

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

According to Which Criteria Should a Return EMS Trip of Long Duration and Distance Be Deemed Ethically Justifiable?

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Abstract

Assessing and adequately documenting a patient's decision-making capacity is a responsibility and skill required of all emergency medical services (EMS) personnel. However, emergency medical technicians' and paramedics' training in a patient's refusal of EMS transport is often limited to evaluating that patient's alertness and orientation. This commentary argues that this approach is too narrow and outlines the obligation of prehospital care personnel to examine the patient thoroughly, obtain a complete set of vital signs, explain prospective risks and benefits of EMS transport, determine capacity, and express support for the patient. Finally, the commentary outlines what it means to appropriately document a prehospital interaction with a patient and express respect for decisions of patients with capacity.

Case

TJ is a paramedic on an emergency medical services (EMS) team that serves a rural community who responds to a call involving a patient, RB, suspected by the caller of having overdosed. TJ's team arrives and finds RB unresponsive, with shallow and irregular breathing, pinpoint pupils, and a bluish tint to the skin. TJ suspects opioid toxicity and administers naloxone. RB regains consciousness, then adamantly declines transport to the nearest hospital (50 miles away), saying, "I'll be charged with possession if I go to the hospital. I'm fine now, and I can manage on my own." RB is known to the local EMS community as previously having refused transport to the hospital. On one prior occasion, the same EMS team had to be called back to RB's home a couple of hours after the initial EMS visit because RB's condition had worsened. RB has the decision-making capacity to autonomously refuse, but TJ still considers how to best address RB's current refusal.

Commentary

What should be the nature and scope of EMS workers' regard for the autonomy of a patient whose risk of harm is exacerbated by long transport distance? Respect for patient autonomy is not just a principle but a crucial aspect of EMS clinicians' responsibilities, regardless of the distance and duration of the transport or return trip. All prehospital care personnel should receive focused education on determining and

documenting the presence, or lack thereof, of decision-making capacity, as this topic is included in national EMS core content.¹ Competence and capacity are commonly confused, with the former being a legal designation and the latter determined by clinical assessment. Up to 20% of EMS calls for service will result in a refusal of transport,² underlining this topic's importance. Initial and ongoing education on patient refusal, autonomy, and decision-making capacity must be proactively emphasized throughout prehospital education and training programs.

In my experience as an EMS educator and medical director, "alert and oriented x 3" (awake, alert, and oriented) alone is sometimes an adequate assessment of decision-making capacity. But EMS personnel should consider 4 specific areas to more fully assess a conscious patient's decision-making capacity.^{3,4}

1. *Understanding.* A patient must be able to understand relevant information. Understanding can be assessed by asking a patient to state in their own words the problem, and, after an explanation has been provided, the recommended care (including transport), the benefits of accepting care, the risks of refusing care, and alternatives.
2. *Appreciation of the situation and consequences.* A patient must be able to appreciate their condition and how their decision to accept or refuse care will influence their condition.
3. *Reasoning.* The patient must be able to offer reasons for selecting an option and communicate why a particular option is better for them. Note that this element focuses on a patient's ability to reason, not on the outcome of the patient's choice, as patients are entitled to make choices not seen as reasonable from a clinical standpoint.
4. *Communication of choice.* A patient must be able to communicate a choice when presented with options.

External influences should also be considered. Drugs and alcohol, for example, can influence a patient's decision-making capacity, but substance ingestion does not always mean that a patient lacks capacity. Intoxication must be carefully and thoroughly evaluated via clinical examination of actions such as gait, speech, cognitive function, and ability to interact with the external environment (eg, by using their phones).

Prehospital care personnel then must ensure that a patient can express their choice in clear, understandable terms. A standard EMS and hospital refrain is to tell patients that "they could die" if they refuse care. This assertion is obviously true in some cases but hyperbolic in many others. It can express a legal self-protection impulse by the EMS clinician, but, importantly, this kind of worst-case scenario thinking tends to be clinician centered and might not result in transport conversion and adequate treatment initiation, which could be especially harmful if that patient is critically ill.

