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BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

In the Matter of the Emergency Medical
Technician- Paramedic License of:

) Enforcement Matter No.: 15-0124
) OAH No.: 2016040426

NICHOLAS FERRARI
License No. P30435

) **DECISION AND ORDER**

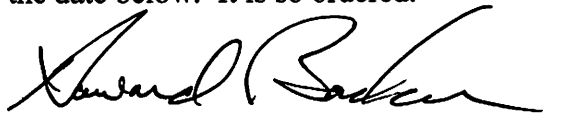
) Respondent.
)
)

The attached Proposed Decision is hereby adopted by the Emergency Medical Services
Authority as its Decision in this matter.

This decision shall become effective 30 days after the date below. It is so ordered.

DATED:

11/17/2016



Howard Backer MD, MPH

Director

Emergency Medical Services Authority

BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

In the Matter of the Accusation Against the
Emergency Medical Technician-Paramedic
License Held by:

NICHOLAS FERRARI,
License No. P30435,

Respondent.

Case No. 15-0124

OAH No. 2016040426

PROPOSED DECISION

This matter was heard before Tiffany L. King, Administrative Law Judge, Office of Administrative Hearings, State of California, on October 11, 2016, in Sacramento, California.

Stephen J. Egan, Senior Staff Counsel, Retired Annuitant, represented Sean Trask (complainant) in his official capacity as the Chief of Emergency Medical Services (EMS) Personnel Division for the Emergency Medical Services Authority (EMSA).

Joe Rose, Attorney at Law, Rose Law APC, represented Nicholas Ferrari (respondent), who was also present.

Evidence was received, the record was closed, and the matter was submitted for decision on October 11, 2016.

FACTUAL FINDINGS

1. On November 2, 2015, complainant, in his official capacity, issued and served the instant Accusation on respondent. Respondent timely requested a hearing pursuant to Government Code section 11505.

2. At all times relevant to the allegations in the Accusation, respondent was a California licensed paramedic employed by American Medical Response (AMR) in San Mateo County, California. EMSA first issued Emergency Medical Technician – Paramedic (EMT-P) license number P30435 to respondent on December 7, 2011. His license is valid through December 31, 2016.

3. AMR operates the advanced life support (ALS) program in San Mateo County under the medical direction and management of the San Mateo EMS Agency (SMEMSA). As a local EMS agency, SMEMSA is statutorily mandated to establish policies and protocols that govern and assure medical control of the San Mateo County's emergency medical services system, according to state standards. (Health & Saf. Code, § 1797.220; Cal. Code Regs., tit. 22, § 100170.¹) In compliance with the enabling statutes and regulations, SMEMSA adopted policies that define and govern the roles, responsibilities, and scope of practice of accredited prehospital responders employed by approved EMS providers such as AMR.

4. Complainant seeks to revoke respondent's license based upon allegations that respondent failed to follow established policies and treatment protocols during the course of responding to an emergency call on October 21, 2014. Specifically, complainant alleges respondent was grossly negligent and incompetent when he removed cervical spine (c-spine) precautions from a trauma patient and did not transport the patient to a trauma center as required by the local protocol, and thereby violated SMEMSA protocols and thereby functioned outside the supervision of a local medical control.

SMEMSA Protocols

5. SMEMSA Operations 22 (Trauma Triage) provides, in relevant part:

1. Triage Criteria for Identifying Major Trauma Victims – See attached algorithm

1.1 Patients identified, by the paramedic, as a major trauma victim shall be directed to a trauma receiving hospital approved as a part of the San Mateo County Trauma Plan. (San Francisco General Hospital and Stanford University Hospital [Stanford])

1.2 If there is any question as to the trauma status of the patient, the paramedic should consult with the TRAUMA RECEIVING HOSPITAL as early as possible in the patient's evaluation

1.3 The paramedic will use the following criteria to identify the major trauma victim

[¶] ... [¶]

1.3.4 Mechanism of Injury: Adult and Pediatric

[¶] ... [¶]

¹ Unless otherwise noted, all statutory references are to the Health and Safety Code.

