BEFORE THE
EMERGENCY MEDICAL SERVICES AUTHORITY
STATE OF CALIFORNIA

In the Matter of the Emergency Medical

Technician-Paramedic License Held by:

BRADFORD E. BUCHANAN,

License No. P44080

Respondent.

Agency Case No. 23-0135

OAH No. 2023070278

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on July 25, 2023, by videoconference.

Attorney Stephen Egan represented complainant Kim Lew, Chief, Emergency Medical Services Personnel Division, California Emergency Medical Services Authority.

Respondent Bradford E. Buchanan appeared representing himself.

The matter was submitted for decision on July 25, 2023.

FACTUAL FINDINGS

1. In August 2022, the State of California Emergency Medical Services Authority (Authority) issued Paramedic License No. P44080 to respondent Bradford E. Buchanan. At the time of the hearing, this license was suspended, as summarized below in Findings 2 and 3. It was scheduled to expire August 31, 2024.

2. On May 23, 2023, acting in his official capacity as Medical Director of the San Mateo County Emergency Medical Services Agency (County EMSA), Gregory Gilbert, M.D., ordered temporary suspension of respondent's license to act as a paramedic. In addition, acting in his official capacity as County EMSA Director, Travis Kusman referred respondent to the Authority for disciplinary action. Gilbert and Kusman made this order and referral because they understood the incident described below in Findings 9 through 25 to constitute cause for discipline against respondent, and to show that respondent would pose an imminent threat to health and safety if he continued to work as a paramedic.

3. On June 8, 2023, in reliance on the order and referral described in Finding 2 and acting in her official capacity as the Authority's Acting Director, Elizabeth Basnett issued an order continuing temporary suspension of respondent's paramedic license. In addition, on the same day, acting in her official capacity as Chief of the Authority's Emergency Medical Services Personnel Division, complainant Kim Lew signed and filed an accusation against respondent. Complainant seeks revocation of respondent's license.

4. As grounds for license revocation, complainant alleges that during an ambulance trip, respondent punched a patient twice in the face, injuring the patient's nose, while the patient's legs were in restraints and while respondent and another

emergency medical provider were holding the patient's arms. Complainant alleges further that respondent caused his ambulance team to transport and treat the patient against the patient's will; that he failed to report the patient's medical condition to the destination hospital; and that he failed to assess the patient properly after the team had restrained the patient fully.

5. Respondent timely requested a hearing.

Professional Experience

6. Respondent has been licensed outside California as a paramedic since 2017. He worked as an emergency medical technician for about 18 months before becoming a paramedic. Respondent was about 30 when he began his career in emergency medical care.

7. Respondent trained as a paramedic in Florida. The evidence did not establish what, if any, other education or work experience preceded respondent's career in emergency medical care.

8. After about five years working in Florida as a paramedic, respondent obtained California licensure so that he could accept travel positions. In May 2023, he worked as an ambulance paramedic for American Medical Response (AMR) in San Mateo County.

Patient Incident on May 11 and 12, 2023

9. On May 11 and 12, 2023, respondent was on duty in an AMR ambulance. Emergency medical technician Richelle Turner was respondent's shift partner, and trainee Ryan Cayago accompanied respondent and Turner. Turner has more than ten

years' experience as an emergency medical technician, but Cayago had worked less than 36 hours in training before May 11, 2023.

10. Around midnight between May 11 and 12, a patient called 911 from a donut shop and told the dispatcher that he wanted to go to a hospital. Respondent and his colleagues arrived at the shop in their ambulance shortly after other emergency responders had arrived. The patient was alert and oriented, although drunk. He showed "no obvious distress," but complained of chest pain.

11. The emergency responders who came to the donut shop before the ambulance included officers from the San Bruno Police Department. One of those officers, Patrick Stack, later wrote a report about the incident. His report states that the patient initially was "irate," but that the officers had calmed him before the ambulance arrived. The report also notes Stack's understanding, from a records review, that the patient had spent the previous week in jail on charges of having battered a "Custodial Officer, Firefighter, EMT, Paramedic, Animal Control Officer, or Lifeguard."

12. Respondent and his colleagues put the patient in the back of the ambulance, on a gurney in a semi-seated position. The patient also had several bags of personal belongings, which the team put into the ambulance with the patient. Respondent attended to the patient, while Cayago drove and Turner rode in the ambulance cab's passenger seat.

13. Respondent applied adhesive electrodes to the patient's chest and performed an electrocardiogram (EKG). The results suggested that the patient was having a myocardial infarction (STEMI, or a "heart attack"). Respondent gave the patient aspirin and re-ran the EKG to obtain a clearer result.

