I. **PURPOSE**

To describe the procedure to be followed by EMS and on-line medical control (OLMC) personnel when confronted with a patient who is an adult, mature minor, or emancipated minor who is refusing to be assessed, treated and/or transported by EMS personnel; and/or to provide guidance in situations where parents, guardians, surrogate decision makers, or others are refusing service for anyone who appears to be in need of emergency assessment, care and/or transportation.

II. **DEFINITIONS for the purpose of this policy**

A. **Adult –** Person who has attained the age of legal majority (18 years)

B. **Autonomy:** Derived from the Greek autos (˜self') and nomos (˜rule'). In healthcare terms, autonomy refers to the obligation of healthcare providers to empower adults and emancipated minors to direct their own clinical care as much as possible. This includes consenting to assessment and treatment as well as directing the nature of their care. The right to self-determination in healthcare is contingent on the patient's legal capacity and their ability to make informed decisions (decisional capacity).

Autonomy is limited when its exercise causes harm to someone else or may harm the patient. When harm to others is sufficiently grave, it overrides the principle of autonomy. Once information relevant to treatment is made available and the patient is deemed capable of making treatment decisions, EMS personnel proposing treatment should not prevent the patient's choice unless respecting the wishes would cause harm to others, or seriously undermine the patient's wellbeing unless allowed by law.

C. **Battery:** Unauthorized touching of body, clothing, or held articles and/or treatment in a harmful or offensive manner without legal justification or consent.

D. **Behavioral health-related emergency** (used interchangeably with mental health crisis in this policy): "Acute situations in which there exists imminent risk of harm to oneself (suicide), harm to others (interpersonal violence), or a severe lack of judgment that may unintentionally endanger either the individual or others." (Feuer, Rocker, Saggu & Adnrus, 2018, pg. 3)

E. **Consent:** Voluntary permission given to another to act, operate or function in a certain manner. Common examples in healthcare are consents for medical treatment and consents for disclosure of medical information. Consents serve to protect the patient and the health care provider from legal claims of unauthorized treatment. It is unlawful to touch a patient with legal and decisional capacity without their consent.

Patients must have legal and decisional capacity to consent or dissent to care.

Consent may be obtained in numerous ways: verbal, written, and implied.

F. **Decisional capacity:** The ability of an individual to understand and appreciate the nature and consequences of a decision to consent/dissent to treatment related to healthcare. This requires respect for an individuals' autonomy as well as the protection of individuals with diminished capacity to make an autonomous decision.

Decisional Capacity is not a permanent designation. It can change and be influenced by biologic or organic illnesses (metabolic, endocrine and autoimmune disorders, infections, seizures, neoplastic diseases, tumors, and vitamin disorders); cognitive disorders (delirium and dementia); degenerative neurological diseases, cardiovascular diseases), psychosocial, socio-cultural, and/or physical trauma, psychotic and non-psychotic disorders (schizophrenia, mood, anxiety, affective, somatoform, and dissociative disorders) medications, substance use disorder, pain, time of day, and other factors. A patient may have capacity to make some simple choices but not more complex treatment decisions.

Decisional capacity may be acutely impaired by the presence of hypoxia, hyper or hypocarbia, hypoperfusion; hypoglycemia, electrolyte imbalance, brain injury/stroke, acidosis, drug or alcohol intoxication. See SOP for a full listing of causes of AMS.

The more significant the consequences of a decision, the greater the evidence of decisional capacity is required. It is not uncommon for patients who have a psychological diagnosis, are developmentally disabled, elderly, brain injured, non-verbal or non-compliant to have their decisional capacity questioned. Though none of these things directly implies or determines lack of decisional capacity, they do indicate the need for a careful assessment.

Decisional capacity is not the same as competency. A determination of incompetency is permanent and is decided by a court.

Tests of decisional capacity:

1. **Understanding**: Ability to comprehend the information being disclosed in regard to their condition plus the nature and potential risks and benefits of the proposed treatment and alternatives (including no treatment). Ensure the person's actual comprehension by having the patient describe the information in their own words.
2. **Appreciation:** The ability to apply the relevant information to one's self and own situation (insight).
3. **Reasoning:** Evidence that the person's decisions reflect the presence of a reasoning process, e.g., ability to engage in consequential and comparative reasoning and to manipulate information rationally.
4. **Expression of a Choice:** The ability to communicate a "clear and consistent" choice

G. **False imprisonment:** Intentional and unjustifiable detention against a decisional patient's will.

H. **Guardian:** Any person, association or agency appointed guardian of the person of the minor under the Juvenile Court Act, the Juvenile Court Act of 1987, the "Probate Act of 1975", or any other statute or court order. (Source: P.A. 85-1440.)

I. **Minor –** Under Illinois law, a minor is a person who has not attained the age of 18 years.

J. **Mature minor:** A person 16 years of age or over and under the age of 18 years who has demonstrated the ability and capacity to manage his own affairs and to live wholly or partially independent of his parents or guardian.(Source: P.A. 81-833.)

