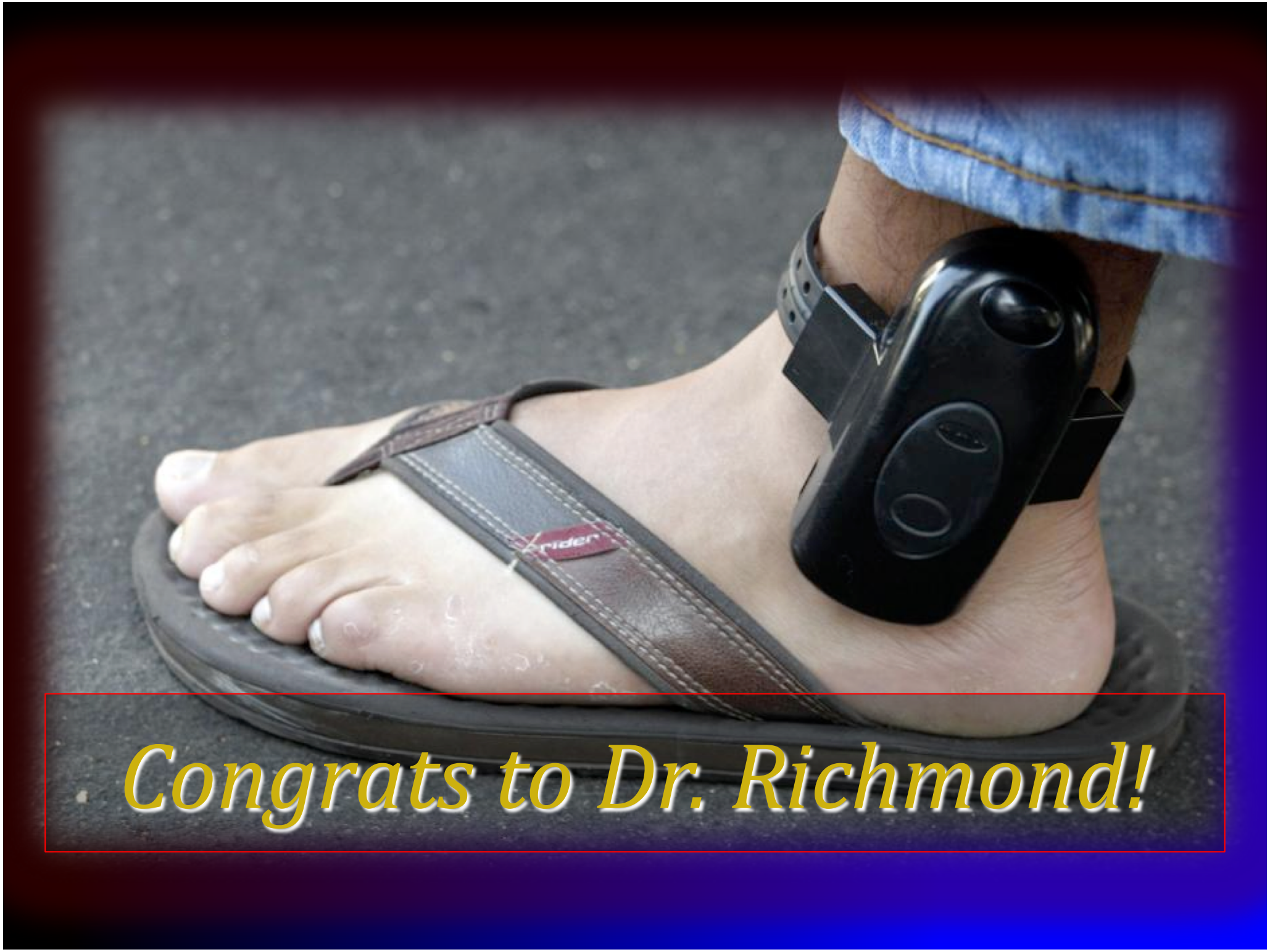
The Determination of Capacity

It CAN'T be DONE!!

