



Ambulance Employee Retires After Many Years of Service By Katherine Cummins -The Fulton Sun



After 38 years of saving lives as a firefighter and paramedic, Steve Steward finally has taken his last ride in an ambulance.

Steward retired on May 1 after 15 years working with the Callaway County Ambulance District full-time, and another nine years of part-time service.

Surrounded by family and friends at a special ceremony Saturday afternoon, Steward - who lost a finger last year during an accident - said after nearly five decades of emergency service, it was time to say good-bye.

"It's finally time for me to hang her up," Steward said.

Steward has served on a number of fire and emergency medical service departments in mid-Missouri since he first became an ER tech in 1969, and his coworkers said that experience will be missed.

"I first met Steve in 1986 when I was still a young, know-it-all EMT," CCAD director Charlie Anderson said. "He always had much advice to offer - most of it unsolicited - and I often ignored most of anything he said.

"Some of it over the years, though, eventually sank in."

He said Steward was well known for his "extreme dedication to his patients."

"That was always the first and foremost thing for him - to make sure his patient had the best care available," Anderson said. "He would spend an hour if that's what it took to make that patient comfortable."

In 1963, Steward was presented with the Life Saving Award by the Columbia Safety Council for his work during the cave rescue of a patient with a broken back. In 1968 he was one of 23 firefighters to receive the Missouri State Legislative Award for extinguishing a major fire at KOMU.

During Saturday's open house, Steward was presented with proclamations from the Callaway County Commission and the Missouri State House of Representatives, as well as a retirement watch from the local firefighter's union and a portrait of his A-shift crew from the ambulance district.

"I liked the people who work here, I liked the people in the community and saw it was going to grow, and I wanted to be a part of it," said Steward, who has served on a number of area fire and emergency medical service departments since 1959. "I'm going to miss the people

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here terribly, but I'll be in to see them."

He said Anderson and A-shift supervisor Linda Ellis - both of whom he took under his wing as young CCAD employees - have been two of his favorite people to work for.

"Linda's been a tremendous boss - you couldn't ask for better," Steward said. "Along with Doug Westhoff, I consider you three the best people I ever worked for."

Steward said he plans to keep his paramedic's license current, although after doing some work on his home in Ashland, he intends to spend most of his time treasure hunting.

"It's a hobby I dearly love and it gives me the opportunity to travel," he said. "I just like to get out and swing my (metal) detector around because I like my gadgets."

The New MEMSA Website – A Communications Tool For Missouri’s EMS Community

It goes without saying that the EMS industry is progressive and always seeking ways to enhance itself and the patient care it provides.

Internal communications tools are vital to every EMS agency so that we may share ideas, news, developments, and so that we can compare experiences and update each other on important related issues and more.

MEMSA’s new website is really much more than a website.

It is a content management system, a media center, a press kit, a job board, directory and forum. In short it is a tool for communications and it is at your disposal.

In each edition of CODE 3, we will provide helpful articles focused on the use of our website, to help raise the level of awareness about the site and its many helpful features.

We believe that good use of our website can actually help to save lives and strengthen the EMS industry across the state of Missouri.

How? Well it’s no different than attending a conference such as the Combined Clinical Conference, which has an obvious value. What you learn there may be

taken home and applied to save a life, perhaps at your next call.

It’s known as viral communications which can actually be much more powerful than a conference. Think of it this way – information you “pick up” at a conference can have a real affect on your ability to care for patients and be spread to other EMS professionals bringing the same positive result. It is often easy and effective to email that information to everyone you know.

MEMSA is turning its website into a virtual center for viral communication. Every piece of information can be easily posted, mass emailed, forwarded, updated, categorized, archived and more.

As we begin this process it is vital that EMS professionals register on the site. This is not so that we can sell you shirts and hats or build a profile on your favorite hobbies. It’s simply to build a network of communicators – those who have information to



share and those who want to stay ‘in the know’.

We urge you to register your name and email address at the top right of this page or on the site’s front page, and also please forward this particular article on to others in our profession. You can forward articles by clicking the little envelope icon at the top right of the story.

The MEMSA website is no longer merely a place to get testing information. It’s a place to build unity amongst EMS professionals, to build and use resources and to help each other grow and advance in our primary objective – protecting our industry and its professionals in order to continue to provide excellent patient care.