K. **Emancipated minor:** A mature minor ordered emancipated under the law shall have the right to enter into valid legal contracts, and shall have such other rights and responsibilities as the court may order that are not inconsistent with the specific age requirements of the State or federal constitution or any State or federal law. (Source: P.A. 100-162, eff. 1-1-18).

L. **Parent:** The father or mother of a lawful child of the parties or a child born out of wedlock, and includes any adoptive parent. It does not include a parent whose rights in respect to the minor have been terminated in any manner provided by law. (Source: P.A. 94-229, eff. 1-1-06.)

A. **Patient:** A person who requests, potentially needs, and/or receives "Pre-hospital care" as defined by the EMS Act: "*Those medical services rendered to patients for analytic, resuscitative, stabilizing, or preventive purposes, precedent to and during transportation of such patients to health care facilities*." It is the EMS provider's responsibility to ensure all potential patients regardless of the size of the incident are offered the opportunity for evaluation, treatment, and/or transport. Practically speaking, a patient means a person encountered by EMS who meets any one of the following criteria:

1. "A person with any sort of [medical] complaint, possible illness, or mechanism of trauma that could suggest injury" (System Policy A-1)
2. Has signs or symptoms of illness or injury that can be assessed by EMS personnel
3. Appears to be disoriented, impaired, and/or lacks decisional capacity
4. Has evidence of a behavioral health emergency and/or suicidal risk/intent
5. Is apparently deceased and requires EMS assessment to confirm their status.

III. **POLICY: Elements of granting or withholding consent**

A. **Adults:** All adults with legal and decisional capacity have a fundamental right to make decisions relating to their own medical treatment, including the right to forgo life-sustaining treatment. Any authorized consenting party who has the authority to consent to treatment has the authority to refuse medical care. To refuse medical care a patient must have the same capacity as that to consent to medical care. A non-decisional patient may not consent to nor refuse medical care.

Supporting information

1. **An adult with decisional capacity must consent before medical treatment is rendered.** Every decisional adult has the right to the possession and control of his own person, free from all restraint or interference of others unless care is indicated by clear and unquestionable authority of law.

2. Adult patients who are conscious and decisional have the right to refuse medical care to the extent permitted by law, even when the best medical opinion deems it essential to life (Pozgar, 2021). A decisional adult **has the right, arising out of the Patient Self Determination Act of 1990, to refuse treatment, even if doing so will result in serious consequences or death**. The right to refuse medical care expressed while decisional and proven by clear and convincing evidence must be honored even if the patient is later declared incompetent or becomes non-decisional.

3. There is a legally recognized "right to die" unless a compelling state interest overrides the rights of the patient. **The state has four interests which may override the individual's freedom to decide:**
    1. Preservation of life; although this has evolving interpretation,
    2. Protection of innocent third parties,
    3. Preservation of the ethical integrity of the medical profession against the patient's rights of bodily integrity and religious freedom, and
    4. Prevention of suicide.

4. Any unpermitted, intentional touching of a decisional adult's person can result in a legal action for **assault and battery**. Coercion through threat, duress, or intimidation must be avoided.

5. **Dissent may take one of several forms:**
    a. Refusal to state a complaint or give a complete history
    b. Refusal to be physically examined
    c. Partial or complete refusal to accept recommended care
    d. Refusal to be transported at all
    e. Refusal to be transported to the nearest or most appropriate hospital
    f. Refusal to be transported in the safest, recommended manner: secured on the stretcher as opposed to patient's insistence on walking

6. An effective consent or refusal for a high-risk procedure should be **"informed"**
    a. EMS personnel should clearly explain the proposed treatments to the patient and when appropriate, the family.

    b. The explanation shall include a **disclosure of risk**

        (1) Nature of the illness/injury
        (2) Nature, purpose and need for the recommended examination/care
        (3) Potential benefits and possible risks and complications of recommended treatment; plus possible results of non-treatment
        (4) Any significant alternatives if they refuse recommended treatment

7. Risks that are remote and improbable can generally be omitted from the EMS disclosure of risk as not material or important to the patient's decision. The System disclosure of risk statement is framed as the “Medical Miranda” on the Refusal of Service form.

B. **Emergency doctrine (implied consent):** An emergency eliminates the need to obtain prior consent, since the law values the preserving of life and the prevention of permanent impairment to health. This rule applies only when the patient is incapable of expressing consent by reason of unconsciousness, mental incompetence, or legal disability. It further applies only when the person legally authorized to consent for the patient is similarly incapacitated or unavailable.

Ill. Rev. Stat. 410 ILSC 210/3 provides that treatment may be rendered to minors if “the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor’s health.”

