

# An analysis of the validity of medical legal documentation in cases where the patient refuses treatment and/or transport

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**Objectives.** We investigated whether patient record forms (PRFs), as currently completed, meet minimum legal standards and provide medicolegal protection to prehospital healthcare providers, and if their qualification levels influence the level of detail recorded in the patient records. **Methods.** We retrospectively reviewed consecutive case reports at a single centre over a 1-month period for cases in which ambulance crews attended a patient and the patient later refused to accept transportation to a medical facility. Scores were calculated for each case report, based on the number of data fields completed. The scores were compared for variation between qualifications. **Results.** A total of 5873 ambulance cases were dispatched during this period. Case reports for refusal of transport ( $n=229$ ) were reviewed. No case report achieved 100% compliance with legal requirements. There was no statistically significant variation between levels of qualification with regard to improved detail being recorded. Young adults were the most likely to refuse transport. Most of the refusals occurred in the late evening. **Conclusion.** Refusal of transport and its documentation are poorly understood and practised by prehospital healthcare providers. The implication is that some patients' rights could potentially be infringed. This could lead to possible grounds for litigation, for which the defence would also hinge on the adequacy of the documentation.

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Refusal of transport has many ethical and legal considerations. The refusal of the transport process comprises several steps which must all be properly completed to comply with ethical and legal standards. Such documentation provides the only lasting proof of which components have been conducted correctly. Correct and detailed documentation of the refusal process can afford protection to ambulance practitioners and service providers against litigation. It can also support valid patients' claims should their rights have been violated.<sup>[1]</sup>

Many services have formalised documents and protocols to aid the navigation of this ethical and legal minefield.<sup>[2]</sup> Their guidance could help healthcare providers (HCPs) adhere to the correct process and thus limit their exposure to legal liability, and also possibly limit infractions of the patient's rights. Patients are afforded the right to be informed of their condition, participate in decision-making, have access to health services, and refuse treatment or transportation if they wish to do so.<sup>[3]</sup> These rights are involved when an ambulance is on-scene with a patient and the patient decides to forego any or all treatment and/or transportation (hereafter inclusively referred to as refusal or refusal of transport).

## Objectives

We investigated whether the current manner in which patient record forms (PRFs) are completed meets minimum legal standards and provides medicolegal protection to prehospital HCPs. We also aimed to determine whether the HCPs level of qualification influences the level of detail recorded in the patient records.

## Methods

This was a retrospective, observational review of consecutive patient care report forms completed by a single urban emergency medical services (EMS) provider for all cases involving refusal of transport by patients over a period of 1 month. Documentation was required to be completed to represent current best practice by the HCPs. Had the HCPs involved in the study been informed that an audit of the PRFs was going to take place, this could have affected the detail with which they completed their documentation, a phenomenon known as the Hawthorne effect. Informed consent for participation was therefore only sought from the EMS service provider, and not the individual practitioners. Research ethics was approved by the Cape Peninsula University of Technology Department of Emergency Medical Sciences Research Ethics Committee (BTech 08/2013).

The research was conducted at an urban ambulance station in the Western Cape Province, South Africa (SA), that serves a population of approximately 1.4 million. The station's efficiency reports indicate an average call rate of approximately 5 000 cases per month.

PRFs in which the patient had refused transport were retrieved daily when possible. At the end of the data-collection period, we compared the station's case statistics to determine if all the case reports for refusal had been accounted for during the continuous retrieval process. Missing case reports were obtained from the service provider's data archives department. All PRFs in which EMS personnel attended a patient who refused transport were included. The following were excluded: when patient transport occurred, when handwriting was illegible, and cases in which patients refused transport between two medical facilities.

Criteria for assessing the case reports were grouped according to four categories, namely: dispatch information, demographic information, medical information, and legal information. All the

required fields ( $n=36$ , scoring 0 = absent, 1 = present) were evaluated and entered into a table created in Microsoft Excel, version 2010. Age and gender were the only patient details recorded for analysis. Other patient details were only assessed and recorded for analysis as being either present or absent in the documentation. Confidentiality of the practitioners attending the case was also ensured, as their names were not recorded for analysis. The practitioner qualification was recorded either as basic life support (BLS), intermediate life support (ILS) or advanced life support (ALS).

