exercise their clinical judgment based on that training. Protocols are a "recommended sequence," not a "mandated" one. Protocols are a toolbox from which the paramedic can work. Protocols have helped narrow the decision making process to provide guidance to a paramedic, but they are no more than "guidance." Protocols do not have to be followed verbatim or even sequentially. Nothing in Chief Heiser's education, training, employment or experience suggested anything to the contrary, and he was not aware of any state or local directives which were inconsistent with his understanding of the nature of protocols. Chief Heiser was an extremely credible and knowledgeable witness.

Chief Heiser opined that respondent generally complied with Protocol 1001, and he had no criticisms of respondent's care and treatment of M.T. He believed that respondent appropriately controlled M.T.'s airway. Moreover, the ALS protocols merely discuss initiating an IV as clinically indicated, and since M.T. had inadequate tissue perfusion when an IV was considered, respondent's not having attempted to initiate an IV involved reasonable conduct.

Evidence Regarding the Alleged Violation of Protocol Reference 5001

17. Protocol Reference 5001, Adult Respiratory Emergencies, contains a section entitled Acute Asthma/Bronchospasm that provides that the BLS Interventions are intended to reduce anxiety, to allow a patient to assume a position of comfort and to administer oxygen as clinically indicated, humidified oxygen preferred. The ALS Interventions contain 10 parts.

Those parts applicable to M.T. advised the paramedic to maintain airway with appropriate adjuncts, administer nebulized Albuterol with Atovent (which may be repeated twice), initiate an IV bolus if there is inadequate tissue perfusion, follow certain steps if continuous positive airway pressure (CPAP) is administered, give Epinephrine (which may be repeated after 15 minutes if there is no response to Albuterol), consider advanced airway per Protocol Reference 4029, Nasotracheal Intubation. The protocol also advises the paramedic that the base hospital physician may order additional medications or interventions as indicated by the patient's condition.

18. Complainant alleged that respondent violated Protocol Reference 5001 in that respondent did not perform the required treatment, no IV attempts were made, IO was not initiated until M.T.'s arrival at the emergency room, epinephrine was not administered, respondent did not attempt to provide intubation, and respondent failed to administer either an IV bolus or epinephrine as outlined in the protocol when the patient went into PEA because respondent had not previously instituted an IV.

19. Mitchell testified that respondent violated Protocol 5001, Acute Asthma/Bronchospasm, BLS Interventions, steps 1 and 2, in that respondent did not document how she reduced M.T.'s anxiety, there was no mention that humidified oxygen was used, and it was inappropriate to use the patient's home oxygen. Mitchell testified that respondent violated the ALS Interventions section; steps 1, 3, 5, 9, and 10 in that respondent did not maintain an airway with appropriate adjuncts, did not initiate an IV bolus, did not administer epinephrine, did not consider nasotracheal intubation, and did not contact base hospital.

20. Respondent testified that she considered administering epinephrine when she first saw M.T., but given M.T.'s presentation - poor peripheral circulation, shunting, diaphoretic, and delayed capillary refill - respondent believed that administering subcutaneous epinephrine would not be effective. Respondent testified that once M.T.'s circulation began shutting down, she believed there would be insufficient blood flow to circulate the subcutaneous epinephrine so respondent planned to administer epinephrine once an IV was established. Once the patient coded, respondent was unable to intubate M.T. because her jaw clinched.

21. Dr. Vaezazizi did not find any violation of Protocol 5001, although he identified some deviations from that protocol; however, he testified that the deviations he observed did not constitute a violation of the standard of care because protocols are not laws and respondent's deviations were reasonable. Although the protocol indicated that

epinephrine may be administered when there is no response to Albuterol, the treatment that was rendered made it apparent that administering epinephrine in the ambulance would not have changed this patient's outcome. M.T. was a long-term asthmatic who had been taking breathing treatments all day long, so epinephrine would not have had any therapeutic effect. Accordingly, it was an irrelevant deviation.

