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Legal and medical aspects associated with the use of direct coercion by emergency medical teams in the light of the applicable law

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Summary

According to Article 68 sections 1 and 2 of the Constitution of the Republic of Poland everyone has the right to health protection. In line with this provision, the Act of 8 September 2006 on the State Emergency Medical Services imposes an obligation on emergency medical teams to provide assistance to "every person experiencing an emergency health condition". The catalogue of medical events and accompanying clinical situations in which emergency medical teams intervene is constantly growing. A significant percentage of such situations are calls for assistance to people with mental disorders or psychomotor agitation, often with reduced ability to recognize the nature of their actions, whose aggressive behaviour is directed both to themselves and to others. Providing the managers of the basic emergency medical teams with the competence to apply and supervise direct coercive measures on their own represents a significant increase in their powers. In addition, it is a significant organisational improvement since, until now, emergency medical teams have not been able to intervene effectively in situations requiring assistance without the help of a physician, and have had to call in a team of specialists. Furthermore, granting paramedics, *expressis verbis*, the status of 'public officers' in connection with the performance of their duties is a desirable legislative measure since it strengthens the protection of this professional group, especially because rescue operations often take place without the patient's consent or with the patient's active resistance. The article contains an overview of current legal regulations concerning the use of direct coercion by emergency medical teams.

Key words: direct coercion, emergency medical teams, applicable law regulations

Introduction

The Constitution of the Republic of Poland of 2 April 1997, in Article 31 guarantees the protection of the freedoms and rights of every human being, and the exclusions in this respect are limited to situations defined in the Act and only if "they are necessary in a democratic state for its security or public order, or for the protection of the environment, public health and morals, or the freedoms and rights of others". In Article 41 section 1 the legislator provided for the integrity and personal freedom of every person. Since a violation of a legally protected good can only occur on the basis of and within the limits of the law, the competence to apply direct coercion by certain persons can be directly inferred from the laws and regulations of the relevant ministers. The Act of 19 August 1994 on the protection of mental health (consolidated text in the Journal of Laws of 2018, item 1878, as amended), the regulation of 21 December 2018 on the use of direct coercion against a person with mental disorders and the Act of 6 November 2008 on Patients' Rights and the Commissioner for Patients' Rights (consolidated text in the Journal of Laws of 2019, item 1127, as amended) are the basic legal acts, which directly regulate the institution of direct coercion in relation to persons manifesting certain mental dysfunctions. The normative environment of professional activities related to the use of direct coercion performed by a paramedic, apart from the aforementioned regulations, also includes the Act of 8 September 2006 on the State Emergency Medical Services (consolidated text in the Journal of Laws of 2019, item 993, as amended), although its provisions do not refer directly to the issue under analysis. These legal acts have already been subject to amendment and have reshaped the scope of powers of paramedics of the State Emergency Medical Services (EMS) System. The authors of the article considered it advisable to present the current legal state of the issue at hand.

The profession of a paramedic and its distinctiveness in the group of medical professions

In Poland different stakeholders are responsible for saving human life and health in situations of immediate danger. Although the scope and forms of assistance vary, it is in fact a duty that no one can evade, under the threat of a criminal sanction. The Penal Code in Article 162 stipulates that it is a civic duty to provide assistance to anyone in a situation threatening him or her with an immediate danger of loss of life or serious damage to health, on condition that assistance can be provided without exposing oneself or another person to the danger of loss of life or serious damage to health [1].

The Polish legislator considered it necessary to establish a specialist service with special competences and powers – the State Emergency Medical Services, which is obliged to act in situations of direct threat to life or health, requiring special skills and disposition for rescue operations.

It is worth noting that previously the Act of 25 July 2001 on State EMS granted the right to initiate and carry out first aid actions, to the extent possible, to "anyone who notices a person or persons in a state of sudden danger to life or health", and at

the same time obliged "anyone" to immediately notify the emergency call centre [2]. Article 4 of the current Act on State EMS has reserved the right to rescue actions in situations of sudden health threat for operators legally established for this purpose, and "anyone" who witnessed such events is only obliged to take actions sufficient and necessary to effectively notify the relevant operators of such situations [3].