ALS includes the Emergency Care Technician (ECT), the Critical Care Assistant (CCA), the National Diploma: Emergency Medical Care (ND EMC), and the BTEch: Emergency Medical Care (B EMC) qualifications. ILS refers to the Ambulance Emergency Assistant qualification (AEA), and BLS refers to the Basic Ambulance Assistant (BAA) qualification.

## Results

Ambulances based at the EMS station were dispatched on 5 873 cases during the month of September 2013, of which 3 043 cases were related to primary responses (Fig. 1). This service classifies cases into 35 general case types. Other trauma and other medical categories are used if the patient does not fit into these specific categories. Unspecified medical conditions accounted for most ( $n=138$ ) of the refusal of transport cases (Table 1). Peak call volumes, calculated by ambulance arrival on the scene, were achieved between 10h00 and 16h00 with a call volume of more than 300 cases per hour (distributed over the study period), with a second peak, with similar volumes, between 19h00 and 21h00. During the day-shift hours of 07h00 - 19h00, 3 506 cases (including 96 refusal cases) were attended, while the night shift attended 2 367 (including 133 refusal cases) (Fig. 2).

### Demographic characteristics of patients who refused transport

The gender of patients who refused transport was evenly distributed (93 males and 94 females). Gender was not recorded in 42 of the PRFs examined.

Ages were not recorded for 89 of the 229 patients; 73 (32%) were in the 18 – 39-year-old group; 20 were minors, of whom 16 were

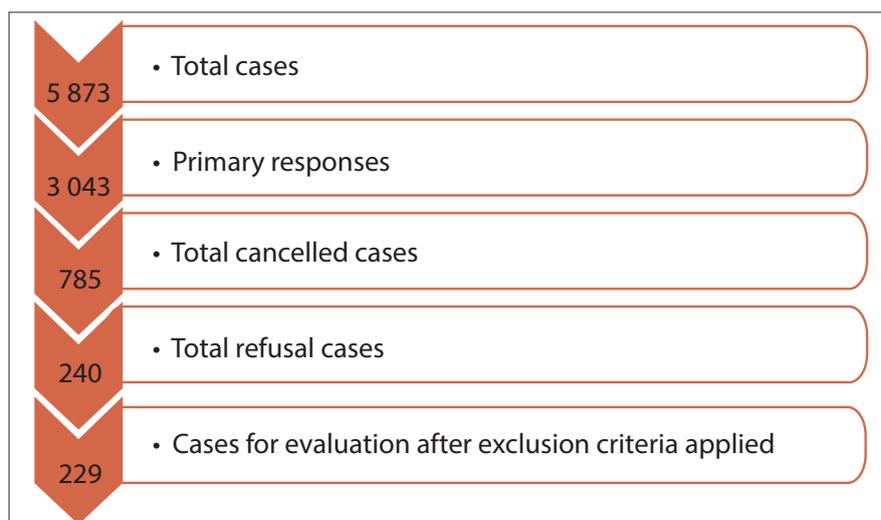


Fig. 1. Study sample selection diagram.

Table 1. Distribution of refusal cases according to call type

Case type	Refusals, $n$	% of all refusals
Other medical	138	60.3
Assault	37	16.2
MVA	16	7.0
Asthma	16	7.0
Other trauma	9	3.9
Diabetes	4	1.7
Overdose	3	1.3
Bites and stings	2	0.9
Burns	1	0.4
CVA/stroke	1	0.4
Ischaemic cardiac event	1	0.4
Accidental poisoning	1	0.4

