

MEDICAL COMMAND BASE STATION COURSE

Pennsylvania Chapter, American College of Emergency Physicians; Emergency Medical Services Office, Commonwealth of Pennsylvania, Department of Health

On-Line Command III: Special Situations

Case #1: Refusals

[Listen to .mp3 audio of call](#)

Case I Transcript

Hey, doc, currently seeing a 30 year old female, involved in a two-car motor vehicle accident... [inaudible background interruption from patient] ...thirty year old female, involved in two-car motor vehicle accident, patient was the driver, restrained, vehicle sustained moderate passenger-side damage, Talking with the witnesses here, the patient was acting rather strangely, so on and so forth, and they believe the patient to be intoxicated. There was no evidence or odor of this. On talking with the patient, she does state that she is on Glucophage, she is not a diabetic. So we did a quick assessment on her, did a blood sugar, which was 57, her vitals are all good and stable, her blood pressure is 108 by palpation, her pulse is 90, respiratory rate is 16, and a good head to toe assessment—I mean, there's no evidence of trauma except over the left clavicle where the seatbelt was, actually brush-burned her skin—doc, I advised her numerous, numerous times that she should seek medical assistance, and allow us to transport and treat her, her family's here, and she's adamantly refusing to be transported. I just wanted to consult you and see what your thoughts are.

Case I Discussion and Questions

Should the EMT have this patient sign a refusal form and let the patient go, or should the EMT force the patient to go to the hospital?

This simple-seeming question has many implications—and the wrong answer could end up in a dead patient and a court appearance. The following questions will test your knowledge of the applicable medico-legal principles and guide you in learning more about these issues.

1. For *medical decision-making purposes*, what are the criteria for determining whether a patient is intoxicated?
 - a. The blood alcohol level is the sole criterion. Due to a recent change in Pennsylvania law, anyone with a blood alcohol of greater than 80 mg/dL (.08) (recently decreased from 100 mg/dL) is officially intoxicated; anyone with a level below this is officially sober.

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- b. If the patient acts intoxicated, you should assume the patient **is** intoxicated. The blood alcohol level is much less important than whether the patient acts intoxicated.
- c. The family should decide whether the patient is intoxicated.
- d. You cannot determine intoxication without a magistrate's decision.

a. is not correct.

It is true that 80 mg/dL is the accepted level for drunk-driving cases before a judge in Pennsylvania. However, for **medical decision-making** this level is nearly irrelevant.

b. is the best answer.

When medical personnel (including EMTs and medical command doctors) are deciding whether a patient is capable of informed refusal, which is the same as [informed consent](#), the courts expect [ref] a **clinical** evaluation. In particular [ref], courts have said the physicians have the capability to decide whether a patient is too intoxicated to make good medical decisions, and rather than second-guessing physicians, tend to give physicians wide latitude in making this decision. The presumption is that the physician made a correct decision unless proven otherwise (regardless of patients screaming "I'll call my lawyer!").

Is the patient's speech slurred? Is the patient ataxic? Is the patient acting inappropriately? Do other observers think the patient is intoxicated? Some chronic alcoholics may be clinically sober with a level over 80 mg/Dl; some first-time drinkers may be grossly intoxicated with a level of 70.

Those with low alcohol levels (or no alcohol at all) may still be intoxicated with other intoxicants (e.g., cocaine, barbiturates, benzodiazepines).

c. is not correct.

While it may be useful to ask the family how the patient is acting, the decision whether the patient is too intoxicated to make medical decisions is reserved, by court decisions, to medical personnel, and specifically to physicians.

d. is not correct.

A magistrate may rule on a person's competence [ref] to make certain decisions, including medical decisions. And, a magistrate may convict a person of drunk driving. However, the courts recognize that decisions about intoxication must be made "on the spot" by medical personnel, often with incomplete information.

2. Although the patient in the above case may not be intoxicated with alcohol or recreational drugs, she may be mentally impaired by a

medical condition (hypoglycemia). As far as her capacity to make medical decisions, does it make a difference whether she is intoxicated or impaired by a medical condition—and how impaired is impaired enough to not be able to make appropriate medical decisions?

- a. It doesn't matter if the impairment is from drugs or a medical illness.
- b. Whether a patient can make medical decisions is a clinical judgment, based not only on the level of impairment, but also the risks involved.
- c. Both of the above are true.

a. is correct.

If the patient is not capable of making reasoned medical decisions, then medical personnel must act "in loco parentis" (in place of a parent), preventing the patient from harming herself until she is once more able to make reasoned medical decisions.

b. is correct.

Rather than citing some absolute level of impairment, the courts say that physicians and other medical personnel should take the level of risk into account in determining whether a patient has the capacity to make medical decisions.

Two opposing principles collide here.

The first principle is that *people should be free*, and in this particular case, from unreasonable detention by medical personnel. Restraining or treating a patient who does indeed have the legal capacity to refuse care, and who does not want to be treated, may constitute [assault](#).