EMS Fairs Well in Missouri Legislative Session By Jason White

While the legislative session was wild and wooly this year, as most are for various reasons, EMS fared pretty well.

A new 'Do Not Resuscitate' law was passed.

While 45 or so states already have such a law, we finally completed this important legislation for Missouri. A coalition of the "Right to Life" groups, the "End of Life" groups and EMS met and worked on a DNR bill since June of 2006.

The new law requires that DHSS develop a DNR form and probably an identification bracelet. EMS services that recognize the new form or identifier will enjoy certain legal protections. We expect that a joint task force including EMS, Hospice and Nursing Homes will work together to draft some sample policies to aid in the implementation of the new law. Please see the new law on the state web page, listed as HB182.

During a state-declared disaster, health care workers who respond to provide assistance will have increased protection from lawsuits. The storm experience of 2006 showed that increased legal protection was needed in order to attract health care workers to volunteer to staff

temporary medical facilities. This bill is listed as HB 579.

Medicaid reimbursement for ground ambulance services

was increased by \$1,000,000. It has been many years since there has been an increase in the amount of money Medicaid had to disburse to ground ambulance services. While the House Appropriations Committee had recommended an increase of \$1.2 million in state money the final decision had been to provide only an additional \$400,000 in state money. For every 39 cents of state money, the federal government will provide an additional 61 cents to support the Medicaid program, thus the additional \$400,000 in state money this year will mean a little over \$1,000,000 in new money for ground ambulance services.

Highway and bridge naming is now possible for EMS personnel who die in the line of duty. HB 732 allows for the naming of bridges and highways in honor of emergency services personnel who die in the line of duty. This is certainly a nice opportunity for remembrance. The Missouri Department of Transportation has a formal process for the naming of these assets.

New Ambulance District Board members will be required to attend a one day class covering the basics of how to perform their job. This comes as a result of the passage of SB 22. This will require that all board members first elected after January 1, 2008, will attend the seminar. Presently, the Missouri Ambulance Association conducts a one day seminar for Ambulance District Board members and we expect them to continue to offer the program.

Seatbelt Law - The effort to pass the seatbelt law failed. Presently 24 states have a seatbelt law where the police can pull you over for not wearing your seatbelt. States that have this primary enforcement have a 10-12% improvement in seatbelt use. Had this increase in seatbelt use existed in Missouri we would have expected 90 fewer deaths a year and over 1,000 serious injuries down graded because of the lifesaving benefit of seatbelts.

Motorcycle Helmets - Current Missouri law requires that motorcycle riders wear helmets. There was a serious effort made to repeal that law. The effort failed meaning that helmets will remain a required item for all motorcycle riders.



EMS Fairs Well in Missouri Legislative Session By Jason White

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Rogue Fire Departments - The rogue fire department bill passed. SB 47 requires all fire departments to register with the fire marshal. Through this mechanism rogue fire departments should be controlled. The problem language which impacted ambulance services was corrected during the legislative process.

Medicaid Reform - SB 577 which reformed the Medicaid program passed at the last moment during the legislative session. The new law creates some new expectations on health care providers regarding Medicaid. There will be protections for employees who turn in suspected Medicaid fraud (whistleblower protections)

just as there are similar protections regarding Medicare fraud at the federal level. The new law also sets the goal of increasing Medicaid payments to the federal Medicare level.

Peer Review - The Trial Attorneys killed peer review numerous times. Peer review was attached to three bills, all of which passed, but in each case the power of the trial attorneys was more than enough to kill our issue. Preparations are already being made for next year's effort so that EMS workers get the same legal protections that doctors and nurses have had for many years.

Death Benefit - The State Council of Firefighters worked hard to create a death benefit from the state which would have provided \$100,000 to the families of

EMS staff who died in the line of duty. Several amendments got attached to the bill which drove the total cost higher than the state could afford thus killing the bill.

Minimum Wage Correction - The minimum wage law passed in November contained some language which led some lawyers to think that the federal protections regarding over time for firefighters and police officers had been vacated and thus cites would need to pay overtime for all hours worked over 40. The effort to make the correction failed in some classic power politics.

Busy year but overall a good year for EMS legislation.

