# Medic
# Decisi
# Makin
# Capac

Jonathan Bar, MD

EMS Fellow

Division of EMS, Disaster, and Transport Medicine

Cooper University Hospital


FAIR LAWN
VOLUNTEER
AMBULANCE CORPS.
FIRST AID
N.J.


# About Me

- Jonathan Bar, MD4
- Former EMT
- Former Wilderness Instructor
- Chief Resident, Hospital of University of Pennsylvania
- Cooper EMS Fellow

# CAMDEN, NJ

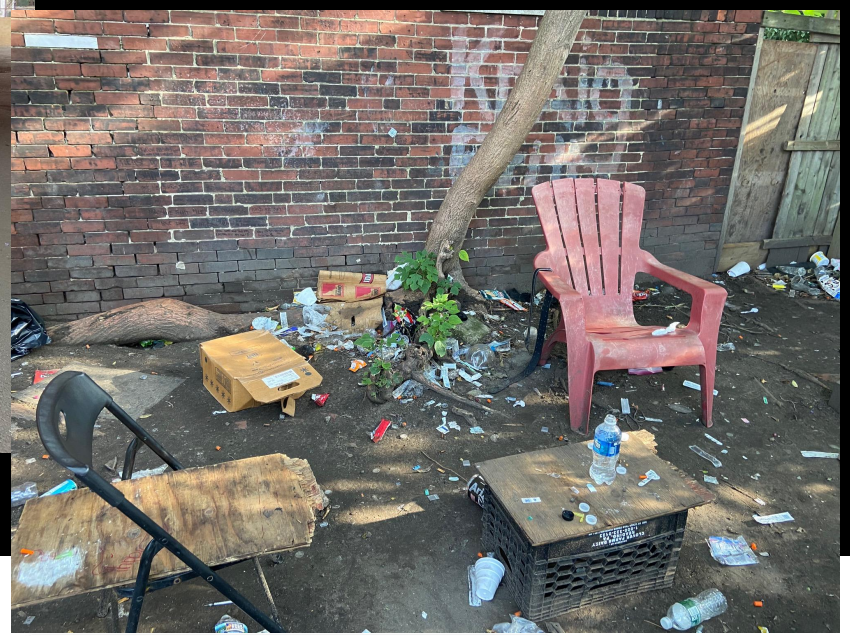


Cooper EMS

Cooper
EMS/Disaster Medicine

EMS PHYSICIAN

# CAMDEN, NJ

Cooper EMS/Disaster Medicine

Cooper EMS

Cooper
EMS/Disaster Medicine

EMS PHYSICIAN

# Disclosures

- I have no financial conflicts of interest to disclose.
- I am NOT a lawyer.  None of what I'm about to tell you should be considered legal advice.  It's for education only.
- There is state-to-state variability on this.  Make sure you check out your local laws
- I am the principal investigator of an unfunded, small research project evaluating EMS providers ability to assess decision making capacity. I will not be sharing any unpublished data today.


Cooper
EMS/Disaster Medicine


GET ON THE COT NOW AND NO ONE GETS HURT!

# Objectives

1. Why capacity assessments matter
2. Define (or at least describe) medical decision-making capacity
3. Review assessment of capacity
4. Case review


Cooper
EMS/Disaster Medicine

# Why Do Capacity Assessments Matter?


1891

# Why Do Capacity Assessments Matter?

- Patients have rights

What can happen if you take someone against their will inappropriately?