The "emergency doctrine" extends to virtually any medical procedure necessary to preserve the life or health of a patient. However, "where a patient is in full possession of all his mental faculties and in such physical health as to be able to consult about his condition," the patient's consent is required (Barnes v Hinsdale Hospital).

C. **Who can consent to and/or refuse assessment/care?**

1. The consent of a decisional adult, mature minor, emancipated minor, parent, legal guardian, or someone authorized to act for a non-decisional or legally incompetent patient (Surrogate/Durable Power of Attorney), must be obtained before any medical treatment is undertaken, unless an emergency justifies treatment under implied consent.

2. In most cases, any party who has the legal authority to consent to treatment has the authority to refuse medical care. See refusal contraindications below.

D. **Situations where consent can be thorny and possibly disputed**

1. **Persons where it is difficult to judge-decisional capacity or suicide risk and/or there is disagreement relative to need to transport; or there is imminent risk of bodily harm to EMS personnel and law enforcement is not present to ensure scene safety:** This policy applies as does the BHE SOP.

2. Persons with legal and full decisional capacity + denying illness or injury and refusing assessment and care + with no apparent cause or evidence of illness or mechanism/S&S suggesting injury: These are not patients. The System does not require EMS documentation for these persons.

3. **Incompetents:** If a patient has been adjudicated an incompetent through court proceedings, there will typically be a guardian, a trustee, or a conservator who will have legal authority to grant consent for treatment.

4. Terminally ill patients with a contested **POLST/DNR order**: See **Policy D-5** ILLINOIS POLST forms and Advance Directive Guidelines.

5. Non-decisional patient who has designated a **Durable Power of Attorney for Healthcare – See Policy D-5.**

6. **Sincerely held beliefs:** If there is any question about the legality or medical implications of allowing an adult to refuse life-saving emergency care because of the patient’s sincerely held personal convictions or religious beliefs, contact OLMC.

7. **Prisoners in custody: See policy L1: Patients in Law-Enforcement Custody**

8. **Persons with mental illness:** If EMS personnel or family members have firsthand knowledge and reasonably suspect that a patient who is refusing care/ transportation is mentally ill and because of their illness would intentionally or unintentionally inflict serious physical harm upon themselves or others in the near future, is mentally retarded and is reasonably expected to inflict serious physical harm upon himself/herself or others in the near future, or is unable to provide for his or her own basic physical needs so as to guard himself or herself from serious harm and needs transport to a hospital for examination by a physician (Ill Mental Health Code) they shall **follow the System SOP for Behavioral Health Emergencies and System Policy E1:** Emotional Illness and Behavioral Emergencies.

E. **Refusal contraindications -** EMS personnel should NOT accept a refusal from an adult, mature or emancipated minor, or a surrogate: in the following instances:

1. EMS has access to the pt + they lack legal or decisional capacity; and/or
2. The pt **poses an imminent risk to self (suicide/self-injurious behaviors), others (homicidal), or meets self-neglect emergency criteria:**

   "Self-neglect": Means a condition that is the result of an eligible adult's inability, due to physical or mental impairments, or both, or a diminished capacity, to perform essential self-care tasks that substantially threaten his or her own health, including: providing essential food, clothing, shelter, and health care; and obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety. The term includes compulsive hoarding, which is characterized by the acquisition and retention of large quantities of items and materials that produce an extensively cluttered living space, which significantly impairs the performance of essential self-care tasks or otherwise substantially threatens life or safety. (320 ILCS 20/) Adult Protective Services Act.
   "Emergency" under the above Act means a situation in which an eligible adult is living in conditions presenting a risk of death or physical, mental or sexual injury and the provider agency has reason to believe the eligible adult is unable to consent to services which would alleviate that risk; and/or
3. The pt. remains **acutely & severely hemodynamically unstable/ in physiologic distress** and/or with AMS after care.
4. Mature minors may not refuse an assessment to determine if they are ill or injured or refuse care if they are ill or injured.
5. Refusal of care for a minor or non-decisional adult by a parent, guardian, agent, or surrogate is not *necessarily* valid. The welfare of the patient is the EMS System's primary consideration. If EMS personnel believe that the patient's health and welfare could be compromised by the refusal, they must contact OLMC before accepting and executing a refusal of service. Each case must be evaluated on its own merits to determine a proper course of action.

IV. PROCEDURE

A. **ASSESSMENT:** If a mechanism of illness/injury exists to a degree that a reasonable person would suspect could cause injury based on a patient's age, co-morbidities and current condition; or they are expressing a complaint/desire for care, or a request has been made on an individual's behalf for examination and treatment, **each person must be provided** an **appropriate screening exam**, to the extent authorized in an attempt to determine whether an emergency medical condition exists.