1.3.4.3 Auto-pedestrian/auto-bicycle/Motorcycle

1.3.4.3.1 Thrown or run over

1.3.4.3.2 Obvious injury

1.3.4.3.3 Complaint of pain or injury

[¶] ... [¶]

5.1 The paramedic will notify the trauma center or receiving hospital as soon as possible via radio

6. SMEMSA Operations 22-a, (Trauma System and Patient Destination), provides that Stanford is the designated trauma center for the Redwood City area. It further provides, in relevant part:

2.3 Transportation of a trauma patient to a non-trauma hospital should only be done if the patient has an unmanageable airway

2.4 Patients who do not meet major trauma criteria may be transported to the nearest available receiving hospital

[¶] ... [¶]

7.1 The on-duty field supervisor shall be notified immediately after the call if any of the following occur:

7.1.1 Any patient identified as a major trauma victim that is not transported to a trauma center

7. SMEMSA Procedure 1(Spinal Immobilization) provides, in relevant part:

1. Indication

1.1 Patients who sustain a mechanism of injury sufficient to produce spinal trauma who do not meet exclusion criteria.

1.2 Patient with complaint of pain in the spine or neurological deficit

1.3 Once the patient is placed in spinal immobilization it should be continued until transfer of care to the receiving hospital.

2. Exclusion Criteria: the need for spinal immobilization in the prehospital setting may be deferred for patients who demonstrate ALL of the following findings on paramedic assessment:
 - 2.1 Absence of tenderness at the posterior midline of the cervical spine
 - 2.2 Absence of focal neurological deficit
 - 2.3 Normal level of alertness
 - 2.4 The ability to communicate well to paramedic independently or through an interpreter
 - 2.5 No evidence of intoxication or impairment due to drugs or alcohol
 - 2.6 No clinically apparent painful injury that might distract them from the pain of a spinal injury

October 21, 2014, Incident

8. On October 21, 2014, respondent was dispatched to a school parking lot in Redwood City where a 14-year old boy (patient) had been struck by a vehicle. Paramedics from the Redwood City Fire Department also responded to the emergency call and were the first to arrive on the scene. Upon arrival, the fire paramedics observed the patient lying supine on the pavement. He was awake, alert and oriented. The patient stated that, as he was crossing the parking lot, he was struck by a vehicle traveling at a mild to moderate speed. The fire paramedics noted the patient had experienced a loss of consciousness as he could not recall what happened after he was struck by the vehicle. They also noted the patient had a “loss of shoe upon impact” and that he “had a large hematoma to the back of his head, [but] negative active bleeding.” The fire paramedics placed the patient in full c-spine precautions.²

9. When respondent arrived on the scene a few minutes later, he observed the patient in full c-spine precautions. One of the fire paramedics reported to respondent that the patient was alert and oriented, and that he had a hematoma with abrasion to the left occipital area. Respondent could not verify the hematoma due to the patient’s placement in full c-spine. The patient did not complain of neck or back pain, numbness, or tingling. The fire paramedic did not mention the patient’s loss of shoe nor did respondent notice his shoe was absent. The supervising fire captain asked respondent if the patient would be transported to Stanford, a trauma center. Respondent replied that he would conduct a further assessment

² “Full c-spine precautions” include laying the patient in the supine position and strapped on a long backboard, applying a C-collar to immobilize the neck, and taping the head and neck to the backboard.

and wait until the patient's parents arrived on the scene. The patient was then moved to the back of the ambulance.

10. In the ambulance, respondent conducted a further assessment. Respondent removed the tape from the patient's neck and head, opened the jump seat, and sat down at the patient's head. Respondent placed the patient's head between his knees, opened the cervical-collar (c-collar), and held the patient's neck in manual c-spine. The patient did not complain of pain upon palpation of the c-spine under the collar or upper back. The patient remained alert and oriented. He complained of mild pain at the back of his head, but did not exhibit any other outward signs of trauma. He denied having blurred vision or nausea.

11. Throughout the assessment, respondent asked the patient several times what had happened. The patient responded consistently that he did not recall being struck by the vehicle, but recalled his head hitting the pavement and the events thereafter. The patient's mother arrived on the scene and requested the patient be transported to Sequoia Hospital as he had been treated previously there and it was closer, approximately 16 minutes from the scene. Respondent directed the ambulance driver to go to Sequoia Hospital, a non-trauma center.

12. En route, respondent palpated the back of the patient's neck. The patient complained of nausea and expressed a need to vomit. Respondent could not roll the patient to his side as such a maneuver required two people and he was by himself. Instead, respondent unclipped the chest strap, continued to hold the patient's head in c-spine and lifted him to a sitting position. The patient vomited once, after which he stated he felt better in the sitting position. Respondent unstrapped the patient's legs, slid the backboard out and turned the gurney up so he could remain in the sitting position. Respondent re-examined the patient and noted a "moderate hematoma ... but no crepitus"³ at the back of the head.

