

Matters of consent—2009

Part one of two

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Objectives

At the end of the CE module, the EMS provider will be able to:

1. Define the following terms.
 - legal competence
 - present mental capacity
 - adult
 - minor
 - emancipated
 - orientation
 - informed consent
 - informed refusal
 - impaired
 - insane
2. Discuss the differences between mental competency and present mental capacity to make a treatment decision.
3. Given a scenario, apply the concepts of consent and refusal to the situation.



Photo by Audra Horton

The purpose of this CE article is to acquaint you with the concepts and methods of problem-solving and documentation that you need to practice in the field. This article is for educational purposes only and does not purport to offer legal advice. All providers should consult their own attorneys for legal advice.

Scenario

You respond to a public park where there has been a fight among several young adults. Sheriff's deputies are on the now-secure scene. You are directed to a patrol car where a young lady is sitting with her hands cuffed behind her. A deputy says that she may have been struck on the head with something and might have been knocked unconscious; he is not sure, and he would like you to "check her out" before he

transports her to the jail. He further tells you that she's being arrested for public intoxication and assault.

You approach the young lady who is not happy and not cooperating. She has dried blood under her nose and on her upper forehead. Dried blood is also in her hair, and the front of her T-shirt has a considerable amount of blood on it. "Can we look at your injuries?" you ask. She responds by spitting at you. You see it coming and duck just in time. You back away and ask her if she wants you to examine her, and she responds with cursing. You tell the officer, "Well, she looks fine to me. We're going back in service. Call us if you need us."

You leave the area and document the call by writing "patient refused" on your patient care form and nothing else.

On your second day off, you get a call from your supervisor asking you to come in and talk about a problem call. When you

arrive, your supervisor tells you that the injured woman was found dead in her cell about 0400 the morning after your call. The autopsy has shown that she had an epidural hematoma from blunt trauma to the left side of her head, which caused the laceration of her middle meningeal artery, which in turn caused her death.

Introduction

We've all read this statement at the beginning of EMS textbooks: "Competent adults have the power to consent to treatment or refuse, and minors can neither consent nor refuse." We don't treat people without consent, and they can refuse treatment if they are adults and they know what they're doing. We simply get them to sign a release if they don't want treatment. So where's the problem?

Problems arise because words like *competent, adult, minor, informed, capacity, impaired, emancipated, oriented, mentally ill, insane, alert* and other similar words are often used loosely and may have differing meanings to different people. That seemingly simple textbook phrase can become difficult when applied in conjunction with the terms above. And the average *release* is little or no help to you if you get sued for failure to treat a patient whose mental capacity was too impaired to refuse treatment.

Consider a situation where a busload of high school students is involved in a minor wreck and all of the students are under 18 years of age. They don't want medical treatment, but Momma and Papa are nowhere to be found. They're too young to either consent or refuse, so what do you do with them? Or what about an overdose patient who calmly informs you that he intended to kill himself, answers all your questions correctly, knows who the president is and absolutely refuses to be treated? What do you do with him? If he signs a refusal form, is that all you need?

Then there is the patient who fell off his barstool after an afternoon of drinking and knocked himself out temporarily, but has "revived" and now just wants to go home? You suspect he's under the influence of alcohol, and you also know that he lost consciousness for a few minutes. He appears to know who he is and where he is, so can you just write "no patient" or "patient refused" on your run sheet?

The situation in the scenario and the

previous examples demonstrate the challenges of patient consent. Most of us who've worked the streets have run into situations like these.

We might have asked the patient to sign the refusal form and gone on our way, but unfortunately, most refusal forms in use today are not worth the paper they're written on if a case is brought to court. They do not document the right things. They often contain lots of conclusions and little factual information. The release usually offers little or no protection in a legal proceeding and, worse, may actually hurt a provider because of what is *not* documented.

Competency vs. capacity

Let's start with the words *competency* and *capacity*. We need to understand those words and how they are used. Both *competency* and *capacity* are used loosely to refer to the mental status of a person, but they may have quite different meanings to different people depending upon the situation in which they are used.

Merriam-Webster's Collegiate Dictionary defines *competent* both as "legally qualified or adequate" and "having the capacity to function or develop in a particular way." *Capacity* is defined variously as "legal competency or fitness" and "an individual's mental or physical ability." To make matters worse, the same dictionary defines *capable* as "having attributes (as physical or mental power) required for performance or accomplishment." Not much help there.

