NO, I won't go!

The reluctant patient.

Pulse Check 2014
NYSVARA
September 12, 2014

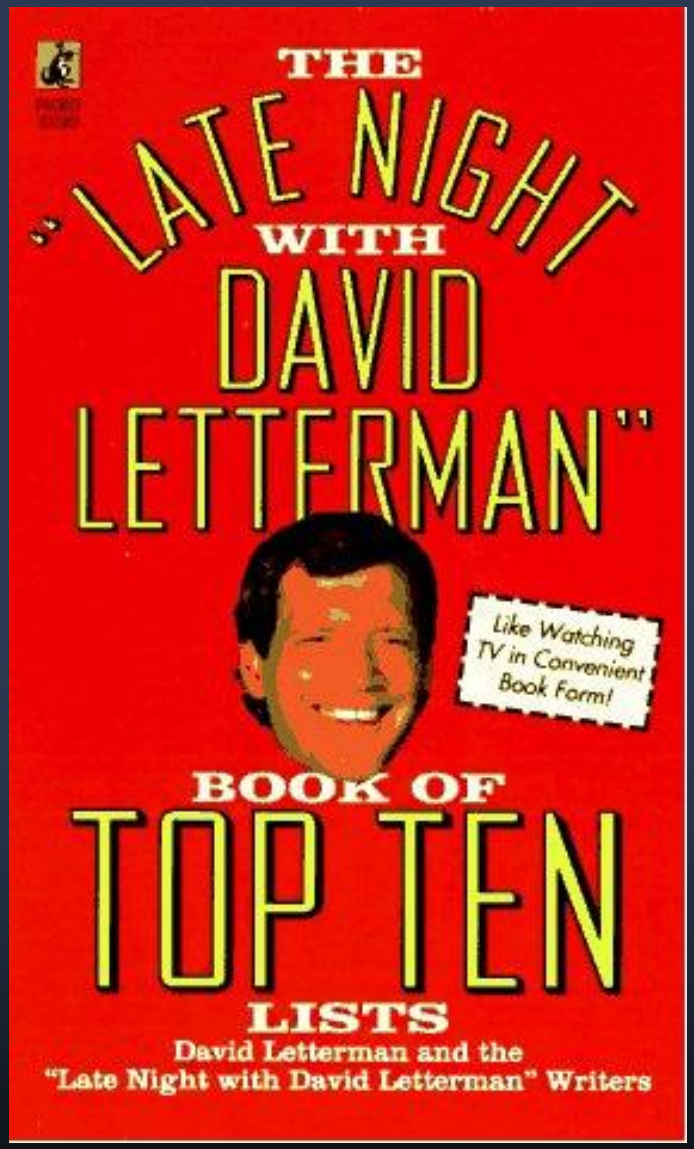
Andrew Stern, NREMT-P, CCEMT-P, MPA, MA
Senior Paramedic
Town of Colonie EMS
AndrewWStern@aol.com

Objectives

- Identify signs & symptoms (‘red flags’) for a patient, not willing to be transported, who could be at risk.
- Understand the right of the adult patient to refuse care and treatment.
- Recognize the public health and legal implications of not attempting a patient transport for a patient in critical need of further medical care and treatment.

Objectives *(Cont'd.)*

- Identify five ways of coping with patients who refuse transport to a medical facility but are in need of additional care.
- Understand the responsibility of the prehospital professional to facilitate a patient transport when the patient refuses but it is not in their best interest.


THE
"LATE NIGHT
WITH
DAVID
LETTERMAN"
Like Watching TV in Convenient Book Form!
BOOK OF
TOP TEN
LISTS
David Letterman and the
"Late Night with David Letterman" Writers

Top 10 "Way-Cool" Things You Can Tell Patients Who Say NO to Transport But Need to Go…

10

Take your time – we can bond! It will be a beautiful thing!

