AMA Calls & Decision Capacity

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(Audio accompanies this slide)

- 30yo male with upper lip lac after assault at a bar. No LOC.
- + EtOH, + Slurred speech
- RR 18, A&O x 2, pupils equal & reactive, moving all extremities
- HR 106, BP 160/102, SpO2 99% ORA, T 98.9
- Patient adamant about leaving AMA.
- “Understands he could die, willing to take that risk”
- Cell phone dead; “doesn’t have access to 911.”
- PD on scene
- “This is gonna be a full on AMA”
- “Answering orientation questions, knows everything that happened”

(Audio accompanies this slide)

- MICN: What do the police say? He doesn't have a decision if he's under the influence. … Going to get a doc involved
- Medic: "At this point because he's intoxicated and he's got that high blood pressure he's not able to demonstrate a clear understanding of what's going on"
- MICN: "I can't approve an AMA when the patient is slurring speech and not comprehending. It would be negligence on my part."
- "If the police are comfortable letting him go, that's a different story." "I don't think the patient is safe enough to be let go."

(Audio accompanies this slide)

- Medic: BP improved on reassessment. Patient still wants to go AMA. “He understands that he could go home and not wake up and he’s totally comfortable taking that risk.” … “And he understands that his choice could result in death.”
- MICN: Just need to know the name of the supervisor clearing this. “We could be clear for an AMA as long as it’s under their approval.”
- Police have “no intent on their end to arrest him for being the victim of a crime. They are comfortable calling a taxi for him and allowing him to go home with his friend.”

Questions for consideration...

- What are your initial thoughts?
- What went well?
- What would you have done differently?
- What would you do if PD was not yet involved?
- What is the role of EMS vs PD in determining capacity for refusal of treatment?

Policy No. S-412: Prehospital Treatment and Transportation of Adults – Refusal of Care or Suggested Destination, Release

III. POLICY

A. All emergency patients will be offered treatment and/or transport following a complete assessment.

B. AMAs

1. Adults have the right to accept or refuse any and all prehospital care and transportation provided that the decision to accept or refuse these treatments and transportation is made on an informed basis and provided that these adults have the mental capacity to make and understand the implications of such a decision.
2. The decisions of a DDM shall be treated as though the patient was making these decisions for him/herself.
3. For those emergency patients who meet Base Hospital contact criteria (see County of San Diego, Emergency Medical Service (CoSD EMS) Policy S-415 "Base Hospital Contact/Patient Transportation and Report") and wish to sign AMA, prehospital personnel shall use their best efforts to make Base Hospital contact prior to the patient leaving the scene and prior to the responding unit leaving the scene. In the event that the patient leaves the scene prior to Base Hospital contact, field personnel shall still contact the Base Hospital for quality improvement and trending purposes only.

4. The Emergency Medical Technician (EMT), Advanced EMT (AEMT), or Paramedic should contact the Base Hospital and involve the Mobile Intensive Care Nurse (MICN) and/or Base Hospital Physician (BHP) in any situation in which the treatment or transport refusal is deemed life-threatening or "high risk" by the EMT, AEMT, or Paramedic.
5. Field personal shall document, if possible, the following for all patients released AMA:
    a. Who activated 9-1-1 and the reason for the call
    b. All circumstances pertaining to consent issues during a patient encounter
    c. The presence or absence of any impairment of the patient/DDM, such as by alcohol or drugs
    d. The ability of the patient/DDM to comprehend and demonstrate an understanding of his/her illness or injury
    e. The patient/DDM has had the risks and potential outcome of non-treatment or non-transport explained fully by the EMT or Paramedic such that the patient/DDM can verbalize understanding of this information
    f. The reasons for the AMA, the alternate plan, if any, of the patient/DDM and the presence of any on scene support system (family, neighbor, or friend (state which))
    g. That the patient/DDM has been informed that they may re-access 9-1-1 if necessary
    h. The signature of the patient/DDM on the AMA form, or, if the prehospital personnel are unable to have an AMA form signed, the reason why a signed form was not obtained
    i. Consideration should be given to having patient/family recite information listed in Sections III.B.5.d-g above to the MICN/BHP over the radio or telephone

Not Included in San Diego AMA Policy

- Easy “checklist” criteria for determining “mental capacity” – because none really exists!
- Police role in determining capacity – because there really isn’t any

