

BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

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

DONALD FLORENCE
License No. P01535

Respondent.

Enforcement Matter No. 09-0354

OAH No. 2010120069

PROPOSED DECISION

Administrative Law Judge Nancy L. Rasmussen, State of California, Office of Administrative Hearings, heard this matter on March 4, July 25 and July 29, 2011, in Oakland, California.

Senior Staff Counsel Cynthia L. Curry represented complainant Sean Trask, Chief, EMS Personnel Division, Emergency Medical Services Authority.

Respondent Donald Florence was self-represented.

The matter was submitted for decision on July 29, 2011.

FACTUAL FINDINGS

Background

1. Respondent Donald Florence holds emergency medical technician-paramedic (EMT-P) license number P01535 issued by the Emergency Medical Services Authority. The license was issued February 1, 1989, and the current expiration date is December 31, 2011. From 1990 until his retirement in March 2010, respondent was employed by the Marin County Fire Department (MCFD). He last worked as a paramedic in December 2009.

Incident on December 5, 2008

2. In December 2008, respondent was working as an engineer-paramedic at the Point Reyes Fire Station. After being off December 3, he came on duty at 8:00 a.m. on December 4. Captain Todd Overshiner (also a paramedic) assigned respondent to the ambulance with Rachael Berey-Phillips, another engineer-paramedic. Berey-Phillips went

through the ambulance, checking the equipment and supplies, and respondent took care of the driver responsibilities, checking the running lights, setting the seat and mirrors, etc. Respondent and Bery-Phillips ran two transports that day, with respondent driving and Bery-Phillips in the back with the patient. When respondent went to bed that night, he had no idea he was going to have "attending" responsibilities in the ambulance. For the following day, he and Overshiner were assigned to the engine, which was also equipped for Advanced Life Support (ALS).

3. At 12:51 a.m. on December 5, a man walked into the fire station carrying his 11-month-old son. Respondent was awoken from sleep, and when he went downstairs he found Bery-Phillips, Overshiner, and firefighter Marc Martinelli in the first aid room. Martinelli had a clipboard, and Bery-Phillips was tending to the child. Respondent recognized the child as someone he and Overshiner had worked on in July 2008, when the boy's father had also driven him to the station.

In July 2008, the child was in a continuous seizure of unknown etiology, and he was very underdeveloped for his age. Respondent and Overshiner had to call for an ambulance in Woodacre, 25 minutes away, and they transported the child to Marin General Hospital (MGH). Respondent treated the child by administering Versed (the brand name for midazolam) through an intraosseous (IO) needle. When he later discussed the call with Dr. James Pointer (who works with or for MCFD), Dr. Pointer critiqued this treatment as being too aggressive.

4. On December 5, 2008, the child's father, who spoke broken English, reported that his son had been having seizures. He brought with him medical records showing that the boy had been evaluated at UCSF Pediatric Neurology in September 2008. Respondent took the documents and thumbed through them to see what had been done since July. He decided to call UCSF for direction on what they should do with the child, e.g., transport him directly to UCSF. In the office next door to the first aid room, respondent made a number of phone calls but was unsuccessful in reaching a neurological consultant or specialist at UCSF. He then went back in the first aid room and talked to the child's father and Overshiner. The father related that his son had been having intermittent seizures that evening, which was not unusual. Since his evaluation at UCSF, the boy had been given phenobarbital when he had seizures, but the family had run out of phenobarbital that night. The father became concerned when the child had some seizures and seemed different than he had been the day before.

Respondent picked up the child, put him in the back of the ambulance, and started getting the ambulance prepared. Ordinarily, he would not have done this, since he was not the primary care provider. Respondent assumed care for the child, however, because he had more years of experience than Bery-Phillips, he had some personal knowledge of pediatric neurology, and he had seen the child before. He disregarded the fact that he had not been in the back of the ambulance and checked to make sure everything was there and set up the way he preferred.