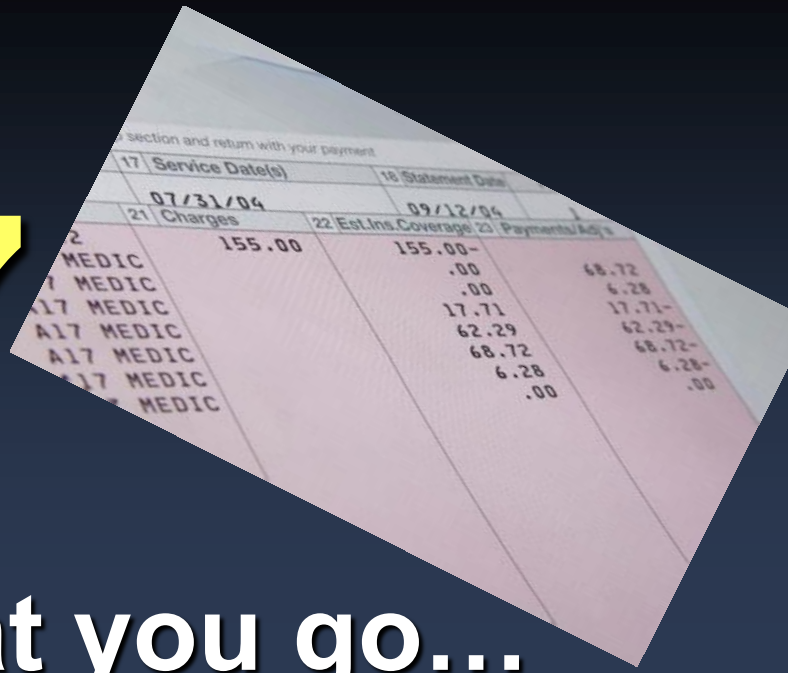
9

You don’t scare me

(Well, maybe a little).