After the amendment, the Act on State EMS regulates and organises the functioning of the emergency medical services system in Poland, based on the constitutional right of citizens to health care, which creates a subjective right "for everyone" in this respect and at the same time establishes a statutory obligation of state authorities to implement this right [4]. In the current version of the Act on State EMS the tasks of a paramedic and the area of operation of emergency medical teams have been significantly extended. A paramedic has been tasked with the following responsibilities:

(1) provision of health services, including medical rescue operations performed independently or upon request of a physician;
(2) securing the persons at the scene of the incident and taking measures to prevent an increase in the number of persons in a health emergency;
(3) transporting people in a health emergency;
(4) providing mental support in situations causing a health emergency;
(5) health education and health promotion.

In accordance with Article 3 section 10 of the Act on State EMS an emergency medical team is a unit of the EMS system, which must meet the requirements set out in the Act. In particular, the team undertakes medical rescue operations in non-hospital conditions. Emergency medical teams (EMTs) are divided into the following groups:

(1) specialist teams consisting of at least three persons authorised to perform medical rescue operations, including a physician and a nurse or a paramedic (all being members of the EMS system);
(2) basic teams consisting of at least two persons authorised to perform medical rescue operations, including a nurse or a paramedic (being members of the EMS system).

According to the data of the Central Statistical Office for 2018, emergency medical teams provided health services to nearly 3.2 million people. In comparison with 2017, the number of specialist emergency medical teams decreased by 77 and the number of basic ones increased by 99. In total, in 2018 there were 1541 emergency medical teams (413 specialist and 1128 basic). The number of professional paramedics in emergency medical teams has increased year on year. In 2018, they constituted 73.8% (an increase of 2.9% compared to 2017), emergency nurses – 10.7% (0.7% less compared to 2017), emergency physicians – 8.9% (1.4% less than in 2017) [5, 6]. Since there are more and more rescue interventions involving basic teams, more and more often it has been necessary to use direct coercion, without the direct involvement of a physician. Difficult working conditions and increased exposure to aggression from patients or their environment lead not only to reduced working comfort but also negatively affect the ability to predict the upcoming threat [7]. Consequently, the emergency medical teams

may decide not to use direct coercion in situations when its use is permitted by law and objectively justified, or may decide to use direct coercion illegally or to abuse the law when there are no objective indications to use it.

The "institution of direct coercion" as a special procedure under the Act on the protection of mental health, applicable in medical emergency

The majority of people accept the necessity of direct intervention in some situations without the patient's consent, provided that the intervention is the least restrictive [8]. In the Polish legal system, it is the Constitution currently in force which is and should be the starting point of any considerations concerning legal interventions in the sphere of freedom and human rights. The Constitution of the Republic of Poland of 1997 builds the concept of human rights and freedoms on the recognition of human dignity as the source of these rights and freedoms. Article 30 stresses the inherent and inalienable character of human dignity and provides for the obligation of public authorities to respect and protect it. Some constitutionalists believe that Article 30 is one of the most important interpretative guidelines for the remaining provisions of the Constitution, and even Polish law in general [9].

The Act on the protection of mental health is the most important source of law, which regulates the issue of direct coercion and allows for its application, if necessary. While in the practice of emergency medical teams direct coercion is usually part of immediate intervention necessarily provided at the site of an incident or during transportation to psychiatric care centres (social welfare), detention or forced delivery, various authors argue in favour of its therapeutic function and claim that it helps to improve or even restore the patient's self-control [10]. The Act clearly indicates the individual aspects of the application of direct coercion, in particular providing a list of persons against whom direct coercion can be applied:

- Article 18 section 1:
  - (1) persons who
    - a) attempt to take their own life or harm their health or take the life or harm the health of another person, or
    - b) are a threat to the safety of the general public, or
  - (2) persons who violently destroy or damage objects in their vicinity, or
  - (3) persons who seriously interfere with or prevent the functioning of a psychiatric health care provider or social welfare organisation;
- Article 21 section 1 lists persons whose behaviour indicates that due to a mental disorder they may directly endanger their own life or the life or health of others, or who are unable to meet basic life needs, and may be subject to a psychiatric examination, including without their consent;
- Article 46a section 1 lists persons who have been placed in a social welfare home or psychiatric hospital following a final court ruling.