5. At 1:09 a.m., 18 minutes after the child was brought to the fire station, respondent and Berey-Phillips departed the station to transport the child to MGH. Berey-Phillips drove the ambulance, and respondent was in back with the patient. Although the child's temperature had not been taken at the station, his skin felt hot and some of his clothing had been removed. At some point, respondent also opened the window of the ambulance as an additional cooling measure. Oxygen was administered at the station with a non-rebreather mask (NRBM), but it is unclear if oxygen was continued in the ambulance.¹ In the ambulance, respondent started a complete pediatric assessment of the patient. He claims that every five minutes he took the child's vital signs, i.e., pulse, respiration rate, and oxygen saturation measured by pulse oximetry, but there was no change in the numbers. The ambulance was missing the pediatric connection for the pulse oximetry part of the Lifepak 12 heart monitor, so respondent used the portable pulse oximeter, putting the adult finger probe on the child's toe. Around Nicasio, respondent took the child's rectal temperature, which was 103 degrees. This seemed consistent with respondent's observations. Respondent would have performed a blood glucose check but the glucometer and the glucose test strips in the ambulance were not compatible with each other. He also would have monitored the child's heart except for some problem with the heart monitor equipment. Respondent did not take the child's blood pressure, because there is no policy in Marin County to take the blood pressure of a child under age three. Also, the patient's pulse and respiration were within normal limits, he was stable, and he had good skin turgor; there was no indication of a blood pressure abnormality.

Respondent witnessed some twitching and frothing by the child and maybe one or two times when the child had a glazed look in his eyes, but this was very sporadic and intermittent. The child was often cooing and looking at respondent. This was quite different from the continuous seizure activity he witnessed in July. Respondent suctioned the child a few times but decided not to insert an IO needle or some other form of vascular access, because he did not believe the child was emergent or critical. Mindful of Dr. Pointer's critique of his IO administration of Versed in July, respondent determined that Versed was not warranted in this situation.

6. Respondent attempted to contact MGH from the ambulance to let them know the patient was en route. After some difficulties with the radio, he was able to get through on the cell phone when the ambulance was about 35 minutes away from the hospital. Respondent advised that this was a special report, an early notification so MGH staff could pull the patient's chart and contact "PMD Hutchinson" (presumably, the physician who treated the patient in July 2008). He gave their estimated time of arrival and was advised to call back when they were five minutes away. Respondent called MGH back five minutes before they arrived.

7. The ambulance arrived at MGH at 1:54 a.m. Respondent and Berey-Phillips moved the patient in from the ambulance and respondent put him in Bed 3 in the Emergency

¹ In an e-mail a few hours after this incident, respondent said that the child was transported with the NRBM, but he testified that oxygen was discontinued in the ambulance.

Department. Respondent asked the nurse who met them whether they had pulled the child's chart or gotten hold of the PMD, and the nurse replied that they had not. At this point, respondent and Berey-Phillips went into the computer room so respondent could prepare the patient care record (PCR) to give to hospital staff. Respondent logged on to the computer and started preparing the PCR. He had obtained some preliminary information from Berey-Phillips and was working on the incident narrative when Berey-Phillips, who had left the room, came back in and told respondent, "You've got to see this." Respondent went out and saw a big commotion around Bed 3. There was a group of hospital staff around the patient, who looked like he was being "mutilated." People were screaming and yelling, and the patient was twitching a little. One person was "harpooning" the child with a catheter; another man trying to insert an IO needle dropped the needle on the floor and picked it up to use it. Concerned about what was happening, respondent asked the scribe nurse who was in charge, and she replied, "There are three [or four] doctors here!"² Respondent asked her if they had seen the UCSF notes he brought in or gotten hold of the PMD, to which the nurse replied, "We don't have time."

In his later e-mail to Chief Michael Giannini, the EMS Officer for MCFD, respondent described the scene as follows:

This kid was being paralyzed, intubated, multiple attempts at IV's, IO's drilled, drugs being pushed, and equipment/supplies being tossed on the ground. I counted 7 trained hospital staff in a mass hysterical frenzy.

The Temp they got was 107. This was wrong. I had 103, and this was after an hour of seizure activity (should be elevated). They continued to yell he was 5 months old, never looking at the chart, not listening to my report, taking a breath and seeing what this kids history is.

