El Dorado County EMS Agency Accreditation Required Reading: Article 1

Tips from an Expert Witness

By Robert G. Nixon, BA, EMT-P

There may come a time in your career when a call does not go quite right. Maybe someone will forget to do something, or someone will make a treatment mistake that jeopardizes the life of a patient. Maybe, despite everyone's best efforts, the patient succumbs anyway.

It's not unheard of that surviving family members file a lawsuit against the crew and the department, seeking redress for perceived wrongdoings. The plaintiff's attorney may well hire a consultant to testify against the EMS crew, and the defense attorney may employ an expert of its own to defend the crew's actions. On either side, the expert witness will examine all the information and give an opinion about the case.

But who is this person, and how can an EMT or paramedic lessen the risk of being challenged by him? Having served as an expert witness in many cases, both for and against EMS professionals, I can provide an understanding of what experts do and offer tips on how to avoid excess and sometimes unnerving scrutiny at their hands.

The Expert Witness

An expert witness is, by one definition, a person with knowledge on a topic that the average person does not possess.[1] A better definition is a person with special training or experience in a technical field who is called on to state an opinion on those technical matters, even though the witness was not present at the event. This contrasts with the role of a nonexpert witness, who is permitted to testify only to observed facts.[2]
The expert who, early in the process, is provided with documents relevant to the case doesn't just testify in depositions or at trial. He often acts as an advisor throughout the entire lawsuit, suggesting questions that his employer should ask other witnesses.

Triggering Scrutiny

Certain things trigger closer scrutiny by an expert witness, and some of the questions that result can be blunt, disconcerting, or even embarrassing. Here are several ways you can avoid follow-up questions and critique.

1. The patient care report must be an accurate reflection of what happened while you were with the patient. The report is a detailed account from the time EMS arrives on the scene until the patient is turned over to an emergency department or another responding agency. Documentation must include where the patient was found; the patient's surroundings, if appropriate; and any assessments, treatments, and responses to treatments.

2. Incomplete or unchecked boxes invite questions. Fully complete any patient care document. Do not leave pertinent boxes or findings omitted or blank. As an example, a patient care report on a patient with a potentially serious head injury did not have all components of the Glasgow Coma Scale checked. The patient, who was inebriated, had fallen, sustaining a laceration to the back of his head. Paramedics treated the patient according to his intoxication and transported him to a receiving hospital that had no trauma facilities. The patient had sustained epidural and subdural hematomas that herniated the brain stem, causing the man's death. Questions that arose concerned the level of assessment the patient had been afforded.

3. If you don't write it down, you didn't do it or it didn't get done. This is an old adage passed along by instructors to nearly every EMT or paramedic. Believe it. If a patient is critically injured and the patient care report says nothing about taking spinal precautions, then such precautions were not taken. An EMS crew may religiously put trauma victims on a backboard, but the one time that it's not documented, it is inferred that the treatment was not performed.

4. If I don't write it down, they can't get me. This corollary to the above statement is a fallacy that too many people believe. Not documenting something because it might look bad provides a false sense of security. During document review, the expert witness will look for incongruities and start posing a lot of disturbing questions based on them.

5. Poor spelling doesn't count, but poor handwriting can pose problems. Not everyone is good at spelling, especially with medical terminology. A few misspelled words are of little consequence. If the report is nearly illegible or disorganized, however, the person evaluating it may question the care given.

6. When in doubt, use national standards. Deviation from local protocol or standing orders should be based on nationally accepted standards. Be able to justify patient care decisions based on the EMT and paramedic textbooks used in training programs or on local policies covering scope of practice. Don't base them on a recent journal article or anecdotal information. When deviating from

protocols, do so in the best interest of patient care, and document everything. There will be questions about it.

7. One set of vital signs cannot tell you that a patient is stable. A 40-year-old man was driving to work when he was involved in a motor vehicle accident in which his car was struck on the driver's side. On initial questioning, the man complained of left chest, abdominal, pelvic, and thigh pain. His initial vital signs were BP: 118/98, P: 90, R: 22. A paramedic on-scene declared the patient "stable." Not exactly. The pulse pressure (systolic minus diastolic) is less than 30 mm Hg (normal is 30 to 40 mm Hg), indicating vasoconstriction and, perhaps, hypo-volemia and stage 2 of shock.[3,4,5] Although pulse pressure by itself is not conclusive, it suggests that follow-up assessments are needed. Subsequent vital signs were BP: 90/68, P: 110, and R: 24. At the hospital, the admitting diagnosis was left hemothorax, ruptured spleen, ruptured bowel, fractured pelvis, and fractured femur. In another example, a 40-year-old woman was driving when her car collided with another vehicle. The paramedics on-scene provided a radio report: Patient is complaining of left shoulder pain with no obvious trauma and full range of motion. Slight abdominal tenderness. Vital signs are BP: 128/90, P: 88, R: 20. The woman was transported to the emergency department and placed in a triage room to await X-ray and rule out shoulder injury. Forty-five minutes later, she was found in cardiac arrest and could not be resuscitated. Cause of death was hemorrhage from a ruptured spleen. One question among many that arose later was if the paramedic was familiar with referred pain to the left shoulder secondary to blood irritating the diaphragm after splenic injury.Tips from an Expert Witness By Robert G. Nixon, BA, EMT-P There may come a time in your career when a call does not go quite right. Maybe someone will forget to do something, or someone will make a treatment mistake that jeopardizes the life of a patient. Maybe, despite everyone's best efforts, the patient succumbs anyway.[6]

