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14D – INFORMED PATIENT CONSENT/REFUSAL

EMERGENCY MEDICAL DISPATCHER
EMERGENCY MEDICAL RESPONDER
EMT
EMT-INTERMEDIATE 85
ADVANCED EMT
PARAMEDIC

A. Competent adults are entitled to make decisions about their health care. They have the right to refuse medical care after they have been properly informed of the benefits, risks, and alternatives to the recommended care. This protocol defines the mechanisms by which a patient who summoned EMS care, or for whom EMS care was summoned, may refuse care and/or transport.

B. To safely allow a patient (or their legal representatives) to exercise their rights while protecting yourself and your organization, you need to follow the following steps – each and every time, with each patient who is ultimately not treated or transported:

1. Perform a complete assessment, maintaining suspicion of serious illness or injury.
2. Evaluate the differential of possible medical conditions. Avoid tunnel-vision on only one explanation for the patient's condition. Assume worst case possibilities. You should be thinking of "ruling in" rather than "trying to explain away" worrisome findings. These worst case possibilities must be communicated clearly to the patient (or their legal representatives).
3. Ascertain the patient's mental status. The patient must be alert and oriented to time, place, and events. You must determine the patient's ability to make an informed refusal, dependent upon their ability to evaluate choices, understand risks and benefits of those choices, and have the capacity to make rational decisions. Factors that could impede or impair comprehension and decision making capacity include clinical, physical, and emotional disturbances. If a patient's legal representative is making a refusal request, similar evaluation of that person's mental status must be accomplished.
4. The patient (or their legal representatives) must be offered transport in a polite and unqualified manner. Discouragement of EMS transport, intentional or not, may represent a breach of duty.

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C. For the purpose of this protocol, legal representatives of patients (by legal custody or Durable Power of Attorney for Health Care), or parents of minor patients may refuse medical care if they:

1. Have capacity to make medical decisions = able to understand the nature of the potential injury or illness and the consequences of refusing medical care and/or transportation to an emergency department.

AND

2. At least one of the following:
    - Adult = 18 years of age or older.
    - An emancipated minor = <18 years of age but living away from parents or guardians and financially responsible for self.
    - Married minor.
    - Minor in the military.

Pregnant minors must still have adult consent (unless the emergency medical care being requested or refused is directly related to the pregnancy) if they do not meet one of the above minor exceptions.

D. At no time may a spouse or relative who is not the legal representative of the patient make a decision to refuse evaluation, treatment, or transportation of the patient.

E. The following patients may be considered **NOT** to have capacity to make medical decisions:

1. Altered level of consciousness, including, but not limited to alcohol/drug use or head injury.

2. Attempted or threatened suicide (verbally or otherwise) recently and related to the call.

3. Suspected cerebral hypoxia due to, but not limited to, head injury or prolonged seizure(s).

4. Adults with sustained severely altered vital signs (pulse >120 or <40; respirations >30 or <8 per min; pulse oximetry <85% if history of chronic respiratory illness or <90% if previously healthy; systolic BP >220mmHg or <90mmHg).

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5. Children with sustained severely altered vital signs (pulse >160 or <40; respirations >45 or <12 per min; pulse oximetry <90%; systolic BP >140 mmHg or < 70 + 2 x years of age).

6. Hypoglycemia defined as blood glucose <50 mg/dL.

7. Making largely irrational decisions in the presence of an obvious life or limb threatening condition (e.g. near amputation, ST elevation acute myocardial infarction), including persons who are emotionally unstable.

8. Under mental hold (Emergency Detention) which has been invoked by a person authorized to invoke such a hold.

9. Known mental retardation or deficiency to the degree of being unable to care for self without constant assistance or supervision.

F. An appropriate Supervisor or OLMC must be contacted for all incidents when:

1. EMS has been requested; AND
2. Patient contact has been established (occurs when EMS personnel are physically with the patient and inquire to the patient's well-being), the patient has evidence of acute medical condition (verbalized symptoms or physical exam findings), but further EMS assessment, treatment, and/or transport has been refused; AND
3. Any one of the following:

    a) Patient may NOT have medical decision making capacity to refuse (see E 1-9 immediately above); **OR**
    b) Age < 2 years or > 65 years; **OR**
    c) Minors (unemancipated or not in military) without ability to contact parent/guardian; **OR**
    d) Communication barrier (language or handicap) to extent patient's understanding of condition and recommended treatment/transport cannot be verified; **OR**
    e) Refusal of further assessment, treatment, and/or transport in the EMS professional's judgment places the patient at significant risk.

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G. After the EMS Supervisor and/or OLMC has been informed of the situation, the EMS Supervisor and/or OLMC should communicate directly with the patient, on a recorded line, to establish the patient's intent. To validate the refusal, the EMS Supervisor and/or OLMC should inform the patient or patient's legal representative of:

1. The patient's condition to the extent EMS assessment allows, specifically noting that EMS assessment is limited in scope and not a replacement for physician evaluation.
2. Given the apparent patient condition, the corresponding potential risks of refusal.
3. EMS will transport the patient to an appropriate emergency department for further assessment and care regardless of the financial status of the patient.
4. Alternate forms of treatment or transport that can be offered.
5. A clear statement that the patient (or patient's legal representative) is voluntarily assuming all health risks that may result from the refusal for care at this time.
6. A clear statement that EMS can be recalled anytime if medical assistance is desired.