This was one of the worst cases of treatment to a kid that I have seen in a long time. RBP [Rachael Berey-Phillips] witnessing this was visibly upset.

Distressed about how the patient was being treated and not knowing what to do, respondent returned to the computer and "typed a few things in" on the PCR. He did not complete the narrative or include all the vital signs he had taken, thinking that he would just put in the basic information that was required for a Field Transfer Form (FTF). Respondent printed out the PCR and left it for hospital staff. He and Berey-Phillips then departed MGH, upset and not sure the patient would live. Respondent asserts that had they not witnessed what they did in Bed 3, he and Berey-Phillips would have taken the time to prepare a clear

² In his e-mail later that morning, respondent said that he was told, "There are 3 doctors here," but he testified that he was told, "There's four doctors here."

and accurate PCR at the hospital. (Respondent still needed to find out from Berey-Phillips what had transpired during the first 15 minutes after the child was brought to the fire station.)

8. Respondent realizes that he should have called the battalion chief and gotten taken out of service. Instead, he and Berey-Phillips drove back to the station at Point Reyes, arriving around 4:00 a.m. Berey-Phillips went upstairs, and respondent went into the supply room and got some supplies. He remembers pulling the heart monitor out of the ambulance and putting it on the ground, but he cannot recall now what else he did.

Respondent then composed his e-mail to Giannini, which he sent at 4:31 a.m. Respondent described the incident in detail, advising Giannini about the poor care at MGH, and asked him to look into the matter.

Before he went off duty at 5:30 a.m., respondent restocked the ambulance with some supplies and drank some coffee. To prepare an addendum to the PCR, he needed to get together with Berey-Phillips and Overshiner to discuss what had been done initially. Respondent did not do this before going off duty.

9. On Saturday, December 6, 2008, Giannini e-mailed respondent to tell him that he would be going in to MGH on Monday to discuss this incident. Respondent had no idea that he might be investigated for deficiencies in his PCR.

On Tuesday or Wednesday, the first time respondent was back on duty, he was talking about the December 5 incident with Berey-Phillips, Overshiner and Martinelli. Respondent received a phone call from Giannini, who said he had met with MGH staff and they had accusations against him and the others for their treatment of the child. Respondent recalls Giannini telling him that they were under investigation, mentioning the Firefighters Bill of Rights, and advising that they might want to think about legal counsel. (Giannini does not recall telling respondent to get legal counsel, but he would have advised him of his rights under the Firefighters Bill of Rights.) Respondent and the others at the station were shocked. Respondent contacted their union representative, who said not to do anything further regarding the incident. According to respondent, this is why he and Berey-Phillips did not prepare an addendum to the PCR, something they otherwise would have done.

Patient Care Record

10. The purpose of the PCR is to document all prehospital care provided to a patient by paramedics, to facilitate an orderly and informative transition to the next stage of medical treatment. (The PCR augments the oral report given by the paramedic to hospital staff upon arrival.) The PCR also provides a mechanism by which the quality of care can be evaluated for training purposes. Typically, the paramedic who was the primary caregiver completes the PCR upon delivery of the patient to the hospital. The paramedic sits down at a desktop computer at the hospital, enters notes and data into the PCR program and creates the PCR document. The PCR program has some drop-down menus, open fields, and prompts based on information entered into a field. Upon completion of the PCR, the paramedic prints

it out and either hands it to a hospital staff member or leaves it with the patient's file. If the paramedic is unable to complete the PCR at the hospital, an FTF can be left in lieu of the PCR, with the PCR to be completed back at the station and faxed to the hospital. (The FTF has less information in it than the PCR.) Marin County EMS Policy No. 7006, which was in effect in December 2008, provides in subsection IV that "The PCR will reflect all care rendered to the patient" (paragraph B), and "The PCR will be completed . . . in a clear, concise, accurate and complete manner" (paragraph C). That policy provides in subsection V, paragraph J:

Full PCRs must be completed for all incidents/patients as soon as possible after completing the call or delivering the patient to the ED. A full PCR must be completed and faxed to the receiving facility as soon as possible. In no case should crew go off duty prior to completing the full PCR.

