

Consent & Refusal of Medical Care

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A competent adult or competent emancipated minor has the right to determine the course of his/her own medical care and shall be allowed to make decisions affecting his/her own medical care. With the exception of minors not requiring parental consent, a patient less than eighteen (18) years old may not refuse evaluation, treatment, or transport for an emergency condition unless a parent or legal guardian concurs with such refusal.

1. **Competence:** In order to be considered competent, a patient must possess both legal capacity and functional capacity.

Legal Capacity. A patient is presumed to have the legal capacity to consent when he or she is over the age of eighteen, or has been emancipated. An individual is considered emancipated when he or she is:

- Married, widowed, or divorced;
- the parent of a child;
- a member of the armed forces;
- pregnant or believes herself to be pregnant; or
- living separate and apart from a parent or legal guardian and is managing his or her own financial affairs.

A patient does not have legal capacity, however, when he or she has a court-appointed guardian. A guardian is a court-appointed person entrusted with the legal power to manage the affairs of another person because the person under guardianship lacks the ability to understand the nature and significance of those affairs.

Decisional or Functional Capacity. The second element required for valid consent to medical treatment or transport is decisional capacity. A patient has decisional capacity if he/she can understand the nature and consequences of authorizing treatment or transport. Language barriers can complicate this assessment. Conditions such as head injury, hypoxia, hypoglycemia, psychiatric illness, and intoxication by drugs or alcohol can affect a person's ability to reason and should be taken into account when evaluating decisional capacity. Specifically, the patient must be capable of understanding:

- The nature and extent of his or her illness or injury;
- The nature of the proposed treatment;
- The potential risks and benefits of accepting such treatment; and
- The potential risks of refusing such treatment.

2. Means of Consent. Consent is either express or implied.
 - 2.1. Express consent exists when the patient gives verbal permission to receive treatment.
 - 2.2. Implied consent results from the circumstances of the particular incident. If the patient is silent and capable of objecting verbally when treatment is initiated, consent is implied. Consent is also implied if the patient exhibits any actions that indicate a willingness to be treated. The most common example of implied consent is in the emergency situation. An unconscious patient, or a patient with altered mental status, is presumed to give implied consent.
3. Competent Patient Refusing Treatment and/or Transport: Patient Refusals must be initiated solely by the patient and shall not be suggested or prompted by the EMS personnel. Except in the case where a valid “section 12” order exists (refer to section 5 of this procedure), when a patient with both legal and decisional capacity is refusing treatment and/or transport, Boston EMS personnel shall:
 - 3.1. Ask the patient (or in the case of a minor, the patient’s guardian) directly which hospital they would like to be transported to. Do not suggest or prompt a refusal of care. Only the patient may initiate such a refusal. Ensure the patient is answering questions appropriately.
 - 3.2. Ensure the patient’s ability to reason does not appear to be affected by illness, injury, drugs, or alcohol. Inform the patient of the need to receive treatment and potential consequences of not receiving treatment and/or going to a hospital. Advise the patient to call 9-1-1 back or seek emergency care if they change their mind or their condition changes.
 - 3.3. Some patient complaints represent potentially higher risk for the patient such as chest pain, shortness of breath, syncope, new onset of severe headache or seizure, TIA/Stroke symptoms, pregnancy complaints, or injury/illness involving elderly or pediatric patients. Supervisor and/or Medical Control advice should be sought as needed to convince high risk patients to be transported.
 - 3.4. A patient refusal shall be thoroughly documented whenever a competent patient refuses to be treated and/or transported to the hospital. The patient, parent, or legal guardian should sign the designated refusal section located in the “Outcomes” portion of the SafetyPad software. If the patient or legal guardian refuses to sign the form, the EMT shall write “Refused To Sign Form” in place of the patient signature.
 - 3.5. In cases where the SafetyPad device is not readily available, the patient refusal may be documented on a Department approved paper Boston EMS Patient Refusal form which shall then be submitted along with other paperwork at the end of the shift. The form will be scanned and attached to the associated electronic PCR.
4. Patient Not Competent to Refuse: In cases where the patient lacks legal or decisional capacity to refuse treatment and transport, every effort shall be made to convince the patient to be transported voluntarily. If the patient cannot be convinced to be transported voluntarily, personnel shall:

- 4.1. Request the assistance of the Field Supervisor and when necessary, the appropriate police agency.
- 4.2. When time permits, notify Medical Control by radio on a C-MED channel, describe the situation, and seek advice.
- 4.3. EMTs may restrain a patient who presents an immediate or serious threat of bodily harm to himself or others. Any such restraint shall be in accordance with the department's restraint policy and documented in the patient care report.
- 4.4. In situations where a patient is thought to be a threat to themselves and has left the scene but is still in the immediate area, attempts will be made to maintain visual contact with the individual from a safe distance so a description and direction of flight can be relayed to law enforcement.
5. MGL Chapter 123, Section 12 (a) or "Pink Paper" Situations. By law, certain individuals in the Commonwealth of Massachusetts (physician, qualified psychiatric nurse mental health clinical specialist, psychologist, licensed independent clinical social worker, police officer) who, after examining a person (or based on the facts and circumstances when an examination is not possible), has reason to believe that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness may restrain or authorize the restraint of such person for the purpose of transportation to a hospital for evaluation.
 - 5.1. Boston EMS may be notified and presented with a "pink paper" in one of two ways: the document may be faxed to the Dispatch Operations Center by the caller requesting that a patient be transported, or the responding ambulance crew may be presented with the document upon arrival at the scene. In either event, the initial patient assessment and treatment is no different than any other emergency response. A patient that consents to treatment and transport, is lacking legal and/or decisional capacity to refuse, or one that the EMTs deem to be an immediate or serious threat to themselves or others shall be treated and transported in accordance with Department policy, Statewide Treatment protocols, and point of entry plan regardless of the "pink paper".
 - 5.2. In situations where Boston EMS is presented with a "pink paper" but the patient named on the order appears competent in the relatively brief assessment by EMS personnel, does not appear to be an immediate threat to himself, and does not agree to be transported voluntarily, the appropriate police agency, if not already on scene, and Division Supervisor shall be notified and requested to respond.
 - 5.2.1. Enforcement of the "pink paper" should then be referred to the appropriate police agency. If a person is restrained by police pursuant to a Section 12 or is under arrest and requires transport by ambulance, a police officer should accompany the patient inside the ambulance when practical to provide protection to the patient and EMTs, as well as to alter the restraints as necessary for medical treatment. If riding in the ambulance is not practical, the police officer will escort the ambulance to the hospital.

- 5.3. Whenever a person with a “pink paper” is transported by ambulance to the hospital- either because they are a danger to themselves, voluntarily, or when the order is enforced by a police officer, the patient should be transported in accordance with established point of entry plans, which may result in the patient being transported to a facility other than the one noted on the “pink paper”. If that is the case, the originator of the pink paper will be notified of the change in destination whenever possible either by the ambulance crew on scene, or through Dispatch Operations. Upon arrival at the hospital, the staff at the receiving facility shall be notified of the existence of the pink paper and provided with a copy (either hand delivered, or faxed by Dispatch Operations). The existence of a “pink paper” shall also be noted in the patient care report.

OEMS A/R 5-610 <http://www.mass.gov/eohhs/docs/dph/emergency-services/ar/5-610.pdf>

Chapter 54 of the Acts of 2000, section

18. <http://www.malegislature.gov/Laws/SessionLaws/Acts/2000/Chapter54/Print>

<http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123/Section12>

OEMS A/R “Requirement for EMT Use of Patient Restraints” See part II.B.b.iii

<http://www.mass.gov/eohhs/docs/dph/emergency-services/ar/5-500.pdf>