

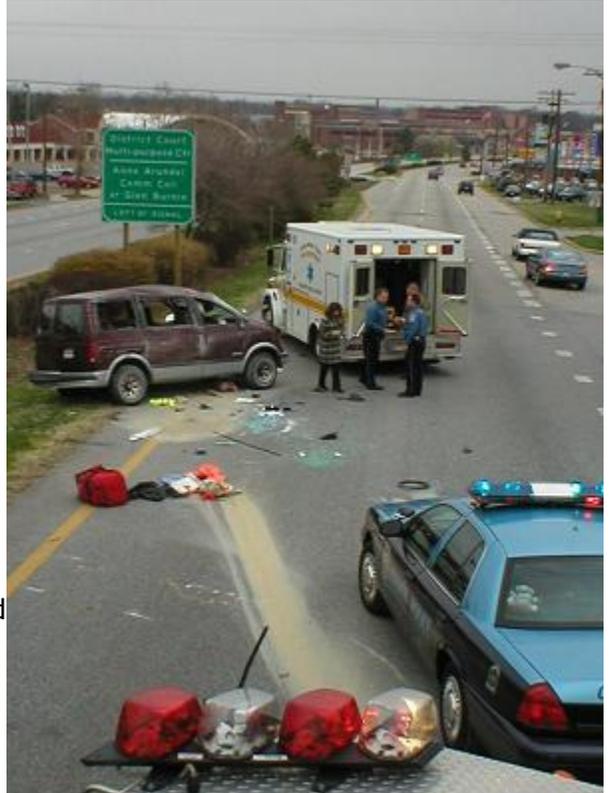
Objectives

After reading this article, you will be able to:

1. Describe the different consents.
2. Describe the treatment priority of patients involved in a mass trauma.
3. Describe the legal rights of the patients with regards to treatment and transport.
4. Describe the role of medical control and protocols.

Case Scenario

Your EMS unit is dispatched to the scene of a single vehicle high speed roll over collision. The car appears to have rolled over several times based on the visual appearance of the car and the damage to the path the vehicle took. Upon arrival you find a chaotic scene and multiple victims. You radio for back up but the nearest unit is still 20 minutes away. Once you begin initially assessing the scene, you realize that there are five patients all in a variety of locations and conditions. The patients present as follows:



- Patient A: You find a 62 year old male trapped under the car. He states that he was driving when he thinks he had a blow out and began losing control of the vehicle. He states that he thinks it rolled five or six times and that he can not feel his legs. He also confirms that not everyone in the car was wearing a safety belt. He is obviously alert and oriented and is oddly calm. He has multiple lacerations and abrasions, and his left arm is severely deformed. He is short of breath and is showing paradoxical chest movement. His respiratory rate is 50 plus breaths per minute, and he has no radial pulses.
- Patient B: The second patient that you find is a 30 year old woman who is still belted in the front seat where you notice that the airbag did in fact deploy. She is hyperventilating and states that she is 5 months pregnant and can not find her 4 year old daughter. She then states that her 4 year old was not in a car seat and she doesn't think she was wearing a seat belt either. Her vitals are stable: BP 150/92, p. 97, respirations 30 and non-labored. She has good radial pulses, and is alert and oriented.
- Patient C: A 4 year old girl found in the floor of the backseat. She is barely arousable with painful stimuli, has vomited at least twice and is losing all arousability with each instant that goes by. She has multiple lacerations and abrasions and a severe deformity of both of her lower legs. Her respiratory rate is 45 and she has a faint radial pulse. She is completely unable to follow commands and is bleeding out of her left ear.
- Patient D: A 38 year old man who appears to have been the passenger behind the driver. His face has multiple lacerations, and he is completely unresponsive. He is displaying no detectable breathing. His respirations are 0, pulse is 0, and he has no detectable radial pulse.
- Patient E: A 25 year old woman who is found about 50 feet from the car. She is conscious and seems to be alert and oriented to time and place and what happened. She is complaining of abdominal pain, neck and back pain. She has multiple mild abrasions and she follows commands. She is able to move all extremities and is sitting on her own. She has a respiratory rate of 25, a strong palpable radial pulse, and is lucid.

