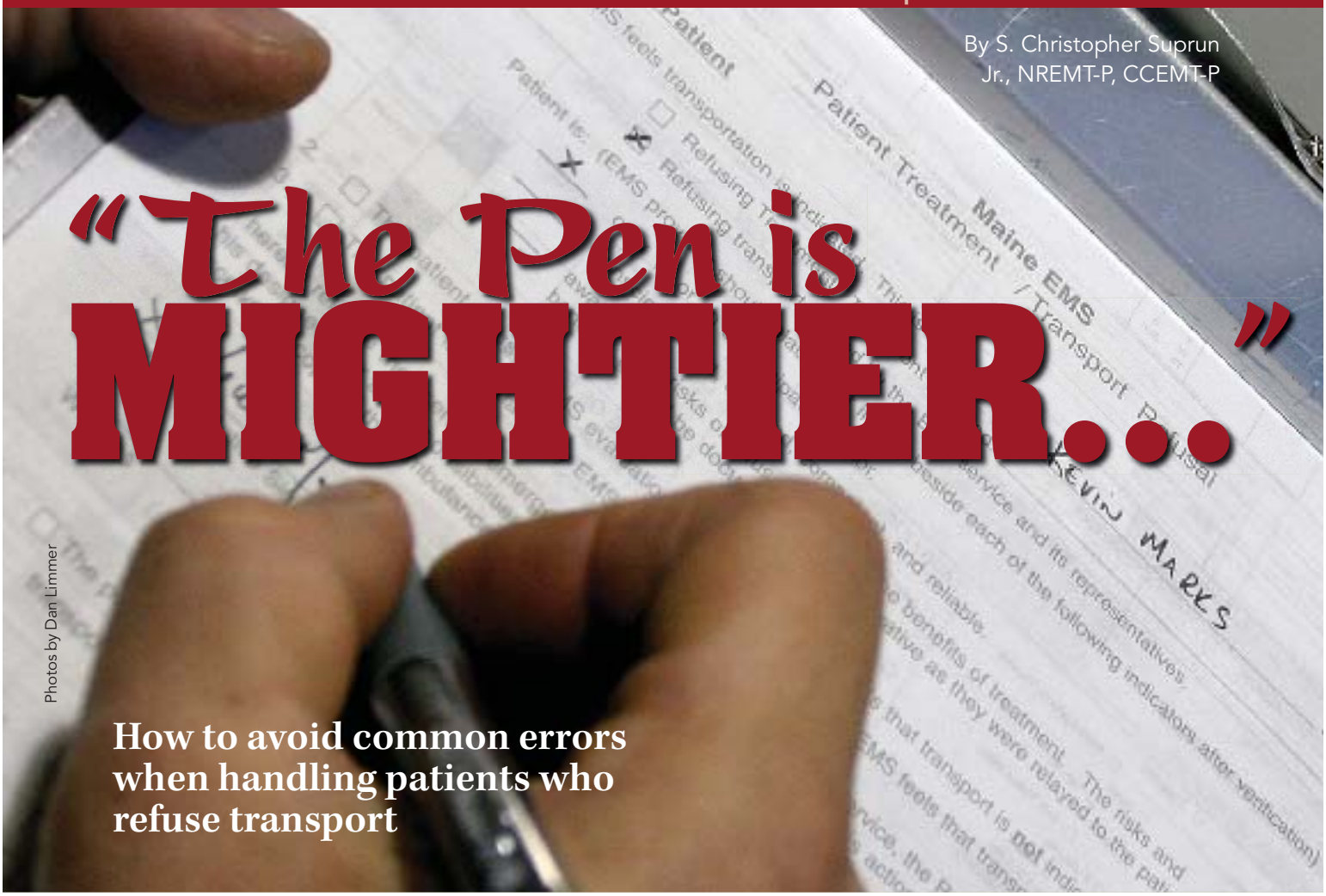
By S. Christopher Suprun Jr., NREMT-P, CCEMT-P

"The Pen is MIGHTIER..."



Photos by Dan Limmer

How to avoid common errors when handling patients who refuse transport

"EMS told us…she was not sick enough to transport," was one of the quotes from family members after a south Texas EMS agency refused to transport a 71-year-old woman who had fallen and was later diagnosed as having broken her wrist.

This situation is one of an increasing number where EMS providers are being challenged by an ever more aware public concerned about the healthcare they receive, whether it be from a personal physician, an emergency department nurse or the local EMS service.