14. Because this second EKG was even more strongly suggestive of STEMI, respondent directed Cayago to elevate the ambulance's response to "Code 3" (lights and siren) and to drive the ambulance to Mills-Peninsula Hospital, a hospital that was better equipped to handle a STEMI than the hospital to which the patient had asked the team to take him. Respondent also initiated transmission of the second EKG result to the destination hospital, although he does not know whether the transmission had succeeded before the ambulance arrived.

15. Respondent told the patient that respondent suspected a heart attack. He said that the ambulance would go to Mills-Peninsula Hospital, and that on the way respondent would start an intravenous (IV) line in the patient so that hospital personnel could begin treatment as soon as the ambulance arrived. The patient immediately became angry. He refused the IV; cursed at respondent; and demanded release from the ambulance.

16. Although respondent did not want to treat the patient against the patient's will, he also did not want the patient to suffer an untreated STEMI. He called to Cayago to stop the ambulance, intending to calm the patient, advise him about his urgent need for medical care, and then either proceed to the hospital or evaluate the patient's mental capacity to make the decision to leave the ambulance against medical advice. Because Cayago had activated the siren and did not hear respondent's request, however, Cayago did not stop the ambulance.

17. The patient continued to rage, as respondent stood to the patient's left side. The patient then pulled his right arm back, with his hand in a fist, as if to punch respondent. Respondent immediately rolled the patient to the patient's right side, holding the patient's left arm and torso on top of the patient's right arm to prevent the patient from swinging his fist. Respondent yelled again, louder, for Cayago to stop

the ambulance and for Cayago and Turner to come to the back to assist respondent with the patient.

18. This time, Cayago heard respondent. He stopped the ambulance at a curb on El Camino Real (a multi-lane arterial street), and he and Turner joined respondent and the patient.

19. Turner and Cayago succeeded in placing restraints on the patient's legs. Cayago then attempted to tie down the patient's right arm while Turner attempted to tie down the left arm and respondent continued to hold the patient's torso.

20. The patient struggled against respondent, Cayago, and Turner. He succeeded in breaking away from Cayago, pulling Cayago across his chest as he again swung his right arm and fist toward respondent. The patient's fist hit respondent in the left cheekbone, just below respondent's left eye. Turner did not see the patient hit respondent, but perceived as she attempted to secure the patient's left side that the patient was trying to hit her.

21. The patient pulled his right arm back, and pulled his left arm free. Before the patient could punch anyone again, respondent punched the patient in the nose. The patient pulled his right arm back for a third try, and respondent punched the patient a second time. The blows caused the patient's nose to bleed.

22. The patient then turned his head away from respondent. Respondent and Cayago regained control of the patient's arms. Cayago and Turner tied down the patient's right arm, and Turner helped respondent tie down the patient's left arm.

23. The patient also was spitting at the team during this struggle. Cayago put a mask on the patient's face. After the patient succeeded in spitting on respondent

through the mask, respondent pulled the patient's shirt up over the mask and again turned the patient's head away.

24. Cayago returned to the cab. He called for police to meet the ambulance at the hospital, and resumed driving. Turner did not return to the cab, but instead stayed with respondent and the patient. She monitored the patient while respondent radioed the hospital to report the patient's medical condition and behavior. During the rest of the trip, the patient attempted to bite Turner, to remove his lap belt, and to break Turner's fingers as she prevented him from removing the belt.

25. At the hospital, the patient continued to struggle and yell, preventing hospital personnel from treating him. Stack, who had come to the hospital in response to Cayago's call, interviewed respondent, evaluated the circumstances, and determined that the officers should arrest the patient for battery on respondent. When the hospital released the patient, Stack and his patrol partner took the patient into custody.

Respondent's and His Colleague's Perceptions

26. A few days after the incident described above in Findings 9 through 25, AMR staff members interviewed Cayago about it. At that time, Cayago expressed misgivings about respondent's behavior: "when he struck the [patient,] I thought that was excessive but his restraining the [patient] was correct." In testimony at the hearing, however, Cayago expressed a different opinion, stating that he no longer believes that respondent overreacted to the patient's behavior.

27. Cayago explained that he had changed his opinion since the interview for two chief reasons. First, during the incident, he did not see what the patient did immediately before respondent struck the patient, because the patient had pulled Cayago down across the patient's torso (as described in Finding 20). Second, now that

he has considerably more experience, he realizes that this patient's behavior was extremely unusual.