The word *legal* crops up in both definitions, and that's an important distinction. Although you can find many instances of imprecise wording strewn throughout medical and legal literature and case law, one general concept can be stated without much fear of contradiction: Whether or not you say *insanity, legal competence, legal competency, or legal capacity*, you are talking about a *legal* concept, not a *medical* concept.

People without mental deficiencies have long been recognized as being legally competent until declared incompetent by a court of law. Legally competent people have



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Effective health care requires collaboration between patients and physicians and other health care professionals. Open and honest communication, respect for personal and professional values, and sensitivity to differences are integral to optimal patient care.

American Hospital Association, A Patient's Bill of Rights, 1993

Legal Competency The legal ability to perform a legally recognized act or function, such as executing a will or a contract.



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also been recognized to have the right to refuse medical treatment. The rights to refuse treatment are based on English common law, U.S. constitutional rights and statutory rights.

Insanity, which can be a synonym for *legal incompetency*, is determined by the legal system, not the medical system.

Insanity Unsoundness of mind sufficient in the judgment of a civil court to render a person unfit to maintain a contractual or other legal relationship or to warrant commitment to a mental health facility. In most criminal jurisdictions, a degree of mental malfunctioning sufficient to relieve the accused of legal responsibility for the act committed.¹

True, the medical system may play a role in determining insanity or legal competency by evaluating the patient, and a physician may present testimony about the person's mental status, but the court will make the determination.

Courts have struggled with the concept of *insanity* for centuries.

An insane person cannot be held legally responsible for his acts, but an insane person may be perfectly aware of his whereabouts and

injuries, for example. On the other hand, a sane person may lack the *present mental capacity* to understand the nature of his condition and make rational treatment decisions. Although a person who had been declared insane by a court might at some time possess the present

mental capacity to make a valid treatment judgment, he could not legally execute a binding release of liability because he lost his *legal* decision-making rights when he was adjudged to be insane. But a legal

determination of insanity or incompetency does not, in itself, necessarily render the person incapable of making a present decision to either consent to treatment or refuse it.

Whether insane or legally incompetent, once so declared by the courts, the status sticks until the courts declare that the person is restored to sanity or legal competency.

Legal incompetency does not equal mental illness

A person who is *legally incompetent* cannot execute a will or deed to property, make a contract, or marry, but his legal incompetency does not necessarily render him unable to understand his present condition and decide whether or not to be treated. He may even be allowed to testify in court as a witness. Whether or not he has the present mental capacity to make

medical decisions must be determined on a case by case basis. A person may be depressed or delusional but still understand that his leg is broken and that he needs to have it cared for. A minor may be perfectly capable of making a rational treatment decision but lacks the *legal* ability to do it.

Perhaps a good way to look at it is to consider *competency* as referring to the ability to perform a legally recognized act or function and *capacity* as referring to a person's actual, present ability to understand and appreciate the nature of his condition and the consequences of either consenting to treatment or refusing it. The term *incompetent* is more of a legal term and *capacity* is more of a practical term.

What determines present mental capacity?

A number of factors must come into play in the determination of a person's present mental capacity to make a medical treatment decision. A patient's *orientation* is an important part of the distinction. In order to help determine whether a person's present mental capacity is adequate for making decisions, a patient must be oriented to person, place, time and event—the person must have a functional ability to know and understand who he is, where he is, when it is and what has happened.

Not only must he be mentally oriented, but he must also be able to think abstractly about his condition, consider it and make rational judgments about it. Therefore the patient must appreciate his condition either from his own perception or from what he is told by others. In addition to knowing and appreciating his condition, he must be able to correlate that knowledge to the need for treatment and the possible consequences of refusing treatment. This will require his memory be sufficiently intact that he can remember what his condition is and what he knows or is told about his need for treatment. He must have enough functioning memory and cognitive skills to assimilate and apply information he gets from attending medics to what he knows about his condition and to come up with a treatment decision that makes sense.

So it is not enough that a patient knows who he is, where he is, and when it is. He must be able to engage in analysis, critical thinking and problem-solving. He must be

Orientation Awareness of one's self and one's environment with respect to person, time, place and event.