Dr. Vaezazizi testified that if respondent thought M.T. was shunting and believed that administering epinephrine would not have any therapeutic effect, that was a reasonable clinical assumption, especially since subcutaneous epinephrine, the only type that may be administered by emergency personnel, requires at least 20 minutes to take effect. Also, because M.T. was agitated, her body would have been naturally producing adrenaline, an epinephrine-like substance, such that it would be unlikely that administering epinephrine would make any difference. Finally, Dr. Vaezazizi testified that since the introduction of Albuterol, the use of epinephrine for asthmatics has become an outdated medical practice.

22. Chief Heiser testified that epinephrine should have been part of respondent's consideration. His review of the documents indicated that treatment focused on the use of bronchodilators and which respondent believed was effectively ventilating M.T., leading to the reasonable conclusion that the bronchodilators were working. Thus, it was reasonable for respondent not to consider the use of epinephrine. If respondent felt the bronchodilators were not effective, she could have considered epinephrine, but nothing in the records suggested that that was the case. If M.T. was shunting, respondent's decision not to use epinephrine was valid.

23. Respondent testified she did not contact base hospital because she knew what drugs were on board the ambulance and base hospital could not offer her more medical options than were being attempted. The only other thing respondent could have attempted was the use of chemical restraints which respondent, as a paramedic, was not permitted to do. Since only seven minutes elapsed between M.T.'s code and arrival at the hospital, there would not have been enough time to contact base hospital and implement any suggestions.

24. Dr. Vaezazizi was not critical that respondent did not contact base hospital because the emergency personnel were extremely busy taking care of M.T.; M.T. had pending respiratory failure upon initial contact with the first responders so it was a "race against time." Dr. Vaezazini, an emergency room physician, was not certain that the base hospital could have offered any additional input in any event.

25. Chief Heiser agreed that a paramedic may contact base hospital if he or she needs help. However, when a paramedic is talking on the radio, the paramedic is not giving full attention to the patient, and interrupting patient care to talk to base hospital is part of the judgment call that a paramedic must make. Chief Heiser was not critical that respondent did not contact base hospital. It took time to render the care that M.T. received, and there is "a lot that goes on in the back of an ambulance with a patient like this." Chief Heiser highly doubted that any paramedic would have spent time setting up equipment; they would have acted like respondent did and rendered care.

Evidence Regarding the Alleged Violation of Protocol Reference 4029

26. Protocol Reference 4029, Nasotracheal Intubation, identifies the Field Assessment/Treatment Indicators relating to the use of a nasotracheal tube, one of which is severe respiratory distress per Protocol Reference 5001 Shortness of Breath. This protocol also outlines the procedure for placing a nasotracheal tube.

27. Mitchell testified that respondent violated Protocol Reference 4029 in that respondent did not utilize a nasotracheal intubation. Mitchell testified that the patient's high level of anxiety was an insufficient justification for respondent's failure to comply with this protocol; but, on cross examination, Mitchell conceded that if a patient is fighting and moving about violently, a paramedic would not want to attempt nasotracheal intubation.

28. Respondent credibly explained her reasons for not performing nasotracheal intubation. These reasons were determined to be sound by Dr. Vaezazizi and Chief Heiser.

29. Dr. Vaezazizi agreed with respondent's rationale, concluding that respondent did not violate the protocol. Dr. Vaezazizi testified that the protocols did not require nasotracheal intubation be performed. Nasotracheal intubation is an attempt to control the upper airway, and that was not M.T.'s problem - M.T. was experiencing a lower airway issue. As such, nasotracheal intubation would have been a very challenging procedure and it would have hastened the respiratory failure that eventually occurred. Dr. Vaezazizi testified that an ICEMA internal review determined that three quarters (75 percent) of nasotracheal intubations performed are unsuccessful.

30. Chief Heiser testified that performing a nasotracheal intubation is a complex skill that dramatically increases a patient's anxiety and apprehension. The protocols emphasize reducing patient anxiety, so electing not to perform nasotracheal intubation for the reasons respondent provided was appropriate in these circumstances. Further, the procedure requires that the patient be capable of exchanging air at a reasonable rate, which was not the case with M.T. The patient was a 16 year-old petite person, and the size of the device that would be used for the procedure could actually have damaged M.T.'s nose. Because respondent felt she was effectively managing M.T.'s airway, there was no need to utilize another airway adjunct.