8. A blood pressure by palpation provides incomplete information. A palpated blood pressure is occasionally permissible during repeat assessments; however, reporting only the systolic blood pressure does not give a full picture of the patient's perfusion status.

9. Repeat vital signs are rarely the same. On many patient care reports, vital signs are always the same. One report documenting a patient with a significant head injury had the following recorded vital signs:

BP: 124/88 R:16

BP: 124/88 R:16

BP: 124/80 R:16

Vital signs taken several minutes apart are rarely the same. A blood pressure and pulse that do not change invite scrutiny and the suspicion that the assessments were actually not made.

10. The narrative must make sense. A 38-year-old woman called 911 after unsuccessfully treating her asthma with five albuterol treatments. After a sixth treatment on the scene, she was placed into the ambulance and transported to the hospital. During the trip, the woman went into respiratory arrest. The paramedic intubated the patient in a moving vehicle and declared the patient had clear breath sounds bilaterally. No pulse oximetry, esophageal detection device, or capnography was used to verify tube placement. Unfortunately, the intubation attempt resulted in esophageal tube placement that was not recognized until arrival at the emergency department. Some of the critical questions that might be posed afterward include the following:

- How can you hear clear breath sounds in a status asthmaticus patient?
- How were you able to detect breath sounds in a moving ambulance, especially one using its sirens?
- Did you use any means other than auscultation to determine tube placement?

Importance of Documentation

It is difficult to remember all of the nuances of patient care, and something is bound to go wrong during a call. When lawsuits are filed and expert witnesses are called in, patient care reports and other documents come under intense scrutiny. Attorneys can pose challenging questions that invite EMS professionals to doubt their abilities.

Even though the care they provided was above reproach, EMTs and paramedics frequently make mistakes in documentation, which in turn invite close evaluation and questioning. Proper and thorough documentation of what happened while in contact with the patient may help defend against litigation.

How to testify

- Review your report before coming to court.
- Bring your report to court to refresh your recollection, if needed, on the stand.
- Wear a suit when possible. Otherwise, your uniform will suffice.
- Show up one half-hour early.
- Once in the courthouse, know that jurors are everywhere, watching everything, listening to everything. You are being evaluated by them even when you are in the hallway. Do not discuss the case.
- Speak with a loud and booming voice from the stand.

- Be confident.
- You may look at the attorneys asking you questions, and you may look at the jury to emphasize particular points, but be yourself while speaking.
- Listen to the question.
- Answer only the question asked.
- Don't add information that is not asked.
- Don't fill in awkward silences with testimony that is not called for by the question.
- You may state that you don't understand a question when you don't understand it.
- You may state that you didn't hear a question when you didn't hear it.
- Show respect to the attorneys from both sides, even if the other side is trying to provoke you.
- Don't give equivocal answers, whenever possible.
- Be definite when you are definite.
- Don't say, "to the best of my recollection U."
- If an objection is sustained, you may not answer a question. If an objection is overruled, you must answer a question.
- You are not the police or district attorney investigator in this case. Your observations are limited to treatment of a patient or to some other aspect of being a first responder; therefore, you are not responsible for taking complete statements or observations from a crime scene

Critical thinking

The expert witness forms opinions using what is known as critical thinking. Critical thinking is not using thoughts to merely criticize; it is a way of interpreting, analyzing, and evaluating information in such a way as to form impressions, explanations, or inferences. Peter Facione of Santa Clara University explains these components as follows:

Interpreting Understanding and expressing, without bias, the meaning of events, situations, and data.

Analyzing Examining ideas and concepts behind experience, information, statements, and data.

Evaluating Assessing the credibility of statements made or actions taken in a given situation.[1]

The opinions or explanations derived from critical thinking form the basis of the expert witness' testimony.

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FireEMS January, 2004
Author(s) : Robert G. Nixon