



Patient Refusals



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“BEST PRACTICES”**

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Best Practices in Patient Refusals

by Bradley M. Pinsky, JD/MHA/EMT-D

There is no other way to say it: Writing a patient refusal is boring and tedious. It is even worse when you have to obtain numerous refusals at a motor vehicle accident that never should have been called in to '911. So, why write patient refusals? What information should refusals contain? Finally, are you familiar with the Department of Health's new amendment to the BLS protocol regarding patient refusals?

This article will address the best practices regarding a patient refusal. The information provided will assist the EMT in exceeding the standard of care.

Why write a patient refusal?

Patient refusal forms are not designed to protect the patient. Instead, they should be designed to protect the treating EMT and the EMT's agency/employer. A well written patient refusal will prove to a court or the DOH that the patient was not abandoned or negligently treated by the EMT. Abandonment is the act of leaving a patient without treatment or transportation without the patient's informed consent. A patient may be deemed abandoned if an EMT fails to inform the patient of the risks of refusing treatment, such that the patient can make an informed choice about the dangers of refusing treatment or transportation.

There are many real life examples of patients who suffered no injury at a motor vehicle accident, and who refused treatment, only to later claim that they were injured at the scene but that the ambulance refused to properly examine and treat them. These false claims are resolved in a "he said/she said dispute", and it becomes the role of a jury to determine who is telling the truth. If the EMT did not adequately complete a PCR, a jury might believe that the EMT failed to examine the patient, denied treatment or transportation to the patient, or in fact, never even spoke with the patient.

Consider also that most patient refusals are obtained for non-eventful situations. Therefore, EMTs are not likely to remember the event or the patient three years after the call, when the EMT is called to testify at a trial. Failure to obtain documentation to serve as proof of the events of that day will be very damaging to the EMT's defense.

Finally, remember that a patient's condition may change from one hour to the next. The EMT must be able to document that the patient had the capacity to refuse care at the time of the encounter with the EMT. If such capacity is not documented in the PCR, and if a patient thereafter experiences a diminished capacity, a judge or jury might not believe the patient had capacity to refuse during the time of the encounter with the EMT. The judge or jury could then find that the EMT abandoned the patient by failing to treat and/or transport him.

When and for whom should a patient refusal be written?

The best practice is to obtain a patient refusal for every person the EMT contacts in a pre-hospital setting. We recognize that common practice is to not obtain a refusal for some encounters. However, the EMT must realize that some people are scrupulous and may allege that the EMT failed to complete a proper examination to locate injuries or illnesses.

One of the most debated issues involves school bus accidents. Admittedly, the popular belief is to

complete one PCR for all children on a school bus. This is a dangerous practice. Consider the angry parent of a child who turns out to have suffered an injury that went undiscovered. The parent will demand to know whether or not the child was examined by the EMTs on the scene. Without a specific PCR for each child, the EMT will not be able to prove that the child was properly examined and did not have any apparent injuries.

Consider a worst case scenario, that the child is injured a day or two after the accident, as a result of an unrelated fall. An unscrupulous parent wants to allege that the injury was caused by the bus accident, and sue the owner of the bus, and the EMT for failing to treat the child. The EMT is in jeopardy of losing any related lawsuit, since the EMT cannot document any actual examination of the child at the bus accident.

While extreme, this example serves the point of proving that why we must document all contacts with patients. However, let us state that this is again the "best practice" and represents a practice more strict than the Department of Health requires.

Who may refuse care?

Only patients who are competent and have the capacity to refuse care may do so. Alternatively, the guardian or adult parent of a child may refuse care. However, it is critical to understand the terms competent and capacity, and to understand the abilities of parents and minors to refuse care.

Competency

Only a judge or physician can determine whether a person is incompetent. It is not a determination that can be made by an EMT in the field. Often times, a person who has been judged "incompetent" will have a guardian to make decisions on his behalf. A health care proxy will not permit another person to make medical decisions for the patient until the patient has been judged incompetent by a physician. However, EMTs may rely on the claim of a person alleging to have a health care proxy to make decisions for a patient. The only exception to this is that a proxy may not instruct EMTs not to resuscitate a patient, unless the EMTs are presented with a DNR or DNR bracelet.