Raymond L. Fowler, MD, FACEP, FAEMS
Professor and Chief , Division of Emergency Medical Services
UT Southwestern Medical Center and
Parkland Memorial Hospital

www.rayfowler.com

www.gatheringofeagles.us


Congrats to Dr. Richmond!


破壊
Neal.....GET READY!!!!


They call us
for help

How can you tell if they "understand"?

Texas statute:
The ability to communicate
= capacity

For Example:
You have a pt. on K2 who is screaming that helicopters are eating their young…

That person is "communicating", but not demonstrating capacity

To Demonstrate capacity:

Alert
"Oriented"
Can explain the risks of refusal


M&P15

To Give a Practical Example

Let's use my opponent's check list

AMA Questions

Question	Answer	Not
Is the patient (or guardian) oriented to person, place, time and event?	Yes	
Was the patient (or guardian) able to understand the risks and benefits of available options?	Yes	
Was the patient (or guardian) able to communicate their Choices to you?	Yes	
Does the patient (or guardian) have the capacity to refuse care?	Yes	
Has the patient (or guardian) been advised that 911 can be re-accessed?	Yes	
What risks were described to the patient? (minimum of 3)	seizure coma death	
In the patient's own words, quote the risks and benefits they were able to describe back to you.	these trips might kill me	
List specific items refused (if any).		

Why is medic capacity determination unreliable?

EDUC/TRNG

Evaluating Patients' Decision-Making Capacity

By Thom Dunn, NRP, PhD May 11, 2015

Print Version

1. *Level of consciousness*. Is the patient aware of his surroundings?
2. *Attention*. Is the patient able to focus or concentrate on one task at a time, or is he easily distracted?
3. *Memory*. Can the patient record data in the brain and repeat it at will? Thorough assessment of memory includes short-term memory, such as the ability to repeat a sequence of objects several minutes after they are first introduced, and long-term memory, such as the names and birthdates of family members or being able to repeat the alphabet.
4. *Cognitive ability*. Can the patient process abstract thoughts coherently, such as explaining, "Why can't pigs fly?" or problem solving word problems, such as "Subtract 7 from 100 as many times as you can," or "Spell the word world backward?"
5. *Affect and mood*. Affect is an objective assessment of the patient's demeanor and reaction to stimuli, while mood is more subjective assessment of the patient's emotional state. Are both appropriate for the patient's current situation?
6. *Probable cause of the present condition*. What is the underlying pathophysiology causing the patient's present state? One commonly used mnemonic is AEIOUTIPS:

1. *Level of consciousness.*
2. *Attention.*
3. *Memory.*
4. *Cognitive ability.*
5. *Affect and mood.*
6. *Probable cause of the present condition.*