"The root cause of documentation problems many times has to do with apathy and attitudes," says Steve Wirth, an attorney who specializes in EMS law and is a partner in the law firm Page, Wolfberg and Wirth. "The main intervention we provide to patients is human interaction, and if you don't communicate well with patients or don't care much about the paperwork necessary to document your care, it is likely the documentation will suffer."

Documentation is an important aspect in our patient care. While documentation alone may not stop a lawsuit, it can certainly shorten it and strengthen the EMS provider's standing in court.

In this first Texas case, the EMS medical director noted for her county governing body that several patient complaints had come in, necessitating policy changes for the EMS service. She followed up with a statement that said "while reviewing these patient records, I found no documentation to disprove any of the complaints." It is a very unfortunate set of circumstances for a medical director to be put into the position of being unable to defend the providers operating under his or her license.

This article reviews legal issues surrounding refusals and documentation for EMS. As lawsuits go, there are several areas that tend to affect us and refusals are at the top of the list. In several references, refusals led to more than half of EMS litigation. While you may not be aware of any issues in your jurisdiction, they may be occurring without your knowledge, with your community settling large sums of money out of court. (A quick reminder that any money spent on lawsuits and settlements is money your jurisdiction no longer has available to pay for raises for EMS providers who try to do the right thing for the community's patients.)

Given that refusals are such an important part of what we do, let us consider some of the factors that go into writing a legally defensible refusal.

PREPARATION AND PAYMENT ISSUES

Expect the unexpected. If you are in management and know that your organization has never suffered through a legal proceeding, congratulations. However, just because

you have never been on a seizure call doesn't mean you should disregard it as a possibility that your agency will have to face. It is important for agency leaders to understand the issues that go into patient refusals and to prepare for the day it happens in your jurisdiction.

It is important to train providers that payment is not the basis for emergency service, the patient is the basis for emergency service. Somewhere in the past decade, EMS has become about pay for service instead of people receiving prompt transportation to the emergency department for significant medical challenges they are facing.

According to attorney Chris Kelly, "9-1-1 is misunderstood. The public doesn't have a concept of an ambulance that isn't an emergency."

Kelly says that one of the problems EMS has is we are allowing the "tail to wag the dog" in that if insurance won't cover it we assume it isn't a needed service.

Kelly, an attorney practicing in Atlanta, GA, handles a heavy load of EMS-related cases. As he says, "insurance and Medicaid dictate what they pay for, not what service we render."

Stories about EMS providers not taking patients either because their injury or illness isn't serious enough or because they may not be able to pay cast EMS in a negative light. In most cases, the street providers do not collect funds for transport, so it seems odd that they would be involved in helping the patient make financial decisions.

Kelly also warns against idle organization management: "Negligence is going to be imputed to the employer." Wirth adds that in many organizations there is an inadequate amount of in-service training on these topics.

MENTAL CAPACITY

In another case in Texas, a seizure patient who lived at home with his parents was having a seizure similar to past episodes. His seizures were generally controllable by medication, and though the family could not verify that the patient had taken his medication, the EMS crew accepted a refusal even though their own documentation noted he only responded to verbal stimuli and was "disoriented/confused." The EMS crew documented that the patient refused care and that the patient's mother also

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requested no transport.

When the same crew returned less than five hours later for an additional episode, the same EMS crew this time transported, noting the patient had seizures earlier in the day and EMS did not transport per the mother's request.

When the crew spoke to the patient's mother later, she noted that it had happened so often she thought it was the standard procedure for seizure patients to not be transported the first time the ambulance arrived at their house.

"When I call the ambulance it's because I don't think he's going to make it," she said. "If someone is panicked enough to call 9-1-1, they are worried their family member is going to die."

The ability to make decisions is not only determined by the patient's orientation level, but also their competency. Whether your patient is under the influence of alcohol or drugs that would impair their judgment could make an informed refusal impossible.

Generally speaking, a competent adult is one who is lucid and able to make an informed decision about his or her medical care. When we treat adult patients we must always consider competency, and that means more than just whether the patients know who they are, where they are and the time of day.

In addition to assessing the patient's level of consciousness, the patient should be free of intoxicants, be mentally sound and not suffering from an illness or injury that could impair judgment.

While paramedics may not be psychiatrists, obvious mental illness or mental retardation may be factors to consider when determining whether a patient is competent to refuse care. Additionally, injuries and illness that affect judgment tend to surround neu-

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rologic issues such as head injury, seizures, and stroke. In these cases, your medical direction team can be of assistance in guiding who may refuse care and under what circumstances.