28. Cayago emphasized in testimony that he based the opinion he had given in his interview on the assumption that the patient was not threatening imminent violence on respondent when respondent hit the patient. With the information and experience he has now, Cayago has revised that assumption, and believes that striking the patient may have been an unfortunately appropriate action to protect respondent, Cayago, and Turner. Cayago's testimony is credible.

29. AMR staff members also interviewed Turner a few days after the incident described above in Findings 9 through 25. She testified at the hearing, and expressed the same opinions she had expressed in her interview. Her testimony also is credible.

30. Turner had worked several times before as respondent's shift partner, and considered him level-headed. She noted that he had responded calmly to previous combative patients, and did not even "get loud." In this incident, Turner did not see the patient hit respondent, because she was busy as described above in Finding 19 with the patient's left-side restraints. She believes, however, that respondent would not have hit the patient unless respondent saw absolutely no other way to interrupt the patient's violence and protect everyone's safety.

31. Both Turner and Cayago also stated in their interviews, and testified, that after the crew had restrained the patient and Cayago had resumed driving to the hospital, respondent was calm and professional. He reported the patient's condition to the hospital and transferred care to hospital personnel when the ambulance arrived.

32. Respondent also testified credibly about the incident, in a manner consistent with the interview he gave to Stack on May 12, 2023, at the hospital.

a. He emphasized that the crew had placed the patient in the ambulance without restraints because the patient initially was cooperative. Even after the patient refused an IV and became argumentative, respondent did not move immediately to restrain him: "I wasn't going to put him in restraints for yelling at me."

b. When the patient became physically combative, however, the crew attempted to restrain him, using their bodies and restraint ties. Respondent hit the patient only after the patient had evaded Cayago's and respondent's holds on the patient's arms, and while the patient appeared to be winding up for a second punch toward respondent and Turner.

c. Respondent believes that his professional responsibility as a paramedic facing a combative patient is to use the minimum level of force necessary to prevent harm to anyone, and that he did so in this case.

San Mateo County and AMR Policies

33. Respondent's employer, AMR, has a "Workplace Violence Prevention Policy" governing employees' uses of and responses to physical force in the workplace. Section 6.0 of that policy addresses patient management and restraint. The policy calls for emergency medical personnel to use "the lowest level of control which is effective for managing a hostile or combative patient," and allows personnel to restrain a patient physically "in accordance with local operational policy and local EMS Agency standards."

34. County EMSA Policy 525 addresses patient restraint. This policy calls for prehospital personnel to "de-escalate aggressive behavior with a calm and reassuring approach and manner when safe to do so." It also allows prehospital personnel to use cloth ties to restrain a patient who is "exhibiting assaultive behavior that presents an

immediate danger to themself or others." While a patient is in such restraints, emergency medical services personnel must monitor "pulse and respiration," as well as circulation and motor function in the restrained extremities.

35. Under County EMSA Policy 525, a patient who "becomes assaultive during transport" may be released, but only "into a safe environment." County EMSA Policy 521 further addresses a patient's right to refuse treatment. This policy requires prehospital personnel to assess the patient's decision-making capacity, including ensuring that the patient understands the potential consequences of declining treatment. It also specifically requires prehospital personnel to take a patient's alcohol intoxication into account in evaluating the patient's ability to make safe decisions. Finally, if prehospital personnel have confirmed the patient's capacity to refuse treatment, they must document the patient's refusal, including obtaining the patient's signature on the document.

36. The County EMSA also has adopted a protocol for prehospital personnel to follow when they suspect a STEMI. In a patient with chest pain, this protocol calls for personnel to administer aspirin and to perform an EKG. If the EKG indicates a potential STEMI, the emergency medical services provider(s) must transport the patient to one of only a few "Approved STEMI Receiving Centers," which include Mills-Peninsula Hospital but not the hospital to which the patient initially had requested transport. In addition, the prehospital personnel must transmit the EKG results to the destination hospital.

County EMSA Referral to Authority

37. The County EMSA disciplinary referral described above in Finding 2 says that respondent hit the patient "with [patient's] legs in restraints and both arms being

restrained" by respondent and either Cayago or Turner. This description is incorrect. As described above in Findings 20, 21, and 32, respondent hit the patient after the patient had escaped from Cayago's and respondent's holds on the patient's arms, and while the patient was attempting actively to hit respondent, Turner, or Cayago.