- Assault
- Battery
- Wrongful Imprisonment


# What can happen if you leave someone behind who doesn't have capacity?

- Negligence
- Abandonment

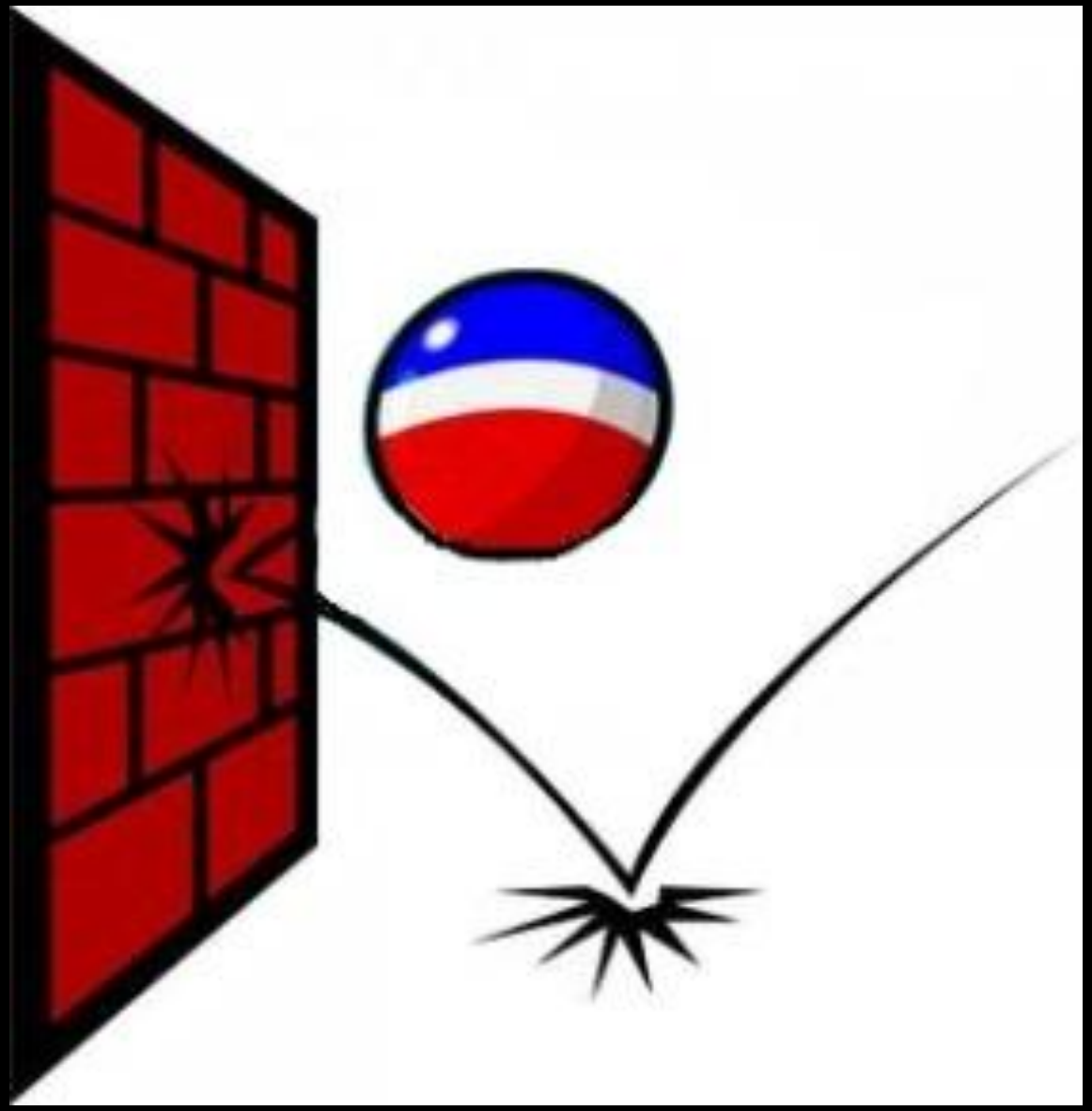
# It could happen to you!

- St. George v. City of Deerfield Beach
- Potts v. Board of Leavenworth County
- Senk v. Village of Northfield, 45 F 3d 431 (6th Cir. 1994)
- Pavlov v. Community Emergency Medical Service, Inc., 491 NW2d 874 (Mich. 1992)
- Taplin v. Town of Chatham, 453 NE 2d 421 (MA 1983)
- Wideman v. DeKalb County, 409 SE 2d (Ga. 1991)

# Why Do Capacity Assessments Matter?

- There are consequences for violating those rights

How good are EMS providers at assessing capacity?



How good are physicians at assessing capacity?