When arriving on a scene like this it can seem a bit overwhelming. You have five patients that are in need of medical care, but all of their conditions are widely different in severity and the time it will take to stabilize each of them. The purpose of triage is to assess the condition of each patient, sort the patients into treatment categories, and optimize the use of field resources for treatment and transportation. In addition, triage addresses the level of provider capability and the level of response needed to care for the patient. Specific triage criteria are essential during multiple casualty incidents to efficiently facilitate the screening, prioritization, treatment, and transport of patients. The triage process then becomes crucial to treat multiple victims.

History of Triage

The word triage, which in the EMS setting is associated with assessing patients, is actually of the French word "trier," which means "to sort." The theory behind setting up a system to actually "triage" patients began hundreds of years ago when a surgeon in Napoleons army had to devise an organized approach to treating soldiers wounded in battle. His name was Dominique Jean Larrey, and his goal was to be able to quickly evaluate and evacuate from the battle scene those with the most serious injuries. He is widely credited with this theory and is also credited as a hero as he did not discriminate by rank, he stuck to a strict triage protocol across the board with all soldiers. Unknowingly, he laid the groundwork for a process that is used in all patient assessments and all situations from mass casualties, to individual treatment⁴. Triage is essentially a brief clinical assessment that determines the time and sequence in which patients should be seen and treated in the field or emergency room settings. In the EMS setting, it also helps to organize not only who needs treatment first but also the speed of transport and which hospital is best suited for the patients suspected condition⁶. These decisions generally are based on a short evaluation of the patient and an assessment of vital signs. The patient's overall appearance, history of illness and/or injury, the mechanism involved and mental status are all important considerations in the triage process as well.

Triage is now a system that is used by all medical and emergency personnel. This term is used widely. When the emergency room is doing their original assessment on a new patient, this is referred to as "triage." Triage in emergency departments occurred sporadically in the early 1900s in the more crowded hospitals of large inner-city populations⁴. However, it was not widely accepted in emergency departments until the later half of the 20th century. In this setting, the term "triage" is used for each individual patient, where as in the field, "triage" is associated with two or more patients. This is when organized departments with on-duty ED physicians became a national standard. Triage has evolved to become a critically important part of the emergency department because it helps to minimize long wait times to see the physician. This also helps to cut down on legal proceedings because the triage process itself helps to ensure that patients in need of instant medical care do not get stuck in the process of checking in and so forth. The triage process helps to ensure that they are triaged immediately and determine if their condition is emergent. In other instances, emergency field personnel use this term to decide how to ration limited medical resources such as personnel and equipment when the numbers of the injured outweighs the amount of help available. The goal then becomes to successfully treat the greatest number of patients possible. Most governments even have a set triage system that is sanctioned and recognized by law as long as it is performed within accepted medical practices⁵.

The positive results of a triage system became obvious immediately. Soldiers that would have otherwise died by just waiting for their turn were suddenly able to be saved. Of course, this meant that injuries that were less severe ended up waiting longer for treatment, but the fatality rates with in the war began to drop instantly. As a result, the armies of several countries began creating their own triage protocol thus triage is the first attempt at organization at the scene of any multiple casualty incident. It is considered the initial step in administering medical care or first aid¹.

Triage is not designed to gather a detailed medical history and definitive treatment. It is designed to get a fast effective assessment of the patients' possible condition, and then assign any emergent treatment that is needed. Once everyone has been triaged, then EMS can assign priority and once all are transported out or stabilized a more efficient assessment can occur. With some 911 systems

a degree of triage begins immediately at the dispatch level as they decide when to send an ambulance and which ambulance may be needed such as basic life support or advanced life support. Once EMS arrives on scene the paramedics or EMT's reassess and assign the patient a high or a low priority category³.

The Necessity of Triage

Without a doubt certain injuries require prompt emergent medical care such as Patient "D" in the above case scenario¹. Especially when dealing with trauma victims, you have to be sensitive to the "golden hour" rule and not waste any field time delaying surgery. You should also consider what hospital you are going to transport to and what resources are available because a surgeon can only handle one trauma patient at a time. You should consider air resources as well as the locations of all local trauma centers and then send patients according to their injuries and hospital resources². For example, you would never want to send a multiple casualty accident with all patients presenting with life threatening injuries to a small unequipped hospital. At the scene the paramedics should assess who needs to go where and try to "even out the load" for the receiving facilities. This will not only help the EMS team that is taking the patient, but it will also help ensure that the patient will receive optimal care. There are multiple considerations that EMS is faced with in these situations that affect the long term outcome of the patients. Effective and organized triage saves lives.