MVA = motor vehicle accident; CVA = cerebrovascular accident

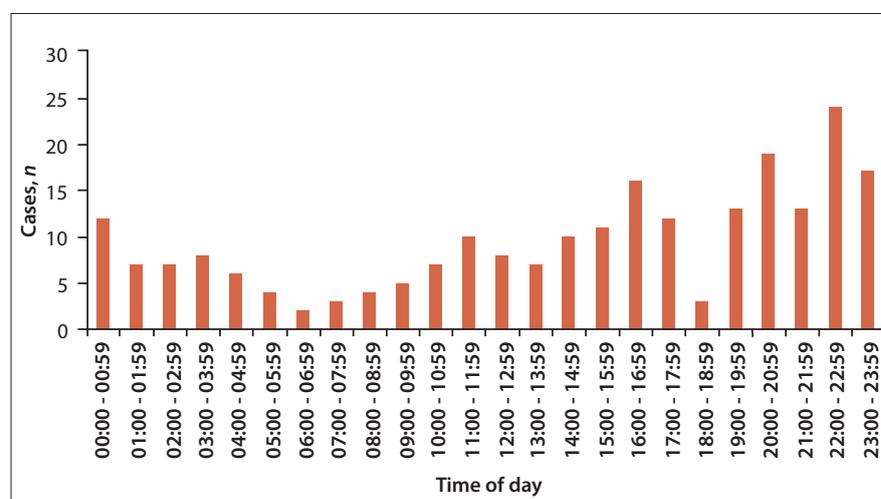


Fig. 2. Distribution of refusal cases according to time of day.

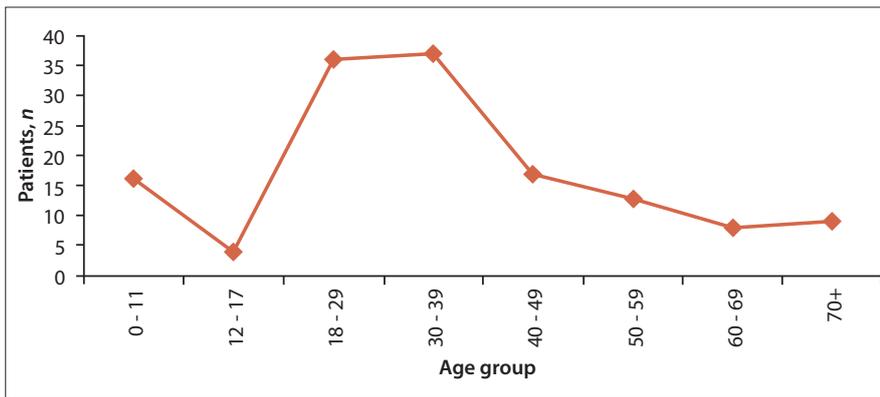


Fig. 3. Distribution of refusal cases according to age group.

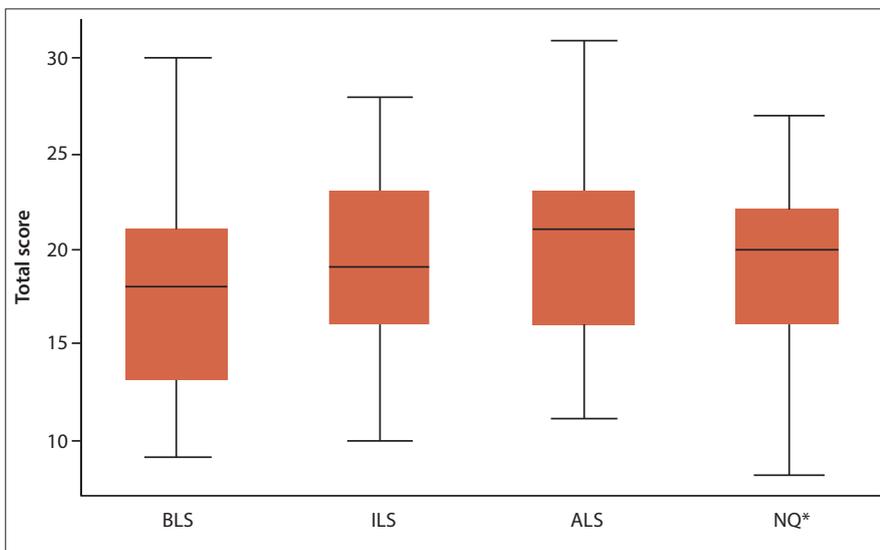


Fig. 4. Comparison of total scores achieved between qualification levels (BLS = basic life support; ILS = intermediate life support; ALS = advanced life support; NQ = no qualification).

below the age of consent (12 years); and nine patients were >70 years old, the oldest being 98 (Fig. 3).

