When the Patient Says NO

Lifestar Conference
The University of Tennessee, Knoxville
August 18, 2012
Overview

- Foundations
- Informed consent/refusal of treatment
- Resources

“Medicine is something we offer people, not something we inflict on them.”
Thom Dick, EMS Magazine May, 2008
Case: Rose

- Patient is a female in her 80s. Daughter called 911 because mother c/o chest pain
- She permits you to assess her, but refuses transport or treatment
  - Skin pale, cool, and diaphoretic
  - Pulse 40, BP 110/90
  - Acknowledges being nauseous
  - Refuses to comment on chest pain
Be it pledged as an Emergency Medical Technician, I will honor the physical and judicial laws of God and man. I will follow that regimen which, according to my ability and judgment, I consider for the benefit of patients and abstain from whatever is deleterious and mischievous, nor shall I suggest any such counsel.

Written by: Charles B. Gillespie, M.D.
Adopted by the National Association of Emergency Medical Technicians, 1978
EMT Code of Ethics

A fundamental responsibility of the Emergency Medical Technician is to conserve life, to alleviate suffering, to promote health, to do no harm, and to encourage the quality and equal availability of emergency medical care.

Written by: Charles B. Gillespie, M.D.
Adopted by the National Association of Emergency Medical Technicians, 1978
“Benefit” “Harm” “Suffering”

- Universal values
  - Everyone wants to be helped, not to be harmed, to be respected

- Individual expression
  - Help to one person may be harm to another person
  - Help in one context may be harm in another context
Informed Consent

- Criteria: Competent decision maker, fully informed, free of coercion

- Goals
  - to ensure respect for patient choices even if we do not agree with those choices
  - to ensure that patients do not make choices under duress, without enough information, or while of limited ability to process information or the consequences of the decision for their lives
Respect for persons means that informed, competent patients have the right to refuse medical treatment -- INCLUDING life saving treatment.

It also means we ensure that they really understand what they’re doing.
Decision Making Capacity

- Patients are “capacitated until proven incapacitated”
  - Incapacitated = unsound *mind*, not unsound *decision*

- Contrasted with legal *competence*

- Contrasted with *cognition/orientation*

- 4 abilities

- Sliding scale
Legal Competence vs. DMC

- All or nothing (or discrete levels)
- Decided by courts
- Fixed
Cognition vs. DMC

- Cognitive impairment is *correlated* with limited DMC, but is not the only criterion
  - Very low cognition usually = lack of capacity
  - Moderately low cognition = not so clear
  - “Orientation” tells us relatively little
Other conditions *may or may not* impair DMC for decision at hand

- Mental health diagnoses
- Renal conditions
- High blood glucose
- Etc…
4 Abilities for DMC: CURA

1. the ability to communicate
   - Communication may be written, verbal, or make use of another method, but must be clear
   - May need to be facilitated by translators, paper and pencil, etc.
4 Abilities for DMC: CURA

- 2. the ability to understand relevant information
  - Diagnosis
  - Likely outcomes of accepting or rejecting proposed treatment
4 Abilities for DMC: CURA

3. the ability to use Reason (i.e. “means-end” reasoning) to process information

- Does the treatment choice map on to the patient’s stated goals?
- Is it consistent with her or his preferences, given the circumstances?
4 Abilities for DMC: CURA

- 4. the ability to **Appreciate** the situation
  - Implications of the choice for her/his life in terms of goals, values, preferences
DMC: the Sliding Scale

- Decision making capacity comes in degrees
  - Can wax and wane, depending on a variety of factors
- Pt can have capacity to make some medical decisions but not others
- Higher standard needed for more serious decisions
- Standard reflects *level of ability* NOT *the decision itself*
Case: Ms. Burton

- 38-year-old woman, had been drinking alone
- Fell from standing height, hitting her forehead
- LOC, if any, would have been brief
- Contusion and abrasion to her left orbit and forehead
- Oriented, alert, intoxicated, combative, and refusing care
- Vital signs unremarkable except for a modest elevated blood pressure and tachycardia
- Neurological exam was unremarkable
Ms. Burton con’t

- Refused transport to the ED, claiming that she couldn't afford it
- Admitted to having a headache at the site of the forehead contusion, but said she'd go home and would go the ED immediately if she "got worse"
- Denied depression, suicidal ideation, alcohol abuse
- Stated she only drank on weekends, that she was a professional, and that this had happened "many times before"
- Refused to allow phone calls to family, friends, or co-workers, claiming that this was "none of their business"
A Tool for Assessing DMC: your ACE in the hole

- ACE = Aid to Capacity Evaluation
- Based on the decision the patient is facing at the moment (not a once-and-for-all pronouncement)
- 8 questions
  - Start with open-ended questions
  - Score yes, no, or unsure
Setting the Stage

- Identify any communication barriers
  - If necessary and possible, use translators, paper and pencil, etc.

- Assure patients that you want to respect their wishes
  - Encourage them to do their best
  - Remind them that the test is not a “trap”
Setting the Stage, con’t

- Disclose and re-disclose information as necessary
  - Use terms familiar to patient
  - Speak at her/his level of health literacy

- Address family who want to “help”
  - Use if appropriate to facilitate communication, but do not let them influence the patient
Questions that Assess *Understanding*

- 1. Current medical condition
- 2. Proposed treatment
- 3. Alternatives
  - If any reasonable options exist
- 4. Option of refusing treatment
  - Skip this one …
Questions that Assess Appreciation

5. Consequences of accepting proposed treatment
   - Financial considerations may be relevant

6. Consequences of refusing proposed treatment
Checking for Depression and Psychosis

7. “Can you help me understand why you are refusing treatment?”
   
   7a. “Do you have any hope for the future?”

   7b. “Do you think anyone is trying to harm you?”
Communication skills

- 97.749862% of all medical conflict can be resolved with good communication

- This means
  - Take time
  - Be professional
  - Find out why
Advance Directives

- Universal DNR: “qualified emergency medical services personnel … are authorized to follow universal Do Not Resuscitate orders” [TCA 68-11-224(c)]

- When an Advance Directive and a proxy decision maker conflict, the AD generally takes precedence over a proxy

- Tattoo flash: “Consider DNR” ??
When No means NO

- Ensure appropriate support (physical and other) prior to departure
- Encourage them to call again if necessary
- Document, even if patient treated at scene but not transported, including:
  - Patient activity at scene
  - Ability to converse
  - Patient improvement
  - Signed waiver (if this can be obtained, it should be)
What About the Family?

- Sometimes the patient isn’t the only patient
- “Will I get sued?” is not a useful question
  - *not* because it doesn’t matter
  - *not* because it can’t happen
  - *but* because it shifts the focus away from patient care
  - *and* focus on good patient care is usually the best way to CYA
Thank you!

Cases and comments always welcome

Annette Mendola, PhD
Director of Clinical Ethics
(865) 305-5180
amendola@utmck.edu