Another term associated with triage is "advanced triage." This is essentially triage taken up another level. This is used when there is a mass casualty such as an attack by a weapon of mass destruction such as a nuclear bomb in which hundreds of thousands of people can be severely injured all at the same time. There is no way that the available medical care in an entire region could take care of so many seriously injured patients². At this point advanced triage means treating those who you know have a chance of survival only. In this extreme case, any medical care given to people doomed to die is care taken away from people who might live if they had been given it. It becomes the unpleasant task of the emergency medical workers to set aside some victims such as severe burn patients, because it would take a staff of several professionals ten days to save their one life at the expense of several dozen other lives. For example there could be thousands of people whom you could initially help, but will probably die in the hospital anyway. An example of this would be victims of such an attack that suffered severe burns or insurmountable amounts of radiation. Although, the paramedics and other workers could stabilize the patient, their long term prognosis is grim, thus these patients would not be a high priority patient to treat. However, others with less severe injuries or exposure will be treated first especially if they will die without it. At the point in which advanced triage is used, the patient receiving medical care should have a reasonable hope for survival once medical care is administered. In advanced triage, doctors may decide that some severely injured people should not receive care because they are unlikely to survive. The available care is then directed to those with some hope of survival. This clearly has severe ethical and emotional implications³.

Trauma Triage

Trauma triage is the most common triage that paramedics will deal with. Whether dealing with the single patient or an accident with multiple victims, usually it is due to a recent trauma such as a motor vehicle accident. Most trauma triage and protocol guidelines are part of a nationally approved and validated criterion. These triage protocols influence to which hospitals patients are transported, how they get there, and in what order they go. Each medical control may have a different triage criteria, but in general most use a combination of the what the mechanism of injury is, the assumed physical injuries, and the medical intervention that is immediately needed, and who can provide it the most efficiently⁵.

Disaster Triage

Disaster medical triage is used for events such as natural disasters like a tornado. It is quick process designed to work at several levels to identify those with life threatening emergencies and establish an overall idea of



in case of a mass emergency. However, if triage tags are not readily available, then a pen or marker will work fine as long as all the workers know what the labels stand for and where to look for the label. For example, if half of the EMS workers are labeling the backs of hands, and half are labeling foreheads, then this could result in double triaging of the same patients.

Once you have arrived on scene and are ready to begin the triage process, the first step is to address all of the patients. In a loud and authoritative voice a designated EMS worker should instruct the patients to move to a pre-designated area. The area should be close and easy to get to, not over a big ditch or down a large hill. This will help with an initial assessment of a portion of the patients because it is safe to assume that these patients can be classified as "walking wounded," thus they do not need immediate transport and care. However, any patient can change categories so do not assume that just because they walked to the designated "safe area" that they are out of the woods completely. For example, a patient in the early stages of shock may have no trouble walking to the triage area, but then may begin to decompensate and then become an urgent patient. However, the walking wounded are usually the largest group of injuries and are in some instances able to help you administer aide to more critically injured patients.

The second stage of the START triage protocol is to begin assessing each remaining person that was not able to walk with the walking wounded patients. The paramedic should then be assessing respiratory effort, perfusion, and the mental status of all remaining patients⁵.

- If a patient is not breathing, then practice the basics of airway management. First adjust their head and attempt to clear their airway. If this does not work and the patient is not able to breathe independently, then this patient should be labeled as deceased and the paramedic should move on to the next patient. While this does seem harsh, the paramedic must remember that if they start CPR and use all resources and personnel on trying to save one patient, several others could die.
- If a patient is breathing either on their own or after the paramedic adjusts their airway, monitor their respirations for one full minute. If they are breathing more than thirty breaths per minute there is a good chance the patient is entering shock, and they should be labeled "immediate." Have a walking wounded sit with the patient to make sure their head position stays corrected and have them elevate the patients' feet and keep them warm with a blanket or coat.
- If a patient is breathing at a normal rate of less than thirty breaths per minute, the paramedic should then assess their capillary refill to make sure the patient is perfusing adequately. This test is performed by pressing on the patients finger nail and if it turns pink within two seconds, one can assume that perfusion is satisfactory. If their respirations are normal, but their perfusion is greater than two, then tag the patient "immediate." If the perfusion is adequate, then move on to assessing their mental state. Check that they are alert and oriented and if they know what happened. If they are unable to reply to your questions, then repeat your question. If there is no definite answer or an answer that indicates the patient is confused, then tag them as "immediate" because it is possible this patient has sustained a head injury, and is beyond the paramedics' ability to help in the field. This patient needs to be transported to the nearest facility.
- If the patient is not confused, but was unable to ambulate to the safe triage area, mark them as "delayed." This indicates that they are stable enough to withstand a delayed transport to a hospital. Quickly assess these patients for any major injuries such as severe bleeding or limb deformities.

