



REFUSAL OF MEDICAL AID (RMA)

1. PURPOSE

- 1.1 To set forth the policy and procedures for accepting and documenting a patient refusal of emergency medical aid (RMA).

2. SCOPE

- 2.1 This procedure applies to all members of the EMS Command and to voluntary hospital ambulance personnel who provide prehospital emergency medical care in the New York City 911 system.

3. DEFINITIONS

- 3.1 **Refusal of Medical Aid (RMA)** – A refusal of emergency medical aid (treatment and/or transport) by a patient or guardian on behalf of a patient.

- 3.2 **Patient** – Any individual for whom an ambulance has been requested for provision of emergency medical treatment and/or transport.

3.2.1 **Patient Contact** – Any instance in which an emergency medical provider has initiated an assessment or treatment of a patient.

3.2.2 **Patient Qualified to Request an RMA** – A patient qualified to request an RMA must be at least eighteen years of age, or if younger than 18 years of age must be one of the following:

- A. A patient who is married.
- B. A patient who is pregnant (for purposes of consenting to medical, dental, health and hospital services related to prenatal care).
- C. A patient who is a parent.
- D. A patient who is seeking treatment for HIV or a sexually transmitted disease.
- E. A patient who is in the military.

3.2.3 **Minor Patient** - A minor patient is any patient under the age of eighteen and who is not qualified to request an RMA.

- 3.3 **Decisional Capacity** – an individual's ability to make an informed decision concerning his or her medical condition or treatment. In order to have decisional capacity, the patient must not be impaired and must demonstrate that s/he understands:
- 3.3.1 The nature of his or her presenting medical condition;
 - 3.3.2 The possible risks and consequences of refusing emergency medical treatment and/or transport for his or her acute or presenting medical condition, including where applicable, the risk of serious adverse health consequences or death.
 - 3.3.3 Treatment and transportation alternatives.
- 3.4 **Guardian** – A person who is legally responsible for a minor, or for a person who is unable to manage his or her own affairs, including health care. For RMA purposes, this also includes grandparents and school officials. A person holding a health care proxy does not qualify as a guardian.
- 3.5 **Impairment** - A condition in which it is suspected that an individual's decisional capacity may be compromised as a result of diminished, altered or impaired intellect, reasoning, insight, or judgment; including any diminishment, alteration or impairment associated with:
- alcohol, drug or toxic substance use;
 - head trauma, dementia, encephalopathy, mental retardation, or other central nervous system (CNS) dysfunction (e.g., Alzheimer's disease, CVA with cognitive deficit);
 - acute or “uncontrolled” chronic psychiatric illness;
 - medical illness, including but not limited to, metabolic or infectious disorders such as hypoxia, hypotension, severe hyperglycemia, hypoglycemia, and sepsis.
- 3.5.1 The fact that a patient has any of the above conditions does not automatically require that the patient be considered impaired, but if the patient is determined to have decisional capacity, the basis for such conclusion must be clearly documented on the Prehospital Care Report (PCR). Examples:
- A. A patient who has consumed an alcoholic beverage provided that the individual demonstrates no clinical signs of intoxication.
 - B. A patient with a chronic psychiatric condition who is not exhibiting any impairment.
 - C. A patient who is chronically disoriented as to time but who is able to demonstrate that s/he has decisional capacity with regard to evaluating the risks benefits and consequences of accepting or refusing treatment and transport for his or her presenting condition.

- 3.6 **High Index of Suspicion** – The concern that an individual may have an acute medical, traumatic, psychiatric, social or other condition that could result in a life-threatening or life-altering outcome. Indications for a high index of suspicion may include, but are not to be limited to:
- 3.6.1 The mechanism of injury;
 - 3.6.2 Assessment of injury/illness severity;
 - 3.6.3 Abnormal vital signs;
 - 3.6.4 A friend, neighbor, co-worker, or family member who has frequent contact with the patient and who expresses concern for the patient's health, **based on a change in the patient's condition**;
 - 3.6.5 A caller to 911 who reports expressed or actual suicidal or homicidal behavior by the patient (regardless of whether the caller is on the scene or not).
 - 3.6.6 The request for assistance originated with a physician or other health care provider (regardless of whether the caller is on the scene or not) who indicates that there has been a **significant change** in the patient's medical condition.
- 3.7 **Low Index of Suspicion** – Any condition that does not merit a high index of suspicion.
- 3.8 **Mechanism of Injury/Illness** – The way in which traumatic injuries likely occurred. This would include the forces that act on the body to cause damage and/or the mechanism or cause of an illness or symptom.
- 3.8.1 **No to Minimal Mechanism of Injury/Illness** – where the expectation of injury, physical damage and/or exposure is minimal and there is a low index of suspicion that the patient is at risk for injury/illness. Examples include:
 - A. A vehicle collision where there is no physical damage to the passenger compartment of a vehicle. Damage is limited to scratches, mirrors or fenders.
 - B. Noxious fumes released in the general vicinity of a person without direct exposure.
 - 3.8.2 **Moderate Mechanism of Injury/Illness** – where the expectation of potential injury, physical damage and/or exposure is likely and may have put occupants at risk for injury/illness but, there is a low index of suspicion for injuries/illnesses with life-threatening or life-altering outcomes. Examples include:
 - A. A collision resulting in noticeable damage to a vehicle but where the occupant may or may not have a current complaint or visible injury/illness.
 - B. The release of noxious fumes where an occupant may have been exposed but has no current complaint or visible injury/illness.