**Dispatch information.** Criteria related to dispatch information were normally well documented, with 163 (71%) of the 229 cases of the required dispatch-related data fields being completed. The crew qualification section was most often found incomplete, with 24% of the PRFs not containing the qualification details of either of the crew members.

**Demographic information.** This information is required to identify and/or contact the patient or the next of kin. Only 12 PRFs contained sufficient information to achieve 100% compliance in all data fields. The patient's name was recorded in only 89% of the PRFs ( $n=204$ ). A name for the next of kin/witness was documented in only 39% of the PRFs ( $n=89$ ). The age of the patient was recorded in only 61% ( $n=140$ )

of the cases, although a date of birth or ID number was recorded more frequently ( $n=156$ ), and therefore the age could have been calculated.

**Medical information.** A chief complaint was documented in only 162 (71%) of the PRFs; however, only 117 PRFs contained any current history relating to the chief complaint. Vital signs were recorded in 147 (64%). A differential diagnosis was only recorded in six (3%) cases, and this impacted on three PRFs (1.3%), which met all medical criteria.

**Legal information.** No PRF met all of the legal criteria. The patient signature in 165 (72%) was the only data field that was regularly completed.

The cases were grouped according to the crew member in attendance with the highest qualification, BLS ( $n=30$ ), ILS ( $n=98$ ), and ALS ( $n=47$ ); 54 cases had no qualification recorded.

Comparing the average scores achieved for the document as a whole showed a small, but non-statistically significant ( $p=0.1356$ ) change in the median scores in favour of the higher qualifications (Fig. 4). Performance in the legal criteria was unanimously poor, with the most frequent score achieved being 1/9 for all of the qualification groups.

## Discussion

A common saying regarding patient records is: 'If it was not documented, it was not done.' We found that many of the recommended and required steps during the refusal of transport process were omitted. The Constitution of the Republic of South Africa<sup>[4]</sup> affords the right to emergency medical treatment to all patients. It is therefore illegal to place the patient under duress to accept treatment or transportation.<sup>[5]</sup> The decision should be made voluntarily by the patients or the person responsible for their care, should they be incapable of making the decision.<sup>[6]</sup>

Of major concern is the number of cases ( $n=25$ ) in which the patient's name was not recorded. Some may be explained by patients being unco-operative or unknown. However, only six record such a situation and the HCP should have attempted to find a witness to corroborate that an unco-operative patient had refused transport.

'Who refused transport and with whom were the discussions held for the refusal to be considered informed?' are two questions linked to the absence of patient names. An absent patient name on a case report could be viewed as evidence that disclosure of relevant details did not occur. Any person involved with the incident could later claim that they suffered adverse medical consequences owing to the HCP not providing the disclosure and possibly claim that they were abandoned at the scene. The PRF would probably not provide sufficient legal protection without a patient name recorded.

The other major concern is the lack of medical evaluation of patients. HCPs in the prehospital environment lack access to many diagnostic tools and rely on history taking and physical examination to make the diagnosis. Without a full examination it is not possible to know what is wrong with a patient. Lack of diagnostic information results in a lack of information relating to the risks of refusing transport and the available treatments that could be offered at the

**Table 2. Recommended elements for inclusion in refusal of transport documentation**

The decision to refuse transport was made voluntarily by the patient.
The patient was deemed to have sufficient mental capacity to make an informed decision.
The patient was informed of his/her current condition.
The patient was informed of the possible risks of refusing further care and the benefits of accepting the proffered medical assistance.
The patient was advised that the current refusal of transport does not waive the patient's right to contact or receive future medical management.
The patient was able to understand all the information provided and the patient was able to relay back to the healthcare provider (in his/her own words) what was discussed.
The patient and a witness (preferably a family member of the patient) should sign the completed document.