The catalogue of the measures of direct coercion, listed in Article 3 item 6 of the Act on the protection of mental health, includes:

- holding – defined as temporary, short-term immobilisation by physical force;
- forced use of drugs that involve the introduction of drugs into a person's body on an ad hoc basis or as provided for in the treatment plan – without the person's consent;
- immobilisation – by incapacitating a person with straps, handles, sheets or a straitjacket;
- isolation – placing a person, individually, in a closed and properly adapted room.

In the specialist emergency medical teams, the use of direct coercion is decided by the physician, who determines the type of coercive measure used and personally supervises its implementation (Article 18 section 2 of the Act on the protection of mental health). However, if assistance is provided by the basic emergency medical teams and it is not possible to obtain an immediate decision of the physician, the application of direct coercion is decided – and its execution is personally supervised – by the person in charge of conducting medical rescue operations, who is obliged to immediately notify the medical dispatcher (Article 18 section 5 of the Act on the protection of mental health). The manager of the basic emergency medical team is indicated by the manager of a unit of the system (Article 36 section 5 of the Act on State EMS). The medical operations are supervised by the manager of the EMT (Article 41 section 1 of the Act on State EMS) or, if more than one emergency medical team has been dispatched to the place of the incident, by a person indicated by the medical dispatcher from among the managers of the dispatched emergency medical teams (Article 41 section 2 of the Act on State EMS). In the course of rescue operations carried out by the basic emergency medical team, the use of direct coercion may include holding or immobilisation (Article 18 section 7 of the Act on the protection of mental health) and, with regard to specialised emergency medical teams, direct coercion may also include compulsory administration of medicines. Direct coercion is applied by the basic emergency medical teams no longer than for the time necessary to obtain medical assistance from a physician, and in the case when it is difficult to obtain it, for the time necessary to transport the person to a medical establishment providing psychiatric healthcare or a hospital indicated by a medical dispatcher. The person against whom the measure of direct coercion is to be taken should be warned before the application of it. In a situation where a person with mental disorders, due to his or her condition, is incapable of understanding the information provided to him or her, the reason for not informing the person about the possibility of applying direct coercion should be noted in the medical records. When choosing a coercive measure, the one that is least onerous for the person should be chosen; at the same time particular care should be taken and attention paid to the well-being of the person. Persons applying direct coercion should act in a firm and calm manner, without hesitation, with the readiness to stop the application of the coercive measure

at any time if the patient voluntarily submits to the intervention and the reasons for the use of direct coercion have ceased [11].

In accordance with Article 18 section 5 in connection with Article 18a section 3 of the Act on the protection of mental health, the obligation to check the physical condition of an immobilised person with mental disorders, at least every 15 minutes, rests with the paramedic or the emergency nurse, who should find out about the patient's behaviour as well as decide on the parameters which should be evaluated based on the decision of the physician who supervises or directs the medical rescue operations. Since there is no *expressis verbis* indication in the Act on the protection of mental health within which time direct coercion should be approved by the physician, it can be inferred that direct coercion could be applied for the period of 4 hours. In accordance with Article 21 section 3 of the aforementioned act, transport to a psychiatric hospital or delivery by the police will take place in the presence of a physician, a nurse or an emergency medical team. In practice, the emergency medical teams are often assisted by the police officers who are also entitled to use direct coercion. Often on the scene of the incident, it is the police officers who make the decision to use direct coercion until the arrival of the emergency medical teams. The admissibility of the use of direct coercive measures and the actual use of direct coercive measures by the police are regulated by the Act of 6 April 1990 on the police (consolidated text in the Journal of Laws of 2020, item 360) and the Act of 24 May 2013 on direct coercive measures and firearms (consolidated text in the Journal of Laws of 2019, item 2418). In the situation when the police apply a selected measure of direct coercion, after the arrival of the emergency medical team the person in charge of the emergency rescue operations decides whether to stop the application of a coercive measure or to continue it.