Chief Heiser was not critical that respondent continued to perform asthma treatments because these had proven the most effective treatments. Once M.T. coded, intubation was appropriate.

As of 2005, the American Heart Association has advised that CPR is the best treatment when a patient codes, and respondent's performance of two minutes of CPR before the patient was intubated was appropriate.

Evidence Regarding the Alleged Violation of Protocol Reference 6004

31. Protocol Reference 6004, Adult Tachycardias, provides guidance when an unstable tachycardia is encountered; it involves a heart rate above 115 and signs and symptoms of poor perfusion. The BLS Interventions are designed to reduce anxiety, to allow the patient to assume a position of comfort, to administer oxygen as clinically indicated and to consider transport. The ALS Interventions are to determine the cardiac rhythm and to proceed to appropriate intervention and initiate an IV bolus. Differing guidelines are provided depending upon the type of cardiac rhythm observed.

32. Mitchell testified that respondent violated the Unstable Tachycardias, BLS Interventions section of this protocol, steps 2 and 3, because she did not document the manner by which she reduced the patient's anxiety and because she did nothing more than administer oxygen with a nasal cannula, a procedure that was not appropriate at this juncture. Mitchell testified that respondent violated the ALS Interventions section of this protocol because she did not proceed to the appropriate intervention and she did not initiate an IV.

33. Dr. Vaezazizi testified that this protocol was not relevant. M.T.'s tachycardia was a physiological response to her pending respiratory failure and following this protocol would have been a "futile, undirected medical management that would have caused more harm." Dr. Vaezazizi equated requiring the use of this protocol with requiring someone to turn off a smoke detector during a fire; once the fire begins, you treat the fire, not the smoke detector. Dr. Vaezazizi opined that it was unnecessary to treat the tachycardia as they were depending on it to buy them time to address M.T.'s pending physiologic failure.

34. Chief Heiser opined that this protocol was not involved because tachycardia is a normal side effect from administering the bronchodilators which does not require treatment. One does not need to treat tachycardia when it is an expected symptom of the treatment being rendered. On cross examination Mitchell admitted that sinus tachycardia is a known side effect of administering Albuterol.

Evidence Regarding the Alleged Violation of Protocol Reference 6015

35. Protocol Reference 6015, Adult Cardiac Arrest, contains BLS Interventions which advised the paramedic to assess the patient and to maintain appropriate airway with the ventilation rate not exceeding 12 per minute. The ALS interventions advised paramedics to initiate CPR, to determine the cardiac rhythm, to proceed to appropriate intervention, and to establish an advanced airway when resources are available, with minimal interruption to CPR. Different procedures are outlined depending upon the cardiac rhythm observed.

36. Mitchell testified that respondent violated this protocol because once M.T. went into full cardiac arrest in the ambulance, there was not an appropriate airway and ventilations exceeded 12 per minute. Mitchell testified that respondent violated the ALS interventions section of this protocol because she did not establish an advanced airway. Mitchell testified that once M.T. was in PEA, respondent violated that portion of the ALS protocol because she did not administer an IV, did not administer epinephrine, and did not consider the administration of Atropine.

37. Dr. Vaezazizi testified that there was no deviation from this protocol; it was not involved in this case because the cardiac arrest occurred late in the patient care and M.T. arrived fairly quickly at the hospital after the cardiac arrest.

38. Chief Heiser opined that this protocol was followed. An IV was not established because of the inadequacies related to M.T.'s veins and because an IO was established as they arrived at the hospital. Chief Heiser opined that not every skill attempted by the paramedic will be successful and that the failure to establish an IV in this case was not a deviation. Also, IO on a conscious patient is an uncomfortable procedure and respondent not performing that procedure until M.T. coded and was unconscious was reasonable. While the records suggested that starting an IV may have been a priority, there was "a lot of stuff going on" and there must be prioritization in dealing with emergent circumstances. Thus, Chief Heiser was not critical of the failure to establish an IV.

Allegation of Acting Outside the Supervision of Medical Control

39. Complainant alleged that respondent's failure to follow established protocols constituted acting outside the supervision of medical control (Paragraph 11). The accusation does not cite to any authority for this assertion.