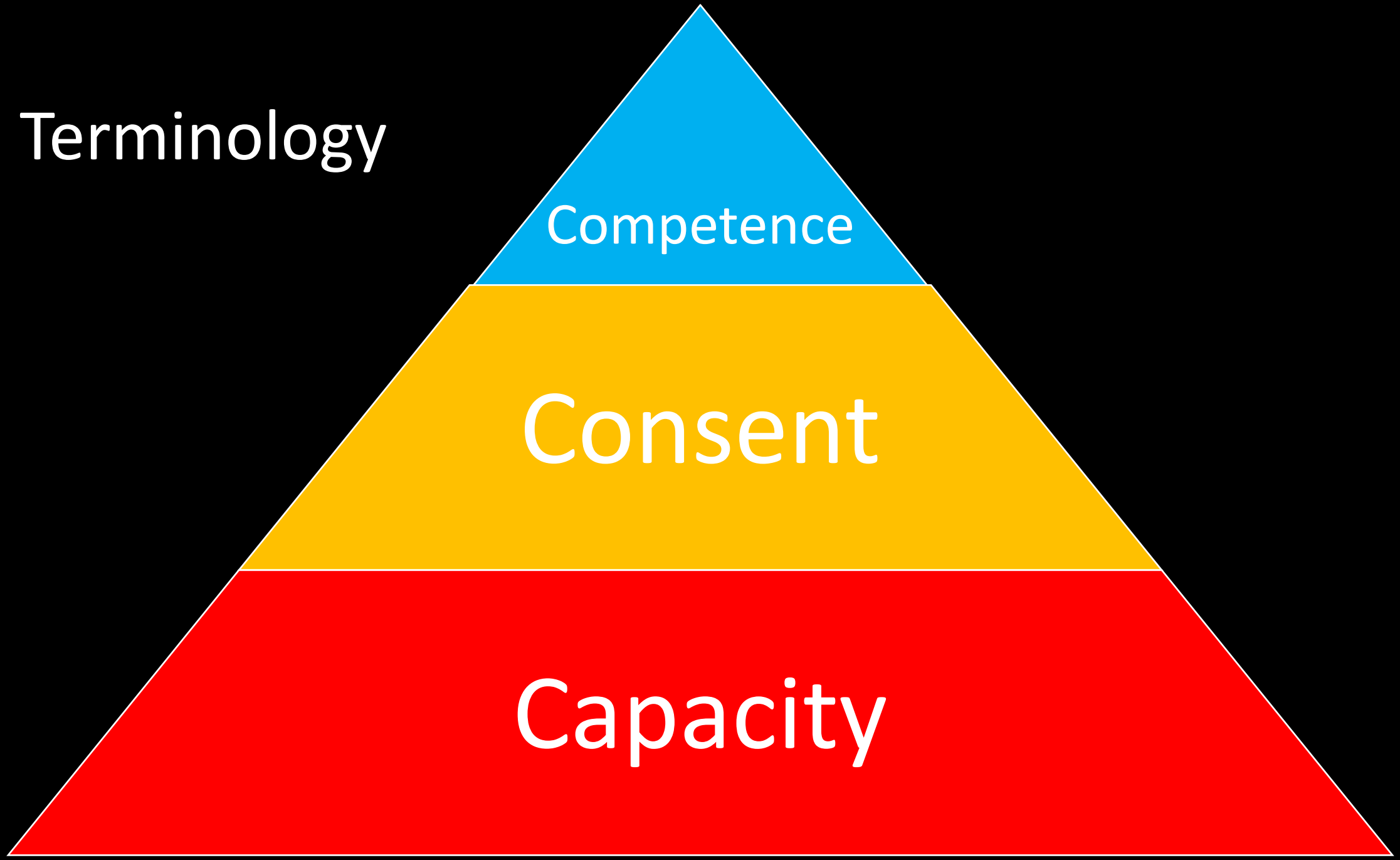
# Why Do Capacity Assessments Matter?

1. Patients have rights
2. There are consequences for violating those rights
3. We aren’t very good at them


DANGER ZONE

# What is Capacity?

# Terminology



# Capacity Definition - NASEMSO

Decision-Making Capacity: Part 1/2

- An individual who is **alert, oriented**, and has the ability to **understand the circumstances** surrounding his/her illness or impairment, as well as the **possible risks** associated with refusing treatment and/or transport, typically is considered to have decision-making capacity.

# Capacity Definition - NASEMSO

Decision-Making Capacity: Part 2/2

- The individual's judgment must also **not be significantly impaired** by illness, injury or drugs/alcohol intoxication. Individuals who have **attempted suicide, verbalized suicidal intent, or have other factors that lead EMS providers to *suspect* suicidal intent**, should not be regarded as having decision-making capacity and may not decline transport to a medical facility.

# Other Elements of Capacity

Pt must understand the relevant information about the proposed diagnostic tests or treatments

Pt must appreciate their situation

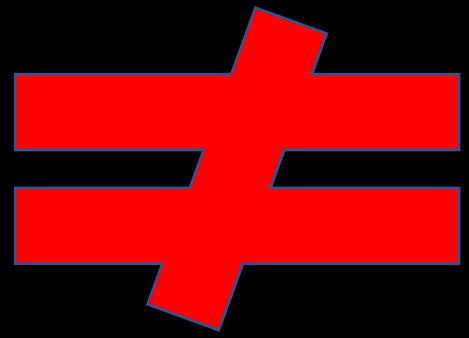
Pt must use reason to make a decision

Pt must communicate their choice

Pt must not be a minor (or must be emancipated)

But Doc!!! He’s answering all the questions. I’m not gonna kidnap him!