8
I am very impressed with your vocabulary – do you kiss your mother with that mouth?

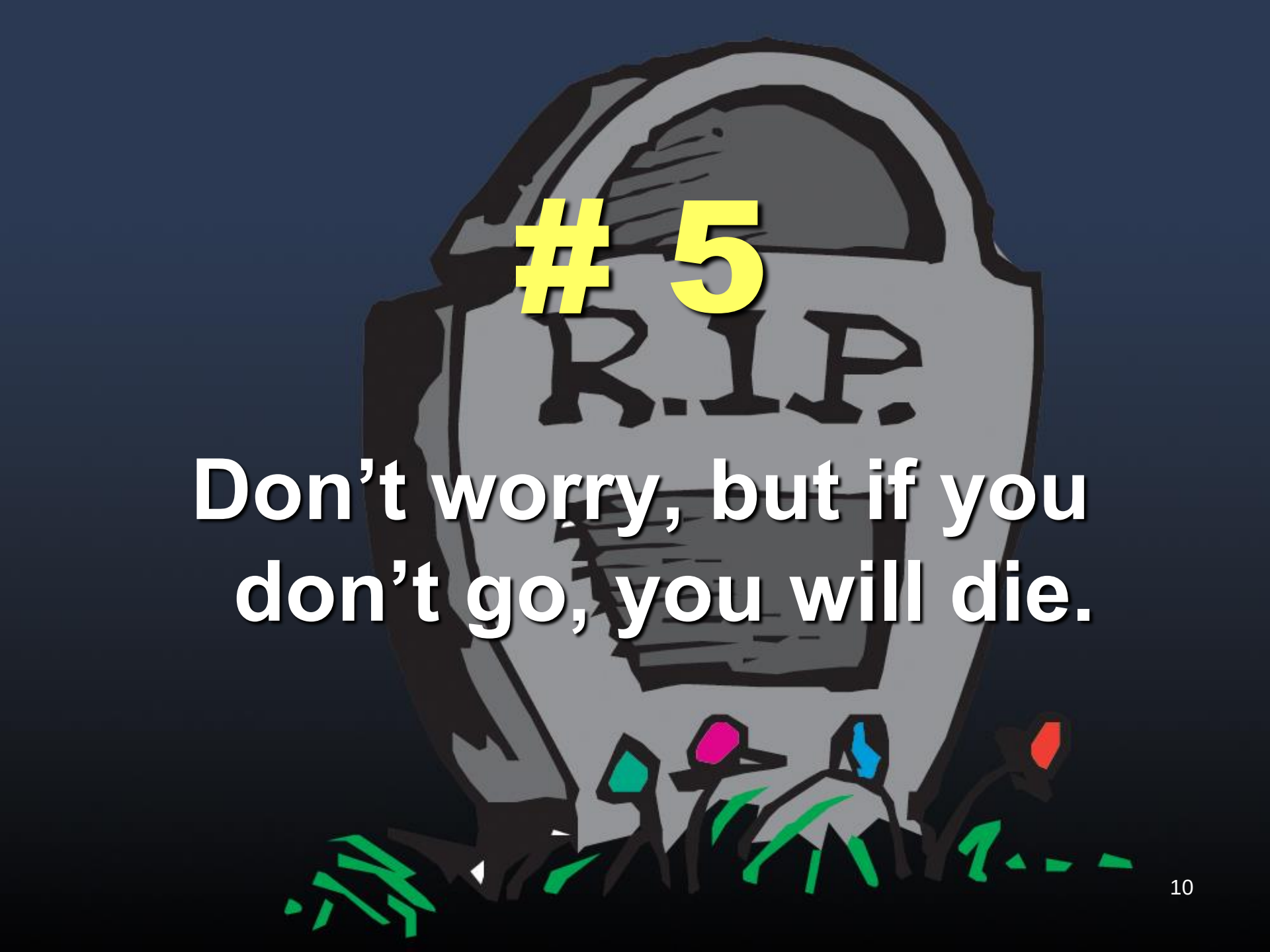
7



It's important that you go… I can't bill if you don't get on the stretcher.

6

But then again –
Go, don’t go, my pay check stays the same.

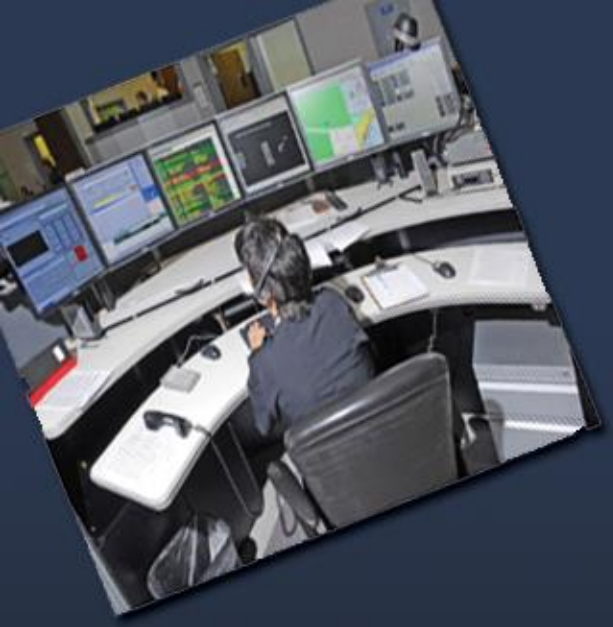


5

Don’t worry, but if you don’t go, you will die.

4

If this takes much longer,
I will need to check out what's in your refrigerator.



3

If you don't go then you're explaining to Dispatch why this call is taking so long.

2

I have Versed®
and I am not afraid to use it.

1

The guy with the gun will take over now.

In the News - - 2006

At 9 o'clock on the evening of January 6, 2006 David Rosenbaum, a retired editor of the New York Times, was robbed and assaulted while walking in Washington, D.C. EMS responded and determined Mr. Rosenbaum to be drunk and a low priority. He was transported to a hospital where he was placed on a stretcher in the hallway and not examined for an hour. He died. It was determined he had a massive head injury.

In the News 2008

On the morning of December 3, 2008 Mr. Edward Givens, age 39, was found lying in the hallway of his Washington, D.C. residence. He was not breathing and subsequently died. Six hours earlier, paramedics had responded to a 911 call at Mr. Givens' home and reportedly told him he had acid reflux. He was not taken to the hospital even though he complained of chest pain and trouble breathing. The Medical Examiner stated the autopsy found arteriosclerotic cardiovascular disease (ACD).

