

Legal matters:

Documenting patient refusals protects you and your service

by Doug Wolfberg

Patient refusals are a common scenario for EMS practitioners. While refusals may be common, they aren't routine, and EMS practitioners must ensure that they document a detailed and accurate record of the call. Doing so will help protect the practitioner in the event of a lawsuit down the road.

First, a thorough and complete Patient Care Report (PCR) – including a detailed narrative – is the starting point in creating defensible documentation in a refusal situation. Many refusal narratives consist merely of statements like “patient refused care.”

Unfortunately, that is not enough! You'll need to document the performance of a patient assessment (or as much of the assessment as the patient permitted) and the findings from that assessment.

Document refusals, narrative

One key finding that must be documented is whether the patient had the legal and mental capacity to refuse care. Legal capacity means the patient must at least be the legal age for giving (and, by implication, refusing) consent for healthcare. This varies by state, but typically it is 18 with certain exceptions for minors in some states. Mental capacity means that the patient must be capable of understanding the risks of a refusal and the benefits of treatment. A patient who suffers from a mental defect, such as dementia, or who is under the influence of drugs or alcohol, may lack the mental capacity to refuse care. Where a patient lacks legal and/or mental capacity to refuse care, be sure to document the identity and relationship (parent, legal guardian, POA, etc.) of the legal representative who refused on the patient's behalf.

The narrative also needs to document the risks that were explained to the patient and that could result from the refusal. For instance, a patient with chest pain who refuses care must



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specifically be informed (in terms that a layperson can understand) that their symptoms could mean a heart attack, and that untreated, a heart attack could lead to death. The narrative should also document that alternatives were explained to the patient, such as calling 911 again if symptoms persist, or taking other steps to promptly seek care if needed.

A good narrative helps to paint a picture of an incident. So, it is acceptable to document the exact words that a patient uses in refusing care. These words may be put in quotation marks when you are sure that you are documenting the exact words used by the patient. If you consulted with online medical control, be sure to document that discussion and any orders or advice given by the online physician.

In addition to a thorough narrative, ensure that all of the operational information on the PCR is complete, such as times, crew member names, nature of dispatch and response, and other essential information.

Obtain signatures

Be sure to obtain the signature of the patient or legal representative. Ideally, this signature should be witnessed and the witness also should sign. Be sure that the refusal form you use for the signatures is appropriately worded and approved by your agency's legal counsel and medical director. A model refusal form is available for download on our firm's EMS law web site, www.pwwemslaw.com.

Documenting patient refusals is an important skill for all EMS practitioners. These incidents should be treated seriously and a thorough, well-documented chart should be prepared. Taking the extra time to document properly can help protect you and your service down the road.

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