Each case of the use of direct coercion is recorded in individual and collective medical records. The legislator has provided for the patient's safety and welfare in Article 11 section 2 of the Act on State EMS, which requires paramedics to take action using their medical knowledge and with due diligence. Furthermore, the general directive formulated in Article 12 of the Act on the protection of mental health provides that decisions about the type and methods of medical treatment should take into account not only health objectives, but also the interests and other personal rights of a person with mental disorders, which practically means that attempts to improve the patient's health condition should always be made in a way that is least burdensome for him or her. On the other hand, in line with provisions of the Act of 25 September 2015 amending the Act on State EMS, the Act on therapeutic intervention and the Act amending the Act on therapeutic intervention and certain other acts, a paramedic should not start any medical rescue action or should even refrain from any medical rescue action or the provision of health services, however on condition that such behaviour does not lead to the loss of life or severe health disorder [12].

The validity of the application of direct coercion by the manager of the medical rescue operations is assessed within 3 days by a specialist in psychiatry authorised by the province marshal. Since the overall objective is to increase the safety of patients and members of emergency medical teams it is important to unify the system of training in the use of direct coercion, taking into account the statutory regulations in force

[13,14]. A general directive concerning the requirement to instruct the members of emergency medical teams about the circumstances, principles and the way of applying direct coercion has been formulated in the Act of 24 November 2017 amending the Act on the protection of mental health and some other acts assigning this responsibility to dispatchers of emergency medical teams [15].

Amendments of legal acts regulating the operation of the emergency medical services system in terms of the possibility of the application of direct coercion

The most important amendment of the Act of 10 May 2018 on State EMS (the so-called "small amendment") clarified who and in what circumstances benefits from the legal protection accorded to public officers provided for in Article 231a of the Penal Code. Beside persons who provide first aid or qualified first aid, Article 5 section 1 of the Act on State EMS lists *expressis verbis* persons who are members of the emergency medical teams, persons providing medical services in a hospital emergency department, a medical dispatcher during the performance of their tasks and the regional emergency medical services coordinator who performs the tasks referred to in Article 29 section 5 of the Act. It is the present authors' belief that since the paramedic, who performs his or her professional duties, often acts in the state of higher necessity, and often in self defence, in the case of a direct and illegal attack on his or her health and life by the patient who is receiving aid, the justifications stipulated in Article 25 and Article 26 of the Penal Code may effectively exclude the criminal liability of persons providing assistance.

At the same time, it is worth recalling that public officers are legally protected also during or in connection with the performance of their official duties if an unlawful attack against them is made, although it is not directly connected with the performance of official duties, but with their profession or position [16].

The guarantees of legal protection are provided for in Article 5 section 2 of the Act on State EMS, which states that a paramedic "may sacrifice another person's personal rights, other than life or health, as well as property rights to the extent necessary to save the life or health of a person in a state of sudden health emergency", and in Article 6 of the Act on State EMS, where the legislator dismissed possible claims for damage to property, arising during the administration of first aid. The amendment of 10 May 2018 established the requirement for the manager of the basic emergency medical team to have 5 years of experience in providing health services in the emergency medical teams or air rescue teams. The text added in Article 11 section 10a-10c of the Act on State EMS should be considered significant from the point of view of the application of direct coercion; it grants the right to provide immediate assistance without the patient's consent to a paramedic during the performance of professional tasks, and the emergency nurse performing medical rescue operations, if, due to the patient's state of health or age, he or she cannot give his or her consent and it is not possible to communicate with his or her legal representative or actual guardian [17].

The most recent regulations, introduced by the Act of 19 July 2019 on the amendment of certain acts in connection with the implementation of solutions in the area

of e-Health, apply to the managers of basic emergency medical teams. It is now the emergency physician who is the manager of the specialist emergency medical team. The position of manager of the basic emergency medical team can be taken by the person indicated by the manager of a unit of the system, and it can be a paramedic or an emergency nurse with experience of at least 5000 hours over the last 5 years in providing health services in the emergency medical teams, air rescue teams or hospital emergency department. The introduction of an additional obligation for the manager of the basic team to have 5000 hours of professional experience can be interpreted as a desirable action of the legislator to increase the autonomy of the emergency medical teams based on the level of competence of their manager, and not only seniority, as provided for in Article 36 section 5 before the amendment of 19 July 2019 [18].