A Field Transfer Form (FTF) may be completed if there is an urgent need for the unit to return to service. It is the expectation that a FTF not be utilized for patients with a medical condition of a serious or critical nature.

11. The PCR completed by respondent at MGH has information in all the relevant boxes or sections, and it contains the following Incident Narrative:

Brought to Point Reyes fire station by father due to intermittent seizure activity. Pt witnessed to be having some type of clonic spastic full body activity every couple of minutes. Temp = 103 rectally. O2 sat 98, last seen at MGH in July 2008 for seizures. Complete evaluation done by UCSF. Early call into MGH for past medical record retrieval and PMD notification. Transported for further MD evaluation. Pt delivered to ED, care transferred at that time.

Respondent concedes that the PCR was not complete, explaining that if he had taken more time, he would have expanded the narrative. In the second sentence, he would have clarified that it was the patient's father, not paramedics, who witnessed "some type of clonic spastic full body activity every couple of minutes." In the Patient Assessment section, the PCR shows an assessment and vital signs taken at 0:55 and 1:15 only, and should have included all the times respondent assessed that patient and took his vital signs.

Patient Care Protocols

12. The Marin County EMS Agency has established policies setting forth patient care protocols for paramedics. Policy BLS 1 requires that paramedics check the vital signs of patients, every five minutes for emergent patients and every 15 minutes for non-emergent patients. In Giannini's opinion, the patient in this case was emergent, because intermittent

clonic spastic full body activity every couple of minutes is significantly abnormal. Respondent asserts that he, Berey-Phillips and Overshiner all agreed that the patient was non-emergent, and during transport to MGH there was no sign of the patient deteriorating or falling into an emergent or critical category. Nevertheless, respondent maintains he took vital signs every five minutes; he just did not enter all this information in the PCR.

It was not established that respondent failed to take the patient's vital signs in accordance with Policy BLS 1.

13. Policy ATG 1 sets forth the protocol for routine medical care (RMC) for ALS transports. For a patient whose condition warrants care by an ALS provider, the protocol lists the following treatments:

- Vascular access as indicated
- Blood glucose monitoring as indicated by ALOC [altered level of consciousness] or patient history
- Cardiac monitor as indicated
- Advance airway management as indicated
- Pulse oximetry as indicated

In Giannini's opinion, this patient "absolutely" warranted care by an ALS provider. Medical patients with seizures are typically managed at the ALS level, and a high fever combined with seizures definitely warrants ALS care.

Policy P 9 sets forth the protocol for pediatric seizures, the indication for which is "Recurring or continuous generalized seizures with ALOC." This protocol requires a paramedic to "Evaluate for and treat hypoglycemia, hypoxia, narcotic overdose, trauma, fever, etc., prior to administering anti-seizure medications." The following treatments are listed:

- ALS RMC
- Vascular access for prolonged seizure
- Check blood glucose and treat if <60 mg/dl (<40 mg/dl neonate)
[Treatment dosages for different ages omitted.]
- Midazolam (Versed) 0.05 mg/kg IV/IO/IM; MR q 10 minutes to maximum dose of 5 mg

Giannini testified that the treatments indicated for this patient included vascular access (by intravenous line or IO), blood glucose monitoring, cardiac monitoring, pulse oximetry and midazolam. None of these is reflected in the PCR, except that the patient assessment at 0:55 indicates a pulse oximetry reading of 98. Giannini asserts that the pulse oximetry should have been continuous for this patient.

Respondent's testimony that he would have checked the patient's blood glucose and monitored his heart, but for equipment problems, amounts to an admission that these treatments were warranted. Therefore, he failed to follow Policy ATG 1 and Policy P 9 by not checking blood glucose, and he failed to follow Policy ATG 1 by not performing cardiac monitoring. Respondent's noncompliance with these policies is extenuated by his inability to carry out these treatments and the fact that he had no reason to check the equipment and supplies in the ambulance before the situation arose with this patient.

Respondent provided a reasonable explanation for his determination that vascular access and midazolam were not necessary. It was not established that these treatments were indicated.