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2007 Statewide Disaster Collaboration Planning Meeting a Success

The 2007 Statewide Disaster Collaboration Planning Meeting was held on Thursday, May 17 and Friday, May 18 at The Lodge of Four Seasons in Lake Ozark, Missouri. The meeting was hosted by the Missouri Hospital Association in collaboration with the Missouri Department of Health and Senior Services, the Mid-America Regional Council and the St. Louis Area Regional Response System.

The overall purpose of the meeting was to enhance the ability of hospitals and other health care systems to prepare for and respond to bio-terrorism and other public health emergencies.

Priority areas for discussion included shifting focus from equipment to planning, partnerships and practice, reviewing key 2006 accomplishments such as mass casualty trailers, communication upgrades and training,



as well as covering the Pandemic and All-Hazards Preparedness Act and its subsequent priorities including integration, at-risk individuals and continuity of operations. Another important priority was planning for surge capacity, (a large influx of patients in demand of medical services), which included important points such as hospital bed capacity, decontamination and communication and information technology.

Specific disaster-related events such as tornadoes, power outages, explosions and ice storms all occurred over the last year in Missouri. Each has tested disaster response planning shedding light on successes and creating lessons learned. The conference provided an

opportunity to share experiences, address areas of improvement and further strengthen existing regional response plans. The activation of special needs shelters, medical shelters and acute care centers was also discussed in detail.

Other organizations also invited to participate at the meeting were the State Emergency Management Agency, Missouri Alliance for Home Care, Department of Mental Health, Missouri Primary Care Association, MO-1 Disaster Medical Assistance Team, local public health agencies, long term care facilities, home care agencies, federally qualified health centers, emergency medical services and the Medical Reserve Corp.

National Online EMS Museum Celebrates Grand Opening By Heather Caspi

--Editor, EMSResponder.Com



The National EMS Museum Foundation's Virtual Museum

<<http://www.nemsmf.org/>>

has officially launched this week in conjunction with EMS Week, preserving the personalities and relics of early EMS through online exhibits and interviews.

"The museum's goal is not just to save a bunch of stuff," said Museum Director Kat Rickey. "It's meant to be informative, educational and entertaining."

Rickey also emphasized that the museum's purpose is not to replace other collections, but to connect them, and to help share those collections with the world. "We want to be an umbrella," Rickey said.

It's clear that many contributors are taking this concept to heart.

"One man bought a scanner so that he could tear his memory book apart and

share it with us; he is one of so many doing things like that," said Julie Scadden, NEMSMF secretary. Others have contributed by traveling throughout their regions to get histories of all the local services.

"It's fabulous," Rickey said. "There's no way this museum can happen without that."

Other contributions, among Rickey's personal favorites, include a set of 500 photos of EMS toys collected by one man in Pennsylvania throughout his life. Another is an exhibit on the history of the stethoscope. "It's really a scholarly work," she said.

Rickey also wants visitors to know that the site includes interviews with EMS "giants," as well as those who have been influential on the local level. People often assume that the museum doesn't want to hear about their local EMS heroes, but, "Yes, we do want to hear about them!" Scadden said. It's common for people to be so humble that they don't realize they have anything to offer, she said.

Scadden said the museum foundation has been excited to see people beginning to utilize and learn from this preserved history. In one

recent case, they corresponded with a college student researching the history of triage, and were able to direct her toward resources explaining its origins in France during the Napoleonic wars. It was a quintessential example of their mission, Scadden said.

This museum may be especially relevant to the many "legacy" people in EMS -- those who are second or more generation EMS providers, yet actually know very little about what their parents or grandparents did, Rickey noted.

In regard to EMS week, the pair said they were in the process of posting an exhibit that includes the first EMS Week proclamation.

The online museum effort began less than one year ago and has been carried out entirely by volunteers. "It's a labor of love," Scadden said. Aside from the many contributors, "It's 12 to 15 people that just love EMS and want to see it preserved."

The museum's online launch completes Phase 1 of the project, and the foundation is excitedly working toward Phase 2, in which they will help organize traveling displays at shows and conferences. Their goal is not to

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make the museum the show, but to facilitate the local EMS community in creating their own exhibit.

"We want to keep people involved," Scadden says. "This is everybody's museum." The museum is open to everyone who wants to participate, and just as importantly, the fact that it's online makes it available to the world, Rickey said.

The first traveling show is planned for EMS Expo in Orlando, Florida this

coming October.