13. As they got closer to the hospital, respondent noted the patient was "more lethargic and slower to respond with concussion symptoms." When they arrived at Sequoia Hospital's emergency room (ER), the attending ER physician was upset that the patient had been transported to Sequoia Hospital prior to a computerized tomography (CT) scan being performed. Sequoia Hospital staff performed a CT scan which revealed the patient had a "small bleed." Thereafter, the patient was transferred to Stanford. There was no evidence that the patient suffered any injury caused by respondent's actions.

Review of October 21, 2014, Incident by S MEMSA

14. In early November 2014, Sequoia Hospital contacted AMR to report the October 21, 2014 incident and complain about respondent's patient care and decision to

³ The Merriam-Webster online medical dictionary defines "crepitus" as "spondylolisthesis" as "a grating or crackling sound or sensation (as that produced by the fractured ends of a bone moving against each other or as that in tissues affected with gas gangrene)." ([http://www.merriam-webster.com/medical/crepitation.](http://www.merriam-webster.com/medical/crepitation))

transport the patient to a non-trauma center. AMR Clinical Manager, Kevin T. Miller, EMT-P, notified SMEMSA of the complaint and initiated an investigation.

15. On or about November 17, 2014, respondent was interviewed by Mr. Miller, SMEMSA Clinical Services Manager Jan Ogar, and SMEMSA Medical Director Greg Gilbert, M.D. They discussed the October 21, 2014 incident. Dr. Gilbert also discussed the risks of closed head injuries, especially in younger patients. He gave the example of Natasha Richardson, an actress who died from an undetected closed head injury, which she sustained from a skiing accident. Dr. Gilbert had had prior interactions with respondent in which they had disagreed on how to assess a patient and the appropriate transport procedure. At the November 17, 2014 meeting, Dr. Gilbert was particularly critical of respondent's handling of the October 21, 2014 incident and what Dr. Gilbert considered to be a lack of understanding on respondent's part.

16. Following the meeting, SMEMSA concluded that respondent lacked sufficient knowledge of SMEMSA's protocols for trauma triage, clinical deficits with patient assessment, spinal immobilization, and general patient care. Respondent was required to take an exam on SMEMSA protocols, which he passed with a score of 86 percent. AMR and SMEMSA also determined that a Clinical Education Assignment (CEA) was appropriate to improve respondent's understanding of SMEMSA protocols and to ensure he applies those policies consistently to all of his trauma patients.

17. Mr. Miller reviewed the CEA with respondent on January 28, 2015. It directed respondent to complete several exercises, including (1) a 500-word essay outlining his understanding of a clinical scenario, which was to be provided, (2) a 250-word essay outlining his patient assessment technique as it applies to a clinical scenario, which was to be provided, (3) a 1000-word essay on the Natasha Richardson case and what occurred leading to her death, (4) an ITLS⁴ Provider Course on a date to be determined, and (5) eight shifts with an AMR field training officer. Mr. Miller did not provide the clinical scenarios to respondent when they met on January 28, 2015. Respondent was to complete each of the assignments by March 19, 2015. The CEA further provided,

If the exercises are determined to be unsuccessful, not meeting the objectives outlined in this CEA, further education and improvement may be determined as this educational plan may be revised or halted.

Respondent signed the CEA after reviewing and agreeing to the following:

I have participated in the development of the above [CEA], have read it thoroughly, and understand its contents. I further understand that it is my personal responsibility to ensure I

⁴ ITLS is an acronym for International Trauma Life Support.

complete all components of this CEA and failure to comply with any or all of the requirements set forth in this CEA may result in this matter being turned over to AMR Operations for disciplinary action, up to and including termination of [my] employment with [AMR], and the [SMEMSA] for referral to the California State EMS Authority for action against [my] Paramedic License.

18. On February 26, 2015, Mr. Miller emailed respondent a reminder that the CEA assignments were due on March 19, 2015. On March 17, 2015, respondent emailed Mr. Miller to request an extension of time to complete the assignments due to his busy schedule. Mr. Miller agreed to extend the due date by one week, to March 26, 2015.

19. After receiving the extension, respondent took an impromptu trip to Bali to “take a break” and “hammer out” the CEA assignments without any distractions. When he arrived in Bali, respondent completed the Natasha Richardson assignment. However, he realized he did not have the clinical scenarios to complete the other CEA exercises. On March 26, 2015, at 7:41 p.m. (PST),⁵ respondent emailed Mr. Miller to inquire about the clinical scenarios and also request another extension. He did not receive a response.