Once you have established a routine of this quick triage, most paramedics can accurately assess patients in an average time of about thirty seconds. The most important rule of the START triage is for the paramedic to not give the care his or herself, but to enlist the help of the walking wounded to act on behalf of the paramedics' instruction. This allows the paramedic to be free to move from person to person at a quick pace. When giving instructions be sure to designate a specific person and that they respond to the commands you are giving. This way, you know that a specific person is taking responsibility for each individual patient.

By the time all patients have been initially triaged, the EMS team should re-evaluate those labeled

immediate and prescribe first aid. Then, enlist the help of the walking wounded to perform the same interventions (with in reason of course.) For example, a walking wounded usually can't start an intravenous line, but they can be quickly educated on how to hang more fluid or they can perform simple life saving interventions such as applying pressure to an open wound. Next, the paramedic should re-evaluate the patients marked "delayed" and begin to provide first aid. Sometimes these patients might be able to self treat if given instruction.

The final step of the START triage system is to assign one of the "walking wounded" to watch over the other walking wounded patients. Quickly educate them on what they might see from a patient if they were to start going into shock. This would include monitoring their respirations, skin texture (cold and clammy), or a sudden change in mental status. If a patient appears to be going into shock, have them sit down, and elevate their legs (to increase blood flow to the trunk area and prevent organ hypoxia.) If this change is seen, change the tag on the patient from "walking wounded" to "immediate."

Once the triage is initially completed all persons should be identified that need advanced medical care. In the field, this can become confusing because usually the evacuation process is going simultaneously to the triage process. However, patients ideally should be evacuated to the appropriate hospitals according to the severity of their individual injuries. The labeling system also helps the evacuation crew be certain that they are on track with evacuating the most seriously injured. The patients that were marked "deceased" should be left where they fell and covered if it is a gruesome sight and if EMS has the resources. Then, the patients marked "immediate" should be transported priority by MedEvac if available or at the very least by an ambulance equipped to provide advanced life support. Once all of the "immediate" patients have been appropriately evacuated, then EMS can begin transporting the patients labeled "delayed." The same is true of the patients marked "walking wounded." They are not transported until all others have been evacuated. These patients were minimally injured and are assumed to be able to remain stable for at least several hours post injury. They should however continue to be monitored through out their time on-scene⁵.

Transport

The transport process of an EMS call has to be well coordinated between EMS dispatch, the receiving unit, and the individual who called 911. The dispatch has considerations to make as soon as an ambulance is dispatched to a scene. Dispatch must assess the patient location, presumed status of possible injuries, pre-arrival instruction, and what resources to dispatch such as a basic life support unit or an advanced life support unit. From the very beginning of any 911 call, the transport is a large consideration. Once EMS is on scene, they must keep and open communication with both dispatch as well as the receiving hospital. The transport itself can be dangerous especially when driving lights and sirens to both the medical personnel and the bystanders on the way to the scene¹.

Most EMS calls are handled with ground units, but occasionally air transport is needed. If MedEvac is ever called to a scene, the paramedics should display extreme caution for both themselves as well as the patient. They should secure an adequate landing space for the helicopter and establish a safe place for themselves and the patient away from it. EMS should never approach a helicopter until the pilot signals that it is secure and everyone is out of danger.

Occasionally EMS will be called out to provide an inter-facility transport. These are usually once a patient has been treated and stabilized by one hospital and needs treatment from a different facility. For example, a trauma patient may have received care for internal injuries, but then will get transferred to a rehab facility for limb fractures or a head injury. The federal law states that a patient can only be transferred when the act of the transfer is expected to have a positive effect on the overall outcome for the patient.