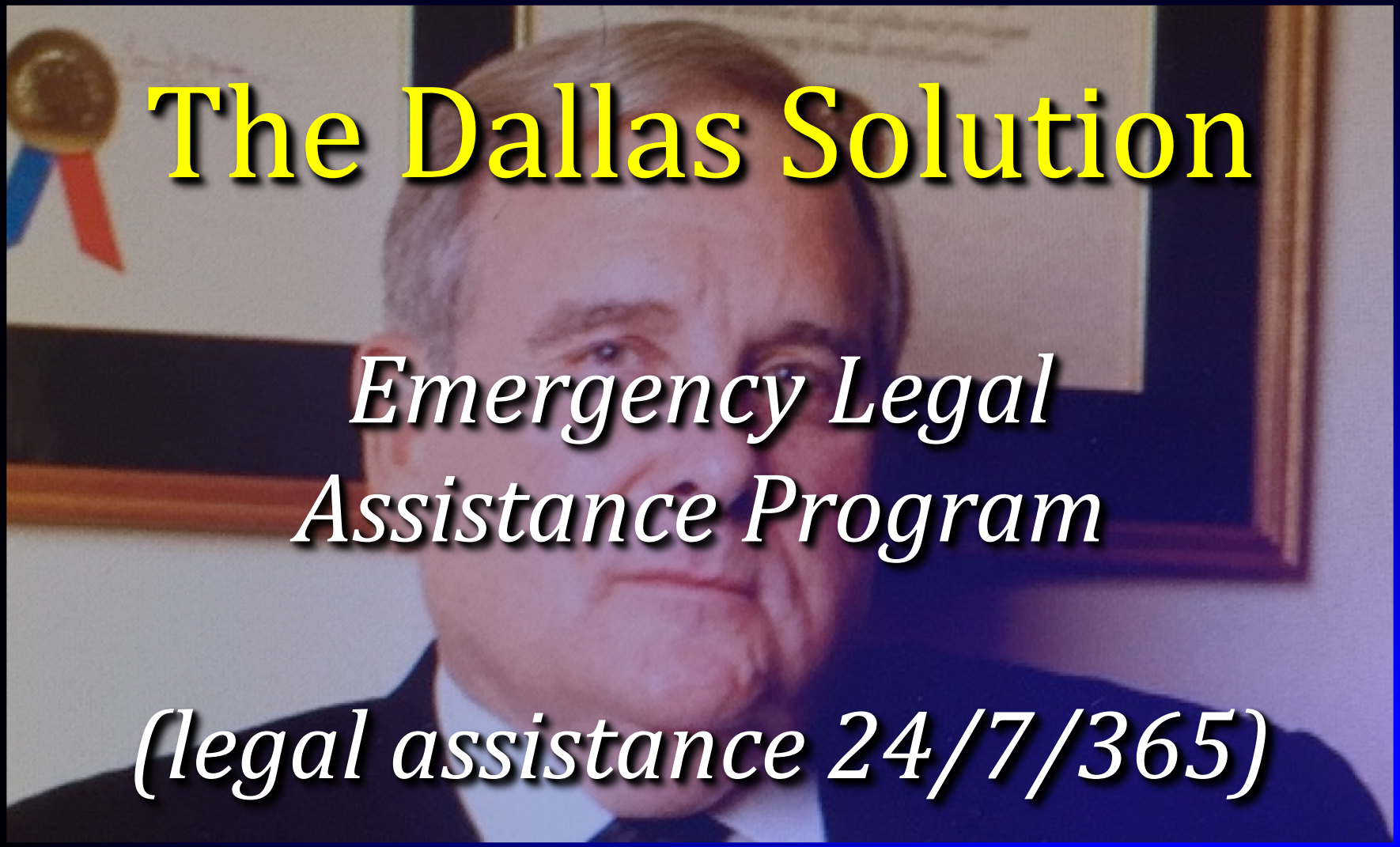
Why can't/don't medics determine capacity sometimes?