Capacity

EMTs are required to determine whether or not a patient has the capacity to refuse care. EMTs are in the best position to judge a patient's capacity at a scene and are forced to make these determinations every day.

At the outset, a patient must be eighteen years of age or older, and be alert, oriented to person, place and time, and have a glasgow coma scale score of fifteen in order to refuse care. The mere fact that a patient appears intoxicated, has received a head injury, or suffers from a mentally debilitating disease such as dementia or Alzheimer's does not mean that a patient who is A&O³ and has a GCS of 15 lacks the capacity to refuse care.

Instead, the EMT must determine the patient's ability to comprehend the risks of refusing care and/or treatment. One word of caution. Realize that elderly persons or persons who have been hospitalized occasionally do not know the date or time. In these instances, the EMT must use other means to determine if the patient has the capacity to refuse care, such as the patient's birth date or social security number.

Minors

This rule is simple. A minor may never refuse care for himself or another. There is no such thing in New York State as an emancipated minor for the purpose of refusing care for himself or another. Again, a person under the age of eighteen years may never refuse care for himself or another. The fact that the minor is married, away at collage, or a parent does not change this rule.

The Public Health Law does permit parents who are minors to consent to care for their born and unborn children. However, do not confuse the ability to consent to care and the ability to refuse care. A related article appears at www.emsfirelaw.com on patient refusals involving minors.

Parents and Guardians

Parents who are at least eighteen years of age and legal guardians of minors may refuse care for their children. Guardians of persons determined incompetent to make decisions for themselves may also make health care decisions.

Can the police assist us with a refusing patient?

The Mental Hygiene law provides that police officers may take persons in custody in very limited circumstances. Section 9.41 of the law states: "Any peace officer, when acting pursuant to his or her special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others. Such officer may direct the removal of such person or remove him or her to any hospital".

The law further states that "Likelihood to result in serious harm" shall mean "(1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or (2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm."

Certainly, there are very limited circumstances where the police may take a refusing patient to the hospital against his will.

Can Medical Control assist with a refusing patient?

The Department of Health Protocol on patients refusing medical care provides that the EMT should attempt to contact the patient's physician or medical control for a patient that refuses treatment and/or transportation. While this is a good idea in theory, many agencies report that a physician will not impose its will on a patient with the capacity to refuse. Indeed, this is the correct stance. However, we believe the DOH wants the EMT to offer to permit the EMT to speak with a physician as a physician may be more persuasive than the EMT.

Who should complete a refusal form?

Any EMT is permitted to complete a PCR. A CFR should not complete the PCR, as for among other reasons, a CFR is not trained to obtain vital signs and is not trained to assess mental capacity. Therefore, fire chiefs who cancel EMS for a minor motor vehicle accident without obtaining a patient refusal, risks

that a patient claims he was injured and lacked the capacity to refuse, that the patient was not properly examined or that he was not advised of the risks of refusing treatment or transportation. The patient might allege that had he been examined by someone with medical training, a sign or symptom of an illness or injury (such as high blood pressure) might have been revealed to the patient. If a non-EMT completes the PCR or a patient refusal form, a well informed lawyer is likely to have the document deemed unreliable and ineffective. The fire or EMS agency will then be left with little or no protection to an abandonment or negligence lawsuit.

Contents of the Patient Refusal

The Department of Health's new protocol on patient refusals outlines the now required contents of a patient refusal. However, there are other items that should be included to protect the EMT.

The best way to complete the patient refusal is to complete the PCR as if the patient was transported. Make sure to note the chief complaint, the age of the patient, that the patient was alert and oriented to person, place and time, the level of consciousness, Glasgow Coma Scale score, the patient's medical history, and the mechanism of injury (if any). Be sure to make note of anything that may affect capacity, such as alcohol, drug use, head injury, or blood loss. Do not ignore these items, or you may be accused of not paying attention to them. Instead, for any patient with a condition or impairment that could impair the patient's capacity to refuse care, be sure to use a phrase such as "Despite a history of dementia, patient understood risks and refused treatment".