Lastly, concise yet thorough documentation of a patient's decision-making capacity is required, although prehospital protocols for refusal documentation that prompt capacity assessment are not consistently implemented^{5,6} and there are no "gold-standard" criteria for prehospital capacity assessment.⁷ Importantly, imperfect execution of

capacity determinations is not exclusive to emergency medical technicians (EMTs) and paramedics.⁸

Refusal of Transport

The rate of refusal of care in prehospital settings is much higher than the rate of discharge from a hospital against medical advice.^{2,9} This finding is presumably due to the presence of second- and third-party callers in the prehospital environment. Patients are often attended to by EMS without ever having requested assistance themselves. An example that frequently results in transport refusals is when well-intentioned bystanders call 9-1-1 when driving past a motor vehicle collision; thus, not all refusals of EMS transport are high-risk refusals. In fact, most transport refusals pose only low risk.¹⁰ High-risk refusals can be those in which EMS personnel identify signs of illness that suggest a higher likelihood of decompensation. These signs might be objective, such as abnormal vital signs, rather than subjective findings like diaphoresis or pallor. EMS protocols should delineate high-risk as well as “difficult” refusal situations, such as when a patient’s decision-making capacity is in question. If these occur in tandem, one could assume a significant increase in patient risk. EMS systems should have protocols to escalate these critical situations to online medical director consultation, as physician input significantly increases conversion from refusal to transport.¹¹

In the case of an **opioid overdose** with subsequent naloxone administration, EMS workers’ respect for a patient’s decision to refuse transport must be informed by their experience and training. A high-risk refusal, for example, could involve hypoxia and respiratory difficulty secondary to intoxication and altered mental status. Recent data suggest an increased risk of future overdose when a patient refuses EMS transport following naloxone administration.¹² However, prehospital care of opioid ingestion patients refusing transport has rapidly evolved to include “leave-behind” naloxone programs and buprenorphine protocol initiation.^{13,14,15} These initiatives will drastically augment care options for prehospital care personnel attending to patients with opioid use disorder though they might not be available in many rural areas, where long distances and the availability of return transportation are just two of the many barriers that can increase the level of resistance to EMS transport. While repeat presentations can be frustrating for clinicians at all levels in all medical settings, it is essential to retain an open mind in every situation to provide high-level patient care.

Adequate documentation of prehospital interactions is the final piece of transport refusal. An EMS patient refusal record should contain substantially more than a generic signature. In our teaching at the Montgomery County Hospital District EMS system, we have implemented the FEARS mnemonic to guide EMS clinicians through the patient refusal process: F = full exam and vitals; E = explanation of actual patient-oriented risks of transport refusal; A = asking for assistance (eg, from family, law enforcement, other first responders) with conversion; R = recording of the event thoroughly and accurately; and S = supportive attitude throughout. Every patient refusal of transport should engender a healthy amount of “FEARS.”

However, RB is concerned about being charged on arrival at the hospital, which suggests that RB perceives law enforcement as a hindrance to seeking care. Yet **EMS and law enforcement partnerships** are crucial in numerous patient care exigencies, such as mass casualty and disaster situations. Law enforcement officers can assist in persuading patients to seek necessary medical care, and police transport of penetrating trauma patients has even demonstrated similar outcomes to EMS transport.¹⁶ In making

decisions about transport in these situations, I recommend that prehospital care personnel focus on medical necessity and potential for clinical decompensation, as this is their area of expertise. Further research and guidance are needed to better streamline law enforcement's and EMS' joint response to opiate overdoses, as law enforcement officers and paramedics value a collaborative relationship but struggle with competing clinical and public safety priorities.¹⁷

Return Trips?

When, if ever, is a signed refusal of transport form sufficient clinical, legal, or ethical justification not to make a return trip for a patient? Except in situations where prehospital care personnel safety is at risk, a past, signed refusal plays no role in the duty to respond to a 9-1-1 call for emergency medical care—the patient has the right to revoke their refusal of treatment at any time. When safety concerns are present, EMS staging while awaiting law enforcement clearance is standard practice. Dispatch caution notes can also be created that tag specific addresses and alert EMS crews to potential difficulties and dangers at particular locations. However, these notes should be monitored closely to avoid inadvertent care delays.

In rural communities that utilize volunteer EMTs and paramedics, it is important to remember that even volunteers must be licensed. Cash et al found that 13% of prehospital care personnel report a volunteer position as their main EMS job, with volunteers being more likely to be EMTs.¹⁸ While core EMS educational content does include capacity assessment,¹ **budgetary constraints** in volunteer EMS systems may limit continuing medical educational opportunities in this high-risk area. Additionally, rural communities might have fewer transport units available, which affects a system's ability to respond to frequent 9-1-1 callers by lengthening transport durations.¹⁹ Regardless of prehospital personnel pay status, location, or potential legal concerns, a patient-centric prehospital approach that includes EMS personnel establishing decision-making capacity while providing the patient with an explanation of actual risks, followed by appropriate documentation, is the key to obtaining a proper EMS refusal of transport.

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Editor's Note

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