- Lack of training

- Overload in the system

- Compassion fatigue

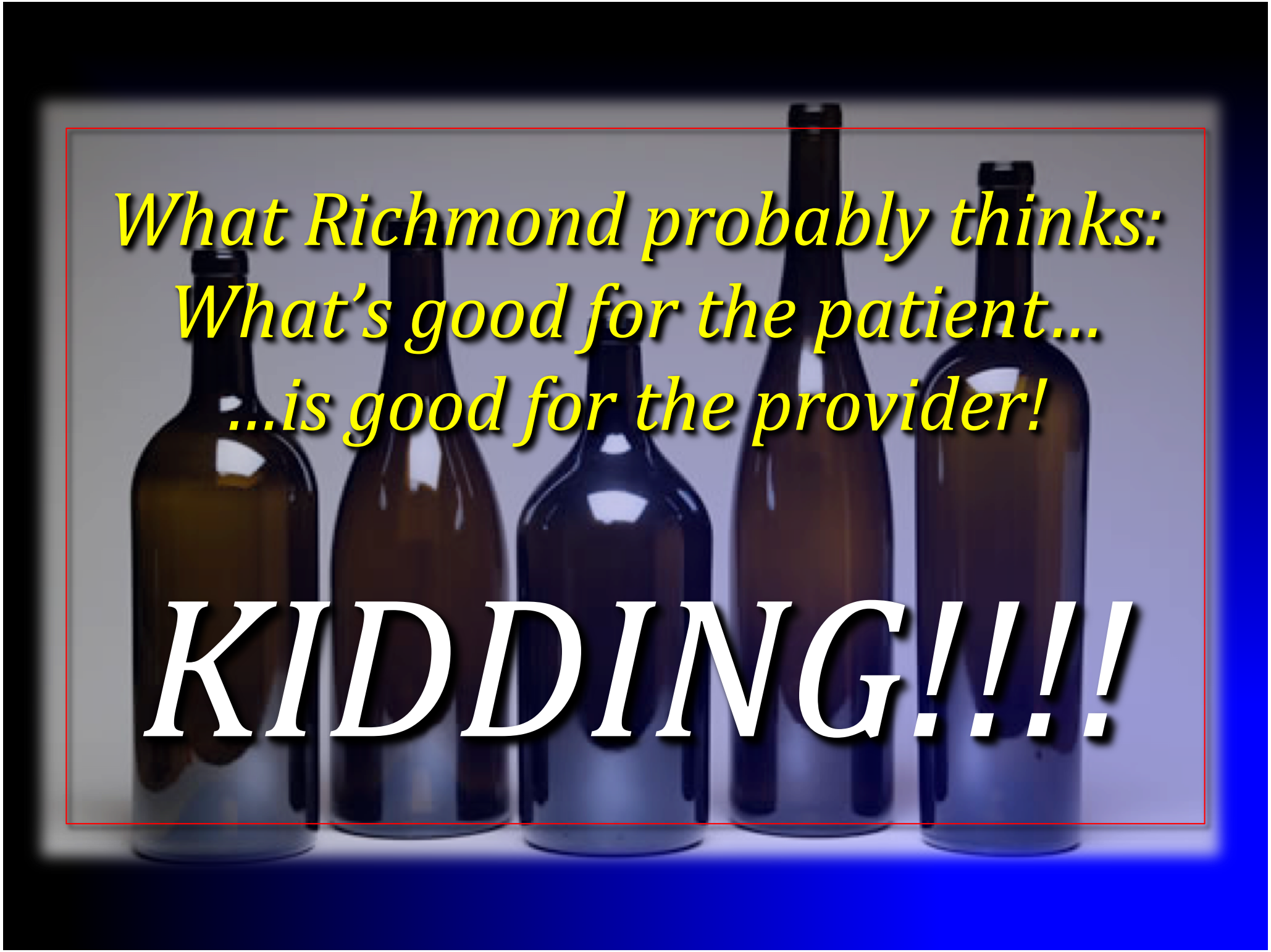
- "Burnout"



The Dallas Solution

Emergency Legal Assistance Program

(legal assistance 24/7/365)


What Richmond probably thinks:
What's good for the patient...
...is good for the provider!
KIDDING!!!!