- 3.8.3 **Severe Mechanism of Injury/Illness** - where the expectation of injury, physical damage and/or exposure is strong and there is a high index of suspicion that the patient is at risk for severe injury/illness with the potential for life-threatening or life-altering outcome. Examples include:
- A. Collisions resulting in major trauma to an occupant in either vehicle.
 - B. The release of noxious fumes where an individual is likely to have been exposed and has current complaints and/or visible injury/illness.
 - C. Exposure to shockwaves from an explosion in a confined space, regardless of current complaint or visible injury.
- 3.9 **Medical Orders for Life Sustaining Treatment (MOLST)** – MOLST provides a single document that is an actionable medical order and that directs patient care, specifically regarding end of life care in different health care settings including prehospital emergency medical care.
- 3.10 **Medication Administration** – Administration of **ANY** medication to a patient by prehospital personnel, other healthcare providers, bystanders, or the patient himself or herself during or just preceding the event for which the request for emergency medical aid was made.
- 3.10.1 For RMA purposes, oxygen is only considered a medication if it is used for the treatment of a patient condition that would be considered a high index of suspicion (e.g., congestive heart failure, major trauma).
- 3.10.2 Bandages, gauze, icepacks, splints, immobilizers, cardiac monitors and oxygen are **NOT** considered medication/treatment that requires OLMC contact for a RMA. EMTs and Paramedics do not require OLMC approval for a RMA unless these treatments are for a condition considered to have a high index of suspicion (e.g., cervical fracture, head trauma, vital sign instability).
- 3.11 **On-Line Medical Control (OLMC)** – Real time communication between a REMAC-certified physician and pre-hospital emergency medical personnel via radio, telephone, telemetry or face to face.
- 3.12 **Out of Hospital DNR (Do Not Resuscitate) Order** – An order written by a physician for use outside of a hospital (including use by EMS providers) directing that if a patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be initiated on such patient. Such Out of Hospital DNR Orders must be written on a New York State Department of Health Out of Hospital DNR form. A DNR bracelet may also serve as evidence of a valid DNR Order.

- 3.13 **Safe Environment** – An environment which is not believed to be an immediate danger to the health or safety of a patient who is refusing medical aid.
- 3.13.1 An example of a safe environment would be a setting with adequate supportive care resources for the immediate future, or in its absence, a location with adequate assistance to reasonably ensure the safe return of the patient to such a setting.
- 3.13.2 An example of an unsafe environment would be a setting lacking adequate supportive care resources for the immediate future, or a location without adequate assistance to ensure the safe return to such setting, or where there is a suspicion of abuse (child, spouse or elder). Adequacy of housing or lack of housing should not automatically be considered an unsafe environment
- 3.14 **Specialty Referral and Specialized Care Centers:** New York State Department of Health Specialty Referral Center designations include Trauma, Burn, and Stroke Centers. Other specialized care centers include hyperbaric, replantation, spinal cord injury, and venomous bite centers, in addition to Percutaneous Coronary Intervention (PCI) centers for ST Segment Elevation Myocardial Infarction (STEMI) patients, hypothermia centers for non-traumatic cardiac arrest patients, Comprehensive Evaluation and Treatment of Child Abuse and Neglect (CETCAN) centers and Sexual Assault Forensic Evaluation (SAFE) centers for sexual assault patients.
- 3.15 **Ten Minute Rule** – A patient requesting transport to a 911 ambulance destination that is no more than 10 minutes additional travel time than would be required to reach the closest 911 ambulance destination shall be honored without requesting permission from either an on-scene EMS Officer or OLMC provided that the patient is stable; does not require treatment at a Specialty Referral or Specialized Care Center; and the requested ambulance destination is not on ambulance redirection or diversion. For all other circumstances, permission for such transport must be requested as follows:
- 3.15.1 If transport time to the requested 911 ambulance destination is expected to be between 10 and 20 additional minutes travel time beyond that required to reach the closest 911 ambulance destination, an on-scene EMS Officer may approve such transport request. In the absence of an on-scene Officer, OLMC contact and approval is required.
- 3.15.2 If transport time to the requested 911 ambulance destination is expected to exceed 20 minutes additional travel time beyond that required to reach the closest 911 ambulance destination, permission for such transport must be requested from OLMC. Permission will only be granted by OLMC if it is determined that the patient's present medical complaint or condition **requires specific immediate knowledge or treatment available exclusively at the specific ambulance destination where the patient receives treatment for that same or related condition.**