20. On March 30, 2015, AMR placed respondent on unpaid administrative leave, pending further investigation of his failure to complete the CEA exercises. On or about April 24, 2015, SMEMSA suspended respondent’s accreditation for San Mateo County and referred the matter to EMSA for recommended disciplinary action.

21. On May 9, 2015, respondent resigned from his employment with AMR. In his email, he noted the reason for his resignation was that he had accepted an international paramedic position in Iraq.

Expert Witness

22. At hearing, complainant called Dr. Gilbert, who testified as a percipient witness and an expert in EMS. Dr. Gilbert is board-certified in emergency medicine. He is a clinical associate professor of EMS at Stanford University and the EMS Medical Director for SMEMSA. Dr. Gilbert is familiar with, and is the approving authority for SMEMSA’s protocols governing the conduct of paramedics, including the Trauma Triage, Trauma System and Patient Destination, and Spinal Immobilization protocols, each of which were in effect at the time of incident.

⁵ PST stands for Pacific Standard Time. The email is dated March 27, 2015 at 11:41 a.m., which represents the Bali time when respondent sent the email. Bali is 16 hours ahead of California, meaning the email was sent on March 26, 2015, at 7:41 p.m. PST.

23. Dr. Gilbert reviewed the Patient Care Report prepared by the Redwood City Fire Department, the Department's 911 dispatch log, the Pre-Hospital Care report prepared by respondent, and was familiar with the October 21, 2014 incident, SMEMSA's investigation of the incident, and the CEA requirements imposed on respondent.

24. Dr. Gilbert testified that respondent violated the protocols for Trauma Triage and Trauma System and Patient Destination when he did not recognize the patient met the major trauma criteria, failed to transport him to the designated trauma center, Stanford, and failed to notify Stanford or the on-field supervisor that he was transporting the patient to Sequoia Hospital instead. Dr. Gilbert noted that the patient met the trauma criteria because he was a minor in a pedestrian-motor vehicle accident which resulted in an obvious injury – i.e., the hematoma at the back of the patient's head – and the patient complained of mild pain. Dr. Gilbert also asserted the patient had been "launched" from his shoe, which indicated the vehicle had struck him with significant force. Because he met the major trauma criteria, the patient should have been transported to a trauma center to rule out an intracranial injury. According to Dr. Gilbert, respondent also violated the Spinal Immobilization protocol by removing the c-spine precautions and backboard from the patient before he was transferred to the receiving hospital. Dr. Gilbert testified that respondent should have turned the patient on his side when he indicated he had to vomit. If a second person was not available to assist respondent in turning the patient on his side, respondent should have let the patient vomit in the supine position and suctioned the vomit out of his mouth. Under no circumstance, opined Dr. Gilbert, should respondent have removed the c-spine precautions to allow the patient to vomit.

25. Dr. Gilbert opined that respondent's deviation from the SMEMSA protocols in this single instance was a "serious error" and constituted gross negligence. He further opined that respondent's failure to complete the CEA assignments, which were intended to address respondent's deficiencies, warranted his dismissal from employment and demonstrated that respondent would pose a threat to public health and safety should he maintain his paramedic license. When questioned about the essay scenarios which had not been provided, Dr. Gilbert answered that the scenario was the incident in question and there was nothing further to be provided. Although not discussed at the meeting, he expected respondent to understand this. Lastly, Dr. Gilbert believed respondent was not interested in completing the CEA assignments because he already had plans to leave for Iraq.

Respondent's Evidence

26. Respondent was first hired by AMR, San Mateo Operation, as an Emergency Medical Technician (EMT) in February 2009. He attended the Paramedic Academy at the National College of Technical Instruction from July 2009 to August 2011. He promoted to paramedic shortly thereafter, completing his clinical internship at Kaiser Permanente and his field internship with AMR, both in Oakland, California. In addition to his AMR job, respondent has volunteered as a medic on several domestic and international projects. In early 2012, respondent was a medic volunteer for the Sister Freda Medical Center in Kenya. From May 2012 to the present, he has volunteered as a medic and team lead for several

projects with Team Rubicon including a refugee camp in South Sudan and response team to Hurricane Sandy. From May 2015 to May 2016, respondent served as an EMT-P for the State Department, Diplomatic Support Hospital in Baghdad, Iraq. He is also certified in Tactical Combat Casualty Care (TCCC) and has served as a lead instructor for a TCCC course to the Peshmerga military force in Kurdistan.