38. In addition, the San Mateo County disciplinary referral described above in Finding 2 says that respondent "willfully and unlawfully detained a patient in his care who verbalized that he wanted out of the ambulance." This description also is incorrect.

a. As described above in Finding 16, when the patient stated that he wanted to leave the ambulance, respondent asked Cayago to stop driving.

b. Furthermore, and as also summarized in Finding 16, respondent testified credibly that his intention before the patient began behaving violently was to advise the patient about the importance of receiving immediate medical care for his apparent STEMI and then to evaluate whether the drunk, agitated patient nevertheless had the mental capacity to decline treatment.

c. Finally, and as described above in Findings 17 through 24, when the ambulance did stop, it stopped suddenly at the side of a busy road in the middle of the night because of the patient's irrational, violent behavior. Under those circumstances, the team could not reasonably or safely have discharged the patient and his belongings from the ambulance right away, even if the patient had calmed himself as soon as the ambulance stopped.

Expert Testimony

39. Complainant presented expert testimony about a paramedic's professional responsibilities from Samuel Stratton, M.D. Although Stratton is not a paramedic, he is board-certified in emergency medicine, has trained paramedics for more than 35 years, and has served as the medical director for multiple county EMSAs.

40. Stratton reviewed reports about the incident described above in Findings 9 through 25, as well as a video recording of Stack's interview of respondent at the hospital. He testified that he understood from these sources that respondent had struck the patient's face while the patient was fully restrained.

41. According to Stratton, the standard of care for a paramedic does not allow the paramedic ever to punch the patient. He believes that if a patient strikes a paramedic, the paramedic must respond by retreating or by enlisting colleagues to cooperate in safe restraint techniques. Stratton acknowledged that patient violence is a genuine concern for emergency medical personnel, and that training programs for emergency medical technicians and paramedics teach safe restraint techniques. He emphasized, however, his opinion that these techniques always should be adequate to address a patient's violent behavior, without resort to additional violence.

42. Stratton's opinion did not address the highly unusual circumstances described above in Findings 17 through 21 and 32. Respondent, Cayago, and Turner could not retreat from the patient, because all four of them were in the back of an ambulance beside a busy road. The team attempted to use safe restraint techniques to control the patient, but those techniques failed. Although respondent harmed the patient when respondent hit him, Stratton's opinion that hitting the patient under these circumstances was a departure from the standard of care is not persuasive.

LEGAL CONCLUSIONS

1. The Authority may discipline respondent's paramedic license upon proof that respondent has violated Health and Safety Code section 1798.200, subdivision (c). (Health & Saf. Code, § 1798.200, subd. (b).) Complainant bears the burden of proving respondent's statutory or regulatory violations, using clear and convincing evidence.

2. Complainant argued that the Authority should give little weight to Turner's, Cayago's, and Stack's testimony, on the theory that these witnesses slanted their testimony in respondent's favor to express support for him as a fellow front-line emergency responder. The matters stated in Findings 9, 11, and 25 through 31 do not corroborate this theory. These witnesses' testimony is credible and consistent, and merits the Authority's consideration in evaluating complainant's allegations.

First Cause for Discipline: Gross Negligence

3. Gross negligence by a paramedic, which is conduct constituting an extreme departure from the professional standard of care, is cause for the Authority to revoke the paramedic's license. (Health & Saf. Code, § 1798.200, subd. (c)(2).)

4. Complainant contends that respondent's conduct during the incident described above in Findings 9 through 25 fell below the professional standard of care for a paramedic because respondent "unreasonably and unnecessarily assaulted a patient under his care." As support for characterizing respondent's actions as unreasonable and unnecessary, complainant alleges that respondent struck the patient while "both [the patient's] arms were restrained." The matters stated in Findings 20, 21, and 32 do not support the allegation that the patient's arms were restrained when respondent struck him. Moreover, the matters stated in Findings 17 through 21, 26

through 30, 32, and 39 through 42 do not establish that respondent's actions were either unreasonable or unnecessary. Clear and convincing evidence does not establish that respondent's striking the patient was gross negligence constituting cause for discipline.

5. Complainant also contends that respondent's conduct during the incident described above in Findings 9 through 25 fell below the professional standard of care for a paramedic because respondent failed "to abide by the patient's wishes to refuse treatment and transport." The matters stated in Findings 16 through 25 do not support this allegation, because they do not show that respondent and his colleagues had any reasonable opportunity after the patient changed his mind about receiving emergency medical treatment to release the patient safely before they had arrived at the hospital. Clear and convincing evidence does not establish that taking the patient all the way to the hospital was gross negligence constituting cause for discipline against respondent.