- 3.15.3 Any transport to a non-911 ambulance destination (e.g., Sloan-Kettering Cancer Center, NY Eye and Ear) requires permission from OLMC. Such transport will be approved **ONLY** if the patient's present medical complaint or condition requires specific immediate knowledge or treatment available exclusively at the specific ambulance destination where the patient receives treatment for that same or related condition. In the absence of such a need, patients should be transported only to a 911 ambulance destination.
- 3.15.4 A patient request to an ambulance destination that is currently on Ambulance Redirection or Diversion may only be honored with permission from OLMC and permission for such transport will be granted only if it is determined that the patient's current medical complaint or condition requires specific immediate knowledge or treatment available exclusively at the specific ambulance destination where the patient receives treatment for that same or related condition.
- 3.15.5 The Ten Minute rule is **not** applicable to the transport of a patient requiring treatment at a Specialty Referral Center (e.g. Trauma, Burn, Stroke Centers) or other specialized care center (e.g., hyperbaric, replantation, spinal cord injury, or venomous bite centers, PCI center for STEMI patients, hypothermia center for non-traumatic cardiac arrest patients, CETCAN center for child abuse and neglect patients or SAFE center for sexual assault patients); or when the Medical Branch Officer at the scene of a MCI directs that a patient be transported to a specific ambulance destination.
- A. If the patient develops an unmanageable airway while enroute to a Specialty Referral Center or other specialized care center, the ambulance must divert to the closest appropriate 911 ambulance destination and the reasons for such diversion must be documented on the PCR.
 - B. If the patient becomes unstable (other than as a result of an unmanageable airway) while enroute to the ambulance destination but it is determined that the patient would gain immediate medical benefits from care at specialty center (e.g., hypotension or arrhythmias following trauma, STEMI, or carbon monoxide intoxication), the ambulance should continue to transport the patient to the nearest appropriate Specialty Referral Center or other specialized care center (e.g., trauma center, PCI center for STEMI patient, hypothermia center for non-traumatic cardiac arrest patients, or hyperbaric center) and the reason(s) for the continued transport to the Specialty Referral Center of specialized care center must be documented on the PCR.
 - C. If the patient becomes unstable for any reason while enroute to a CETCAN (child abuse and neglect) or SAFE (sexual assault) Center, the ambulance must divert to the closest appropriate 911 ambulance destination (nearest hospital or trauma center) and the reasons for such diversion must be documented on the PCR.

3.15.6 EMS personnel shall consider overall transport time versus time spent on scene in making a transport determination. The decision process should not unduly delay the patient's transport.

3.16 **Unmanageable Airway** - A situation in which an EMT or Paramedic is unable to effectively ventilate, oxygenate, or provide adequate airway protection.

4. POLICY

4.1 A patient qualified to RMA who demonstrates decisional capacity has the right to refuse emergency medical treatment and/or transport.

4.2 Prior to accepting an RMA from a patient, EMS personnel must perform a complete assessment, determine an index of suspicion, evaluate the patient's environment, offer appropriate treatment and transport to the patient, and determine if the patient has the decisional capacity to refuse such treatment and/or transport.

4.2.1 If necessary, a translator or alternative to verbal communication (e.g., family, friends, bystanders, ATT Language Line, sign language or computer) may be used as a substitute to speaking directly with the patient, if the patient is non-English speaking or otherwise unable to communicate verbally (e.g., if patient communicates utilizing sign language, computer or other alternative communication methodology). If a translator is used, the translator's name, address, and phone number should be documented on the PCR.