27. Respondent testified regarding the October 21, 2014 incident. Upon his arrival at the scene, he observed the patient was alert and oriented and complained only of minor head pain. The fire paramedic had reported to respondent that the vehicle had been traveling at approximately 5 miles per hour (mph) at the time of impact, and that the patient was alert and oriented and had no loss of consciousness. Although the fire paramedic advised the patient had a hematoma at the back of his head, respondent could not see the injury due to the c-spine precautions. When respondent conducted his own assessment of the patient in the ambulance, the patient appeared alert and oriented, did not complain of neck or back pain or nausea, or demonstrate any other neurological deficits. Based on these factors, at the time, respondent did not believe the patient satisfied the major trauma criteria set forth in the Trauma Triage protocol and there was no requirement to transport him to Stanford. However, in an email to EMSA investigator Nicole Walker, dated April 27, 2015, respondent admitted “that after everything was said and done, especially with noted CT findings, the [patient] would have been better served being seen initially at [Stanford]... .”

28. Regarding removal of the c-spine precautions, respondent asserted that it was unorthodox but necessary to allow the patient to vomit. He argued that allowing the patient to vomit while remaining in the supine position, he would have vomited all over himself thereby creating a risk of choking and restricting his airway – a “worst case” scenario as respondent was taught in school. Although there was a suction device on the ambulance, it would only remove any fluid and was insufficient to remove any chunks in the vomit which would have to be removed by hand. Respondent also admitted that unstrapping the patient’s legs from the backboard to allow him to sit up was unorthodox but nonetheless within his discretion as a paramedic to do so. Respondent considered the spinal immobilization protocol in Procedure-1 and believed the patient met all the exclusionary criteria to warrant his removal from the c-spine precautions. Finally, respondent testified he did not believe the patient should have been placed in c-spine precautions in the first place.

29. Respondent admitted he did not complete the CEA assignments as directed. At the time, he was working full-time shifts for AMR and as the California field operations coordinator for Team Rubicon. He was also preparing for his travel to Iraq. Respondent tried to work on the assignments when he could, but requested an extension when he realized he could not complete them on time. After being granted a one-week extension, respondent realized he “was stretched out too thin” and needed to take time off to sequester himself and allow him to focus on the CEA assignments. He bought a ticket to Bali, requiring three days of travel before he reached his destination. Once in Bali, he nearly completed the Natasha Richardson essay and realized for the first time that the scenarios were not attached to the CEA. He attempted to contact Mr. Miller regarding the scenarios, but had limited wireless access in Bali.

30. Respondent believed he would be given a different assignment if he did not complete the CEA assignments on time. Notwithstanding the admonition contained in the CEA, which he reviewed prior to signing it, respondent did not believe his failure to complete the CEA assignments on time would result in his loss of accreditation or other disciplinary action.

31. Respondent testified credibly that he learned from the October 21, 2014, incident. Specifically, he learned that protocols are in place because things can happen which the paramedic does not anticipate, and that it is better to err on the side of caution. If his paramedic license is revoked, respondent “would lose everything” as he is required to maintain a license from his home of record to work as a medic internationally.

32. Respondent submitted four character reference letters from his supervisors and coworkers at the Diplomatic Support Hospital in Baghdad, Iraq:

- (a) Catherine A. Gill, M.D., is a Captain in the Medical Corp for the U.S. Army and the assigned military physician at the Diplomatic Support Hospital. She has worked with respondent to provide medical care to more than 100 patients, and considers him “to be reliable, knowledgeable, and highly skilled when it comes to his clinical acumen.” She continued, “he demonstrates a superior level of professionalism as a medic and our patients have repeatedly voiced appreciation for his involvement in their care.”
- (b) William Lange, M.D. is the Chief Medical Officer for the Diplomatic Support Hospital where he worked with respondent for approximately six months. In his letter, Dr. Lange characterized respondent’s skill set and knowledge base as “outstanding” and noted he has “never had occasion to question his competence as a medical provider.” Dr. Lange “would not hesitate to hire respondent again in the future and would have no issues with him caring for any of [his] family members.”
- (c) David Cammarano, Registered Nurse (RN), is the RN Nurse Lead and Director of Nursing for the Diplomatic Support Hospital. RN Cammarano worked “side by side” with respondent for several months, and witnessed respondent “seamlessly triage, treat, and hand off ... patients to other agencies both civilian and military (sometimes multinational).” She described his triage skills as “impeccable.”
- (d) David S. Tarnstaffl is the Paramedic Lead for the hospital and was respondent’s supervisor during his tenure there. Mr. Tarnstaffl described respondent as a “hardworking and knowledgeable paramedic.” He also wrote that he “cannot conceive of [respondent] ever being a threat to patient safety or negligent in any way.” Mr. Tarnstaffl also praised respondent as a strong patient advocate who is professional and compassionate.