The family informed the district they will sue for "individual acts of negligence" and "systemic errors."

In the News 2009 Update

On December 9, 2009 a $17 million wrongful death suit was filed in Washington, D.C. court by the mother of Mr. Givens. The suit claims that the District of Columbia Fire & EMS (DCFEMS) Paramedics did not recognize the severity of the patient's condition. The claim states the patient was advised to take Pepto Bismol® and the crew failed to discuss repercussions of not seeking further medical care.

In the News 2010

On February 10, 2010 at 4:40 AM infant Stephanie Stephens was having difficulty breathing and her mother called 911. Washington, D.C. Fire/EMS Medic Unit 33 (Paramedic/EMT) arrives at the residence at 5:08 AM. Reportedly no equipment, except a stethoscope, was brought into the residence. A brief exam was performed and a conversation between crew members ensued and the mother was told the patient had a little congestion (mild cold or croup) and she was advised to provide steam mist and get Tylenol® the "next day." The family was told the patient did not need to go to the hospital. The crew left the residence (without the patient) ~10 minutes after arrival.

In the News 2010 (continued)

Approximately 8½ hours later 911 was called again as Stephanie had worsened. She was transported to the National Children's Medical Center at 2:30 PM. She died at 12:33 AM the next day.

The diagnosis was severe pneumonia.

Subsequently, no documentation could be produced that the patient (mother on the child's behalf) refused transport for the first 911 response. In fact, no patient care report was believed to have been completed.

A lawsuit filed requested $ 17,000,000.

Legal Case - FDNY 2008

A NYC wrongful death legal action, in part, for a call on 11/10/08 for a 17 year old with shortness-of-breath with the following issues:

- Allowing a minor to refuse medical care.
- Not following protocol for refusal of medical attention.
- Failure to properly evaluate and treat.
- Failure to transport in a timely fashion.

The patient died two days later on 11/12/2008.

There was testimony provided that suggested that if the patient had been transported when originally seen 2 days earlier that she would have survived.

Words of Wisdom

"… it's often easier to take a 'no' response to transport and sign the patient AMA [RMA], though in truth it may be poor medicine and certainly not what the patient needs."

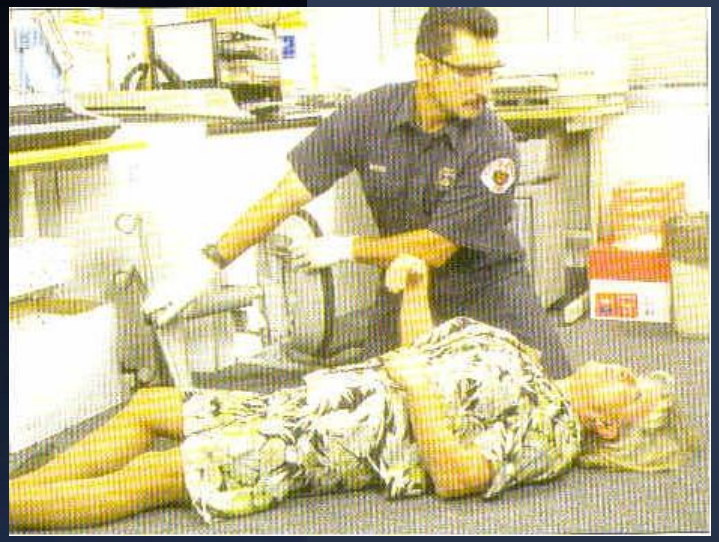
Smith, M, *"When No Means Maybe"*, EMS World, page-#20, August, 2013.

Case # 1

At 8:00 PM you are dispatched to the home of a 72 yo Alzheimer's patient with severe abdominal pain. Family member on scene.

Patient reluctantly agrees to an exam but says she will not go to the hospital. Your exam identifies tachycardia (~ 120 bpm) and a rigid abdomen.

