When the Patient Says NO

Lifestar Conference

The University of Tennessee, Knoxville

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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

EMT Oath

- 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.

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“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

Underlying conditions

- 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: **C**URA

- 1. the ability to **C**ommunicate
  - 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: C**U**RA

- 2. the ability to **U**nderstand relevant information
  - Diagnosis
  - Likely outcomes of accepting or rejecting proposed treatment

4 Abilities for DMC: CU**R**A

- 3. the ability to use **R**eason (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: CUR**A**

- 4. the ability to **A**ppreciate 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

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