LEGAL CONCLUSIONS

1. Health and Safety Code section 1798.200, subdivision (b), authorizes the Emergency Medical Services Authority to suspend or revoke an EMT-P license or place an EMT-P licenseholder on probation for any of the actions listed in subdivision (c) of that section. Subdivision (c) provides, in relevant part:

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:

[¶] . . . [¶]

(5) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.

[¶] . . . [¶]

(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.

2. The accusation alleges that respondent committed fraudulent or dishonest acts by falsely documenting his PCR. The evidence did not prove this allegation. While respondent's PCR was not complete, it was not established that he deliberately falsified the

PCR or otherwise acted fraudulently or dishonestly. Cause for license discipline does not exist under Health and Safety Code section 1798.200, subdivision (b) and subdivision (c)(5).

3. California Code of Regulations, title 22, section 100169, provides, in relevant part:

The medical director of the local EMS agency shall establish and maintain medical control in the following manner:

(a) Prospectively, by assuring the development of written medical policies and procedures, to include at a minimum:

[¶] . . . [¶]

(6) Requirements for the initiation, completion, review, evaluation, and retention of a patient care record as specified in this Chapter. . . .

California Code of Regulations, title 22, section 100170, subdivision (e), provides: “The paramedic is responsible for accurately completing the patient care record referenced in Section 100169(a)(6)”

Respondent violated California Code of Regulations, title 22, section 100170, subdivision (e), by failing to accurately complete the PCR. That violation constitutes cause for license discipline under Health and Safety Code section 1798.200, subdivision (b) and subdivision (c)(7).

4. California Code of Regulations, title 22, section 10045, subdivision (c), provides, in relevant part:

. . . [A] licensed paramedic, as part of an organized EMS system, . . . while at the scene of a medical emergency or during transport, . . . *may* perform the following procedures or administer the following medications when such are approved by the medical director of the local EMS agency and are included in the written policies and procedures of the local EMS agency. [Italics added.]

California Code of Regulations, title 22, section 10045, subdivision (c)(1), sets forth a long list of procedures under “Basic Scope of Practice.” Subdivision (c)(2) sets forth provisions relating to “Local Optional Scope of Practice,” including:

(A) Perform or monitor other procedure(s) or administer any other medication(s) determined to be appropriate for paramedic use, in the professional judgement [*sic*] of the medical director of the local EMS agency, . . . when the paramedic has been

trained and tested to demonstrate competence in performing the additional procedures and administering the additional medications.

The accusation alleges that respondent violated California Code of Regulations, title 22, section 10045, "in that he acted outside the authority of the basic scope of practice of a paramedic and acted outside the authority of the local optional scope of practice for a paramedic in that he failed to follow local protocols." California Code of Regulations, title 22, section 10045, subdivision (c), sets forth the procedures which a paramedic *may* perform or the medications which a paramedic *may* administer within the basic scope of practice, and provides that the local optional scope of practice may include other procedures or medications. This section does not prohibit any conduct or require that a paramedic follow local protocols. Respondent's failure to follow local protocols in not checking blood glucose or performing cardiac monitoring does not constitute a violation of California Code of Regulations, title 22, section 10045. Cause for license discipline does not exist under Health and Safety Code section 1798.200, subdivision (b) and subdivision (c)(7).

5. Since paramedics are required to function within set parameters and follow set protocols, respondent's failure to follow local protocols in not checking blood glucose or performing cardiac monitoring constitutes functioning outside the supervision of medical control in the field care system at the local level. Cause for license discipline therefore exists under Health and Safety Code section 1798.200, subdivision (b) and subdivision (c)(10).

6. Although the causes for license discipline under Health and Safety Code section 1798.200, subdivision (c), are, per se, "considered evidence of a threat to the public health and safety," the threat posed by respondent's incomplete PCR and his failure to check blood glucose or perform cardiac monitoring when he lacked the equipment to do so is minimal. There is no evidence of patient harm or prior discipline or warnings. It would not be contrary to the public interest to allow respondent to keep his EMT-P license on a probationary basis.