Discussion

33. Respondent violated the Trauma Triage and Trauma System and Patient Destination protocols when, on October 21, 2014, he failed to treat the patient involved in a vehicle-pedestrian accident as a major trauma victim. Respondent's explanation regarding why he did not consider the patient to be a major trauma victim was not persuasive. Upon arrival at the scene, respondent was advised the patient had a hematoma at the back of his head, an "obvious injury" which satisfies the major trauma criteria. That respondent could not visually confirm the hematoma due to the patient being in c-spine precautions is irrelevant; he had no reason to disbelieve the fire paramedic who responded to the scene first. Respondent was then asked by the fire captain if he was transporting the patient to Stanford, an indication the fire captain believed the major trauma protocol applied. The request by the patient's mother to have the patient transported to Sequoia Hospital instead does not relieve respondent of his obligation to treat the patient as a major trauma victim. Respondent did not explain to the mother the risks of a possible intracranial injury or have her talk to the trauma physician so that she could make an informed decision before refusing the transport to Stanford. Finally, even if respondent did not initially recognize the patient met the major trauma criteria, he should have realized it once the patient became more lethargic and exhibited concussion-like symptoms during the transport to Sequoia Hospital.

34. The propriety of respondent's actions in removing the c-spine precautions and unstrapping the patient from the backboard is less clear. In a non-major trauma situation, his explanation regarding why he sat the patient up to vomit would appear reasonable under the circumstances. Respondent was the only paramedic in the back of the ambulance and could not lift the patient and backboard onto the side by himself. Furthermore, the Spinal Immobilization protocol states that once a patient placed in spinal immobilization, "*it should be continued until transfer of care is to the receiving hospital.*" (Italics added). The use of word "should" instead of "shall" suggests maintaining spinal immobilization is not mandatory but rather is left to the discretion of the treating paramedic.

However, as discussed in the Factual Finding 33, respondent should have recognized that the patient met the major trauma criteria and that removing him from the c-spine precautions, which the fire paramedic had deemed necessary, would create a risk of greater injury to the head, neck and spine. Though respondent did not believe having the patient vomit while in the supine position was ideal, it was the available option which respondent should have exercised. His decision to remove the patient from the c-spine precautions instead was not reasonable.

35. It was not established, as alleged in the First Cause for Discipline, that respondent was guilty of gross negligence. "Gross negligence" is defined as "[a]n extreme departure from the standard of care which, under similar circumstances would have ordinarily been exercised by a reasonably prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties if confronted with a similar

circumstance.”⁶ While respondent exercised poor judgment during the incident, his actions did not rise to the level of an “extreme departure from the standard of care.” Dr. Gilbert’s testimony that respondent’s removal of the c-spine precautions and failure to treat the patient as a major trauma victim constitute gross negligence was not persuasive. First, Dr. Gilbert was involved in SMEMSA’s review of the incident and ultimate suspension of respondent’s accreditation. Indeed, he testified he thought respondent’s accreditation should have been revoked immediately after the November 10, 2014 meeting, rather than give respondent a CEA to educate respondent. Second, Dr. Gilbert’s opinion was based, in part, on his assumptions that the patient had been struck with sufficient force by the vehicle as to cause him to be “thrown from his shoe.” However, Dr. Gilbert was not present during the incident and none of the reports he reviewed support his assumption the patient was “thrown from his shoe.” He also admitted he had been unaware that respondent was the only person in the back of the ambulance with the patient. Finally, at hearing, Dr. Gilbert exhibited an obvious bias against respondent that was based not only upon the subject incident but also his prior interactions with respondent. He admitted he was “angry” and “appalled” during the SMEMSA meeting with respondent to discuss the incident. Dr. Gilbert seemed to take personal offense to respondent, asserting “I felt I had been nice to him before this [incident]”, and his belief that respondent “blew off” the CEA because he was preparing to leave for Iraq. When considering these factors as a whole, Dr. Gilbert’s opinion that respondent was grossly negligent was neither objective nor credible.