H. If the EMS Supervisor and/or OLMC cannot successfully intervene to affect further assessment, treatment, and transport in an obvious life or limb threatening condition (e.g. near amputation, ST elevation acute myocardial infarction), AND on-scene personnel believe physically restraining the patient at this juncture to be unsafe or otherwise ill-advised, the EMS Supervisor and/or OLMC should consult the EMS System Chief Medical Officer or his/her designee for further consultative directives.

I. If a patient is determined to NOT have medical decision making capacity, the patient should be treated by implied consent. If this patient continues to refuse assessment, treatment, and/or transportation, all reasonable measures, including law enforcement assistance and/or appropriate use of physical restraint should be used to assess, treat, and transport the patient. The Medical Control Board does not expect EMS professionals to place themselves in physical danger in this process. If a physical threat is imminent, withdraw to a position of safety, requesting additional appropriate resources, while attempting to leave the patient in the care of a responsible adult.

J. All patients (or their legal representatives) who are allowed to refuse further assessment, treatment, and/or transport must have the risks, benefits, and alternatives of their decisions explained to them by EMS personnel and demonstrate an understanding of this discussion. The reason(s) of refusal stated to EMS, benefits of recommended treatment and/or transport, alternatives to initially recommended care and/or transport, and risks of the refusal explained to the patient (or their legal representatives) and the reactions to this explanation must be documented in the patient care report in addition to the patient's chief complaint, vital signs and physical assessment.

K. All patients (or their legal representatives) who are allowed to refuse further assessment, treatment, and/or transport must be advised to seek further medical examination and care by a licensed physician (M.D. or D.O.). The limitations of EMS scope of assessment and practice must be explained. Document this information as it was explained.

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L. All patients (or their legal representatives) who are allowed to refuse further assessment, treatment, and/or transport are to sign a refusal statement. A witness (preferably a friend or relative of the patient) is to countersign the refusal to verify its accuracy. The signature of release may or may not actually "release" an EMS professional or EMS organization from liability. One of the many purposes of using a release, however, is to further demonstrate good faith and diligence in meeting responsibilities to the patient. Together, with prudent actions, it helps to defend against assertions of abandonment. If the patient (or their legal representative) refuses to sign a valid refusal form, EMS professionals should also document the details of this encounter, including reasons for refusal to sign. EMS professionals should also document on the refusal form "Patient refused to sign." with at least one colleague signing as a witness.

M. Leave the patient (or their legal representatives) any applicable medical care instruction sheets. Document in the patient care report what instruction sheet(s) were given.

N. All dispatches not resulting in the transport of a patient require completion of the appropriate no transport information.

<u>Additional Notes</u>:

1. **DO NOT** ignore clues to potentially serious injuries or illnesses, such as abnormal vital signs, unconsciousness which may be followed by a transient lucid stage (head injury with epidural hematoma), concern of family members or witnesses, or inconsistencies in information obtained from different sources.

2. A red flag needs to be raised anytime with thoughts such as "this patient is just a drunk", "it's not that bad, this patient can't afford an ambulance", or "an ambulance shouldn't be tied up on this type of call". These rationalizations encourage underestimating the patient's condition and treatment shortcuts, resulting in substandard patient care and patient endangerment.

3. Refusal of assessment, treatment, and/or transport situations are often emotionally and potentially legally charged situations. Maintain duty to act in the best interests of all patients by avoiding any potentially discouraging tone, language, or body positioning that conveys unwillingness to provide humane, compassionate patient care.

4. Every patient has a right to EMS full service and attention. While a perception of "system demands" may be commendable, it cannot supersede a patient's needs and rights unless in the most dire of disaster conditions. Take patients one at a time and give them the best care morally, ethically, and legally possible.

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Special Considerations in Care of Minors

A. If a minor aged patient presents with life or limb threatening condition, but no parent or guardian is present, do not delay indicated care. Provide treatment and transport per applicable protocol(s) and assign other public safety colleagues the task of notifying the child's parent/legal guardian of the incident, any obvious illness/injury, and hospital to which the child was transported.

B. If a minor needs medical treatment, but no parent or guardian is present, EMS professionals may treat per applicable protocol(s) if the parent or guardian cannot be reached after reasonable attempts and the minor gives verbal and physical consent.

C. IF THE PARENT/GUARDIAN CANNOT BE REACHED AFTER REASONABLE ATTEMPTS AND THE MINOR REFUSES TREATMENT:

1. Consult an appropriate EMS Supervisor for advice, which may include, but is not limited to:

    - Police assistance, taking the minor into their protective custody.
    - Utilization of family members outside the immediate parents/legal guardians.
    - Utilization of reliable adults with prior knowledge of the minor.
    - As a last resort, allowing the minor refusal of service under the same requirements and procedures as listed above for adult patients (or their legal representatives).