ORDER

Emergency medical technician-paramedic license number P01535 issued to respondent Donald Florence is revoked pursuant to Legal Conclusions 3 and 5, jointly and separately. However, the revocation is stayed and respondent is placed on probation for two years upon the following terms and conditions:

1. Probation Compliance: Respondent shall fully comply with all terms and conditions of the probationary order. Respondent shall fully cooperate with the EMSA in its monitoring, investigation and evaluation of respondent's compliance with the terms and conditions of his probationary order.

Respondent shall immediately execute and submit to the EMSA all Release of Information forms that the EMSA may require of him.

2. Personal Appearances: As directed by the EMSA, respondent shall appear in person for interviews, meetings and/or evaluations of his compliance with the terms and conditions of the probationary order. Respondent shall be responsible for all of his costs associated with this requirement.
3. Quarterly Report Requirements: During the probationary period, respondent shall submit quarterly reports covering each calendar quarter which certify, under penalty of perjury, and document compliance by respondent with all the terms and conditions of his probation. If respondent submits his quarterly reports by mail, they shall be sent by certified mail.
4. Employment Notification: During the probationary period, respondent shall notify the EMSA in writing of any EMS employment. Respondent shall inform the EMSA in writing of the name and address of any prospective EMS employer prior to accepting employment.

Additionally, respondent shall submit proof in writing to the EMSA of disclosure, by respondent, to the current and any prospective EMS employer of the reasons for and terms and conditions of respondent's probation.

Respondent authorizes any EMS employer to submit performance evaluations and other reports which the EMSA may request that relate to the qualifications, functions, and duties of prehospital personnel.

Any and all notifications to the EMSA shall be by certified mail.

5. Notification of Termination: Respondent shall notify the EMSA within 72 hours after termination, for any reason, with his prehospital medical care employer. Respondent must provide a full, detailed written explanation of the reasons for and circumstances of his termination.

Any and all notifications to the EMSA shall be by certified mail.

6. Functioning as a Paramedic: The period of probation shall not run anytime that respondent is not practicing as a paramedic within the jurisdiction of California.

If respondent, during his probationary period, leaves the jurisdiction of California to practice as a paramedic, respondent must immediately notify the EMSA, in writing, of the date of such departure and the date of return to California, if respondent returns.

Any and all notifications to the EMSA shall be by certified mail.

7. Obey All Related Laws: Respondent shall obey all federal, state and local laws, statutes, regulations, written policies, protocols and rules governing the practice of medical care as a paramedic. Respondent shall not engage in any conduct that is grounds for disciplinary action pursuant to Section 1798.200. To permit monitoring of compliance with this term, if respondent has not submitted fingerprints to the EMSA in the past as a condition of licensure, then he shall submit his fingerprints by Live Scan or by fingerprint cards and pay the appropriate fees within 45 days of the effective date of this decision.

Within 72 hours of being arrested, cited or criminally charged for any offense, respondent shall submit to the EMSA a full and detailed account of the circumstances thereof. The EMSA shall determine the applicability of the offense(s) as to whether the respondent violated any federal, state and local laws, statutes, regulations, written policies, protocols and rules governing the practice of medical care as a paramedic.

Any and all notifications to the EMSA shall be by certified mail.

8. Completion of Probation: Respondent's license shall be fully restored upon successful completion of probation.
9. Violation of Probation: If during the period of probation respondent fails to comply with any term of probation, the EMSA may initiate action to terminate probation and implement actual license suspension/revocation. Upon the initiation of such an action, or the giving of a notice to respondent of the intent to initiate such an action, the period of probation shall remain in effect until such time as a decision on the matter has been adopted by the EMSA. An action to terminate probation and implement actual license suspension/revocation shall be initiated and conducted pursuant to the hearing provisions of the California Administrative Procedure Act.

The issues to be resolved at the hearing shall be limited to whether respondent has violated any term of his probation sufficient to warrant termination of probation and implementation of actual suspension/revocation. At the hearing, respondent and the EMSA shall be bound by the admissions contained in the terms of probation and neither party shall have a right to litigate the validity or invalidity of such admissions.

DATED: October 7, 2011



NANCY L. RASMUSSEN
Administrative Law Judge
Office of Administrative Hearings