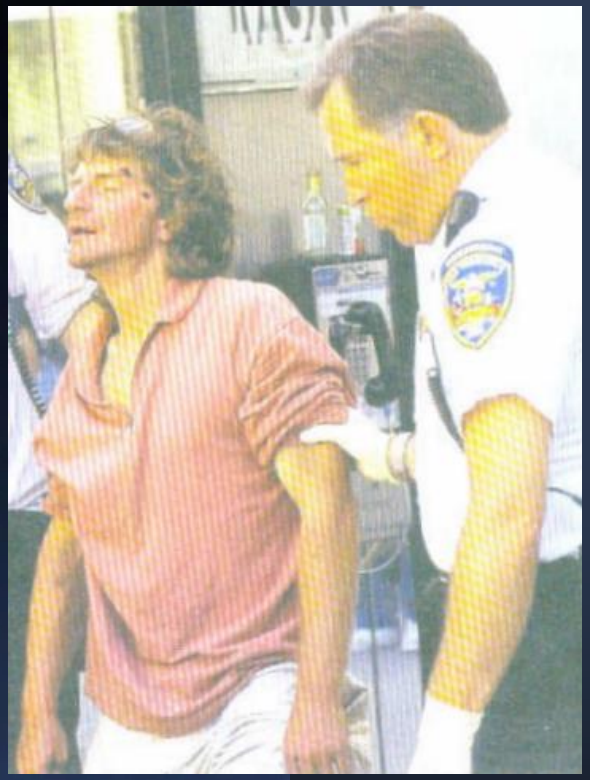
Case # 2



Called to an insurance claims office at 9:30 AM for a 43 yo patient having a seizure. Upon arrival, the patient is postictal with a laceration on her forehead. When helping her on the stretcher she pushes you away and says she “won’t go.”

Her boss wants her taken to the hospital and tells you they are unable to locate any family.

Case # 3



At 6:00 PM (interrupting dinner) you are dispatched for a psychiatric patient at a mall. Upon arrival an apparent delusional patient is walking near the food court. From his mannerisms and information provided by mall security he does **NOT** appear violent. He resists when you try to prepare for transport.

Legal Advice

WWW.PWWEMSLAW.COM

Legal Issues

- This is only an overview.
- I am NOT a lawyer nor do I play one on TV.
- Consult an attorney (preferably the one that has your back).

Legal Issues

- No known criminal cases
- Very few civil cases
  - battery
    (intentional touching of a person in a harmful or offensive manner)
  - false imprisonment
- Most states have mental health procedural acts (dealing with issues of a danger to self or others)

Some legal stuff
Refusal of Care

In the U.S. Supreme Court:

"…a competent person [has] a constitutionally protected right to refuse life-saving medical treatment." (Cruzan v. Director, Missouri Dept. of Health; 1990)

"Every human being of adult years and sound mind has a right to determine what shall be done with his/[her] own body."

Mottley, L.: *"Refusal of Prehospital Care"* in EMS Medical Directors' Handbook (A. Kuehl, editor)

More legal stuff
{The bottom line}

A person of sound mind, mentally competent to make sound decisions, and of the age of majority can probably say no even if their life is thought to be in significant peril.

This legal stuff doesn't stop

Does the patient have the capacity to give informed consent based on his/her understanding of the following:

- Nature (seriousness) of illness/injury – ASSESSMENT!
  - Legal Competence
  - Mental Competence
  - Medical Competence
- The benefit of the care being offered
- Risk of refusing care

Competence . . . Definition

. . . capacity of a person to act on his/her own behalf; the ability to understand information presented, to appreciate the consequences of acting–or not acting–on that information, and to make a choice.

McGraw-Hill Concise Dictionary of Modern Medicine. © 2002

What have we been taught?

Consensus

- The patient must be mentally **competent** and oriented.
- The patient must be fully informed.
- The patient must sign a release form.

A big question

When is treat and release OK?