The museum foundation doesn't physically house most of the items in the virtual museum; collectors are asked to hold on to their items, and if they wish to donate the items, a transaction is documented. However, for anyone who can no longer store their collections, perhaps because their spouse is threatening to clean out the basement, the museum foundation will accept it and store it.

Eventually the foundation will move on to Phase 3 of the project, in which they

will create a permanent location for the museum and its collections. This was originally a 10-year goal, but may come significantly sooner.

The museum was initially funded by a \$5,000 grant from NAEMT, and the foundation is currently in the process of becoming a 501c3 non-profit organization.

The foundation is thrilled and proud of the fact that the project has come so far, so soon. "We could not have done this without all of the people who stepped up," Rickey said.

An Open Letter to the Fire Service



The following is an opinion piece by Best Practices publisher, John Becknell

Dear United States Fire Service:

You are big, strong and the nation's undisputed all-hazard responder. You have 30,000 departments across the nation and more than 1 million firefighters. You respond to millions of emergency medical calls each year in addition to your firefighting responsibilities. You have widespread respect from the public, a high-level

fire administration in the federal government, the largest caucus in Congress, one of the most powerful labor unions in the country and envious political clout, as evidenced by your hosting the first Presidential Forum of the 2008 election earlier this year.

Despite this considerable strength, your recently released paper, Prehospital 9-1-1 Emergency Medical Response: The Role of the United States Fire Service in Delivery and Coordination, sounds awfully defensive. Even worse, in my opinion,

the paper fails to meet its objective of proving that the fire service should be the coordinator and point agency for EMS in every community in the nation.

You did not need to ransack history to point out that the fire service has been involved with medical care since the Crusades. No one doubts that firefighters can provide medical aid. But your paper makes numerous unsubstantiated assertions that come off as reactive and defensive and hardly help your cause.

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An Open Letter to the Fire Service

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In stead of just saying that the fire service is the nation's EMS champion, why don't you just become that champion? You can start by becoming truly passionate about EMS. Make EMS a fire service priority. Tell the world that EMS is mostly what you do. Make EMS the headliner of your conferences. Grow the IAFC's EMS section from 1,200 members to 12,000. Demand that the fire service trade journals dedicate more than a column and an occasional article to EMS.

You applaud Miami Fire Rescue for recognizing the importance of medical response and changing its name to include the word "rescue." I suggest all fire departments stop calling themselves fire departments, and instead embrace EMS in their titles.

If you truly want to be the nation's EMS champion, advocate for EMS at a national level and for the needs of all EMS providers. Your fire caucus and lobbying organizations have left EMS out in the cold for too long, thus resulting in a growing movement among non-fire-based EMS organizations to organize and advocate for

EMS as a distinct and important part of health-care, public health and public safety. True EMS advocates clamor for more

attention and dollars for EMS on a federal level. They want to strengthen EMS' place in the federal government through the creation of an EMS Congressional caucus and a single, high-level, federal EMS agency. If this movement worries you – join the fight.

As the big and powerful fire service, you can lead the fight for more recognition for EMS without bullying. Embrace the fact that EMS is diverse and that no one system design has been proven universally effective. Everyone will respect your honesty. Use your clout to push the government to recognize the critical importance of EMS in every community. As you do, all ships will rise with the tide, but no one will fail to notice



that yours is the largest ship.

If you are serious about the fire service taking the point position on EMS, why not change the names (and attitudes) of the US Fire Administration and the Congressional Fire Services Institute to include EMS? As the nation's EMS champion, why not join with all of the non-fire-based EMS groups in an effort to bring attention to the flawed fee-for-transport system and help create something new? Such unity would be difficult to ignore. And while you're at it, use your clout to help the nation figure out how to provide quality EMS care in rural areas where workforce shortages are huge, and there are no union jobs. Such efforts would make your predecessors, the Maltese Knight, proud.

Patient Refusal: What to do when medical treatment and transport are rejected

**By JON BELDING, BA,
EMT-B - JEMS Magazine
- Vol. 31 Issue 5**

The rural N.Y. volunteer fire department I ride with was dispatched to a supermarket for a woman who had fainted. Another EMT-B and I arrived on scene to find a young woman sitting on a chair at the cash register, looking dazed but conscious. The manager of the store explained that she had called 9-1-1 after the cashier slumped to the floor while ringing up a customer and then regained consciousness almost immediately.