1. Before executing a refusal, assess/document the following unless impossible to do so:

   a. **Inspect environment** for bottles, meds/drugs, letters/notes, sources of toxins suggesting cause

b. **Inspect patient** for Medic alert jewelry, tags, body art; odors on breath; poor grooming/hygiene, skin edema, discoloration and/or lesions and rashes that may provide clues

c. **Consider patient vulnerability/risk factors**: younger/older age, dementia, functional impairment, malnutrition, substance use disorder

d. **Past Medical History (PMH) and history of present illness (HPI):** Ask bystanders/patient if changes are acute or chronic; if acute ask about S&S immediately prior to change in mentation; S&S during event; duration of event, interventions provided, resolution of event (if applicable). Consider medical causes for their behavior as listed on page 1 of this policy.

e. **Physical exam findings:** Assess glucose level, SpO_2; $ETCO_2$ number & waveform, ECG if indicated; pupils/EOMs; visual deficits; motor/sensory and cerebellar exam; nuchal rigidity; consider need for qSOFA, stroke and/or suicide screens. Assess for evidence of pain: facial expression, body movements, muscle tension, vocalization.

f. Assess **decisional capacity** per Psych/Behavioral Health Emergency SOP (all factor in to ultimate capacity determination) If any of the below are abnormal or impaired, attempt to assess and document whether changes are new to patient's baseline or features of chronic illness; and how grossly abnormal EMS interprets the exam findings to be. Consider use of the Richmond Agitation Sedation Scale (RASS) – See bottom of 3rd page BHE SOP

(1) **Alertness (GCS)**

(2) **Orientation**: A&O X 4 (person, place, time, situation); attention span. Answers accurately: Name, location, age, month; situation.

(3) **Speech**: Speaking in full sentences with normal rate, volume, articulation and content.

(4) **Affect:** Is mood and emotional response consistent with environmental stimuli? Note if patient's affect appears to be sad, depressed, flat, anxious, irritable, angry, hostile, elated, fearful, inappropriate, and incongruent with speech content (Note abnormality in narrative). Consolable or non-consolable?

(5) **Behavior:** Note body language (posture, gestures). Is the patient quiet, restless, inattentive, hyperactive, demonstrating compulsive, repetitive behaviors, agitated, aggressive or violent? Are they able to remain in control? Aggressive behaviors can be triggered by medical causes, such as brain injury or pain, and by psychiatric disorders, such as psychosis and behavioral disorders.

(6) **Cognition**: Intellectual ability/thought processes. Ability to answer simple question accurately. Note if confused, experiencing flight of ideas, obsessions, phobias, delusions, hallucinations, delirium, or not making sense. (Note abnormality)

(7) **Memory**: Immediate, recent, remote; any acute amnesia

(8) **Insight**: Can the patient appreciate the implications of the situation and consequences of their decision? Do they understand relevant information? Can they draw reasonable conclusions based on facts? Can they communicate a safe and rational alternative choice to recommended care?

B. **EMS personnel have a duty to attempt to convince a patient to receive needed assessment, care, and/or transportation.**

C. **Minimum staffing required to process dissent to care/refusal of service**

1. Adults or minors who have received or are candidates to receive **BLS** care may be processed by an EMT.

2. Adults or minors who have received or are candidates to receive **ALS** care must be processed by at least one Paramedic or PHRN. If the refusal is contested by EMS or OLMC, it shall be documented as AGAINST MEDICAL ADVICE and requires two EMS practitioners (1 ALS) to witness the disclosure of risk and sign the refusal form.

D. **ADULT with LEGAL and DECISIONAL CAPACITY**

1. If an adult with legal and decisional capacity steadfastly refuses assessment, care, and/or transportation, they must be provided with disclosure of risk. Advise the patient of their medical condition as known by the facts available to EMS personnel at the moment and explain why care and/or transportation is advised. Continue to encourage consent if the patient is undecided or if you believe they may change their mind, as many people who initially refuse are actually in need of such care.

2. Each person refusing some aspect of recommended EMS assessment, care, and/or transportation should be asked to attest to what they are refusing by checking all the relevant section(s) on the NWC EMSS Release of Liability form and note their dissent (withholding of consent) by signing the form (paper or electronic); see below.

E. **ADULTs LACKING DECISIONAL CAPACITY**

1. If an adult shows evidence of lacking decisional capacity, efforts shall be made to explain to them the nature of their condition, the possible consequences of refusing assessment and/or treatment, and the necessity of transporting them to a healthcare facility. **A non-decisional adult may NOT make healthcare decisions (consent or dissent).**
2. Determine if a legal surrogate is on the scene to provide consent
3. Adults lacking decisional capacity must have their rights and safety protected and shall be assessed, treated, and transported per SOP and policy to the nearest appropriate healthcare facility (against their will if necessary).
4. **If efforts to gain the patient's cooperation are unsuccessful, they have agitated delirium and/or are combative,** refer to the Psych/Behavioral Health Emergencies SOP and Policy E1 for instructions regarding de-escalation strategies, use of sedation, and restraint.
5. **Requests from a guardian/surrogate to transport the patient to other than the nearest appropriate facility will be considered on a case-by-case basis and must be approved in advance by OLMC** based on the patient's medical stability, PMH and location of the patient's primary care practitioner, the potential risk of harm due to a longer transport time, plus individual EMS Provider Policies.