In general, patients should be transported to the closest most appropriate facility that is equipped to handle their injuries. Receiving hospitals are required to offer the capabilities to treat patients, stabilize their conditions, and be able to contribute to a positive outcome². Patients that are

mentally stable have the right to refuse transport as well as dictate where they are taken for treatment. EMS should honor this as long as medical control gives permission and the request is within the realm of point-of-entry protocols.

Specialized facilities should be designated within every protocol to take patients with special considerations. For example, the victim of a major trauma, that is unresponsive and apneic will not receive optimal care in a small town hospital with dated equipment. In this instance, this patient needs a trauma center and the protocol should have a designated facility for these patients⁴. This protocol allows the EMS unit to bypass local hospitals for the best possible care for patients. This is a common act with severe trauma, and burn patients.

Protocols

Protocols are developed to deal with operational, administrative, and patient care issues. They define a standardized, acceptable approach to commonly encountered problems. Protocols should reflect regional and national standards, as well as the uniqueness and limitations of the local environment in a clear and precise manner. The medical director has the responsibility to address protocols dealing with patient care, such as triage and treatment, and should be readily available to help the field workers handle any crisis or question.

Treatment protocols describe the authority and responsibility of providers and offer guidance for medical evaluation and care². Optimal care and medical accountability require standardized protocols, algorithms, and standing orders that outline specific actions providers can take without contacting a physician for orders. Any deviation from these standing orders must be considered a breach of duty and must result in an audit. On-line medical direction is crucial in systems requiring decision making to provide guidance and assume some of the patient-care responsibilities. An example of this would be a patient refusing transport or treatment³.

Consent

When transferring any patient from the field to the appropriate facility, EMS must receive some sort of consent. If the patient themselves is not able to give their own consent, such as an under aged child, then consent must be given from their legal guardian. Consent must be obtained before treatment and transport. Every patient has a right to both refuse treatment and consent to treatment as long as they are competent and of sound mind.

Every patient has the right to consent to what treatment, if any they desire. They are able to decide if they want to be transported to a hospital, which hospital they want, what treatment you are allowed to administer, and if you are even allowed to touch them at all. The patient can consent to certain interventions and refuse others. For example, a patient may want oxygen but refuse to let the paramedic start an I.V. or hook up the EKG monitor. They may wish to be transported to a hospital facility, but not want any treatment in route. Also, any given patient has the right to refuse treatment of any kind and then change their mind and want treatment, or vice-versa, they may consent for a procedure and then withdraw their consent.

How does a patient usually consent? In most cases, the patient is able to give consent on their own behalf by volunteering to treatment. Even if consent is easily obtained, the patient should still be informed in detail, in a language they understand, about what is happening and why they are receiving the treatment that they are receiving. There are three types of consent:

- Implied consent-This is used most commonly in patients that are unconscious. The paramedic is legally able to assume that if the patient were conscious, they would want help with their medical problem. The law states that rational patients would consent to treatment if they were conscious.
- Expressed Consent- This is when the patient makes a decision for medical care on behalf of his or her own well being. This must be obtained from a competent, reasonable, stable, adult that is exhibiting rational behavior.
- Consent for mentally incompetent adults and minor children-Mentally incompetent adults and children are not legally able to consent to their own treatment as well as refuse treatment. This population of patients must be consented for treatment by their parent or legal guardian.

EMS cannot provide treatment unless it is a life-threatening situation or illness without permission. However, the law states that if this is a life-threatening circumstance and the guardian is not present, care may be administered based on implied consent⁶.

Refusal of Treatment

Many times, despite the best effort of the EMS team, a patient that is in obvious need of medical treatment can refuse. This can be due to a variety of reasons ranging anywhere from denial to financial concerns. Patient refusal of care is a major source of lawsuits against EMS. Therefore, the paramedic must document every aspect of the refusal to show that the very best efforts were made to convince the patient to seek medical care. If the paramedic suspects that a patient is possibly going to refuse care, he or she should make sure that there are mentally competent witnesses from the beginning of the refusal to the signing of the refusal form at the very end of the case⁵. On-line medical direction should be obtained for all calls that result in no transport. This includes cases in which providers decide not to transport, the patient refuses care, or the patient is triaged to a lower level of care. Otherwise, the provider may be perceived as practicing medicine without a license and could be charged with such an offense.

A patient can refuse medical treatment from EMS by verbally telling you "no," by shaking their head no, or by withdrawing their hand from you when you try to treat them. In many instances, the paramedic may gain consent, only to have the patient change their mind the next minute. The patient is allowed to do this⁶.