- ✓ Diabetic Patients
- ✓ Minor (non-emergent) medical problems
- ✓ Assist the invalid

Let's go to the Literature

72.2% patients with field assessment findings consistent with hypoglycemia refused transport. 6.1% relapsed with no deaths reported and 2 hospital admissions.

Conclusion: Out-of-hospital treatment of hypoglycemic diabetic patients appears to be effective and efficient.

Academic Emergency Medicine

Out of-Hospital Treatment of Hypoglycemia:

Refusal of Transport and Patient Outcome

(Socransky et al.) 5(11): 1080-5, November, 1998

Patient Perspective

FEARS

- Losing control
- Hospitals
- Leaving home-#1 (feel safe)
- Leaving home-#2(who will take care of …)
- Financial (No insurance)

- Denial
  (Patient believes there is no medical reason)
- Won't come home
- Lack of trust

The Provider's Perspective

- Why does the patient need to go?
- What does EMS/ED have to offer?
- Is it in the patient's best interest?
- Is there a public health/social service consideration?

The Provider's Perspective (Information from Patient)

- **Findings on assessment**
  - Medical
  - Trauma
  - Psychiatric
  - Drug/Alcohol Intoxication
  - Multiple Issues

The Provider's Perspective
(Information from other sources)

- Dispatch information
  - Who called (3rd Party)
- What other sources available
  - Family
  - Care taker
  - Neighbor
  - Friend
  - Documentation

Consequences of not going: "RED FLAGS"

- Disability to patient
- Deterioration of health
- Deleterious consequences
- Danger to self
- Danger to others
- Death

Chameleon Symptoms {Examples}

Presenting	Possible Cause
Intoxication	Hypoglycemia
Vertigo	Cerebral Hemorrhage
Syncope	Hypertension, stroke, seizure, cardiac problem
Flu-like Symptoms	MI, sepsis
Abdominal bloating	Cancer, ectopic pregnancy
Paranoia	Mental disorder, OD
Numb hands	Stroke, MI, hypertension

Nower, R.W.et al., "Processing the Patient Refusal, EMS World, page-#35, December, 2011

What approaches can be used?

One size does *not* fit all.

What have we been taught?

Actions

- High-quality care (standard of care).
- Spending time to speak to the patient (Try more than once.).
- EMS must use their power of persuasion – YOU ARE THERE!
- Informing the patient if the consequences of not going to the hospital.
- Consulting medical direction.

What have we been taught?

Additional Actions

- Contact family member to help
- Call law enforcement if necessary
- Try to determine why the patient is refusing
- Encourage the patient to seek help again after you leave if they change their mind or symptoms return or additional problems develop.

Special Circumstances

- Advanced Directive or Living Will
- Cultural/Religious Issues
- Language Barrier
- Pediatric Patient thought to be at risk

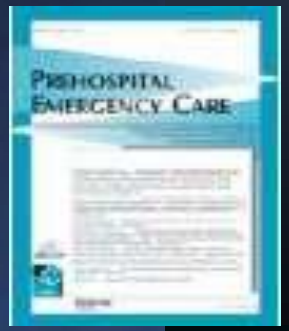
Let's go to the Literature

Follow-up survey of pediatric patients who refused care.

84% received follow-up in ED or with MD.

11% (3 pts.) were subsequently admitted to the hospital

Conclusion: Children whose parents refused EMS transport received medical follow-up in the majority of cases.



Prehospital Emergency Care

Outcomes Study of Minors

After Parental Refusal of Paramedic Transport

(Seltzer et al.)

5(3): 278-83, July-Sept., 2001

What's in the toolbox?