# Orientation



# Capacity

# Capacity is a spectrum

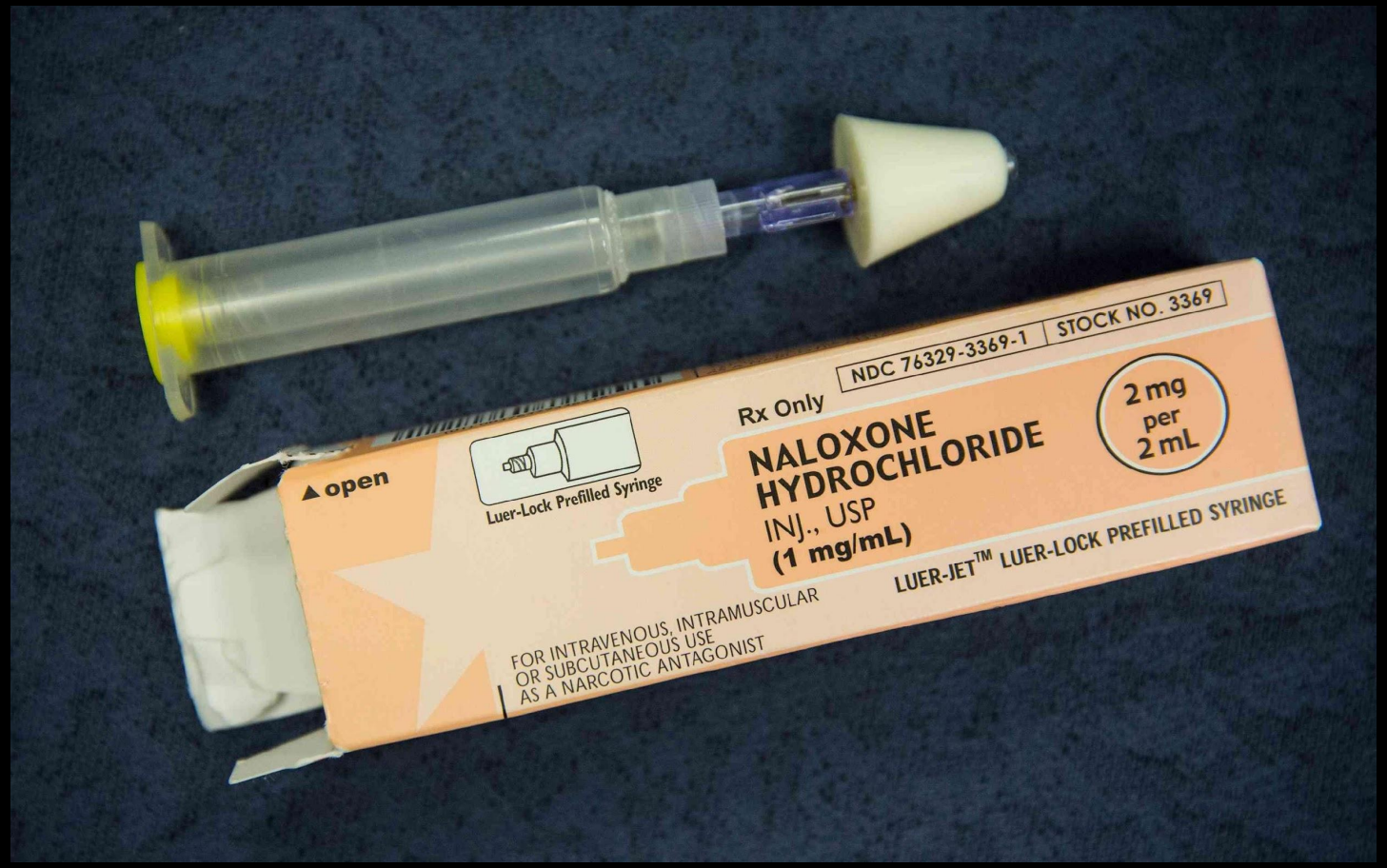

No Capacity

Limited Capacity

Full Capacity

Capacity varies over time

# Capacity can be optimized




# Capacity Assessment

**Check for disqualifiers**

- Age <18 (not emancipated)
- Clinical intoxication
- +SI/HI
- Pt unable/unwilling to communicate
- If yes, to any of the above, patient does **not have** capacity

**Risks and benefits**

- Explain the risks and benefits to the patient.
- Check that the patient **understood** the risks/benefits.
- If patient cannot demonstrate understanding of risks/benefits, then patient does **not have** capacity.

**Check Reasoning**

- Is the choice based on a reason? You don't have to agree with the reason.
- If not (Ex. I don't want to go to the hospital because the sky is blue), then the patient **does not** have capacity.