4.3 CFR-D providers cannot accept an RMA **under any circumstances**. If a patient seeks to RMA in the presence of only a CFR-D provider, the CFR-D provider shall inform the patient that s/he is not authorized to accept an RMA and shall make every reasonable effort to encourage the patient to remain at the scene until an ambulance or EMS Officer arrives.

4.4 Any person, determined to be a patient, in the custody of the New York City Police Department, New York City Department of Corrections or other law enforcement authority, may refuse medical aid in a manner consistent with this policy.

4.4.1 If EMS personnel believe that a person in the custody of the New York City Police Department, New York City Department of Corrections or other law enforcement authority is being encouraged to refuse medical care, that patient should be considered to have a high index of suspicion and OLMC and a Conditions Officer should be immediately contacted.

- 4.4.2 The New York City Police Department, New York City Department of Correction and other law enforcement authorities may require, based upon existing protocols for medical care of persons in their custody, and safety and security concerns, that persons in their custody be transported to certain specially designated medical facilities, provided that the facility is a 911 receiving hospital. This is acceptable unless the following exceptions exist:
- A. A patient with an unmanageable airway **MUST** be transported to the nearest 911 receiving destination and
 - B. A patient whose medical condition requires immediate medical care from a Specialty Referral Center or other specialized care center (e.g., PCI center for STEMI patient, hypothermia center, hyperbaric center, CETCAN or SAFE center) **MUST** be transported to the 911 System center.
- 4.5 A patient seeking to refuse medical aid who presents with conditions that may indicate impairment shall not automatically be considered impaired but shall be evaluated to determine if s/he has the decisional capacity to refuse medical aid.
- 4.6 EMS personnel shall make all reasonable attempts to persuade patients requiring emergency medical treatment and/or transport to accept such aid. **Under no circumstances shall any patient be encouraged to refuse medical aid.**
- 4.7 EMS personnel shall provide care consistent with a patient's MOLST form or New York State Out of Hospital DNR form. MOLST forms may be utilized in place of the New York State Out of Hospital DNR form subject to the same requirements as an Out of Hospital DNR Order.
- 4.8 EMTs and Paramedics may accept an RMA without requesting the assistance of OLMC provided that the RMA request is from:
- 4.8.1 A patient qualified to RMA with decisional capacity, **OR** the parent or guardian of a minor patient who is 6 years of age or older when following an assessment by EMS personnel it is determined that **ALL** of the following are present:
 - A. There is a low index of suspicion that immediate medical treatment and/or transport is required
 - B. There has been no administration of medication
 - C. The patient is in a safe environment.
 - 4.8.2 A patient, with or without decisional capacity, and regardless of the index of suspicion, who has a properly executed MOLST form or Out of Hospital DNR form indicating that the treatment(s) or transport in question should not be provided.

- 4.9 EMTs and Paramedics **MUST** contact OLMC prior to accepting an RMA when that the RMA request is from:
- 4.9.1 a minor patient with no parent or guardian present at the scene
 - 4.9.2 the parent or guardian of a patient who is 5 years of age or younger.
 - 4.9.3 A patient qualified to RMA with decisional capacity, **OR** the parent or guardian of a minor patient who is 6 years of age or older when following an assessment by EMS personnel it is determined that **ANY** of the following are present:
 - A. The patient requires immediate medical treatment and transport to an ambulance destination, based on a high index of suspicion
 - B. There has been administration of medication
 - C. The patient is in an unsafe environment
 - 4.9.4 A patient qualified to RMA who, although alert, is unable or unwilling to provide sufficient information for EMS personnel to determine his/her decisional capacity, index of suspicion, or whether s/he is in a safe environment.
 - 4.9.5 A patient who lacks decisional capacity even if following an assessment by the EMS personnel it is determined that **all** of the following are present:
 - A. There is a low index of suspicion for conditions requiring immediate treatment and/or transport
 - B. There has been no administration of medication
 - C. The patient is in a safe environment
 - 4.9.6 A health care proxy on behalf of a patient lacking decisional capacity, because in New York State, health care proxies cannot be honored by EMS in the pre-hospital setting.
- 4.10 When necessary to contact OLMC, EMS personnel shall use **ANY** means available to them (e.g., radio, telephone, 12 watt) to establish contact.
- 4.11 When a request is made by EMS personnel for an OLMC physician to speak to a patient and/or other interested party, the OLMC physician **MUST** speak with the patient and/or other interested party.
- 4.12 A PCR must be completed for every patient contact. Every RMA situation requires the completion of a PCR, including instances where the patient refuses to cooperate with a physical assessment or respond to questions from EMS personnel. The PCR shall clearly document the patient's refusal to cooperate.