DEFIBRILLATOR


ZOLL
NARCAN
ADVISED
AED

"Lassiez le

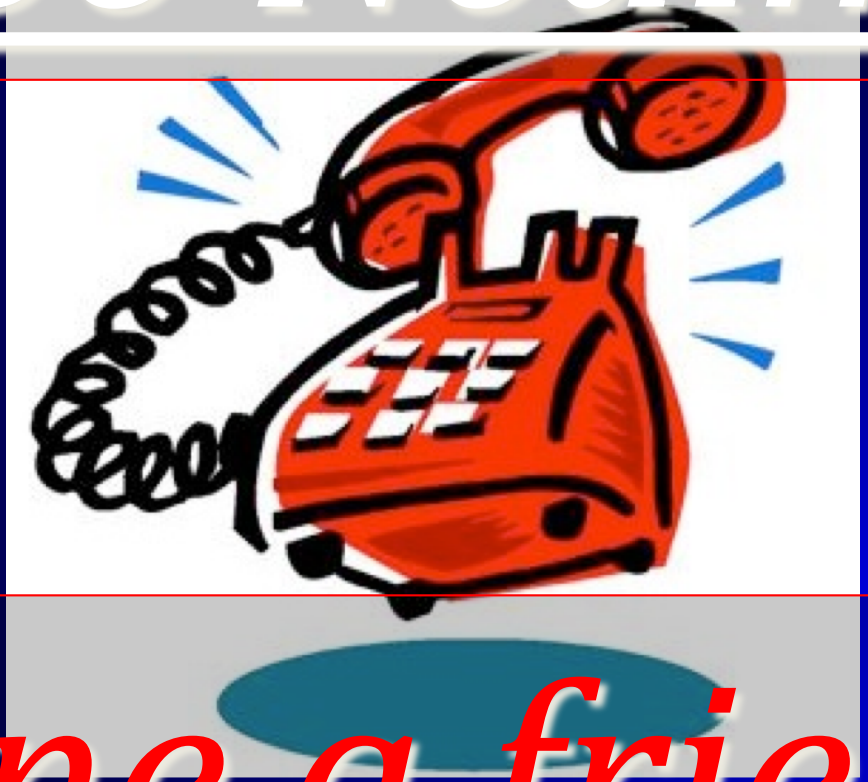
no loads rouler!!"


PLANET HYPE
Don't believe
the hype!

Purging at Last

Neal, here is a hope
for your recovery…

So Neal!!



Phone a friend!!


MEDSTAR
601
Critical Care Transport
MEDSTAR
MEDSTAR
601
MEDSTAR
MEDSTAR
TEXAS
108-0998

or


Thank
you so much!

When your patient has no decisional capacity?

Sometimes you just got to do the right thing

Neal J. Richmond, M.D., FACEP

None of this

Ray Fowler ‘BS’

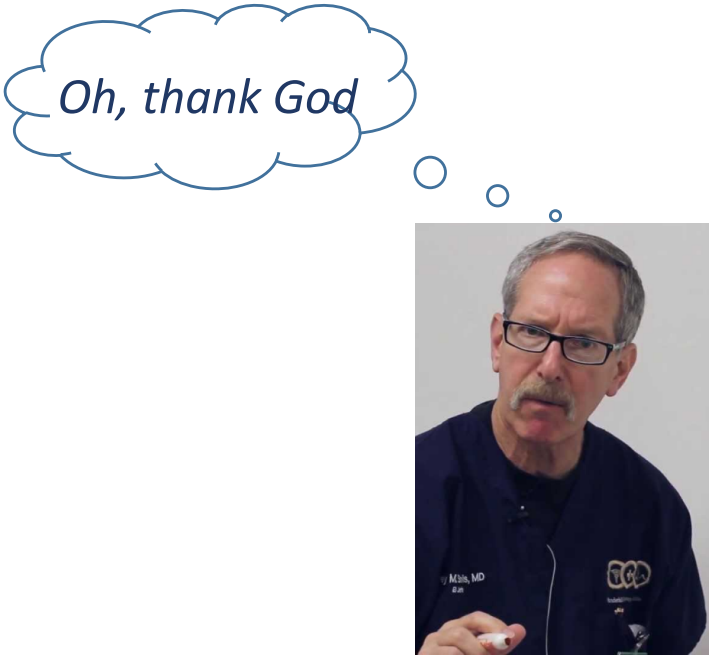
Ray Fowler M.D., FACEP, FAEMS, gEEk, neRD, WIMp

You know the drill

10-minutes

- 8-minutes to insult Ray
- 1-minute to throw a little shade at Paul
- 1-minute for anything vaguely resembling intellectual content

5-myths



Happy XX Anniversary

Eagles 2018

God bless Gail

Dear friend and super-smart, skilled guide

- Kindest of souls, warmest of hearts

God Bless Gail

All around mother confessor

- Pretty much a saint for putting up with all of that Pepe nonsense

With great respect & affection

Terry Valenzuela

- Recently spotted kicking dogs in the Sonoran desert

He's aware

For all of his missteps during today's debate

- 'Just Culture'
  - Human Error
  - At risk
  - Reckless behavior

Poster boy

Ray's participation today

Sponsored by the ~~#MeToo~~ #MeThree movement

Not only has Ray managed to offend

Members of the ‘opposite sex’

- In his case something that’s not so easily defined

But also…

A variety of small animals

- Inanimate objects

BOOM

Thank you

A typical day in EMS

911 call for 69 y/o female ‘lift assist’

- Found on the floor by daughter in the morning
- Patient care report (pcr) narrative (assuming you even have one)

“The patient didn’t appear in distress and denied complaints.