36. It was also not established, as alleged in the First Cause for Discipline, that respondent was guilty of incompetence. The EMS Guidelines define “incompetence” to mean: “The lack of possession of that degree of knowledge, skill, and ability ordinarily possessed and exercised by a licensed and accredited paramedic.” Incompetence generally refers to an absence of qualification, ability or fitness to perform a specific professional function or duty. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040; *Pollack v Kinder* (1978) 85 Cal.App.3d 833.) Complainant’s sole witness, Dr. Gilbert, did not testify that respondent’s actions on October 21, 2014, constituted incompetence as defined by EMSA.⁷ Therefore, this allegation was not established.

37. It was established, as alleged in the Second Cause for Discipline, that respondent violated the Trauma Triage and Trauma System and Patient Destination protocols. By violating said protocols, respondent functioned outside the supervision of medical control in the field system operating at the local level.

⁶ This definition is derived from the EMSA’s Recommended Guidelines for Disciplinary Orders and Conditions of Probation (eff. July 26, 2008) (hereafter, “Guidelines”), which are incorporated as regulations. (Cal. Code Regs., tit.22, § 100173.)

⁷ License disciplinary cases heard under the California Administrative Procedure Act require expert testimony where the professional significance of underlying facts seems beyond lay comprehension. (*Franz v. Board of Medical Quality Assurance* (1982) 31 Cal.3d 124, 141.)

Disciplinary Guidelines

38. The EMSA Guidelines provide that the following relevant factors may be considered in determining the measure of discipline to be imposed:

1. Nature and severity of the act(s), offense(s), or crime(s) under consideration;
2. Actual or potential harm to the public;
3. Actual or potential harm to any patient;
4. Prior disciplinary record;
5. Prior warnings on record or prior remediation;
6. Number and/or variety of current violations;
7. Aggravating evidence;
8. Mitigating evidence;
9. Rehabilitation evidence ;
- [¶] ... [¶]
12. Time that has elapsed since the act(s) or offense(s) occurred.

In determining an appropriate suspension period, EMSA or an administrative law judge may give credit for a suspension term imposed by a respondent's employer.

39. Under the Guidelines, 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, carries a maximum disciplinary recommendation of revocation and a minimum disciplinary recommendation of revocation, stayed, one year probation with minimum terms and conditions of probation and the completion of an Ethics course and the completion of an oral skills examination.

40. Alternatively, the Guidelines provide that an administrative fine of up to \$2,500 per violation may be imposed on any licensed paramedic found to have committed any of the actions described in section 1798.200, subdivision (c). The Guidelines further provide: "The administrative fine may not be imposed in conjunction with a suspension for the same violation, but may be imposed in conjunction with probation for the same violation

except when the conditions of the probation require a paramedic's personal time or expense for training, clinical observation, or related corrective instruction."

LEGAL CONCLUSIONS

1. Complainant bears the burden of proving the allegations in the Accusation. 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.) 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.)

2. It is well-settled that the trier of fact may accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted. (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67 [citations omitted].) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Nevarov v. Caldwell* (1958) 161 Cal. App.2d 762, 777.) Moreover, the trier of fact may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) The testimony of "one credible witness may constitute substantial evidence." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.)

3. Section 1798.200 provides in relevant part:

(b) The authority may deny, suspend, or revoke any EMT-P license issued under this division, or may place any EMT-P license issued under this division, or may place any EMT-P licenseholder 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 denial, suspension, or revocation of a certificate or license issued under this division, or in the placement on probation of a certificate holder or licenseholder under this division:

[¶] ... [¶]

(2) Gross negligence.

[¶] ... [¶]

(4) Incompetence.

[¶] ... [¶]

(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

4. Section 1798.210 provides:

(a) The authority may impose an administrative fine of up to two thousand five hundred dollars (\$2,500) per violation on any licensed paramedic found to have committed any of the actions described by subdivision (b) of Section 1798.200 that did not result in actual harm to a patient. Fines may not be imposed if a paramedic has previously been disciplined by the authority for any other act committed within the immediately preceding five-year period.

(b) The authority shall adopt regulations establishing an administrative fine structure, taking into account the nature and gravity of the violation. The administrative fine shall not be imposed in conjunction with a suspension for the same violation, but may be imposed in conjunction with probation for the same violation except when the conditions of the probation require a paramedic's personal time or expense for training, clinical observation, or related corrective instruction.

(c) In assessing the fine, the authority shall give due consideration to the appropriateness of the amount of the fine with respect to factors that include the gravity of the violation, the good faith of the paramedic, the history of previous violations, any discipline imposed by the paramedic's employer for the same occurrence of that conduct, as reported pursuant to Section 1799.112, and the totality of the discipline to be imposed. The imposition of the fine shall be subject to the

administrative adjudication provisions set forth in Chapter 5 (commencing with Section 11500 of Part 1 of Division 3 of Title 2 of the Government Code.