5. PROCEDURE

5.1 **RMA Sought by or for a Patient Lacking Decisional Capacity** - Any patient who lacks decisional capacity **AND** does not have a properly executed NYS Out of Hospital DNR Order or MOLST form may not refuse treatment or transport. EMS personnel must contact OLMC for approval to withhold treatment and/or transport for such patients.

5.1.1 If EMS personnel determine that a patient may lack decisional capacity, EMS personnel shall:

- A. For patients **with** a properly executed NYS Out of Hospital DNR Order or MOLST form, provide only those treatment/transport actions that are consistent with the DNR Order or MOLST form. OLMC should only be contacted if there are questions or concerns regarding application or understanding of the DNR or MOLST form with regard to the patient's present circumstances
- B. For patients **without** a properly executed NYS Out of Hospital DNR Order or MOLST form, or those who have an Out of Hospital DNR Order or MOLST form but such order or form is not applicable to the patient's present medical condition or circumstances:
 1. If the patient or his/her caretaker is able to communicate, EMS personnel shall contact OLMC so that OLMC may speak directly with either the patient or his or her caretaker. EMS personnel shall treat and transport the patient in accordance with the direction of OLMC following this communication. Such direction will be based on OLMC determination that the patient lacks decisional capacity **AND** any of the following conditions are met: a high index of suspicion for life-threatening or life-altering outcomes, medication administered **OR** the patient is in an unsafe environment.
 2. If both the patient **AND** his/her caretaker are not able to communicate, OLMC shall request that an EMS Officer respond to the scene so that the Officer may provide additional information to OLMC in order to facilitate their treatment and transport determination.

5.1.2 If OLMC determines that treatment/transport is required and EMS personnel determine that treatment/transport cannot be safely accomplished, then EMS personnel shall contact Dispatch to request that assistance of an EMS Officer and the appropriate law enforcement agency to facilitate treatment/transport.

- 5.1.3 If OLMC determines that treatment/transport is not required, the RMA portion of the PCR shall not be signed by a patient who lacks decisional capacity. In such instances, EMS personnel shall note on the PCR that, “the patient requested an RMA but had no decisional capacity and OLMC made the determination that treatment/transport was not medically necessary.”
- 5.2 **RMA Sought by Patients with Decisional Capacity** - If a patient who has been determined to have decisional capacity refuses treatment and/or transport, members shall attempt to perform a complete patient assessment to determine the necessity of treatment and/or transport. If it is determined that the patient requires such treatment and/or transport, all reasonable efforts shall be made to convince the patient to accept such treatment and/or transport.
- 5.2.1 EMS personnel may accept an RMA from a patient qualified to request an RMA with decisional capacity without contacting OLMC only if:
- A. The patient does not meet any of the criteria requiring contact with OLMC (high index of suspicion, administration of medication, OR unsafe environment) and
 - B. EMS personnel at the scene and involved in the patient assessment or care are in agreement that the patient meets the RMA criteria.
- 5.2.2 If the patient is a minor patient 5 years of age or younger, or if the patient although demonstrating decisional capacity otherwise meets the criteria for contacting OLMC, EMS personnel shall:
- A. Contact OLMC for assistance in convincing the patient or parent/guardian to accept emergency medical treatment and/or transport, and document such contact on the PCR including:
 - 1. The name and identification number of the OLMC Physician, or when applicable, the name and shield number of the OLMC Officer.
 - 2. The appropriate final disposition code.
 - B. If the patient or parent/guardian refuses to speak with OLMC, EMS personnel shall request the response of an EMS Officer.
 - C. If NYPD or other law enforcement agency will not assist in the transport of the patient contact the Citywide Dispatch Supervisor and request a law enforcement agency supervisor and if assistance is still not provided, then document the names, ranks, shield numbers and the commands of the law enforcement agency members on the PCR and notify OLMC.
 - 1. Request that the dispatcher make appropriate documentation into the call history.