If a patient is adamantly refusing care, and it is obvious you are not going to be able to change their mind, the patient must meet the qualifications to successfully refuse transport¹. First of all the patient must be a mentally competent adult, he or she cannot be altered by any sort of physical ailment that could ultimately affect their judgment such as a head injury or a chronic condition such as Alzheimer's. Second, the patient must be fully informed about what treatment is needed and the possible consequences to not receiving the appropriate medical help. Third, the patient should sign a "release" form in which they are essentially signing that they have been explained all of the risks of denying treatment and that they are in fact still refusing. Depending on the department, some medical controls want to be contacted for refusal of treatment. In many instances medical control can help persuade the patient especially if a doctor speaks directly to the patient in question. Use all of your resources especially if you feel it is a potentially critical condition. Be sure that you document vitals according to protocol in this situation, because you want to know if their may be an unknown injury affecting the patients judgment or mental status. Usually protocol will state to reassess vitals and Glasgow/AVPU every 5-10 minutes².

Before finalizing the refusal reassess the patient for any obvious medical or physical conditions that could limit their rationale. Ask yourself:

- Does the patient have a known psychiatric or behavioral disorder?
- Has their behavior changed since the original assessment began?
- Is the patient a present danger to themselves or others around them?
- Is there currently abuse of drugs or alcohol?
- Does the patient have a history of Alzheimer's?
- Does the patient thoroughly understand the risk of refusing treatment?
- Is there any evidence of patient abuse?

Once you have exhausted all of your abilities to provide treatment advise the patient one final time of his or her rights to treatment, what you believe their medical problem needs, and how your propose to treat it and why it is absolutely necessary. Ask the patients if they understand what you are saying and ask them to repeat it back to you. Once you are convinced the patient understands, have them sign the refusal. You should also have objective witnesses to sign the refusal of treatment as well. For your own safety, you should get the witness' contact phone numbers and addresses incase there is a problem with this patient or the patients family in the future. Don't be short or pushy with the patient, sometimes they will change their mind in the last minute especially

if the EMS crew has gained trust with the patient and or their family³.

Documentation of the patient refusal situation is crucial to avoid a future issue with the patient and or family such as a lawsuit³. You should accurately document the patients name, age, chief complaint, level of consciousness (every 5-10 minutes throughout entirety of call), a specific description of the patients behavior, the mechanism of injury, and all of the circumstances related to the call as well as who actually called EMS out and why? If the patient refuses all exams including vitals, then chart what you can observe about the patients condition as well as the care you would like to provide⁶.

Thoroughly document your efforts to gain consent and write down exactly what it is you said to the patient to try to help them understand why they needed to receive medical treatment. Also, write down exactly what the patients' response was to all of your efforts. Use phrases like "patient states," and "Per patient." Then have the patient sign to their comments on the refusal form. Document that you have exhausted all of your resources and that the patient is still refusing treatment despite extreme efforts such as calling medical control, or offering transport via a private car⁴. Make sure that the person documenting and providing the medical advice is someone who is EMS trained, as this is the person evaluating the mental capacity and ability to withdraw consent for medical treatment. For example, if the paramedic arrives on scene and a police officer or firefighter (without an EMT-P certificate) says that the patient is of sound mind, but refusing care by all emergency workers, so go ahead and fill out a refusal paper, the paramedic would be jeopardizing his own license as well as the patients life. The paramedics should always do their own thorough examination and go through the refusal process themselves².

What if the patient refuses to sign?

In some instances EMS will go through all of the possible options available to educate a patient on why they shouldn't refuse care, and the patient states that they understand but still refuses not only medical care, but also to sign a refusal. This poses a huge threat to the paramedics on the call. The best option is to obtain police assistance for witnessing, and document thoroughly using the patients' own words. Make sure that the witness sign not only to the fact that the patient refused medical care, but also that the patient refused to sign the refusal form¹.

Incompetent Patients and Consent

In many situations a patient may appear to be competent or swear that they are competent when in fact they are not legally allowed to refuse medical treatment and or transport. Some of these situations could be the result of a trauma. For example, a patient that is suffering from altered mental status, unconsciousness, or experiencing shock. In other instances, the patient may be showing signs of altered mental status from alcohol or drug use, severe depression and or anxiety, a diabetic crisis, or mental retardation⁶. Whatever the cause, the consent then becomes implied. The paramedic should never withhold medical care that is a life saving intervention while waiting to obtain consent. It is safe to assume, that if the patient were of sound mind that they would consent themselves for the necessary treatment and that their legal guardian would do the same if they were present.