F. **Minors: Also see Consent by Minors to Medical Treatment (Appendix)**

1. In Illinois, in general, a minor cannot consent to or refuse medical treatment, and a parent, guardian, or person in loco parentis must consent to their treatment. If called for a minor, the duty of EMS personnel is to first determine the nature of the health problem and institute appropriate emergency resuscitative care under the Emergency Doctrine and Implied consent if applicable. Then determine their legal status.

2. An **emancipated minor** has the same rights and responsibilities as an adult. Treat as above in the adult provisions.

3. **Parent/guardian (surrogate decision-maker) ON SCENE:** Steadfast refusal by a minor with decisional but not legal capacity to consent to recommended assessment, treatment and/or transportation shall be discussed with a parent or other legally responsible adult, e.g., guardian or caretaker (including school administrators) with authority to act on behalf of the parent while EMS personnel are on the scene.

   If treatment appears necessary, the responsible adult should be informed and consent for treatment solicited from them. A mature minor cannot refuse care and/or transportation that is consented to by the parent/guardian/surrogate.

   If assessment/treatment/transportation appears unnecessary, the adult may provide authorization for refusal of service on behalf of the minor.

4. **Parent/guardian/surrogate NOT on scene:** If the parent or a responsible adult is not present, EMS personnel must attempt to contact them by phone from the scene BEFORE treatment is begun (unless emergency doctrine applies) or a mature minor is released.

   a. **If phone contact is established and treatment appears necessary**, the responsible adult should be informed about the minor's condition and verbal consent for treatment solicited from them.

   b. **If phone contact is established** a**nd treatment/transportation appears unnecessary,** the adult may give verbal authorization for refusal of service on behalf of the minor. This refusal of service must be thoroughly documented on the ePCR and the refusal confirmed with OLMC.

   c. **If unable to establish contact with a responsible adult from the scene,** and a mature minor appears to be exhibiting rational behavior with decisional capacity, and based on the EMS assessment there is **no apparent illness or injury**, and EMS believes that no foreseeable harm will come to the mature minor as a result of not receiving immediate care and/or transportation, EMS shall seek OLMC authorization to honor the mature minor's refusal of service and release them to the circumstances in which EMS personnel found them, unless releasing the individual would place them at risk of harm.

      (1) EMS must contact OLMC at the nearest System Hospital from the scene BEFORE the mature minor is released. Describe the situation and determine a course of action.

      (2) OLMC shall consider allowing the mature minor to be released on their own signature. The circumstances of the call must be thoroughly documented on the patient care report (PCR) and Communications Log, and must be verified by witnesses.

      (3) EMS shall **attempt to contact the responsible adult as soon as possible after return to the ambulance quarters.**

      (4) **Follow up notice**: If no contact can be made with a responsible adult during that shift, a follow-up letter, must be sent to the parent/guardian immediately thereafter, describing the circumstances of the call, the nature of the evaluation, including any other information that the scene personnel deem significant so the parent/guardian is aware of an EMS response for their adolescent. A copy of this letter should be scanned and added as an attachment to the electronic PCR.

G. **Minors:** <u>There are several exceptions that permit a minor to consent for themselves. These exceptions depend upon either the minor's legal status or the medical condition or treatment received by the minor.</u>

1. **Exceptions based on legal status**: Emancipated by court order; member of the United States Armed Services, are married, pregnant, or are a parent.

2. **Exceptions based on medical treatment needs:**

   a. **Medical emergencies:** Emergency care may be provided to a minor without obtaining parental consent when, in the sole opinion of the provider, obtaining consent is not "reasonably feasible under the circumstances without adversely affecting the condition of the minor's health.

   b. **Medical treatment/counseling for criminal sexual assault or abuse**: When a minor is a victim of sexual assault or abuse, a provider may furnish healthcare services or counseling related to the diagnosis or treatment of "any disease or injury arising from such offense" without obtaining the consent of the minor's parent or guardian. A minor victim of sexual assault or abuse may consent to such counseling, diagnosis, or treatment. A minor sexual assault survivor may consent to and be provided emergency hospital services, forensic services, and follow-up healthcare without the consent of a parent, guardian, custodian, surrogate, or agent.

   c. **Sexually transmitted diseases & HIV:** A minor 12 years of age or older who may have come into contact with a sexually transmitted disease ("STD"), including HIV may consent to STD testing and to healthcare services and/or counseling related to the prevention, diagnosis, or treatment of a STD. Minors 12 years of age or older also have the right to anonymous HIV testing.