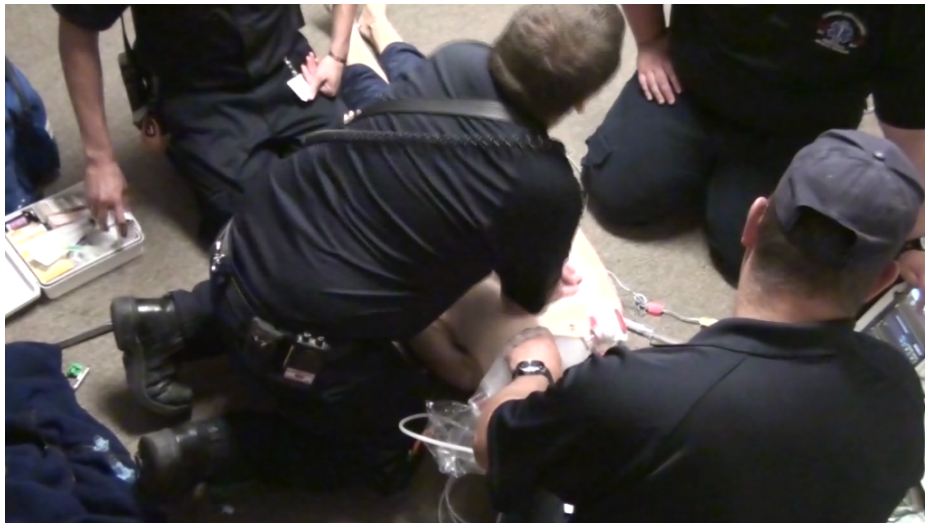
Crew assisted patient to her walker/chair “

- No past medical history, review of systems or risk factors documented
- No vital signs or exam documented
- Release-at-scene completed and the EMS unit ‘cancelled’

Hours later

Daughter calls back 911

- 2nd EMS unit sent
- Patient found in cardiac arrest



A little perspective

Quick back-of-the napkin calculation

- **Cardiac arrests** = 1% call-volume
  - About half are worked & maybe 5% - 6% survive
- 100k calls-for-service ⟶ 25-30 'walk out' of the hospital alive
  - Requires extraordinary personnel, financial & political capital
  - A good thing but it takes a lot to make a difference

- **No-loads/refusals/releases** = 15% - 70% call-volume
- 100k calls-for-service $\xrightarrow{\text{25\% refusals}}$ 25k at risk to get worse or die
  - Even a little attention can make a difference

Myth #1

Everyone needs to be transported to the hospital

- A whole lot of people don't need an ambulance or an ER
  - Typically primary or chronic care complaints
- You just have to figure out which ones

Determine whether your patient has

Decisional capacity

- To make an informed refusal of consent
  - Not in general, but just in this one instance
- Awake/alert/able to communicate their wishes
  - Understand the risks & consequences of refusing treatment or transport

Myth #2

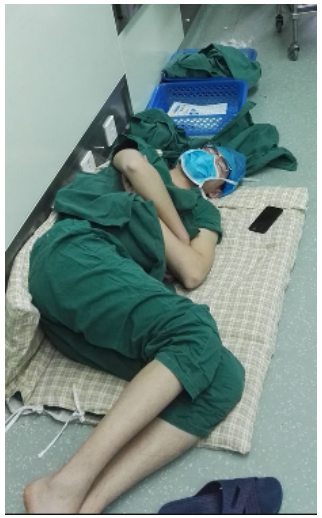
Your patient has to be alert and oriented (A&O x 3 or 4)