Document a physical exam, if warranted by the situation. The DOH requires that at least one complete set of vitals was taken.

Most importantly, document that "The risks of refusing care and transportation were explained to the patient and the patient appeared to understand these statements". What risks must you explain? Be practical, since EMTs cannot truly diagnose the cause of every sign or symptom, simply inform the patient that "By refusing treatment and/or transportation, you increase the risk of further injury or illness, including death". It is not necessary for you to attempt to explain the risks further.

Finally, you should obtain the signature of the patient refusing care, or the patient's parent or guardian. However, although you are required by the DOH to obtain a signature on the back of the PCR, this signature has no real legal significance. A refusal form should have a release of liability, where the patient signs a form releasing the EMT and the EMT's agency from any liability for not transporting or treating the patient. The PCR does not accomplish this form. Although not required by the DOH, the PCR should have a witness signature stating that the witness observed the EMT explaining the risks of refusing care and transportation and that the patient appeared to have understood the EMT. The PCR does require a witness signature, but it simply does not go far enough to protect the EMT and the agency.

The Solution: Create a Patient Refusal Form

The PCR is not the best document to remind the EMT of all of the items to be addressed when obtaining a patient refusal. The DOH requires statements to be included for which there are no "check boxes" on the form, such as a statement that risks of refusing care and transportation were explained.

More importantly, the PCR does not contain a release form that protects the EMT or the EMT's agency from legal prosecution. Attached to this article is a proposed form to be used by EMS and Fire Agencies, or regional councils (REMSCO) and medical advisory committees (REMAC).

Should your agency have its own refusal policy?

Agencies might consider not implementing any policy that imposes any higher burdens of care upon an EMT. Alternatively, agencies should change the title of their "standard operating procedures" or "standard operating guidelines" to "best practice guidelines". The law does not permit either the DOH or a court to determine that an EMT was negligent or incompetent based upon the failure to adhere to the "best practice" or a higher standard than the standard of care. Instead, negligence and incompetence is determined in comparison to the standard of care. Since both of the titles stated above use the term "standard", they might be confused with the standard of care, and be used against an EMT.

Conclusion

Patient refusals are tedious, but they are vital documents to protecting the EMT and the agency from lawsuits. Careful attention to detail will provide ample protection. Remember that these documents are not for the protection of the patient, but are designed to protect the providers of care.

Bradley M. Pinsky, Esq. can assist with drafting a refusal form to protect your corporation, volunteers and employees.

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Tip of the Week Archives

May 15, 2003

Patient Refusals and HIPAA

While writing "The Ambulance Service Guide to HIPAA Compliance - Second Edition," as well on a few occasions since then, we have internally debated whether patient refusal situations require covered entity ambulance services to furnish a Notice of Privacy Practices (NPP) and attempt to obtain a signed acknowledgment from persons who refuse care. This continues to be a "frequently asked question" of us under the HIPAA Privacy Rule.

The regulations (Section 164.520(c)(2)) say that a covered entity health care provider with a "direct treatment relationship" must furnish its NPP "no later than the date of the first service delivery" (subject, of course, to the "emergency" exception, which for the sake of argument we will assume is not applicable since we are dealing with a refusal situation in this example). "Service delivery" is rather broad, and, interestingly enough, the regulations did not use the term "health care services" here. It can certainly be argued that a proper refusal interaction is still the delivery of a "service" -- it is an emergency health care response, an evaluation (hopefully) and a set of recommendations from the EMS personnel based on their findings.

Furthermore, EMS personnel should generate a patient care report or other refusal documentation, which would certainly constitute Protected Health Information (PHI).