Mental Capacity In medicine, the present ability to understand and appreciate the nature and consequences of one's condition and to form a rational treatment decision.

able to follow simple directions and remember what is told to him. It is the measurement and documentation of these abilities that cause EMS personnel trouble when they need to determine and document a patient's refusal of treatment.

We can also get into trouble when managing patients who are uncooperative and want to refuse treatment if we fail to probe deeply enough into their mental status to make the above determinations. The uncooperative patient poses the greatest problem for us in executing a full assessment, but we as health care professionals must use all the tools at our disposal to overcome the patient's lack of cooperation. We must recognize that we may be dealing with someone who lacks present mental capacity to make the decision to cooperate with us. Further, it does us no good in defending our actions if we simply document our conclusions that the patient was awake, alert, oriented to time, place, person and event, understood that he might need further care and was refusing that care. We must obtain and document objective facts to support our conclusions. Otherwise we're cannon fodder for lawyers who take us to court.

Minors and consent

People who have not yet reached the age of consent for purposes of medical treatment, which varies from 18 to 21 years depending upon what state you're in (it's 18 in Texas), are considered *minors* and are under a legal disability. Generally speaking, minors can neither consent to nor refuse medical treatment, nor can they execute a will, sign a deed to property, marry or enter into a legally binding contract. Some minors, however, are *emancipated*, which means either that a court of law has removed their minor's disability to make legally binding decisions or that, as a practical matter, they are living apart from their parents and functioning on their own as adults.

During encounters with patients, a medic will have little opportunity to determine whether a minor is emancipated or not. Few emancipated minors carry a copy of a court order around with them, and even if they did, we have no means to verify its validity. Whether or not a minor is *de facto emancipated* depends upon facts that we have neither the time nor the means to determine or verify.

Therefore, *emancipation* is an elusive condition that is not much help in many emergent situations.

Who is a patient and who is not?

This is a question that arises frequently. The answer would appear to be simple at first glance, but it can present perplexing problems for emergency responders.

One dictionary defines *patient* as "one who is under medical care or treatment."² Another defines it as "a person who is ill or who is undergoing treatment for disease."³ However, this does not solve the problem that comes up when a person is in need of treatment but has not yet begun to receive it. Is that person a patient? Does the patient make the determination that he is a patient, or does someone else? What happens when a third party believes that someone requires emergency care and calls 911 without the knowledge or consent of the presumed patient? This happens often as a result of third-party calls regarding minor motor vehicle crashes, for example.

Perhaps *casualty* is a better word than *patient* to use when defining a person who needs emergency care. A *casualty* is a person who is the victim of an accident, injury or trauma.⁴ This would appear to be a more objective term than *patient*.

In emergency care it is clear that two situations, at least, can exist. One is when a person declares himself a patient because he believes, rightly or wrongly, that he needs medical care. Another is when, by observation, it is plain that the person is injured or sick and needs care.

Normally, patient or non-patient status is determined through mutual discussion between the caregiver and the patient, or, when the patient is unable to communicate, under the rules of implied consent.

According to "A Patient's Bill of Rights, 1993" created by the American Hospital Association, "Except in emergencies when the patient lacks decision-making capacity and the need for treatment is urgent, the patient is entitled to the opportunity to discuss and request information relative to the specific procedures and/or treatments, the risks involved, the possible length of recuperation,



Adult One who has reached the age of legal consent for medical treatment. An adult is age 18 in Texas, but ranges up to 21 in other states.



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and the medically reasonable alternatives and their accompanying risks and benefits.”⁵

But what if the patient refuses to avail himself of those rights and opportunities and does so because he is lacking in the present mental capacity to do so? This creates a dilemma for the emergency caregiver, but careful assessment and documentation, together with use of existing law and cooperation with law enforcement authorities can protect both patient and caregiver.

Analysis of the scenario

It should be obvious that an adequate assessment of the patient and documentation of her physical condition and mental status did not happen. All patients with obvious injuries must be assessed completely to discover any possible life-threatening injuries and to determine to the fullest extent allowed by a field examination any other injuries that might have occurred.