40. Mitchell admitted that Health and Safety Code section 1798, subdivision (a), vests medical control with the local agency's medical director, in this case Dr. Vaezazizi. Mitchell admitted that the medical directors have medical control of their system. Mitchell discussed this call with Dr. Vaezazizi as part of her investigation and she admitted that Dr. Vaezazini advised her that he would have handled the call in the same manner as respondent. Mitchell did not know if Dr. Vaezazizi had conducted a call review when she interviewed him as her discussion with him pertained primarily to the ICEMA protocols.

41. Dr. Vaezazizi defined "medical control" as "our off-line medical control" which includes "my duties and the actual development, research and maintenance of protocols by emergency medical personnel." On cross examination he admitted that medical controls also include the base hospital. Dr. Vaezazizi testified that the review of this matter established nothing to indicate that respondent practiced outside of the medical control established by EMSA. Respondent functioned within the medical control on this call. While there were some deviations from protocols, none of those deviations established that respondent practiced outside of the protocols. Dr. Vaezazizi testified that deviations from the protocols happen on a daily basis. The review concluded that the deviations in this matter did not impact the patient outcome.

Dr. Vaezazizi opined that respondent did not act outside the supervision of medical control based on his review of all the evidence. If he had made that determination, he would have referred the matter to EMSA; however, he did not do so here because he "found no reason to make a referral to EMSA."

42. Chief Heiser opined that there were no significant deviations from any of the protocols. He explained that a deviation from the protocols does not automatically mean that a paramedic has operated outside of medical controls. Paramedics are taught to use their own skills and judgment; it is an "expectation or mandate" that they understand what they are doing when rendering patient care.

Failure to Document Allegation

43. Complainant alleged that respondent failed to adequately or completely document this patient care call in the patient care report as mandated by both California Code of Regulations, title 22, section 100170 (e), and the ICEMA protocols. Complainant alleged that respondent and her intern completed two conflicting Patient Care Reports (PCR) and that respondent prepared a supplemental report 27 days after the incident which contained additional conflicting information.[6]

Mitchell testified that respondent's PCR was inaccurate, untimely and incomplete. Respondent violated the regulations pertaining to record-keeping because the patient's chief complaint was not clearly spelled out and because the emergency care rendered and the patient's response to that treatment were not accurately documented. Respondent did not identify the intern in the documents or indicate what care he provided. Mitchell admitted on cross-examination that nowhere on the AMR computer form was there an area to document the "chief complaint" and that the forms provided to respondent had areas where only minimal information could be supplied. Although Mitchell also testified that the patient disposition was inaccurately documented as the records "just drop off at 14:09," providing no more information of M.T.'s condition, this appeared overreaching as it would not be reasonable to expect a paramedic to continue documenting a patient's condition after transferring that care to hospital personnel.

Mitchell testified that there was information contained in the respondent's supplemental report that was not contained in her computer printout. The purpose of a supplemental report is to provide additional information, not to alter the patient care report after the fact. Mitchell testified that the purpose of the patient report is to provide accurate documentation of what transpired at the scene, that a patient care report is used by emergency rooms as a baseline for how the patient presented and how she is progressing, and is used by counties for obtaining data and by courts to determine the care provided. Mitchell testified that while she was interviewing respondent, respondent advised that they had

---

[6] Respondent admitted during investigation that there were numerous errors due to a new computer program and that she took no steps to correct the errors or handwrite her PCR. Respondent failed to include all treatment rendered to the patient, including failing to document attempts to establish an IV, other entries were erroneous or failed to mention the intern had performed interventions.

attempted to place an IV four times. Mitchell informed respondent that there was no documentation of those attempts to which respondent advised that those attempts were documented in the supplemental report, which was the first time Mitchell learned there was a supplemental report.