- Certainly have to be awake/alert/able to communicate
  - But most of us have no idea what day it is
- Able to demonstrate understanding, judgment, insight
  - May be as simple as having a conversation about what's on the TV news
- Patient's who are fully oriented may have no decisional capacity
  - Acutely decompensated schizophrenics

Myth #3

Most 69 y/o females on the floor are EMT's or paramedics

- **You** first have to understand the risks & consequences
  - And explain it to them in language they can understand
- You can't just assume they get it
  - They have to be able to explain it back to you in their own words



Myth #4

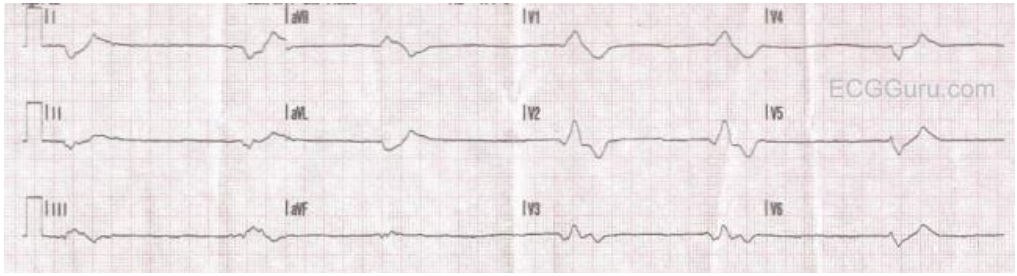
Telling the patient they might die = informed consent

- Just doesn't cut it
- You need to come up with some kind of differential diagnosis
- Why they went to ground
  - Urosepsis
  - Hip fracture
  - Stroke
  - Cardiac dysrrhythmia (bradycardia or tachycardia)
  - Toxic/metabolic disorder (O/D, glucose, hyperkalemia)

Which means you have to check & document

At least a few things

- Past medical history & risk factors (hypertension, diabetes)
- History of present illness/review of systems
- Vitals signs/physical exam
  - Neuro/stroke scale
  - Extremity tenderness, range-of-motion, able to weight-bear
- A few ancillary tests
  - Glucose
  - EKG



If you do all that

You're not just sitting out there on a broken limb

- Less chance you'll miss something bad
- Better chance sick patients will get seen
- At least your patients (& you) can both make informed decisions

Pick your favorite intoxicant

55 y/o male ‘making no sense’

- Family states he’s been drinking & using methamphetamine
  - Fell this morning & worried he’s going to hurt himself
- Appears grossly intoxicated
- Demonstrates no decisional capacity
- Doesn’t want to go
- EMS takes refusal and leaves

Several hours later

Family calls back 911 (patient unresponsive)

- 2nd EMS unit is dispatched
- Patient found in cardiac arrest
- Resuscitative efforts unsuccessful
- Medical examiner follow-up = polypharmacy O/D + TCA's

What are you gonna do?

No easy answers

- Decisional capacity, informed, implied & involuntary consent
  - Reasonably well-established
- Federal, state and local laws and regulations
  - You got to know your own

Ground rules

U.S Supreme Court

"A conscious adult, even with a life-threatening condition, has a Constitutional right to refuse treatment"

- **Principal of Involuntary Consent**
  - Narrowly defined when you can treat/take someone against their will
    - Under arrest, incarcerated, court-ordered, elder/minor abuse