The second principle is that *when people are impaired*, and are likely to hurt themselves as a result, *those with responsibility for them must act so as to protect them*. In the case of medical personnel, letting an impaired patient inappropriately refuse care may constitute [abandonment](#).

Despite all of the drunks in EDs screaming about suing those who put them in leather restraints, there is almost no case law on unlawful medical restraint. Given the uncertainty and need for immediate decisions, courts generally give wide latitude to police officers and to medical personnel, particularly physicians, in making these determinations.

For example, if, say, you are working in the ED and see a grossly drunk patient taking out his car keys and getting ready to go out and try to drive home, you must do your best to prevent the patient from leaving and driving the car, though not at physical risk to yourself. If you don't, and the patient comes to harm as a result—or worse yet hits some innocent person with his car—you may be liable. Consider for example a famous case where ED personnel let a drunk patient walk out--the drunk patient tried to walk across a highway and was hit by a car and killed. Those in the ED were found liable for his death.

Although this case involves a patient in the ED, the same legal principles apply to your handling of medic calls for refusals. If told the medic to let

this patient go, and then the patient then drove off the road, killing a two-year-old child, do you think a court might hold you responsible for the two-year-old's death?

In the specific medical command call given in the audio snippet and transcript above, what is the risk?

This patient, despite the surprising (and as it turned out, erroneous) information that the patient *doesn't* have diabetes mellitus, *is* on a long-acting antihyperglycemic and is both clinically and by laboratory evidence hypoglycemic. And, in general, the standard of care for this situation is not only ED evaluation, but overnight admission on a dextrose drip. The risk is of recurrent and sometimes profound hypoglycemia, sometimes causing brain damage or death. If this risk is bad enough to require admission, it is bad enough the patient is capable of making a reasoned decision to refuse transport before you and your medic should allow this patient to refuse transport.

The medic command doctor told this medic to obtain assistance from the police, and to restrain the patient if necessary, and transport the patient to the nearest appropriate facility for medical evaluation. When faced with this (and pressure from her family, which the medic enlisted and was helpful), the patient consented to be treated for the hypoglycemia and to go to the ED where she was admitted.

3. What are the specific legal requirements to demonstrate capacity to provide informed consent to sign out of the ED against medical advice, to refuse medical treatment in the ED or on the street, or to refuse EMS transportation?
 - a. The patient understand the relevant information.
 - b. The patient must be able to manipulate the information.
 - c. The patient must be able to make and communicate a choice.
 - d. The patient must be able put all three of the above requirements together to appreciate the situation and its consequences.

a. is correct but incomplete.

The first test is of simple understanding. If a patient can't understand the danger, and you do understand the danger, you have an obligation to protect her.

Also, as a side issue related to understanding, consider that the medic may not appreciate the danger—it is common for medics to treat those with hypoglycemia *from insulin*, where there is much less danger of recurrent hypoglycemia, and release them. This medic did not, in fact, understand that hypoglycemia from oral agents is different and much more dangerous. This is an example of where your deeper medical understanding may lead you to appropriately overrule a medic—or better, educate the medic, and jointly come to an agreed-on plan to transport the patient regardless of the patient's refusal.

Asking the patient to paraphrase what the medic told her can help assess this understanding better than asking her to simply regurgitate information. If a person is disoriented, providing a nonsensical history (on diabetic drugs but no history of diabetes) or acting intoxicated, it is hard to support a conclusion that she appreciates a personal danger.

b. is correct but incomplete.

The second test is of the ability to consider alternatives. To determine whether this woman can successfully manipulate information, your medic could ask her about hypothetical situations based on what a rational person would do. For example, your medic could ask her what she thought an average woman would do if a doctor informed her she she a medical condition that might kill her, or worse yet, turn them into vegetable, if she wasn't admitted to the hospital overnight. In this way a person with normal capacity, but differing values, can demonstrate that understanding. For instance, she might say she was on her way to see her child who only had a few hours to live and this was more important to her than the possibility of dying. (This was certainly not the case here, though.)

c. is correct but incomplete.

The third test is whether the patient can make decisive choices. Different responses within a short time suggests that she cannot organize her thoughts and choose a course of action is confused and unstable. Patients who repeatedly change their minds should be protected until their decision-making process is stabilized.

d. is the best answer.

The last test is the complete ability to appreciate the outcome of her behavior and give reasons for her choice. The goal is to evaluate her **ability** to do this, not to make value judgments based upon her choices.

The bottom line is: what is best for the patient's health? If restraining a patient is the best way to ensure that outcome, then restrain the patient. The advice to treat the patient as you would your own mother is a good guideline.

One final note. A [published survey paper](#) showed that fewer than a third of EMS services had a refusal policy that met minimal legal requirements, so medical command physicians should not plan to rely on the EMS service's protocol to provide for patient safety and for the medical command physician's medico-legal safety.

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Case #2: Psych and Restraint Issues

Case #3: DNR and Advanced Directives

Case #4: DOA/Ceasing Resuscitation

Case #5: Child and Elder Abuse

Case #6: Physician on Scene