2. EMS personnel shall not forcibly restrain any patient.
- 5.2.3 If a patient with decisional capacity for whom OLMC contact is required attempts to leave the scene before an RMA can be accepted, or cannot be persuaded to remain at the scene pending OLMC contact, the crew shall ask the patient to sign the RMA portion of the PCR, and the crew shall document the circumstances of the refusal on the PCR and notify OLMC. If the patient refuses to sign the RMA portion of the PCR, this shall be clearly documented on the PCR.
 - 5.2.4 If unable to establish contact with OLMC when OLMC contact is required, request assistance from an EMS Officer.
- 5.3 **Patient Seeking to RMA because of Ambulance Destination** - When a patient seeks to RMA **solely** because s/he wishes transport to an ambulance destination other than the closest appropriate ambulance destination and the requested ambulance destination is no more than 10 minutes additional travel time than would be required to reach the closest 911 ambulance destination shall be honored without requesting permission from either an on-scene EMS Officer or OLMC provided that the patient is stable; does not require treatment at a Specialty Referral or Specialized Care Center; and the requested ambulance destination is not on ambulance redirection or diversion. For all other circumstances (see below) permission for such transport must be requested as follows:
- 5.3.1 If transport time to the requested 911 ambulance destination is expected to be between 10 and 20 additional minutes travel time beyond that required to reach the closest 911 ambulance destination, an on-scene EMS Officer may approve such transport request. In the absence of an on-scene Officer, OLMC contact and approval is required.
 - 5.3.2 If transport time to the requested 911 ambulance destination is expected to exceed 20 minutes additional travel time beyond that required to reach the closest 911 ambulance destination, permission for such transport must be requested from OLMC. Permission will only be granted by OLMC if it is determined that the patient's present medical complaint or condition **requires specific immediate knowledge or treatment available exclusively at the specific ambulance destination where the patient receives treatment for that same or related condition.**
 - 5.3.3 Any transport to a non-911 ambulance destination (e.g., Sloan-Kettering Cancer Center, NY Eye and Ear) requires permission from OLMC. Such transport will be approved **ONLY** if the patient's present medical complaint or condition requires specific immediate knowledge or treatment available exclusively at the specific ambulance destination where the patient receives treatment for that same or related condition. In the absence of such a need, patients should be transported only to a 911 ambulance destination.

- 5.3.4 A patient request to an ambulance destination that is currently on Ambulance Redirection or Diversion may only be honored with permission from OLMC and permission for such transport will be granted only if it is determined that the patient's current medical complaint or condition requires specific immediate knowledge or treatment available exclusively at the specific ambulance destination where the patient receives treatment for that same or related condition.
- 5.3.5 Refusal by any patient or his or her guardian to go to a Specialty Referral Center or other specialized care center (e.g., Trauma, Burn, Stroke Centers, hyperbaric, replantation, spinal cord injury, venomous bite centers, PCI center for STEMI patients, hypothermia center for non-traumatic cardiac arrest patients, CETCAN center for child abuse/neglect patients and SAFE center for sexual assault patients) requires OLMC Approval.
- A. If the patient develops an unmanageable airway while enroute to a Specialty Referral Center or other specialized care center, the ambulance must divert to the closest appropriate 911 ambulance destination and the reasons for such diversion must be documented on the PCR.
- B. If the patient becomes unstable (other than as a result of an unmanageable airway) while enroute to the ambulance destination but it is determined that the patient would gain immediate medical benefits from care at specialty center (e.g., hypotension or arrhythmias following trauma, STEMI, or carbon monoxide intoxication), the ambulance should continue to transport the patient to the nearest appropriate Specialty Referral Center or other specialized care center (e.g., Trauma center, PCI center for STEMI patient, hypothermia center, or hyperbaric center) and the reason(s) for the continued transport to the Specialty Referral Center or specialized care center must be documented on the PCR.
- C. If the patient becomes unstable for any reason while enroute to a CETCAN (child abuse and neglect) or SAFE (sexual assault) center, the ambulance must divert to the closest appropriate 911 ambulance destination (nearest hospital or trauma center) and the reasons for such diversion must be documented on the PCR.
- 5.3.6 EMS personnel shall consider overall transport time versus time spent on scene in making a transport determination. The decision process should not unduly delay the patient's transport.
- 5.4 **Completion of PCR – Obtaining Applicable Signatures** - A PCR must be completed for each patient contact, including each RMA and each determination that treatment and/or transport is not required. All information relevant to the RMA shall be fully and legibly documented on the PCR.
- 5.4.1 If the patient is uncooperative in providing information, EMS personnel shall obtain as much information as possible and fully document the circumstances of the call.