6. Complainant contends that respondent's conduct during the incident described above in Findings 9 through 25 fell below the professional standard of care for a paramedic because respondent "failed to initiate an Against Medical Advice (AMA)." The matters stated in Findings 16 through 23 do not support this allegation, because they show that respondent did attempt to assess the patient's capacity to refuse treatment but stopped to address the patient's escalating violence. Clear and convincing evidence does not establish that respondent exhibited gross negligence constituting cause for discipline in his response to the patient's initial demand for release from the ambulance.

7. Complainant contends further that respondent's conduct during the incident described above in Findings 9 through 25 fell below the professional standard

of care for a paramedic because respondent “failed to notify Base hospital regarding the patient’s condition.” The matters stated in Findings 14 and 24 do not support this allegation, because they show that respondent did notify Mills-Peninsula Hospital about the patient’s condition. Clear and convincing evidence does not establish that respondent exhibited gross negligence constituting cause for discipline in communicating with the hospital about the patient.

8. Finally, complainant contends that respondent’s conduct during the incident described above in Findings 9 through 25 fell below the professional standard of care for a paramedic because respondent “failed to assess the patient after the restraints had been applied.” The matters stated in Finding 24 do not support this allegation, because they show that respondent’s partner, Turner, monitored the patient as the ambulance continued to the hospital. Clear and convincing evidence does not establish that respondent exhibited gross negligence constituting cause for discipline in monitoring the patient after restraining him.

Second Cause for Discipline: Violating Laws or Regulations

9. Violation by a paramedic of any statute or regulation governing prehospital personnel is cause for the Authority to revoke the paramedic’s license. (Health & Saf. Code, § 1798.200, subd. (c)(7).)

10. Complainant characterizes the conduct alleged as cause for discipline under Health and Safety Code section 1798.200, subdivisions (c)(2), (c)(10), and (c)(12) as cause also for discipline under subdivision (c)(7). As summarized in Legal Conclusions 4 through 8, 12 through 14, and 16, clear and convincing evidence did not establish that respondent’s actions violated any such laws and regulations. These

matters do not constitute cause for discipline against respondent for statutory or regulatory violations.

Third Cause for Discipline: Functioning Outside Local Supervision

11. Violation by a paramedic of any local EMSA law or policy governing prehospital personnel is cause for the Authority to revoke the paramedic's license. (Health & Saf. Code, § 1798.200, subd. (c)(10).)

12. Complainant characterizes the actions described above in Findings 9 through 25 as violating the San Mateo County policies described above in Findings 34 through 36.

a. In light of the matters stated in Finding 36, the matters stated in Findings 13 through 15 are not clear and convincing evidence showing that respondent failed to follow the County EMSA's STEMI protocol.

b. In light of the matters stated in Finding 35, the matters stated in Findings 15 through 24 are not clear and convincing evidence showing that respondent failed to follow County EMSA Policy 521 with respect to a patient who refuses emergency medical treatment.

c. In light of the matters stated in Finding 34, the matters stated in Findings 17 through 24 are not clear and convincing evidence showing that respondent used restraint on the patient inappropriately under County EMSA Policy 525.

13. Complainant also contends that the actions described above in Finding 21 constituted "retaliation" against the patient for hitting respondent, "at a time when the Patient's arms and legs were restrained." As summarized in Findings 20 and 21 and in Legal Conclusion 4, clear and convincing evidence does not support the allegation

that respondent hit the patient when the patient was fully restrained. Moreover, and as summarized in Findings 24, 31, and 32, clear and convincing evidence also does not support complainant's contention that respondent's behavior showed his "inability to manage his anger."

14. Overall, the matters stated in Findings 9 through 42 and in Legal Conclusions 12 and 13 do not constitute cause for discipline against respondent under Health and Safety Code section 1798.200, subdivision (c)(10).

Fourth Cause for Discipline: Patient Abuse

15. The Authority may revoke a paramedic's license for "mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance." (Health & Saf. Code, § 1798.200, subd. (c)(12)(A).)

16. The matters stated in Findings 9 through 32 and 39 through 42 do not establish by clear and convincing evidence that respondent's actions constituted an objectively unreasonable use of force against the patient. These matters do not constitute cause for discipline against respondent for patient abuse.

ORDER

1. The accusation against respondent Bradford E. Buchanan, Paramedic License No. P44080, is dismissed.

2. In accordance with Health and Safety Code section 1798.202, the order temporarily suspending Paramedic License No. P44080 is dissolved.

DATE: 08/01/2023

JULIET E. COX

Administrative Law Judge

Office of Administrative Hearings