It has been suggested that someone who refuses care is not a "patient" -- and therefore that a HIPAA-covered ambulance service therefore need not furnish their NPP to such a person. The question of "who is a patient" is much-debated in EMS (and, incidentally, was a question that we undertook to address in an article on MergiNet.com titled "[Who Is a Patient? A Commonsense Take on Consent, Refusals, and Negligence in EMS.](#)" While in that article we made the argument that persons who refuse care might indeed not be classified as "patients," we also argued that the question may really be moot since the documentation issues don't stop with that determination.

Also, add this to the argument: the mere fact that EMS care or services were not requested does not necessarily mean that the person is not a "patient." It is often the case in health care where providers render services to patients involuntarily under several legal premises (e.g., implied consent, persons in custody, mental health commitments, etc.) so it would not seem that "refusing" care versus "vountarily accepting" services is necessarily the deciding factor either.

In short, we have always advocated that EMS providers in a refusal situation should obtain a patient refusal signature whenever possible. While it is debatable, it appears that the HIPAA Privacy Rule certainly can be read to require that an ambulance provider furnish an NPP to and make a good faith attempt to obtain a signed acknowledgment of receipt from a person who refuses care after an evaluation. Providing the NPP and attempting to obtain the signature doesn't pose that much of an additional burden under the circumstances, and there is no reason under HIPAA that you can't include the NPP acknowledgment language, such as "I acknowledge receipt of ABC Ambulance Service's Notice of Privacy Practices," directly on your refusal form in order to minimize the additional paperwork in a refusal situation.

For more information from Page, Wolfberg & Wirth, LLC about effective documentation, be sure to visit our Tip of the Week Archives for previous Tips on documentation and patient refusals. Also, check out the 90-minute audio cassette from our recent National EMS Law Audio Conference, "[Write it Right: Effective Documentation for Patient Care, Reimbursement and Compliance.](#)"

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Beware Patient Refusals

By Jay Weaver, JD

For EMS administrators, the most problematic patients are sometimes those who do not want an ambulance at all. EMS providers who transport a patient involuntarily may face allegations of assault, battery or false imprisonment. Conversely, those who leave a patient behind may be accused of negligence. Because an employer may be held liable for the on-duty actions of employees, their EMS agency or system stands a good chance of getting sued as well.

Many EMS provider organizations have tried to protect themselves by adopting operational policies to guide field personnel in managing reluctant patients. Unfortunately, most of these policies prove woefully inadequate. Some rely on inappropriate criteria. Others are too abbreviated. A few actually increase the likelihood of litigation by recommending action that violates accepted legal principles. As a result, EMS administrators who rely on these policies as a shield from liability often fall victim to a false sense of security.

Because both EMS systems and laws vary from one jurisdiction to the next, each EMS agency must craft its own refusal policy. But certain essential elements belong in every policy. At a minimum, such policies should include standards for competence, documentation and supervision.

Competence

U.S. courts have long upheld the right of well-informed, mentally competent adults to accept or refuse treatment as they see fit. This right of refusal is by no means absolute, however. In a medical emergency, EMTs and paramedics may force a patient rendered mentally incompetent by illness, injury or intoxication to accept life-saving care, no matter how strongly the patient objects.

The challenge for EMS administrators is to define for field personnel the circumstances under which a patient should be presumed incompetent.

Historically, many EMS systems have relied on an orientation standard, permitting a patient who has demonstrated an awareness of person, time and place to refuse care. Don't make this mistake.

Because an oriented patient may not necessarily possess the ability to process information effectively, refusal-of-transport policies should instead focus on the patient's comprehension. The patient should demonstrate a capability to understand:

The nature of the condition;

The risks and benefits of the proposed treatment; and

The risks and benefits of refusing care.

Some legal experts recommend using a sliding scale of competence, requiring patients to demonstrate greater comprehension as the risk of refusal increases. Although valid in theory, this method requires too much subjectivity on the part of prehospital personnel.

Paraphrasing may provide the best method for ensuring competence. Before accepting a patient's refusal of transport, EMS personnel should explain the nature of the emergency and the risks and benefits of both treatment and refusal. They should then ask patients to use their own words to explain what they have been told to determine if they understand all three elements.