- 5.4.2 If the patient demonstrates decisional capacity, EMS personnel shall ensure that the patient and a witness sign the refusal of medical aid acknowledgment (on the back of the PCR).
 - 5.4.3 If the patient lacks decisional capacity, the patient should not sign the refusal of medical aid acknowledgement. The emergency medical provider and a witness should sign the refusal of medical aid acknowledgment (on the back of the PCR).
 - 5.4.4 The witness may be a family member, friend, bystander, police officer, caregiver or other involved individual.
 - 5.4.5 If no witness is available or a witness is present but refuses to sign the PCR, EMS personnel can sign the PCR acknowledgment and fully document in the PCR narrative section the reason(s) that a witness signature could not be obtained.
- 5.5 The On-Line Medical Control (OLMC) Physician shall:
- 5.5.1 Prior to making a determination concerning a patient's decisional capacity and the need for emergency medical care and/or transport, ensure that all necessary information for making such determinations has been provided by the EMS personnel, the patient or other reliable sources and document appropriately.
 - 5.5.2 When a request is made by EMS personnel for an OLMC physician to speak to a patient and/or other interested party, the OLMC physician **MUST** speak with the patient and/or other interested party.
 - 5.5.3 To the extent possible, the OLMC physician shall communicate directly with the patient, family members or other caregiver (e.g. physician, visiting nurse, family members) present at the scene in order to:
 - A. Assess the patient's decisional capacity to refuse emergency medical treatment and/or transport.
 - B. Determine the necessity for emergency medical treatment and/or transport, the "normal" health status of the patient, and any acute change in that status.
 - C. Provide the patient and/or others on scene with information regarding the necessity for treatment and/or transport to the hospital, particularly when there is a high index of suspicion.
 - 5.5.4 In cases where there are difficulties assessing the patient and/or the environment, the OLMC physician may request that an EMS Officer respond. A specific reason for this request must be documented and communicated to the Officer by OLMC. The EMS Officer will then communicate his/her findings to OLMC. Unless additional evidence has been obtained to the contrary, OLMC will accept those findings.

- 5.5.5 In the case of a minor patient without a parent or guardian on scene, the OLMC physician may still determine that an RMA is in the best interest of the patient. For such cases, there must be another responsible party at the scene, a low index of suspicion and the OLMC physician must make every effort to contact a parent or guardian by phone.
- 5.5.6 Authorize the EMS personnel to accept or deny the RMA.
- 5.6 The On-Line Medical Control Officer shall:
 - 5.6.1 If an OLMC Physician is not immediately available and a patient is refusing emergency medical treatment and/or transport and OLMC is contacted, offer appropriate guidance.
 - A. Accept routine RMA and routine transport decisions consistent with OLMC protocols.
 - B. Refer medical concerns pertaining to RMAs to the OLMC Physician on duty, or the OLMC Medical Director, as appropriate.
 - C. Provide, as directed by OMA and the OLMC Medical Director, telephone follow-up and ensure completion of all necessary documentation.
- 5.7 EMS Officers shall:
 - 5.7.1 Respond to the scene of assignments involving patients refusing medical aid and/or transport as requested by on-scene EMS providers or OLMC.
 - 5.7.2 After consultation with OLMC, determines that there is a low index of suspicion for requiring treatment and/or transport of the patient and the patient is in, or will be in, a safe environment, may authorize EMS personnel to accept or deny the RMA.
 - A. Provide information to OLMC and, as appropriate, authorize the EMS personnel to accept or deny a request to RMA or to not treat/transport a patient, in accordance with this procedure and ensure that the ambulance personnel appropriately document the determination on the PCR.
 - 5.7.3 When a transport decision is authorized by the EMS Officer, the Officer shall document the patient transport decision as a miscellaneous entry in the CAD call history or through the GD Command.
 - 5.7.4 If the patient is determined to require transport to an ambulance destination but physically resists and cannot be safely treated or transported, request the assistance of the appropriate law enforcement agency to facilitate treatment and transportation.
 - A. Coordinate efforts with EMS personnel and/or appropriate law enforcement officers to facilitate transport.

- B. If the appropriate law enforcement agency refuses to assist in the transport of a patient without decisional capacity but for whom OLMC has authorized transport, contact the Citywide Dispatch Supervisor and request a law enforcement agency supervisor.
- C. If NYPD or other law enforcement agency will not assist in the transport of the patient, document the names, ranks, shield numbers and the commands of the law enforcement agency members on the PCR, notify OLMC, and upon completion of the assignment generate an Unusual Occurrence Report (UOR).

5.7.5 Ensure the EMS personnel complete all appropriate documentation on the PCR.

5.8 The Citywide Dispatch Supervisor shall:

5.8.1 In conjunction with the OLMC Physician or OLMC Officer, evaluate requests to transport patients to the 911 System ambulance destination of their choice when the refusal of treatment and/or transport is based solely on ambulance destination selection, and approve or deny such requests, as appropriate.