The patient’s alcohol intake together with her obvious injuries would lead a reasonable and prudent medic to assess the patient further than was done in the scenario. It is no excuse that the patient was uncooperative; we are trained to deal with uncooperative patients. It is no excuse that we are busy, tired or frustrated when dealing with an uncooperative patient. She is still a patient until we determine, through objective analysis, that she is not, or until she executes a valid, informed refusal. Her obnoxious and assaultive behavior must be viewed as further evidence of her possible impairment for decision making.

This patient lacked present mental capacity to refuse treatment due to alcohol ingestion and alleged loss of consciousness, which should have caused the medics to press for further examination. No attempt was made to diffuse the situation by trying to gain the patient’s trust and cooperation. No attempt was made to educate the patient as to her possible danger from her injuries. No attempt was made to examine her and to gain more information about the history

of her injury and mental state. And the sheriff’s deputies were not asked to help. They could have ordered her treatment and transport, and there were at least three grounds for arresting the patient: public intoxication, assault and being a person chemically dependent who was a danger to herself.

Using verbal communication tools to persuade, educate and convince the patient may help, but if that fails, employment of police assistance would be the next strategy. Verbal strategies are beyond the scope of this article, but there are many sources that you can consult for help.⁶ In this case, the police would have probable cause to intervene because the patient may be under the influence of alcohol and because she engaged in inappropriate behavior by spitting at you, which could be the basis for an arrest for assault. If the police are less than cooperative, you should attempt to convince them of the need to cooperate through calm, factual conversation, reminding them of the possible consequences to all of you—patient, police and medics—if she is jailed without assessment and treatment.

In a similar circumstance where an injured person is not under arrest, both you and the police might be liable if you let her go and she drives a motor vehicle and has a wreck that injures someone, or if she acts to injure somebody in another way. Therefore you can’t leave her untreated. She obviously lacks the present mental capacity to understand and appreciate the nature and quality of her injuries and to make a rational treatment decision.

She can be treated either under *implied consent* or upon the order of the sheriff’s deputy if she is taken into custody for public intoxication or assault, which is the case here. Texas also has a specific statute that gives law enforcement the power to arrest a person without a warrant if the officer has reason to believe that the patient is suffering from chemical dependency (in this case alcohol), is an immediate threat to self or others, and there is no time to obtain an arrest warrant. Invocation of this law will not normally be necessary, but it’s a good tool to know about.⁷

Treatment under implied consent is based upon the premise that she lacked the present mental capacity to understand and appreciate her situation because of alcohol ingestion and head trauma. This is a common-law concept

Release A legal document having the effect of releasing another person or company from liability for something. Releases usually involve the payment of money or some act of legal consideration in return for granting the release. Often coupled with an *informed refusal* for treatment.

Informed Refusal A written refusal of treatment signed by a patient who has the present mental capacity to understand and appreciate the nature of his illness or injuries, understands the consequences of a refusal to be treated and states the same in factual terms that demonstrate his understanding.

that states that if a patient cannot consent to treatment because of illness or injury, she may be treated upon the assumption that if she were able to consent, she would. This is slightly different from the consent provided in the Texas Health and Safety Code that requires that the patient be unable to communicate due to illness or injury. While the argument can be made that this patient's communications are not appropriate, it is probably a better idea to base treatment on the common-law concept since the patient was communicating, albeit not rationally.⁸

It could also be said that when in police custody, she was in the position of a ward of the state and that the sheriff's officer then had the power to make the treatment decisions.

The actions of the medics were negligent and would subject both them and their employer to legal liability. And their lack of documentation compounds the predicament.

Whatever you do, and whatever the outcome, you must document enough facts to demonstrate that what you did equaled or surpassed the standard of care required. Failure to document will leave you defenseless if you get sued, as can the wrong kind of documentation. Documentation of conclusions without the facts upon which they are based is practically worthless.

For example, the documented statement "*Patient A&A&Ox4*" is a pure conclusion. You must document **facts**, including questions and statements directed to the patient by you and her answers. Years later when your case comes up, you will not remember the details. You must document the facts that led you to your conclusion that she was "awake and alert and oriented to time, place, person, and event." Whenever possible, document the patient's statements in quotes. Yes, that's lots of documentation, but if you expect to survive serious litigation without a judgment being rendered against you, it's not only well worth it, it's mandatory. Many ask how this can be done with electronic charting or forms where there is not enough room in the narrative section of the form for proper documentation. The answer is practical, not legal. The remedy may be to write a supplemental report and attach it to a hard copy of the document, or to press for a change in the digital program to permit adequate documentation. Regardless,

adequate narrative documentation is essential for good legal defense.