My partner took a set of vitals while I questioned the patient about her situation. She stated that she was a 17-year-old diabetic who had miscarried a few days earlier. We found her alert and oriented to person, place and time, and my partner stated that her vitals were within normal limits except for a slightly high blood pressure, which the patient described as normal for her. Still, my partner and I both felt that it was in the patient's best interest to go to the hospital and get checked out.

At this point, the patient became emotional and said that she didn't want to go. We explained our rea-

sons and stated that because she was under age 18, she must go to the hospital by law. She reluctantly consented, and we transported her to the hospital without incident. Back in quarters, my partner and I wondered whether the patient's status as a recently pregnant woman should have influenced our decision not to allow a refusal.

A recent study of EMS calls in Utah showed that 5.1% resulted in a situation in which the patient refused medical transport in direct conflict with the advice of the providers on scene.¹ Although this number may not seem particularly large, it's large enough to point out the need for us to refresh ourselves on the protocols and laws involved, because these situations can be both confusing and potentially dangerous for the patient and the provider.



Patients' rights - Since 1970, the U.S. Department of Trans-

portation has set forth the standards and curriculum for EMS. Each states that all patients have the right to accept or refuse care as an informed decision about the care to be provided and the risks. This is the concept of informed consent that has become universal to all health-care professionals.

The major exception to this rule, as judged by the courts and our social ethics, is that in an emergency situation, an incapacitated person may be treated by EMS with life-saving care under the assumption that a normal person would consent to prehospital care. This concept has come to be known as the doctrine of implied consent. But let's first discuss the history behind informed consent before we get into the exceptions.

The patient's rights movement of the 1980s and '90s ushered in the concept of a patient's right to refuse medical care of any kind. The Supreme Court finalized this issue in 1990 in *Cruzan v. Director, Missouri Department of Health*.³ In it they stated that the "United States Constitution would grant a competent person a constitutionally protected right to refuse life-saving medical treatment." Whether for financial, spiritual or religious reasons, a patient

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has the ultimate say over what is done to his or her body. This concept was best stated by Justice Cardozo of New York in 1914 when he wrote, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."

This definition points out the two most important stipulations of informed consent and, thus, the two most important stumbling blocks that EMS personnel come across in the field: a patient's capacity to make decisions and their age.

The medical term that defines whether or not a person is of "sound mind" is capacity. A person has decision-making capacity when they are able to understand the risks and benefits of both proposed treatment and non-treatment. In truth, this can be a very difficult evaluation to undertake in the field, but many EMS protocols use "alert and oriented to person, place and time" as a baseline for determining capacity.

If a patient is deemed incapacitated by illness or injury, the exception to informed consent is viable. This is true only for an emergency situation and only if two conditions can be met as

stated by the National Association of EMS Physicians: First, the patient is incapacitated by shock or trauma and unable to give informed judgment. Second, a life-threatening or health-threatening disease or injury that requires immediate treatment is present, and delay would mean death or impairment.

In these specific situations, EMS is allowed to suspend the concept of informed consent and transport the patient, even against their wishes. In this case, as with many others, however, field providers must contact medical control for approval because only a trained physician can declare capacity.

State policies on consent -

Although implied consent is referenced in the most recent curriculum for EMTs, it's expressly stated for application only in some states, including but not limited to California, Florida, New York, Hawaii, Kansas, Missouri, Montana, New Mexico, South Carolina and Texas. The law in these states allows EMS personnel to transport an incapacitated or intoxicated person against



their wishes with the approval of either online or offline medical direction, depending on the state.⁵ Title 29, chapter 401, section 445 of Florida Statutes is a prime example. It states that a health-care provider may examine, treat and transport a person, even against their wishes, if that person is intoxicated, under the influence or is experiencing an emergency condition, and a normal patient would reasonably undergo examination, treatment or transport.

Arkansas, Mississippi and Nebraska allow for transport against the patient's wishes, but only when the patient shows signs of material and morbid change.⁵ Other states, such as Iowa, Indiana and New Jersey, although not deliberately stating the doc-

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trine of implied consent, remove civil liability from any health-care provider who does not obtain consent if the provider has acted in good faith in an emergency situation.

Finally, such states as Alabama and Pennsylvania include implied consent in their EMS protocols for dealing with an incompetent patient's refusal, but it's not written into the state's statutes. In these situations, however, online medical direction must be established before transport.