44. Respondent testified that after M.T.'s care was transferred, her partner advised respondent to document the case well because she overheard a conversation at the hospital. Respondent attempted to do so. Respondent testified that AMR had just implemented a new electronic record-keeping computer system which was only a few weeks old and that this was the first time respondent had used the system on a critical call. Respondent testified that she was still learning how to use the system, that she was unfamiliar with it, and that it had a series of drop down screens for inputting information which were confusing. Accordingly, respondent hand wrote a supplemental report while she was at the hospital which included information she was unable to input on the computer. Respondent testified that they were getting ready to transport M.T. to another hospital and she wanted all of the information to be available to the next treaters. Respondent turned in all of her documentation, as well as her intern's report, to her AMR supervisor and she informed him of the difficulty she had with the computer program. Respondent was informed one month later that her supplemental report was lost. Her supervisor requested she write another one. Respondent testified that her second supplemental was "substantially the same" as the one she originally wrote. Thus, the supplemental report dated April 27, 2008, which was introduced at hearing, was actually the second supplemental report created by respondent.

On cross-examination, respondent testified that she spent approximately one and one-half hours completing the computer print-out because of her difficulty with the computer. She told her intern to accurately proof his records, but she admitted that she and the intern were being pressured to get out of the hospital as other emergency calls were happening that required AMR's response. Once information was inputted into the computer, respondent was unable to correct any mistakes. Respondent explained that the computer record is erroneous because all of the information is inputted in reverse order with the earlier times containing the later assessments and vice versa. Respondent credibly explained that because of her difficulty working the new computer system, she entered some information incorrectly. The computer print-out corroborated that testimony. Respondent also admitted that the documentation of a "Hand held Nebulizer" was wrong because she used a Medication Nebulizer. Respondent acknowledged that the intern's name was omitted from the document, but she testified that at the time of this call, she was still learning how to input that information on the computer. Respondent credibly explained that other boxes containing wrong information were most likely due to her hitting the wrong computer key.

No evidence was offered to refute respondent's testimony regarding the new computer system. A reading of all of the documents demonstrated that respondent's explanation for the erroneous computer print-out was credible, reasonable, and fully supported by other records and percipient witness testimony.

Respondent testified that the on-board computer set the times for certain events that transpired, i.e. arrival on scene, departure to the hospital. Those times were then sent to the paramedics through a pager system. Respondent explained that she used those times as "landmarks" and from them she estimated the times that other events occurred. That testimony explained why different reports contained different times when care was rendered. Here, the varying times noted in the County Fire, AMR and hospital records provide a perfect example of why recorded times are so problematic; they merely reflect after the fact entries made by the various providers who do their best to recall the times the various treatments took place. It goes without saying, that their first priority is patient care and that caregivers do their best after rendering that care to document what time it was rendered. As seen in these records, different treaters document different times.

45. Chief Heiser testified that he was not surprised by the inconsistencies in the documents related to the times that care was provided because most of the time recordings are done after the fact and based upon a recollection of events; most paramedics care more about sequencing the care and not the exact times care was rendered. Chief Heiser testified that the primary concern is patient care and not after the fact documentation.

Dr. Rudnick's Report

46. A May 30, 2009, memorandum from Eric Rudnick, M.D., F.A.C.E.P., an EMSA consultant, was introduced. Dr. Rudnick reviewed this case, observing it "has been difficult to review, summarize, and come to conclusions based upon the multiple inconsistencies in the detailed summaries. Dr. Rudnick believed that the most accurate accounts were those rendered proximate to the event and that his opinions were based greatly upon the written details provided by the health care providers and not solely the family's accounts.

Dr. Rudnick provided an overview of the care provided. He noted that M.T. had multiple prior emergency department visits and hospitalizations as a result of her chronic illnesses and that she had received between three and eight breathing treatments prior to the arrival of emergency personnel. Observations about cigarette smoke helped explain the conditions in which M.T. lived and the co-morbidities that led to her death. Dr. Rudnick noted that "comments from both sets of care providers do raise the question to how quickly the family recognized that this was not a routine exacerbation of asthma."

Dr. Rudnick detailed the care that was provided. Dr. Rudnick concluded:

> In summary, addressing the question did the paramedics violate the "standard of care" in this case is a difficult question to answer. I don't believe after deliberation that they violated the "standard of care." The providers did not recognize the severity of this patient's illness. This was not gross negligence but a deviation from protocol and an education issue.