In the executive regulations to the Act on State EMS related to medical rescue actions and health services other than medical rescue actions, which can be provided by a paramedic, direct coercion has not been identified as a medical rescue action or a health service, although *de facto*, situations may be mentioned when its use already brings about the therapeutic effect for the patient, e.g. release from pain, or e.g. prevents the suicide attempt. In other cases, through appropriate patient immobilisation, such action may enable the assessment of the patient's condition or taking necessary emergency medical services or eliminate the possibility of secondary injuries during transport. This type of application of direct coercion has a strictly "salvage" character, the purpose of which is subordinated to the patient's welfare and not only to the comfort of the person providing assistance.

It seems that the provision of Article 5 item 40 of the Act on healthcare services financed from public funds, defining health services in terms of actions aimed at prevention, preservation, rescue, restoration or improvement of health as well as other medical actions resulting from the treatment process or separate legislation regulating the principles of their provision and Article 3 section 4 of the Act on State EMS, defining "emergency medical services", create the grounds for the adoption of a more precise definition of direct coercion, adequate to the specific working conditions of emergency medical teams [19, 20].

On 21 December 2018, on the basis of the delegation resulting from Article 18f of the Act on the protection of mental health, the Minister of Health issued a new regulation on the use of direct coercion against a person with mental disorders, which clearly defines how direct coercion should be documented and how the legitimacy of its use and the physical condition of an immobilised or isolated person with mental disorders should be evaluated. The regulation also defines the types and templates of documents used in the performance of these activities [21].

New important changes were introduced after 1 January 2021, when medical dispatcher's centres became organisational units of regional offices, which allows governors to take over the supervision of the State Emergency Medical Services system in Poland and propose new practical solutions for EMS teams.

Conclusions

The use of direct coercion by emergency medical teams can only take place on the basis of and within the limits of the law when other forms of therapeutic action have been exhausted and after the safety of the patient and the emergency medical team has been ensured. As direct coercion results in the restriction of freedom and violation of the individual's personal integrity, its application requires the definition of standards of conduct and legal regulations of a statutory nature [22].

In the Polish legal system such standards are expressed in the Constitution of the Republic of Poland and the Act on the protection of mental health, which is the most important source of law regulating direct coercion. The objectives of the use of direct coercion by emergency medical teams in practice, although they usually have the character of an ad hoc intervention related to the necessity to provide assistance at the scene of an incident, are in fact an important measure of respect for the autonomy and subjective rights of patients and indirectly even for the functioning of the public health care system. The transposition of provisions regulating the application of direct coercion from executive acts to the Act on the protection of mental health and granting the "status of a public officer" to paramedics during the performance of their tasks, is, *expressis verbis*, a necessary legislative action, strengthening the position of both the paramedic and the patient, in particular because emergency medical actions taken are often performed without the patient's consent or with his or her active resistance. Providing managers of basic emergency medical teams with the competence to apply and supervise direct coercion on their own is a significant increase of their powers, as well as an important organisational improvement. It might be a good idea to develop guidelines for the use of direct coercion in the form of recommendations of the paramedic's conduct within the framework of the existing "Good Practices of the State Emergency Medical Services System". They would standardise the work of the emergency medical teams in this area, both functionally and medically.

Legislative work on the draft act on the profession of a paramedic, containing comprehensive regulations for the profession, is coming to an end. Due to the growing role of the profession in the health care system, the explanatory memorandum to the draft emphasises the role of the state in ensuring appropriate qualifications of persons joining this profession, as well as the necessity of continuous improvement of qualifications of persons already practising the profession [23]. The proposed regulations are the basis for the recognition of the profession of a paramedic as a "profession of public trust", within the meaning of Article 17 section 1 of the Constitution of the Republic of Poland.

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