THE REFUSAL

It is fair for the competent adult patient to refuse care. This could happen because of personal or religious beliefs, socioeconomic concerns on the part of the patient, or denial that the illness or injury is actually an issue that needs to be addressed right away.

It should also be noted that refusals do not have to occur at a specific time in the call. The classic case of this may be the diabetic patient whom you find incoherent with a blood sugar of 42. Recognizing that his problem may be sugar related, the paramedic manages the airway, initiates an intravenous line, and then administers 50% glucose per his standing orders.

In this instance, the paramedic is acting on implied consent to initiate treatment. After correction of the underlying issue, the patient regains consciousness and objects to further treatment and demands absolutely no transport.

After some gentle coaxing the patient agrees to be re-vitalized and his blood glucose level is recorded as 174. The patient's other vitals all appear normal or within normal limits and he refuses further care.

It should be understood that several factors go into documenting a patient refusal.

First and foremost, document the patient's condition accurately and adequately. This means excellent documentation is required for who and what you are seeing. Is this patient sleepy or awake, do they appear cold, clammy and confused? Have you documented why you were called, the issues leading up to the condition and what is being described to you? Is this a patient whose wife says he is having chest pains, or does he admit that he has chest pain that radiates to his left arm, the pain is an eight on a 10 scale, and he is diaphoretic, but he is sure the pain "will go away on its own"?

What are you telling the patient at this point? Document what you say to persuade the patient to allow you to transport him or her to the emergency room. What was the patient's response? Does the patient understand the implications of denying you the chance to help? Make it clear that your goal is to give the assistance that is needed.

Revisit the question of competency. Document your reasons for believing this patient is competent. Again, this likely involves more than just an AVPU level of consciousness or Glasgow Coma Score.

Make sure you tell the patient and document possible issues with the medical condition. On the other hand, do not mislead the patient by creating false senses of deterioration that don't fit. For instance, if someone sprains their ankle and wants to refuse care, it is probably not reasonable to tell the patient that if he doesn't go with you he may deteriorate and die.

Are you sure this patient needs to go to the hospital, but the patient is sure she doesn't need to go? Now might be the time to be humble

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and invite your medical director into the discussion. While many in the general public treat us with great deference and respect, others still view us as "those ambulance drivers." Obviously, with all our training we aren't ambulance drivers, but perhaps bringing in our medical direction team and asking them to help convince our patient to go to the hospital will make a difference.

According to one study, we undertriage patients. This makes medical direction involvement in refusals a valuable tool in protecting ourselves from liability issues and allowing the medical directors out there to reinforce the image of professional EMS providers by supporting our suggestions against the patient refusing our care.

Ultimately your patient may sign a patient care refusal, but do not consider this release of liability to be a true release of liability in and of itself. Certainly have the patient sign the release and have a witness sign it. Where possible, a disinterested third party would be best for the witness. When at an accident scene, I tend to use a police officer if available. At the patient's home, a family member or close neighbor is someone I would certainly consider if immediately available. At work, coworkers and supervisors are at the top of my list.

In addition to the basic signatures, make sure you document all the issues associated with the refusal. Document the circumstances you see and explained to the patient, what conditions might cause the problem, and reasonable expectations of possible deterioration.

Perhaps as important, tell the patient you are willing to transport them to a local emergency department. If they don't want to go now, tell them you're happy to come back if they change their mind and document, document, document. Remember, if you didn't write it down, it didn't happen. Therefore, document that you told the patient you were willing to transport him now or later if he changed his mind.

CONCLUSION

This article highlights some of the concerns EMS providers have in completing appropriate refusals of medical care, and helps them understand some tools that can assist in overcoming liability issues.

In the meantime, EMS providers should remember that public complaints and newspaper articles about providers who won't provide service will alarm many in our community. The public-relations consequences could be significant. The alarms of the public will likely be answered by responsive elected officials who control already-tight budgets. Before this happens, we in the EMS community need to consider this and answer the alarms that come into squad rooms with professionalism, speed and the degree of humanity you would expect an ambulance crew to deliver to your family. ■

S. Christopher Suprun Jr., NREMT-P, CCEMT-P, has taught and written on EMS, terrorism response and incident management for fire departments, federal and local law enforcement, and in private industry. He is a frequent conference speaker and currently active as a paramedic/firefighter, instructor, and director of education for Consurgo. Contact him at csuprun@consurgo.org.

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