Arguments

47. Complainant argued that it had met its burden of proof and requested discipline be imposed.

48. Respondent argued that complainant lacked jurisdiction and was collaterally estopped from prosecuting this matter because the local EMS medical director had concluded that respondent acted in substantial compliance with the ICEMA protocols. That argument is rejected as the statutory scheme permits EMSA to discipline its licensees. Alternatively, respondent also argued that complainant had not met its burden of proof and requested dismissal.

Evaluation

49. Mitchell's opinions regarding respondent's deviations from the standards of care were based upon a strict construction of the language contained in the various protocols. Mitchell's testimony that the protocols were mandates requiring obedience in every instance was not believable. The protocols were replete with the phrases "as clinically indicated or available" and "may," which supported respondent's claim that the protocols were intended to be guidelines to assist paramedics in the field and that they were not intended as absolutes.

The testimony of Dr. Vaezazizi and Chief Heiser regarding the protocols was far more persuasive than Investigator Mitchell's, as was their testimony regarding respondent not deviating from the standards of care. Respondent's witnesses credibly explained that the protocols served as guidelines and that the paramedic's clinical judgment must be a necessary component when providing patient treatment. When there are good reasons to deviate from the protocols, sensible deviations are permissible and do not rise to the level of acting outside the scope of medical controls.

M.T. was a critically ill patient. A "Scoop and Go" and a wild ambulance ride to the hospital ensued very shortly after respondent arrived at the scene. Respondent's decisions were well founded and her clinical judgment was supported by the credible expert testimony. Respondent's witnesses were far more persuasive than complainant's witness, and their believable testimony rendered Mitchell's testimony far less than compelling. Dr. Vaezazizi, who is entrusted by statute to create, review and oversee the implementation of ICEMA protocols, agreed with respondent's decision-making and concluded that no material deviations occurred. His testimony was extremely compelling.

Although there were a few inadequacies and discrepancies in respondent's patient care records, respondent offered viable explanations for those shortcomings. Given the new computer system, the critical nature of this call, and AMR losing her original Supplemental Report, the clear and convincing evidence did not establish a violation.

LEGAL CONCLUSIONS

Purpose of Administrative Discipline

1. Administrative proceedings to revoke, suspend, or impose discipline on a professional license are nonpenal; they are not intended to punish the licensee, but rather to protect the public. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 768.)

The Standard of Proof

2. The standard of proof in an administrative action seeking to suspend or revoke a certificate that requires substantial education, training, and testing is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

3. Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

4. Substantial education, training, and experience is required to apply for a paramedic license in California, and the applicant must pass a nationwide written and practical qualifying examination before licensure; a licensee must meet continuing education requirements after licensure. On this basis, the clear and convincing standard of proof applies in this disciplinary proceeding.

Relevant Statutory Authority

5. Health and Safety Code section 1797.1 provides:

> The Legislature finds and declares that it is the intent of this act to provide the state with a statewide system for emergency medical services by establishing within the Health and Welfare Agency the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state activities concerning emergency medical services.

6. Health and Safety Code section 1797.7 provides for a dual control over paramedic practice in the state and in each local jurisdiction.

7. Health and Safety Code section 1797.42 authorizes paramedics to perform advanced life support services.

8. Health and Safety Code section 1798 authorizes the local EMS authority to develop policies, procedures and protocols.

9. Health and Safety Code section 1798.200 provides in part:

> (b) The authority may deny, suspend, or revoke any EMT-P license issued under this division or may place any EMT-P license holder on probation upon the finding by the director of the occurrence of any of the actions listed in subdivision (c)...
>
> (c) Any of the following actions shall be considered evidence of a threat to the public health and safety and may result in the . . . suspension, or revocation of a certificate or license issued under this division, or in the placement on probation of a certificate or license holder under this division:
>
> [¶] . . . [¶]
>
> (7) Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.
>
> [¶] . . . [¶]
>
> (10) Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification. . . ."

Applicable Regulations

10. California Code of Regulations, title 22, section 100136, defines the Quality Improvement Program (QIP) as the "methods of evaluation that are composed of structure, process, and outcome evaluation which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care."