- Talking to the patient
- Family & Friends
- Contact patient's doctor
- Medical Control
- Police

Patient's Doctor

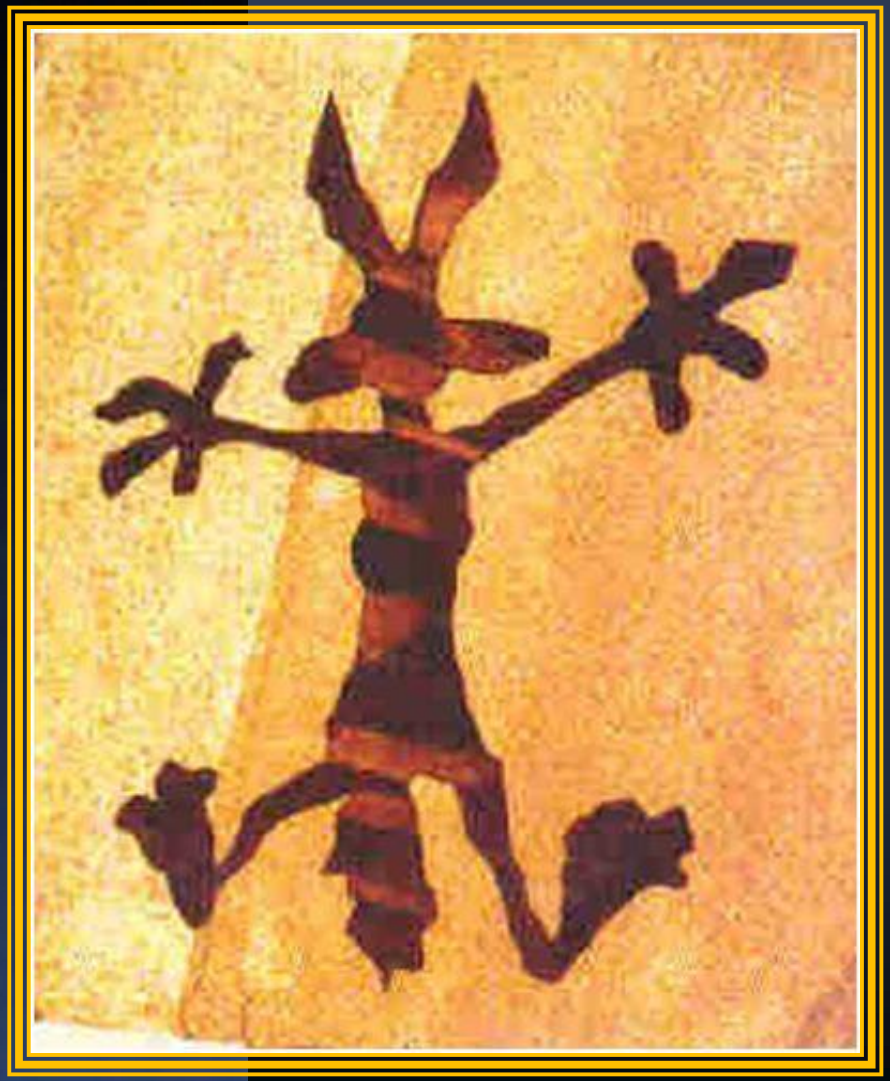
- Is the juice worth the squeeze?
  - What response?
    - From MD: "If you think it is needed, transport."
    - From the Office Nurse: "If you think it is needed, transport."
    - From the Answering Service: "Will try and locate the doctor, but I was told to tell you that If you think it is needed, transport."

Talk to the patient – 7 Ts

1. Tone
2. Tact
3. Trust
4. Truth
5. Threat
6. Tenacity
7. Temper (yours)

Using an EMS colleague

- It may not be your day (move on)
- Bad chemistry
- You are getting frustrated
- Patient may respond to authority
- Your partner is really good at this



Even when you try hard and do your best you may still hit the wall.

Medical Control

- Follow protocols.
- A safe haven.
- Patient talking with MD.
  - Is the patient willing to do this?
  - Discuss with patient first.
  - See if they will be compliant and participate before contacting medical control.
    - ✓ Also, make sure the assessment is complete and ready before contacting.

Let's go to the Literature

- 53% refused TXP
- 47% were transported
  - ✓ When on-line medical control physician thought the pt. needed TXP and became more assertive the patient was more likely to agree to TXP. ($p<0.01$)

Conclusion: Contact with a medical-control physician appears to markedly improve the TXP rate for patients who initially attempt to RMA.