**Callback Precautions**

- If the patient has capacity and is going to refuse, advise them that they are always free to call back or seek care in other ways.
- Warn them about concerning signs, symptoms, or other things to watch out for.

# Language Matters! Head trauma on blood thinners

It's not enough to say, "if you refuse you could die."

"You hit your head and on you are on a medication that increases the risk of bleeding. I am worried that you have bleeding around your brain, and we won't be able to tell that without a CT scan. If you don't go to the hospital, the bleeding could get worse, which could result in permanent disability or death. Do you understand? Please **repeat** these concerns back to me."

Cooper EMS

Cooper EMS/Disaster Medicine

EMS PHYSICIAN

# Case review

- Adult female called police after her house was broken into
- Made statement to PD that she was so upset that she ‘wants to jump off a bridge’
- On EMS arrival, she recants this statement, denies any psychiatric or physical complaints
- Is AOx4, normal vitals, does not want transport
- WHAT DO YOU DO?

# Case review

- Adult male patient found down outside on the street, unresponsive, apneic
- Pinpoint pupils and drug paraphernalia noted on scene
- After 10 min of ventilation and 4mg IN naloxone, he is awake and alert
- Answers questions appropriately, wants to refuse
- Tachycardic, hypertensive, diaphoretic
- WHAT DO YOU DO?
- WHAT MORE DO YOU NEED TO KNOW?

# Case review

- 15 year-old boy crashes his bike
- No LOC, has abrasion to arms and legs, otherwise appears well
- No complaints, vitals normal
- Parents are not on scene
- WHAT DO YOU DO?

# Case review

- You are called to a residence by PD after they responded to a domestic
- Patient is a female in her 40s erratic, agitated, shouting
- Unable to answer questions or hold a conversation
- Throwing things onto the street
- Possible weapons in the house
- Patient has locked herself inside
- WHAT DO YOU DO?

# Case review

- Elderly male at home, denies complaints, you were called for a psychiatric emergency
- He doesn’t know why you were called
- PD state they were called for possible sounds of gunshots
- Patient denies physical or psychiatric complaints, does not want to harm himself or anyone else
- On further questioning, he reports seeing people in the woods outside his house, and does report firing a shotgun at them
- WHAT DO YOU DO?

# Case review

- Elderly male at a bowling alley, EMS called for a slip and fall
- Hit his head, no LOC
- Has scalp hematoma, otherwise normal exam and vitals, no deficits
- Has had ‘2 beers’
- Is on Eliquis
- WHAT DO YOU DO?

# Case review

- Adult female, paraplegic in wheelchair with chronic foley
- Family called for confusion and fever
- They report recent admission for UTI with sepsis and organ dysfunction
- She is awake and alert, but unable to sufficiently answer questions regarding risks of refusal
- Physically resisting transport, grabbing wheels on wheelchair when you try to move her
- WHAT DO YOU DO?


# Thank you!

# References


1. Weaver J, Brinsfield KH, Dalphond D. Prehospital refusal-of-transport policies: adequate legal protection? Prehosp Emerg Care. 2000 Jan-Mar;4(1):53-6. doi: 10.1080/10903120090941650. PMID: 10634284.
2. Soler JM, Montes MF, Egol EB, et al. The ten-year malpractice ex-perience of a large urban EMS system. Ann Emerg Med. 1985;14:982–5.
3. Ayres JR Jr. Patient consent and the law. J Emerg Med Serv.1981;7(6):39–41.
4. Siegel DM. Consent and refusal of treatment. Emerg Med Clin North Am. 1993;11:833–40.
5. Cone DC, Kim DT, Davidson SJ. Patient-initiated refusals of prehospital care: ambulance call report documentation, patient outcome, and on-line medical command. PrehospDisaster Med 1995;10:3–9.
6. Seldom B, Schnitzer PG, Nolan FX, Veronesi JF. The "no-patient" run: 2698 patients evaluated but not transported by paramedics. Prehosp Disaster Med 1991;6:135–42.
7. Sessums LL, Zembrzuska H, Jackson JL. Does This Patient Have Medical Decision-Making Capacity? *JAMA.* 2011;306(4):420–427. doi:10.1001/jama.2011.1023
8. Paris PM, Roth RN, Verdile VP (eds). The Art of On-Line Medical Command. St. Louis: C.V. Mosby, 1996.
9. Goldberg RJ, Zautke JL, Koenigsberg MD, et al. A review of pre-hospital care litigation in a large metropolitan EMS system. AnnEmerg Med. 1990;19:557–61.