(d) If a paramedic does not pay the administrative fine imposed by the authority and chooses not to renew his or her license, the authority may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the authority may have to require a paramedic to pay costs.

(e) In any action for collection of an administrative fine, proof of the authority's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(f)(1) Except as provided in paragraph (2), the authority shall not license or renew the license of any paramedic who has failed to pay an administrative fine ordered under this section.

(2) The authority may, in its discretion, conditionally license or renew for a maximum of one year the license of any paramedic who demonstrates financial hardship and who enters into a formal agreement with the authority to reimburse the authority within that one-year period for the unpaid fine.

(g) All funds recovered under this section shall be deposited into the state General Fund.

(h) Nothing in this section shall preclude the authority from imposing an administrative fine in any stipulated settlement.

(i) For purposes of this section, 'licensed paramedic' includes a paramedic whose license has lapsed or has been surrendered."

5. Health & Safety Code section 1798.211 provides:

When making a decision regarding a disciplinary action pursuant to Section 1798.200 or Section 1798.210, the authority, and when applicable the administrative law judge, shall give credit for discipline imposed by the employer and for any immediate suspension imposed by the local EMS agency for the same conduct.

Causes for Discipline

6. No cause for disciplinary action exists under section 1798.200, subdivisions (b) and (c), subsections (2) and (4), by reason of the matters set forth in Factual Findings 5 through 13, and 33 through 36. It was not established by clear and convincing evidence that respondent's conduct constituted either gross negligence or incompetence.

7. No cause for disciplinary action exists under section 1798.200, subdivisions (b) and (c), subsection (7). It was not established by clear and convincing evidence that respondent violated, attempted to violate, or assisted another to violate any EMSA statute or regulation pertaining to prehospital personnel, based upon the Factual Findings as a whole.

8. Cause for disciplinary action exists under section 1798.200, subdivisions (b) and (c), subsection (10). By reason of the matters set forth in Factual Findings 5 through 13, and 33 and 37, clear and convincing evidence established that respondent violated applicable SMEMSA protocols and functioned outside the supervision of medical control.

Appropriate Discipline

9. The matters set forth in the Factual Findings and Legal Conclusions have been considered. Respondent is an experienced and skilled EMT-P, who has a passion for his work and has provided important EMT-P services to the public, both domestically and internationally. Respondent committed errors on October 21, 2014, when he failed to recognize the patient met the major trauma criteria and did not transport the patient to Stanford. He recognized these errors in his April 27, 2015, email to the EMSA investigator. At hearing, he asserted he had learned a valuable lesson from the subject incident. (See, *Seide v. Committee of Bar Examiners of the State Bar of California* (1989) 49 Cal.3d 933, 940 ["Fully acknowledging the wrongfulness of his actions is an essential step towards rehabilitation."].) The incident occurred more than two years ago. Thereafter, respondent served as a paramedic in Iraq, where he earned the respect and praise of both his coworkers and supervisors.

10. Respondent has no prior discipline and there was no evidence that the patient involved in the October 21, 2014 incident suffered actual harm from respondent's actions. Respondent's accreditation was suspended by SMEMSA in April 2015, and thereafter, respondent resigned from his position at AMR. Considering the evidence as a whole, an administrative fine in lieu of probation, suspension or revocation is appropriate.

11. The EMSA regulations provide a minimum and maximum range for an administrative fine applicable to each violation of section 1798.200. The minimum fine for a violation of section 1798.200, subdivision (c)(10) is \$250 and the maximum fine is \$2,500. Here, respondent's deviations from the SMEMSA protocols were serious. He failed to assess a 14-year old patient as a major trauma victim, and delayed his admission to Stanford, the designated trauma center for Redwood City. In addition, by removing the c-spine precautions, he unnecessarily increased the risk of further injury to the patient. While there

was no evidence that respondent's actions resulted in actual injury to the patient, the potential for such injury was nonetheless present. A total fine of \$1,500 is appropriate and sufficient to put respondent on notice that his errors were significant and cannot be repeated.

ORDER

An administrative fine of \$1,500 is imposed on respondent Nicholas Ferrari, EMT-P License No. P30435, as a result of his violation of Health and Safety Code section 1798.200, subdivision (c)(10). The administrative fine shall be paid within 60 days of the effective date of this Decision.

DATED: November 14, 2016

DocuSigned by:



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TIFFANY L. KING

Administrative Law Judge

Office of Administrative Hearings