Competency

- Legal term
- “Incompetent person” indicates a ruling by a court that a person is unable to manage his or her own affairs
- Serves as basis for conservatorship
- Not common
- Not in our scope

vs

Capacity

- Medical term based on clinical assessment
- “Patient lacks capacity” - unable to make decisions about his or her healthcare and implicitly consents to medical treatment in emergency situations

Capacity

- The patient must: **understand**, **communicate**, & **reason**
- Dynamic entity dependent on the **patient** and the **situation**
- A typically competent adult may lack capacity temporarily
- Context-dependent

Criteria for Determining Capacity

- *Communication* → decreased GCS due to illness or trauma; psychosis
- *Understanding* → memory, attention span, developmental disability
- *Appreciation* → depression/suicidality
- *Reasoning* → psychosis, depression, anxiety, phobias, delirium, and dementia

Red Flags

- Denial of medical conditions or possibility of adverse outcome
- Drug or alcohol intoxication
- Confusion at any point during interview
- Major trauma involving: head injury, significant blood loss, severe injury
- Frequent reversals of decisions
- Any behavior that suggests the patient is a danger to self or others
- Emotional upset
- Signs of psychosis such as auditory or visual hallucinations
- Distortion of reality
- Fear of legal, economic, or social repercussions

The Four P's

- *Paraphrase* – Is the patient able to paraphrase the information that was presented?
- *Process* – Is the patient able to process the information?
- *Plan* – Is the patient able to plan for the future?
- *Put it together* – Can the patient put together all of the information to appreciate the consequences of their decision?

Five Helpful Questions

- Have you decided what you want to do?
- What are the risks of the options we have discussed?
- What could happen if you choose to do nothing at this time?
- Why do you think this is the best option for you at this time?
- Why have you chosen the option that you did?

The patient (with capacity) is refusing care – what now?

- Talk to the patient
    - *Why is the patient refusing?*
    - *Explain the process*
    - *Discuss risks/benefits*
    - *Solicit help of friends/family*
    - *Talk to the patient alone*
    - *Validate reasonable fears*

The patient (with capacity) is refusing care – what now?

- Present alternatives
- Contact med control
- Document everything

What if we're just not sure about capacity?

- When in doubt, do what you'd rather defend
- Courts most often rule in favor of clinicians acting in good faith on behalf of their patients in emergency situations
- Successful litigation regarding consent against a provider acting reasonably & consistent with standard of care is rare
- We're more likely to be sued for failure to treat when capacity is in question than for providing reasonable treatment without consent.

The patient with impaired capacity is refusing – what now?

- Agitated delirium? Treat it!
- Determine need for law enforcement assistance
- Law enforcement does NOT determine capacity
- What if EMS & law enforcement disagree? - this is rare
    - *Base hospital physician can call PD supervisors to discuss further*
    - *Document everything*

Our Case

- 30yo male, lip lac after assault, +EtOH, slurred speech, A&Ox2
- MICN concerned due to intoxication
- Did medic say if patient has capacity?
- Do you think he had capacity?
- How high are the stakes in this case?
- Bottom line: We determine capacity, and this should be clearly documented. Physician should be involved & speak to patient when possible. PD planning to let patient go from their nonmedical perspective is icing on the cake.

Take Home Points

- Competency = legal term, non-medical judgement
- Capacity = medical term, clinical judgement
- Capacity is determined by communication, understanding, appreciation, and reasoning
    - Clinicians assess for capacity
    - Physician should be involved
    - PD role is supportive for our medics, not part of medical assessment
- Document everything!

References

- Jones RC, Holden T. A guide to assessing decision-making capacity. *Cleve Clin J Med*. 2004;71(12):971–975.
- Brenner JM et al. The ethics of real-time EMS medical direction: Suggested curricular content. *Prehosp Disaster Med*. 2018 Apr;33(2):201-212.
- Colwell C. Know When Uncooperative Patients Can Refuse Care and Transport. *JEMS*. 10 Dec 2020. https://www.jems.com/patient-care/know-when-uncooperative-patients-can-refuse-care-and-transport/
- Dean B. Documenting the patient refusal: CASE CLOSED. *EMS World*. 31 May 2019. https://www.emsworld.com/article/1222817/documenting-patient-refusal-case-closed

Thank you!

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