Documentation

A patient's refusal of transport makes good documentation vital. Because lawsuits sometimes don't commence until many years after an incident, these documents often provide factual information that otherwise would be lost to the fading memories of witnesses.

At a minimum, the patient care report on a patient refusal should include:

Physical examination findings;

Vital signs;

Factors that may affect a patient's ability to reason (e.g., the presence of drugs or alcohol); and

The EMS treatment offered.

In addition, providers should ask the patient to sign a refusal/release form. This document supplements the patient care report by showing that the patient—not the EMTs or paramedics—made the decision to refuse transport. EMS personnel should ask any witnesses to sign this as well.

An adequate refusal/release form must do more than simply state that the patient refused transport; it must indicate that the patient was advised about the suspected medical condition and understands both the nature of the proposed treatment and the potential consequences of refusal. Also, consider working with your attorney to draft a release-from-liability provision to include on this form.

Supervision

Whenever possible, field providers should ask a medical control physician to supervise a patient's refusal of transport. Although a physician generally has no greater right than an EMT to force unwanted care on a competent patient, a doctor may prove useful in convincing the patient to accept transport. In case of a bad outcome, a physician's testimony may later support the field providers' contentions that they handled the situation properly.

By implementing a refusal policy containing these standards, EMS systems may significantly reduce their liability.

About the author

Jay Weaver, JD, has been a paramedic for the city of Boston for 15 years. A graduate of Harvard University and Suffolk University Law School, he has lectured on prehospital patient autonomy at a number of colleges and physicians' conferences. Contact him via e-mail at Frappe760@aol.com.



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Tip of the Week Archives
March 16, 2003

Handling Patient Refusals: A³E³P³!

Patient refusals must be handled properly to minimize the potential liability that can arise. Over the years, we have developed and modified a set of refusal guidelines we call "A³E³P³" to help EMS providers remember the important things to consider in dealing with refusal situations.

1. Assess

ASSESS the patient's legal and mental capacity to refuse care. Is the patient 18 years of age, or does the patient meet your state's exceptions for emancipated minors? Is the patient suffering from any mental condition that might prevent them from making an informed decision?

2. Advise

ADVISE the patient of their condition and your proposed treatment. We don't diagnose in EMS, but we should tell a patient what's going on with their condition and how we would propose to help them so their refusal decision is *informed!*

3. Avoid

AVOID the use of confusing terminology when talking to your patient. Make sure you communicate with your patient in terms they can understand!

4. Ensure

ENSURE that the patient's decision to refuse care is the product of their own informed decisionmaking, and not the result of improper influence or coercion by others.

5. Explain

EXPLAIN the alternatives to your patient if they refuse your care and transportation. Make sure they know their options, such as calling 911 again; calling their physician; going to the E.R., etc.

6. Exploit

EXPLOIT uncertainty! Many patients are unsure about whether or not to go to the hospital, and that uncertainty should be used to your advantage in advising the patient to obtain the care they need.

7. Persist

PERSIST in trying to persuade your patient to obtain care they need. Sometimes you have to make several attempts to convince a patient that they need to go to the hospital.

8. Protocols

PROTOCOLS -- follow them! If your service or your EMS system has protocols in place regarding patient refusals, be sure to adhere to them.

9. Protect

PROTECT yourself with adequate documentation of the refusal. Write a thorough narrative, obtain the patient's signature whenever possible, and try to get the names and addresses of impartial witnesses.

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Tip of the Week Archives January 15, 2003

Five Simple Ways to Improve Your Documentation Skills!

As we have preached so many times in the past, good documentation is important to you and your ambulance service for many reasons. Good documentation can facilitate good patient care, help protect you from liability and can favorably impact your ambulance service's reimbursement.

This EMS Law "Monthly Tip of the Week" presents five quick and easy things you can do to improve your documentation right now!