Academic Emergency Medicine

Refusal of out-of-hospital medical care: effect of medical-control physician assertiveness on transport rate

(Burstein et al.) 5(1): 4-8, January, 1998

Police

- The physical presence may be enough
- Have them ‘request’ the patient to go
- Explain alternatives (“It won’t be pretty.”)

The police are essential (probably mandatory) if a patient is moved against his/her will.

(Legal ramifications)

Transport against patient's will!

Protocols (A Sidebar)

- Need to be in-place
- Medically based –
  Medical Director must have input
- Legally sound –
  consult your attorney
- Quality Improvement used to adjust as needed

Use of Restraints

- The patient MUST go; it is medically correct, legal, and there is no other alternative.
  - Physical Restraints (the law may prescribe)
  - Chemical Restraints (Follow Protocol)
  - ONGOING ASSESSMENT!

A few important thoughts…

- First do no harm – Primum non nocere (This is the 1st Rule of Medicine).
- Don't blame the patient (Remember, this is prehospital care medicine).
- Respect the patient (It is a tenet of the profession).
- Don't make decisions because they are expeditious (Ask: is it in the best interest of the patient or public health?).

A few important thoughts…

- Don’t make the patient feel helpless
  - Think how you would feel.
- Ask the patient what they want (in most cases they still have control.)
- Think about legal consequences
  - (Hopefully, it will not be what forces the agenda to transport.)

Good Documentation

- Document – Document – Document
- Be precise
- Be ***VERY*** thorough
- Explain/Describe using clinical facts
- What did you tell the patient about consequences of not going.

Good Documentation (PCR Content - Important)

- Physical Exam (including vital signs)
- Evidence that patient was alert, oriented and have age appropriate responses (assessment of mental capacity)
- No impairment; alcohol, drugs, mental illness, or organic
- Treatment & transport was offered and instructions about calling 911
- What you specifically told patient including consequences of not going and patient acknowledge as understanding
- Encouragement to seek care and who remains with patient after EMS left

What most of us do…

- Have the patient sign some type of standard release form
- Explain the risk of not going to the hospital
- Some providers may even give written instructions

Let's go to the Literature

All were explained risks before refusal.

- **55% recalled receiving written instructions.**
- **22% remembered an explanation of risk.**
- **26% believed they did NOT fully understand their condition or circumstances**

Conclusion: **A substantial proportion of patients refusing transport do not recall receiving verbal or written instructions.**

Academic Emergency Medicine

Do patients refusing transport remember descriptions of risks after initial advanced life support assessment?

(Schmidt et al.) 5(8): 796-801, August, 1998

Thoughts about the paperwork

- Write as an AMA (Against Medical Advice) vs. RMA (Refused Medical Assistance)
- Include what was said (by patient, EMS, etc.)
  - In quotes
- Nothing will bite you in the @$$ more quickly than a poorly written prehospital care report

Thomas DiNovo (Attorney at Law)
O'Connell and Aronowitz
Albany, NY

Patient Refusal Form

RMA CHECK SHEET (The RMA check sheet is a guide to use while completing a Refusal of Medical Attention for any patient.

CAPACITY of the patient or guardian making the decision to refusal of medical care:

_____ Patient Alert to Person Place and Time

_____ Clear & Coherent Speech

_____ No known or presumptive medical, legal or psychological conditions

_____ The patient is willing and able to engage in meaning full conversation

_____ No evidence of alcohol or drug use

_____ Is patient older that 65 or younger than 5 consider contacting medical control

_____ Has the patient suffered any head trauma or injury including stroke

RISK of the patient not seeking medical attention:

_____ Explained to the patient of all potential problems associated with the presenting problem up to and including death & permanent disability

_____ Advise the patient to seek medical attention and/or follow-up as soon as possible

CALL BACK offer and document the ability for the patient to call for help again

_____ Advise patient to call EMS to return in the event they change there mind or feel they would like transportation to seek medical care

Quality Improvement

- It is not an option
- It should be done as soon after the call as possible…
  particularly if a problem
- Embellish the good
- Adjust the bad


QUESTIONS ?

Okay, you can leave now!