- A. EMS personnel shall consider overall transport time versus time spent on scene making a transport determination. The decision process should not unduly delay the patient's transport.

5.8.2 Facilitate requests for an NYPD Supervisor.

6. RMA DISPOSITIONS

6.1 **10-93** - the patient has the decisional capacity to refuse emergency medical treatment and/or transport and the patient continues to refuse treatment and/or transport.

6.2 **10-93A** - a patient who lacks decisional capacity and the OLMC physician determines that there is a low index of suspicion for requiring treatment and/or transport of the patient and the patient is in, or will be in, a safe environment.

7. ON-LINE MEDICAL CONTROL (OLMC) CONTACT INFORMATION

7.1 Phone number: (718) 899-5062

7.2 Toll-free phone number: (800) 281-TELM (8356)

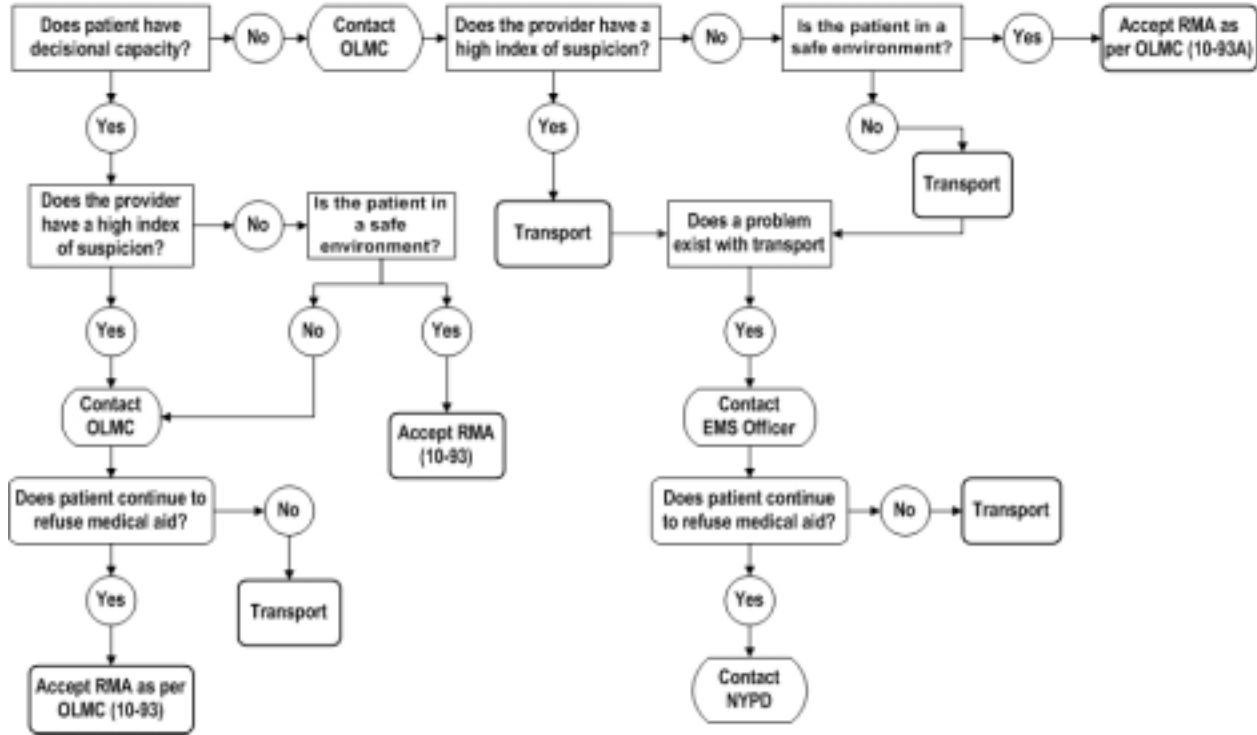
7.3 400 MHz Radio: ALS Med Channels 9 and 10

7.4 800 MHz Radio: Channel 6M

7.5 ALS 12-Watt Radio

8. REFUSAL OF MEDICAL AID FLOWCHART

Refusal of Medical Aid (RMA) Process



NOTE: No treatment/transport actions can be taken that are inconsistent with properly executed New York State (NYS) Out of Hospital DNR or MOLST forms. Any questions, contact OLMC.

BY ORDER OF THE CHIEF OF EMS COMMAND AND THE OFFICE OF MEDICAL AFFAIRS