   d. **Drug use or alcohol consumption:** A minor 12 years or older who may be determined to be an addict, an alcoholic, or an intoxicated person, or who may have a family member who abuses drugs or alcohol, may consent to healthcare services or counseling related to the prevention, diagnosis, or treatment of drug use or alcohol consumption by the minor or the effects on the minor of drug or alcohol abuse by a member of the minor's family.

   e. **Outpatient mental health services**: A minor 12 years of age or older may request and receive outpatient counseling or psychotherapy without consent of a parent, guardian, or person in loco parentis. Until the consent of a parent, guardian, or person in loco parentis has been obtained, minors 12 to 16 years of age are limited to receiving eight, 90 minute sessions. Minors can access more than eight sessions if the provider believes it is in the minor's best interest to continue or that parental involvement would be detrimental to the minor's well-being.

   f. **Voluntary inpatient mental health services**: A minor 16 years of age or older may consent to admission to a mental health facility for inpatient services if the minor executes the application for voluntary admission. Unlike outpatient services, providers must immediately inform the minor's parent, guardian, or person in loco parentis of the admission, even if the minor does not consent to the disclosure.

V. **On Line Medical Control (OLMC) for Refusals**

A. OLMC contact with the nearest system hospital (when required) must be made while ON THE SCENE BEFORE the individual is released to appropriately discharge the EMS provider's duty to the patient(s).

B. **ALL patients who have received, or are candidates to receive, ALS assessment, treatment and/or transport must be called in** on a recorded line

C. **The following BLS refusals must be called in:** All BLS patients refusing assessment, treatment, and/or transportation in whom a **high risk potential exists**. OLMC contact should be first attempted on the MERCI (VHF) radio. If no MERCI (VHF) radio is available, a standard phone line may be used.

1. **All minors** (legal definition) ≤17 years **(whether or not parents/guardians or surrogates are present on scene or have consented to the refusal);**
2. **All persons 65 years or olde**r;
3. Patients with AMS who cannot comprehend the risk of refusal decisions, plus those with abnormal VS, breath sounds, SpO_2 or capnography readings;
4. Pregnant patients not needing ALS care
5. Patients under the influence of drugs or alcohol with GCS 15
6. Patients with psychological/behavioral complaints with low or no risk; or when
7. EMS personnel have doubts about the appropriateness of the refusal.

D. **OLMC is not required for BLS adult patients (ages 18-64)** refusing care and/or transportation who are alert, oriented, decisional, hemodynamically stable, and do not meet one or more of the above criteria.

E. ECRNs shall relay Communication Log number to EMS personnel for hospital verification of call.

VI. **IF A REFUSAL IS CHALLENGED OR QUESTIONED BY OLMC**

A. In all instances where EMS personnel or OLMC questions the patient's decisional capacity or has just cause to suspect that the patient may sustain harm due to the lack of medical evaluation/care and do not believe that the refusal should be honored, the ECRN shall immediately inform an on-duty physician. The physician shall personally assume control of the call and shall speak directly to the patient over the radio or phone.

B. If, in the judgment of the physician, the patient does not need or does not meet the legal threshold to be brought in against their will, EMS personnel shall release the patient following standard procedure. OLMC personnel shall fully document the facts as presented by EMS, the statements made by the patient, and confirm that the patient had been fully informed of the risks inherent in refusing care and/or transportation and understood the consequences of their decision. **Under these circumstances, the patient will be released under an alternate disposition plan noting that the refusal is Against Medical Advice (AMA).**

C. If the patient's personal physician or Primary Care Practitioner has called EMS to transport, and the patient appears decisional and is refusing to be transported, attempt to contact the PCP and have them speak directly to the patient to persuade them to come in.

D. If an ED physician believes that a patient lacks decisional capacity to refuse care and/or transportation, and/or the patient appears to be at risk of harm or in a position to imminently harm themselves or others or be unable to care for themselves, the patient shall be transported, even if against their will. Evidence of imminent harm may be found posted by the patient on electronic or print media, intentionally inflicted wounds on their body, clinical evidence of impairment, malnutrition, hallucinations, delusions, statements made to others present on scene who will sign a petition form; or if EMS believes the patient may be a victim of abuse or human trafficking.

VII. **Documenting a Refusal of Service**

CAREFUL DOCUMENTATION IS ESSENTIAL!! The best defense to a disputed refusal is a thoroughly documented PCR

A. EMS personnel should enter the incident number (if known) and location into the ePCR. Obtain the **required demographic** information including the patient's name, home address, date of birth, gender, and phone number.

Document the following on the PCR: patient's decisional capacity, the extent or limitations of the EMS assessment; patient understanding of the EMS impression and all attempts to convince the patient to receive care; any EMS concerns about the refused interventions or transport; disclosure of risks and benefits provided to the patient; state clearly if the refusal is being executed AMA; and state that the patient was instructed to seek medical care if their condition changes.