What they say at the state level

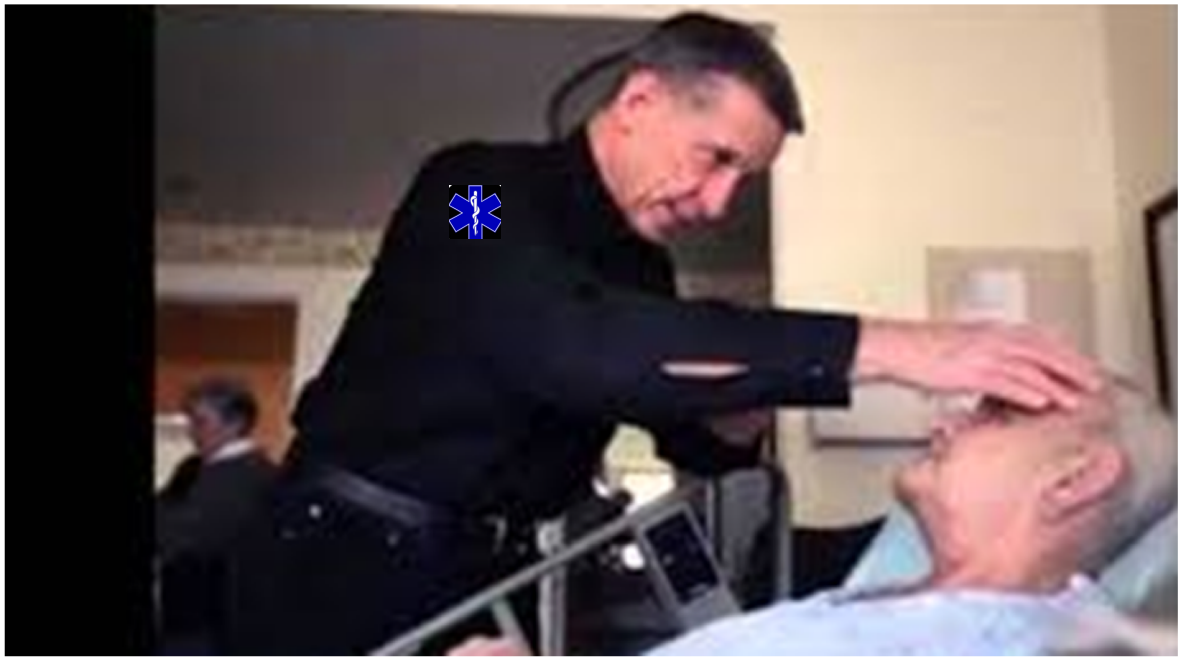
You're in Texas now, son

- Emergency consent is implied only if a patient
  - Is **unable** to 'communicate'
    - **Not because they don't want to communicate**, cooperate, or engage with you
  - Appears to have a life-threatening condition

Bottom line

It’s kind of tricky

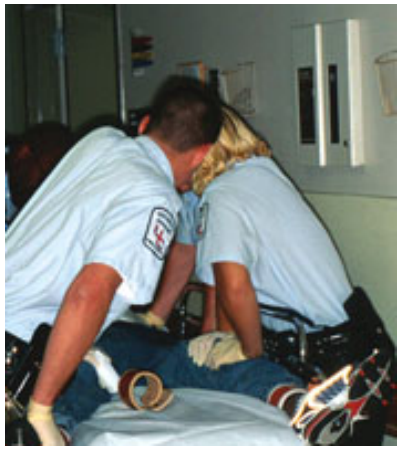
- **Fowler approach**
  - Take a refusal (EMS-performed ‘last-rights’)



Bottom line

It's kind of tricky

- **Drug & drag 'em approach**
  - Might feel like the right thing to do
  - Might all be considered 'medical battery' (as in '*assault and battery*')
    - Even though 'ability to communicate' is ill-defined
  - You (and your Medical Director) might both end up in court



So…

Life is complicated

- Do everything you can to fully inform your patients
  - Ensure that they have full decisional capacity
- Document everything out the wazoo
  - More is always better than less

When you're in the grey zone

Sick patient, no capacity, doesn't want to go

- Call in the cavalry
  - Supervisor, **Medical Director**/Medical Control, PD
- You may have a little room to navigate
  - If the patient starts to crash
  - Especially if they lose the ability to communicate (but it's very grey)

In the final analysis…

Medical Director

- Has to be able to sleep with himself (especially Fowler)
- May be better for someone to defend you for saving a life
- Than for somehow having missed the boat

luv ‘ya Ray, baby