Summary

Insanity and *mental competency* are legal terms, and there is a presumption of legal mental competency unless a person has been declared insane or mentally incompetent by a court of law.

Present mental capacity refers to a person's present mental ability to understand and appreciate the nature and consequences of his condition and to make rational treatment decisions.

One who is legally competent may lack present mental capacity to make a valid treatment decision; or one who is legally incompetent or insane may have the present mental capacity to make many treatment decisions, particularly the decision to be treated for an immediate illness or injury.

When evaluating a patient for the ability to consent to treatment or refuse treatment, the medic must determine whether or not the patient possesses the present mental capacity to understand and appreciate the nature and consequences of her condition and to make rational treatment decisions. Such an evaluation must take into consideration not only the patient's orientation to person, place, time, and event, but her memory function and her ability to engage in associative and abstract thinking about her condition, to respond rationally to questions and to apply information given to her by the medics who are taking care of her.

Patients with impaired mental capacity may be treated under implied consent.

Finally, the medic's findings must be documented with facts, not conclusions, and such documentation must be sufficient to demonstrate the patient's mental status and understanding of her condition and the consequences of refusing treatment.

In the next issue of Texas EMS Magazine, this article continues with a discussion on ways to measure and document a person's present mental capacity to make a medical decision.

Notes

1. *The American Heritage Dictionary of the English Language*, 4th ed., Houghton Mifflin.

2. *Random House Webster's College Dictionary*, 1998.
3. *Dorland's Illustrated Medical Dictionary*, 31st ed., Saunders, 2007.
4. The Free Dictionary, available at <http://legaldictionary.thefreedictionary.com/Casualty>.
5. A Patient's Bill of Rights, American Hospital Association, 1993.
6. Dernocoeur, *Streetsense: Communication, Safety, and Control*, 3rd ed., Published by the author.
7. Texas Health and Safety Code, Chapter 773, Section 462.041.
8. Texas Health and Safety Code, Chapter 773, Section 773.008.

Consent for emergency care of an individual is not required if:

- (1) the individual is:
 - (A) unable to communicate because of an injury, accident, or illness or is unconscious; and
 - (B) suffering from what reasonably appears to be a life-threatening injury or illness;
- (2) a court of record orders the treatment of an individual who is in an imminent emergency to prevent the individual's serious bodily injury or loss of life; or
- (3) the individual is a minor who is suffering from what reasonably appears to be a life-threatening injury or illness and whose parents, managing or possessory conservator, or guardian is not present.

Patient Consent Quiz

1. Mr. Addington is a 55-year-old who has spent most of his adult life in and out of mental institutions following a court commitment for insanity. While on furlough from the institution he is brushed by a car in the parking lot and sustains cuts, bruises and a possible fracture. Which of the following is correct?

- A. He cannot consent to treatment under any circumstances.
- B. He can consent to treatment if he can demonstrate appropriate present mental capacity to consent.
- C. His legal guardian must be found and asked to consent before any treatment can be done.
- D. He cannot refuse treatment due to his court-imposed mental disability.

2. Insanity is:

- A. A precise medical term synonymous with psychosis
- B. A lay term without a specific definition
- C. A legal status determined by a court of competent jurisdiction
- D. A term that refers only to schizophrenia

3. Robert, 17, was determined by a District Court in Texas to be able to execute legal

documents without parental consent. He is:

- A. A consenting minor
- B. Unable either to consent or refuse medical treatment
- C. A legally emancipated minor
- D. Able to refuse medical treatment under all circumstances

4. A 19-year-old person in the state of Texas

- A. Cannot vote but may purchase alcoholic beverages
- B. Cannot consent to medical treatment other than in an emergency
- C. May authorize you to treat and transport her for a headache
- D. May authorize you to treat her alert and oriented mother who is refusing treatment

5. An informed refusal should contain:

- A. Factual information demonstrating the patient's orientation
- B. A statement that the patient is "A&A&O X 4"
- C. The signatures of three adult witnesses to the patient's signature
- D. None of the above