11. California Code of Regulations, title 22, section 100144, provides that the local EMS agency shall be responsible for enforcing standards, regulations, policies and procedures.

12. California Code of Regulations, title 22, section 100145, outline a paramedic's scope of practice.

13. California Code of Regulations, title 22, section 100147, provides that the local EMS agency that authorizes an advanced life support program shall establish policies and procedures approved by the medical director of the local EMS agency that shall include revocation, suspension and monitoring of paramedic service providers, assurance of compliance with provisions of this chapter, and the development, implement meditation and enforcement of policies for medical control, medical accountability and quality improvement program of the paramedic services.

14. California Code of Regulations, title 22, section 100169, provides that the medical director of the local EMS agency shall establish and maintain medical control in several ways, including prospectively by developing written medical policies and procedures which shall include treatment protocols encompassing the paramedic scope of practice and requirements for initiating, completing, reviewing, evaluating and retaining patient care records. Retrospectively the medical director is required to provide an organized evaluation and continuing education for paramedic personnel.

15. California Code of Regulations, title 22, section 100170, governs the recordkeeping requirements and provides that the paramedic is responsible for accurately completing the patient care record which shall contain information about the patient, a chief complaint, the emergency care rendered and the patient's response to that treatment, the patient disposition and the name(s) and unique identifier number(s) of the paramedics. A local EMS agency that utilizes electronic means of collecting and storing the information contained in the patient care record shall establish policies for the collection, utilization and storage of such data.

16. California Code of Regulations, title 22, section 100174, provides:

> (a) For the purposes of denial, placement on probation, suspension, or revocation, of a license, pursuant to Section 1798.200 of the Health and Safety Code, or imposing an administrative fine pursuant to Section 1798.210 of the Health and Safety Code, a crime or act shall be substantially related to the qualifications, functions and/or duties of a person holding a paramedic license under Division 2.5 of the Health and Safety Code. A crime or act shall be considered to be substantially related to the qualifications, functions, or duties of a paramedic if to a substantial degree it evidences present or potential unfitness of a paramedic to

> perform the functions authorized by her/his license in a manner consistent with the public health and safety...

17. California Code of Regulations, title 22, section 100175 provides that when considering discipline, the EMS Authority shall consider rehabilitation criteria which includes the nature and severity of the act, evidence of any subsequent acts, the time elapsed since the commission of the act, and any evidence of rehabilitation.

Cause Does Not Exist to Impose Discipline

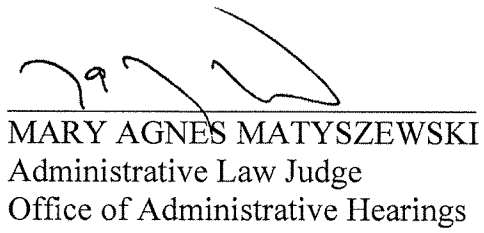
18. Cause does not exist to impose any discipline under Health and Safety Code section 1798.200, subdivision (c)(7). The clear and convincing evidence did not establish that respondent violated any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel

19. Cause does not exist to impose any discipline under Health and Safety Code section 1798.200, subdivision (c)(10). The clear and convincing evidence did not establish that respondent functioned outside the supervision of medical control.

ORDER

The Accusation in Case No. 08-0200 filed against Lynn Thompson-Northey, Emergency Medical Technician-Paramedic License No. P22489 is dismissed.

DATED: February 13, 2012



MARY AGNES MATYSZEWSKI
Administrative Law Judge
Office of Administrative Hearings

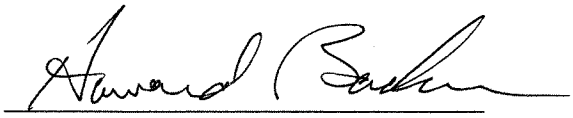
BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

In the Matter of the Emergency Medical Technician-Paramedic License Held by: LYNN THOMPSON-NORTHEY, License No. P22489 Respondent.	Case No. 08-0200 OAH No. 2010060536

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the EMSA as its Decision in the above-entitled matter.

This Decision shall become effective 3/21/2012.

IT IS SO ORDERED.

Date: Feb 21, 2012