B. **Execution of the Refusal Form**

1. If using the paper Refusal form, EMS personnel should complete the top two lines of the form, noting the EMS Agency's name, date, incident location and number (if known).

2. If using the electronic form:

   a. Complete the patient's name (first and last) in the "Patient" tab of the ePCR at a minimum prior to obtaining the patient's signature electronically.

   b. Within the "Signature" tab, click on the "+ADD" to add a signature to the report.

   c. Select "Patient" or "Patient Representative or Guardian" as the person signing the ePCR.

   d. Select the correct applicable "Signature Reasons" to which the patient or patient representative is signing.

      (1) Refusal of Treatment: For all patients that are refusing further treatment as recommended by EMS personnel.

      (2) Refusal of Transport: For all patients that are refusing transport by EMS personnel to a healthcare facility for further treatment and assessment.

      (3) Refusal of Assessment: For all patients that have refused or are refusing further assessment by EMS personnel.

      (4) Refusal of Recommended Destination: For all patients who refuse to be transported to the recommended healthcare facility by EMS personnel and chose to be transported to a health care facility of their choice and is compliance with the local agency's policy.

      (5) Request Private EMS Transportation: For all patients who refused to be transport and are electing to have a private care ambulance provide transport to the patient's desired healthcare facility.

C. Inform the patient/legal decision maker of the risks inherent in refusing care and/or transportation. Convey, and/or allow the patient to read the **"Medical Miranda"** located under Patient Refusal of Service in the Refusal of Service tab, or on the Release of Liability form:

Paper Form:

"I (or my guardian) have been informed regarding the state of my present physical condition to the extent I allowed an examination, and I (or my guardian) hereby refuse to accept such medical care and/or transportation as recommended by representatives of the EMS System listed above. I (or my guardian) do hereby for myself, my heirs, executors, and administrators and assigns forever release and fully discharge said EMS System, its officers, employees, medical consultants, hospitals, borrowed servants or agents from any and all conceivable liability that might arise from this refusal of care and/or transportation, and I (and my guardian) therefore agree to hold them completely harmless.

I (or my guardian) have been informed that a refusal of care and/or transportation for an evaluation my cause me to suffer pain, disability, loss of function, worsening of my condition, or even death as a result of my illness/injury. As a competent adult, I (or my guardian), fully understand al of the above, and am/is capable of determining a rational decision on my own behalf.

Electronic Form:

I (or my guardian/legal representative) have been informed regarding the state of my present physical condition to the extent I allowed and examination. The evaluation and/or treatment provided by the Emergency Medical Services (EMS) personnel is not a substitute for medical evaluation and treatment by a doctor or primary care practitioner if additional assessments/care are advised by EMS.

I have been informed from the history of my complaints, the mechanism of injury, or the findings of a physical exam, that I should receive emergency care and transportation to the nearest appropriate healthcare facility for a more detailed evaluation by a physician or approved healthcare practitioner. I (or my guardian/legal representative) have been informed of the reason(s) I should go to a healthcare facility for further assessment/emergency care.

I (or my guardian/legal representative) have been instructed to contact a physician or Primary Care Practitioner for an examination and/or treatment if my condition changes in any way. I (or my guardian/legal representative) have also been instructed to recontact EMS if my condition changes and is perceived to be urgent or and emergency.

I (or my guardian/legal representative) hereby refuse to accept such Medical Care and/or Transportation as recommended by representatives of the EMS system above. I (or my guardian/legal representative) do hereby for myself, my heirs, executors, and administrators and assigns forever release and fully discharge said EMS system, its officers, employees, medical Consultants, hospitals, borrowed servants or Agents from my and all conceivable liability that might arise from this refusal or care and/or transportation.

DISCLOSURE OF RISK: A refusal of care and/or transportation for an evaluation may cause me to suffer pain, a delay in care that could make my condition or problem worse, disability, loss of function, worsening of my condition, or even death. I (or my guardian/legal representative) have been informed of the potential consequences and/or complications that may result from my (or my guardian/legal representative's) refusal to accept further assessment, care, and/or transportation.

If the patient is under the age of 18 or unable to sign, I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered unless I am legally responsible for a minor child.

I (or my guardian/legal representative) , fully understand all of the above, and am/is capable of determining a rational decision on my own behalf.

D. The patient or agent must initial (**on the printed form**), to **each of the specific statements** that apply to the situation. **Not** Applicable should be checked for any statements that do not apply to the situation.

The following statement, *"I have been instructed to contact a physician for an examination and/or treatment if my condition changes in any way",* **must be initialed on the paper form by every patient** refusing care and/or transportation. This language is included on the electronic form with selection of "Refusal of Transport" or "Refusal of Treatment" signature reasons.