1. Paint a Picture

Think of your documentation as painting a picture of the incident. However, instead of using a paintbrush or a camera, you are using words. Set the scene. For instance, at an accident scene -- Where are the cars? Is there broken glass and tire marks? Is there significant damage to the vehicles and was the passenger compartment compromised? What are sights, sounds and smells are registering on your senses?

2. Use Chronological Narratives

Avoid the tendency that some EMS providers have to jump around as things enter their minds. Stay focused; write your narrative so it flows in chronological order and that the steps of your dispatch, assessment, treatment and transport are documented in a logical fashion. This can be especially problematic when too much time passes between the call and the time the documentation is done. Document when the call is as fresh in your mind as possible.

3. Stick to the Facts

A well-written patient care report is *objective* instead of *subjective*. This means that your charts should stick to the facts, and leave out the personal interpretations and "spin." For instance, don't say your patient simply was "intoxicated." Instead, document the *facts* that lead you to that conclusion, such as "patient's speech was slurred"; "odor of alcohol on patient's breath;" "patient admitted drinking 8 beers in the past hour" and other such objective facts.

4. Abandon Home-Grown Abbreviations

Many EMS providers love to use home-grown abbreviations. Reading their charts is like grading a test and they're the only ones who have the answer key! Abbreviations are fine, but stick to ones that are common and accepted in the health care professions. Your service can even consider adopting a

standard table of abbreviations to be used in your company's patient care reports.

5. Spelling Counts

Finally, we know that this is a tough one, and not everyone has top-notch spelling skills, but proper spelling and grammar is important. Remember, if a jury looks at your chart someday, and your chart is full of errors, it may lead a jury to conclude you are as sloppy at patient care as you are at documentation. Nobody's perfect in this department, and medical terminology can be especially tricky to spell properly. So, pick up an EMT textbook or get a medical dictionary at the station and commit to learning a new word or two on each shift. It helps your vocabulary – both in EMS and in life – and improves your trip sheets to boot.

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Refusing Treatment or Transport

By Todd Talbert

April 2001, MERGINET - When a patient refuses treatment or transport from on-scene EMS personnel, many difficult situations can arise that place either the patient or the involved paramedic at risk. One of the most reliable records of what has transpired during a paramedic-patient contact is subsequent documentation on the associated Patient Care Report (aka PCR or run sheet). Not only is the PCR an important link for health care participants who might become involved in the patient's chain of care, it's also a key piece of documentation that an attorney may use to reconstruct the events of the call or to pursue a claim against an EMS provider. These two facts make it clear that when a patient refuses aid, documenting only that "patient refused transport and further care" is legally insufficient.

In America, a patient has the right to determine his or her health care. However, a patient's desire for self-determination can only occur when the patient presents as a competent adult. Not only does this mean that a competent adult patient must formally consent to any prospective medical care, it also means that a competent adult patient has the right to refuse current (and future) health care treatments.

Language used to describe patient competency is sometimes open to interpretation, but usually describes an adult patient as capable of accurately responding to a standardized questioning process that seeks to identify if the patient is fully oriented. A status of *fully oriented* or *alert and oriented* is determined by whether the patient can communicate name (person), location (place), month, day, and date (time), and current situational circumstances (event).

Even though a patient may be obviously intoxicated, such a person still may present as legally competent. According to *Health and the Law*, "...intoxicated and/or addicted persons have no specific legal status that would affect their ability to consent to treatment" (Christoffel 272). A paramedic on the scene of a call must question an intoxicated patient's competency to self-determine personal medical decisions. *The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, (Decision-making Capacity)* has established:

In the view of the commission, any determination of the capacity to decide on a course of treatment must relate to the individual abilities of the patient... Decision-making capacity requires, to a greater or lesser degree: (1) possession of a set of values and goals; (2) the ability to communicate and understand information; (3) the ability to reason and to deliberate about one's choices (Furrow et al. 1101).

It could then be argued that when an intoxicated patient refuses treatment or transport, even if "medically competent," the patient's medical capacity might have altered and hindered the ability to reason and to deliberate about his or her choices. Consent, as it relates to minors, the developmentally disabled, and the mentally ill, presents a few other situations that make issues surrounding pre-hospital treatment refusals even more complex.