The other major component of informed consent is the caveat that the patient must be of "adult years." By law, minors cannot provide informed consent to medical care and, therefore, cannot legally refuse care either. A child's medical decisions are made by their parent or legal guardian, or in emergency

situations might fall under the category of implied consent. Some states, including California, New York and Alabama, also allow minors older than 12 years of age to consent to certain types of health care with regard to drug rehabilitation, sexually transmitted diseases (STDs) and rape.

A problem arises when EMS providers encounter an emancipated minor. They are viewed by law as having the privileges of adults and, therefore, can provide informed consent. The major problem for EMS providers is that emancipatory status is dictated by the states rather than on a national level. Thus, pre-hospital providers must know their state's laws in order to provide the most informed care.

Most states set the minor age limit at 18 years of age; however, Mississippi, Alabama, Alaska, Nebraska and Wyoming set the age at 19.¹⁰ All states agree that certain lifestyles or decisions should entitle a person to emancipation. Court rulings and proof of financial independence entitle a minor to adult privileges, including consent and refusal, in all states.¹¹ Some examples are provided here, but this list is by no means ex-

haustive. With regard to health-care decisions and consent, Alabama states that any 14 year old, high school graduate, married person or pregnant female may give consent for themselves or children.¹² Delaware has similar standards, except that the age is still 18 and pregnancy gives the minor consent rights only for their child but not themselves.

Illinois gives any 18 year old, married person, parent or pregnant person full rights for both themselves and their child.¹⁴ Indiana, like Alabama, lowers its consent age to 14 in terms of health-care consent, and includes military service but excludes pregnancy or parenting as criteria.¹⁵ Maine also has these rules, except the age of majority remains at 18.

Montana Code dictates that minors may consent to health care if they are married, parents, pregnant, graduated from high school or have a communicable disease or substance abuse problem. New Jersey law grants health-care power to all married and pregnant minors on behalf of themselves and their children.¹⁸ North Carolina, on the other hand does not consider pregnancy to be emancipating, but military service is.¹⁹ Texas also grants emancipatory



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status to active service men and women, as well as 16 year olds who live apart from parents, pregnant women with respect to pregnancy, or parents for themselves and their children.

New York, Florida, Pennsylvania and Utah also consider pregnant females to be emancipated, although they stipulate that a pregnant female has consent only with regard to prenatal care. New York, California, Pennsylvania and Florida also stipulate that any parent is emancipated. Finally, active duty in the military grants emancipated status in New York and California.

This is only a small listing of the differences in state policies on consent. Individual providers should check their county's protocols for further details about how their emergency medical system deals with refusals for minors and adults.

Managing patient refusal

Members of the Dallas EMS system developed the Parkland Protocol to deal with refusals more efficiently. The first step is to determine the patient's emancipation status based on state laws. Second, the provider must determine the level of com-



petency or consent based on the three categories of voluntary, involuntary and implied. Parkland Memorial Hospital provides 24-hour legal counsel to help obtain permission and to support the medical director's decision.

Tips to avoid refusals: First, always attempt to establish a good rapport with your patient. We must remember that we can often be battling unseen forces, such as negative feelings toward hospitals, the medical profession or insurance companies. Showing a friendly and helpful face to the patient could make the difference when you must try to convince them to go to the hospital for their own good. Try to find a balance between what's best for them physically and what they're willing to agree to mentally.

Second, remember to contact online medical direction when you have a difficult case and then document it. Talking to a physician has been proven to change some patients' minds.

If, however, the patient still refuses care or transport,

make them aware of all of the risks and rewards of treatment and non-treatment as necessary in implied consent, complete a patient refusal form (usually located on the back of a standard PCR), and obtain the patient's signature. Document your medical opinions and the patient's reasoning and steps taken to convince the patient to accept treatment and transport.

Finally, encourage the patient to seek health care immediately if certain symptoms worsen or "if any of the following happen," and then give them a list of symptoms.

Always put the patient's welfare first.

Jon Belding, a first-year medical student at Case Western Reserve University School of Medicine in Cleveland, is interested in pediatric surgery. He volunteered as an intermediate firefighter/ EMT-B in the Hamilton Fire Department while earning his BA in History at Colgate University in Hamilton, N.Y.

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