E. **Patient signature**: EMS personnel must have the patient or their agent sign the Release of Liability form on the line provided as a final mechanism of documenting their refusal of care and/or transportation. Electronic signature capture is acceptable. **Electronic signatures are time stamped upon selecting the "✓ADD" button on the top of the signature pop up box.**

F. If a patient refuses to sign the paper Release form, the "Refusal to Sign a Release Statement" must be checked and witnessed by at least two EMS personnel.

G. If the patient refuses to sign the electronic Release form, EMS personnel must document such within the "EMS Crew Member" signature by doing the following:

1. Select the "Patient Unable or Refused to Sign" signature reason within the "EMS Crew Member" or "EMS Primary Care Provider for this Call" signature panel.

2. Select the most appropriate reason from the selection list to answer the why the patient or guardian did not sign.

H. There must be at least two witness signatures on the electronic release or printed form. One must be the EMS provider who provided disclosure of risk and is responsible for obtaining the patient/guardian's signature on the form. The other may be a second crew member or a police officer who can verify that the person refused care and/or transportation, was given full disclosure of risk and still steadfastly refused service.

I. For an all refusals, call information is to be entered into the EMS software and posted whether on the scene, at a System hospital or at a Provider's facility as soon as possible, but no longer than two hours after the incident.

J. **Form distribution:** If using a printed form, retain the original signed copy for the EMS agency's records It should be scanned and added as an attachment to the electronic PCR. Inform the patient/agent that a copy of the form is available from the EMS agency upon their written request and give them contact information.

K. **Printed form acquisition:** The print edition of the Refusal form is available in English and Spanish. Both are posted to the System website (www.nwcemss.org) under the Policy Manual tab associated with this policy. They may be duplicated for use by an EMS Provider Agency without change to any of the language.

Matthew T. Jordan, M.D., FACEP
EMS System Medical Director

Connie J. Mattera, MS, RN, PM
EMS Administrative Director

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Wolfberg, D. (2021, Oct. 5) A case for eliminating patient refusals in EMS. EMS1. Accessed online: https://www.ems1.com/legal/articles/a-case-for-eliminating-patient-refusals-in-ems-88CvNJ4EBnohVoc4/

EMS DISSENT TO CARE/REFUSAL OPTIONS

<table>
<tr><th colspan="4">Adult or emancipated minor present</th><th>Persons not present</th></tr>
<tr><td colspan="3">Mechanism of illness/injury possible</td><td>NO mechanism of illness/injury
Called by mistake</td><td rowspan="2">NO mechanism of illness/injury
Called by mistake
No patient contact
No refusal or PCR necessary for EMS System</td></tr>
<tr><td>Apparent Illness/Injury
Decisional and refuses care:
Attempt to assess/provide care to the extent allowed by patient
Provide full disclosure of risk; have patient sign refusal form; contact OLMC from scene.
Note if refusal is AMA.
ePCR required.</td><td>Apparent Illness/Injury
Non-decisional or incompetent pt refuses care:
CANNOT REFUSE;
contact OLMC from scene.
May need to sedate/restrain pt to provide emergency care and transportation.
ePCR required.</td><td>No apparent illness/injury:
Decisional and refuses care:
Provide full disclosure of risk; have patient sign refusal form; contact OLMC from scene.
ePCR required.</td><td>Decisional and refuses assessment/care and transport
Considered a no patient contact
No refusal form or ePCR necessary for EMS System.</td></tr>
</table>

<table>
<tr><th colspan="4">Mature minor or minor child present: Mechanism of illness/injury possible</th></tr>
<tr><td>Adolescent
Apparent Illness/Injury
Legal decision maker on scene
Provide care to the extent allowed by parent
Adolescent cannot refuse unless emancipated
Contact OLMC from scene
ePCR required</td><td>Adolescent
Apparent Illness/Injury
Legal decision maker NOT on scene
Attempt to contact parent/guardian
Contact made: Follow their wishes unless harm would result
No contact made: Adolescent cannot refuse unless emancipated
Contact OLMC from scene.
May need to sedate/restrain pt to provide emergency care and transportation.
ePCR required.</td><td>Mature minor
No apparent illness/injury:
Decisional and refuses care:
Attempt to contact legal decision maker
Contact made: Follow their wishes
No contact made:
Contact OLMC from scene to OK refusal
Provide pt w/ full disclosure of risk; have patient sign refusal form
ePCR required.
Reattempt contact w/ parent
No contact: Send follow up notice</td><td>Minor
No apparent illness/injury:
If legal decision-maker on scene or contacted by phone: follow their wishes
No legal decision maker on scene and/or cannot contact:
Contact OLMC from scene.
Treat and transport child.
They cannot refuse.
Apparent Illness/Injury
Decision-maker cannot refuse life-saving care – consider need for temporary protective custody</td></tr>
</table>

Final word: WHEN IN DOUBT, DO GOOD (Beneficence) and Do NO HARM (non-maleficence) allowing for patient autonomy when legally possible