The PCR is often a key item used by attorneys to reconstruct the events of an EMS call. Using the example of a PCR that states only, "patient refused transport and further care," it fails to address the events that took place while the emergency provider was in contact with the patient. Failure to record what transpired on scene, especially if a bad patient outcome were to result, exposes the paramedic to a potential claim of negligence or abandonment.

A properly documented PCR communicates competency and credibility, and that documentation can prevent allegations of negligence.

A PCR that fails to document an orientation level or a physical assessment does not verify that the

standard of care was met; essentially, claims such as abandonment or negligence made by the plaintiff would be reduced to a "my word against your word" defense by the defendant. Since information closest to the date of the event is generally viewed as the most credible, a defense containing "after the fact" memories about a patient's condition decreases the defendant's own credibility and impression of competency. For example, a paramedic or EMT who fails to document a patient's vital signs, even if the procedure was actually performed, will have his or her judgment and clinical competency questioned. A properly documented PCR communicates competency and credibility, and that documentation can prevent allegations of negligence.

The PCR can be used to document the patient's verbal responses and interactions with those attempting to provide care. "Typically, one of the best things that you can do when a patient refuses EMS services is to document their verbal replies in quotations" (Hiatt, 2000). Quotes from patients, especially if they are hostile, can speak volumes to a jury, and can help a jury measure patient behavior. For example, if a patient having chest pain stated, "Get the h--- out of my house!" immediately after the paramedic arrived, and this quotation was documented on the PCR, difficulties or obstacles encountered by rescuers charged with rendering care might be easier understood.

According to *EMS and the Law*, all patient refusals should be accompanied with a written release that, at minimum, contains the following:

...(a) the patient has been told of his or her condition, (b) the patient understands the risks of refusal, (c) the patient refuses assistance transport [or whatever assistance was offered], (d) that the patient assumes all risks, and (e) the patient releases EMS personnel from liability. The release should cover both the employee and the employer (Goldstein 74).

Additional guidelines might be necessary to help reduce liability. This assumption is based on a literature review comprised of research published between 1990 and 1998:

Key concepts identified in the review of this literature were: refusals of medical care in the pre-hospital setting occur at a relatively high rate; non-transport of a patient is the most common pre-hospital patient care event leading to litigation; oftentimes patients are unable to recall instructions and risks as explained by paramedics; cases of informed consent are the most common ethical conflict paramedics face; outcomes of patients that refuse care range from admission to the hospital to death... (Schryer, 1998).

In *Legal Aspects of Documenting Patient Care*, author Ronald Scott advocates the need to include communicating "reasonable alternatives" for patients who refuse transport. Scott states that a checklist is a valuable tool to help document informed consent for treatment, or for situations when treatment is refused. Thomas Schryer, who compiled the previously mentioned literature review, advocates that the following twelve items be included on the checklist suggested by Scott:

1. Physical examination, including vital signs
2. History of event and prior medical history to include medications
3. Patient or decision-maker determined to be legally capable of refusing medical care
4. Risks of refusal of medical care and transportation explained
5. Benefits of medical care or transport explained
6. Patient clearly offered medical care and/or transportation
7. Refusal of Care Form prepared, explained, signed, and witnessed
8. Patient confirmed to have a meaningful understanding of the risks and benefits involved in the medical care decision
9. Patient advised to seek medical attention for complaint
10. Patient advised to call 911 for medical assistance if condition continues or worsens
11. Base consultation occurred according to local policy
12. Supervisor was notified if any of the above was not accomplished

Given the potential for poor patient outcome and litigation when a patient refuses to consent to ambulance transport, it is necessary to establish and follow a standardized approach. Since

"implied consent" essentially covers situations when a patient presents as uncooperative or disoriented, questionable cases should err on the side of the patient. In a nutshell, your interactions will always depend upon your assessment of the scene and/or the patient. Failure to document those assessments can open the door to claims of abandonment or other forms of negligence.

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