hospital.<sup>[1]</sup> Failure to obtain the information required to make a diagnosis for HCPs to fully understand the risks of the patient's condition(s) limits their ability to provide full disclosure, which could invalidate the refusal of transport process.<sup>[1]</sup>

Should the patient not wish to submit to an examination, or the knowledge of the crew be insufficient to determine the diagnosis, the limitations of the examination and the conclusions that could be drawn should be explained to the patient and properly documented.<sup>[7]</sup>

PRFs that contain evidence of all the recommended procedural elements (Table 2) for the refusal of transport process should provide the best chance of defence against claims of misconduct by a patient. Of the PRFs, 97% contained three or fewer of the nine possible criteria that were evaluated. The service provider and the HCPs who were on the scene could be held liable if any such cases result in a claim of misconduct resulting from possible related adverse events. Insufficient evidence was recorded to show that the correct procedure was followed in allowing the patient to make an informed decision.

The PRF assessment method did not allow for a detailed analysis of the ability of the patient to understand the discussion and thereby make an informed decision. This could be the focus of future qualitative studies in which the patient is interviewed.

The high incidence of refusal of transport in cases of assault and motor vehicle accidents (MVAs) could be explained by the patients feeling that their injuries did not warrant transport and evaluation by an emergency department doctor. A study of the incidence of refusal of transport among head-injured patients found that

young adult male patients were more likely to refuse transport.<sup>[8]</sup> Patients might underestimate their current condition owing to their situational physiological and psychological stress.

To counter this situation, the assessment by the emergency care practitioner should be sufficiently detailed to ensure that possible delayed adverse events can be predicted or that consequences are minimal or excluded. Follow-up instructions should be provided to the patient regarding warning signs and symptoms of deterioration for possible emergent conditions, and instructions on how and when to access further medical care.<sup>[9]</sup> This study revealed that the highest percentage of refusals occurred during the night. Considering the socioeconomic status of the population for whom the EMS station caters, this finding could be related to the lack of public transport to return home. Despite hospital evaluation and management being completed within a reasonable period, the patient may still be unable to obtain transport home after discharge until the next morning. Possibly confounding and exacerbating this situation might be the impact of the cold and rainy conditions during the study period.

Society may also utilise EMS response as a 'safety net' as it is available at all times.<sup>[10]</sup> Refusal of medical transport might be related to the cost of transport,<sup>[11]</sup> although in SA costs are usually waived for indigent patients. Another possibility could be that patients use the ambulance service for a free mobile medical consultation while not considering acceptance of transport as a possibility.

The stratification phase of the analysis shows no major variation in the quality of PRF completion. This indicates that despite improved medical knowledge, there seems

to be no significant improvement in the knowledge and application of medical law and ethics pertaining to prehospital medicine. Studies showed that improved knowledge of the HCP could decrease the number of refusal cases<sup>[12,13]</sup> and were based on a system using consultation with physician-manned, on-line medical command. A confounding factor to consider is that this study assigned the PRF to the qualification level based on the highest-qualified member of crew on the vehicle. The HCPs with the highest qualification might not necessarily have completed the documentation process, although they would still ultimately be responsible for its quality.

### Study limitations

To ensure that the patient's right to an informed refusal of transport has not been violated, the documentation does not necessarily reflect that the patient understood the discussion. In SA, with 11 official languages, the language barrier that might exist between the patient and the healthcare provider could often lead to information relayed by the practitioner not being understood by the patient. This would therefore still infringe the patient's right to informed decision making. The present study did not assess the use of an interpreter. Service providers each have variations of PCRf documentation that may require other levels of detail and include specific refusal-of-transport sections for added guidance to the HCP at the scene. Therefore the results of this study cannot be generalised to the overall population of HCPs within all EMS services.

### Conclusion

We found that the refusal of transport process and its documentation are poorly understood and practised by prehospital HCPs. The implication is that some patients' rights might potentially be infringed, which could lead to possible grounds for litigation, for which the defence would also hinge on the adequacy of the documentation.

The implementation of a standardised refusal-of-transport document and additional training in medical law and ethics is advisable to correct the current practices and to limit future risks to the patient and the HCP and/or service provider.

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