If the patient appears to be severely emotionally disturbed such as a suicidal patient, or a patient showing erratic behavior EMS should call the police department to assist in controlling the patient and protecting all of the EMS workers on the scene as well as bystanders. In this situation you must document why it is reasonable to believe that the patient is in clear and imminent danger unless EMS and the local police department are able to treat the patient, thus justifying implied consent¹.

Restraining Patients for Transport:

If EMS is on a scene that a patient is refusing to consent to treatment and the patient is behaving erratically, the use of restraints may be indicated within the guidelines of the local protocol⁶. Depending on individual protocol, many instances the police are required to be present when restraints are used. Restraints should only be used if there is a real threat of personal harm to both the patient and the EMS crew and any other bystanders that EMS is unable to retreat to safety. Any

time that restraints are used it should be maintained with the least amount of discomfort to the patient². However, depending on how combative the patient is being restrained may still be uncomfortable despite the best efforts of EMS.

Once restraints have been successfully applied, keep the patient in the most appropriate position. Consider all circulation issues, as well as any airway compromise. Continue an on-going assessment including a full set of vitals at least every five minutes and maintain open communication with medical control. Make sure that the reason the patient is restrained is well documented as well as all treatment and attempts to help the patient before the decision to use restraints was final as well as who authorized the decision to use them⁴. If ever a patient is harmed or feels neglected due to the use of restraints or lack of proper use, the patient or patients' family may have grounds for legal action.

Patients that are threatening to attempt suicide and refusing to let you help them, EMS should immediately call for police back up. These patients' should basically be handled to same as emotionally disturbed, however in many instances suicidal patients may be mentally competent, thus gaining consent for transport can sometimes be a difficult task. Like mentally incompetent patients, consent is not needed if the patient does not seem to have the mental capacity to provide a valid consent to deny treatment¹. If the patient is a danger to themselves or others, then reasonable force may be necessary to restrain, treat, and eventually transport. This should only be handled in conjunction with the local police department with adequate personnel to handle any complications.

What about persons in police custody?

If EMS is dispatched to patient in police custody such as a jail or a scene of police action, the police department has the authority for all consent. The persons in police custody are never able to refuse treatment or transport³. However, police will not take a mentally competent adult that has not done anything wrong and that is not a threat to themselves or the bystanders into any sort of custody simply for the purpose of obtaining a forced consent.

What about refusals in suspected child abuse?

In EMS calls involving small children, they are never allowed to provide consent for themselves if they are under the age of 18. In most cases, parents want what is best for their child thus gaining consent is not usually a big deal. However, in some instances you may be dispatched for possible child abuse or informed by a neighbor or family member that the child is suffering from abuse. If this is the case and the parents are refusing medical treatment for their child, contact the local police department for assistance. Do not try to forcibly remove the child from the parents' custody. If the child appears to be in serious need of medical assistance and the parents continue to refuse, then standby with all possible equipment that you think you may need to administer aide so that the child can receive treatment and transport as soon as possible when the police can legally provide the consent for the minor child⁴.

When dealing with consent or a lack of consent, there is only so much on scene that EMS can do. Be sure to accurately document and ask yourself this series of question to make sure nothing has been missed:

- Was every attempt made to evaluate this situations and assess the patient for head injuries or any sign of altered mental status?
- How do you know that the patient is alert and oriented and truly understands the risks and consequences of refusing treatment and transport?
- What efforts did the EMS crew make to persuade the patient to go to the hospital?
- Did you notify and include medical control?
- Did you document accurately?
- Did you use all possible resources?

If you are ever in doubt when dealing with a difficult patient or a patient that is adamantly refusing treatment and transfer, and certainly if you are questioning a patients competency; always contact

medical control to help you make the appropriate decisions. Medical control can sometimes successfully help you to persuade a patient to accept care.

Conclusion

The key to a successful run on any EMS unit is organization. Transportation and triage protocols are designed for just this reason. They help ensure that the paramedics are able to provide the absolute best care possible in a variety of situations. With written protocols as well as immediate on line medical control, the triage and transportation of any given patient is a well thought out and supported process.

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