

# Matters of consent—2009

## Assessing and documenting mental status

### *Part two of two*

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*Illustration photo by Daniel White.*

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

In part one of this article, printed in the May/June 2009 issue of Texas EMS Magazine, we discussed the *importance* of determining and documenting a patient's mental status in quantifiable terms. A patient must possess the present mental capacity to understand and

appreciate his condition and make a rational decision either to **consent** or **refuse** medical treatment and transport. Part two will discuss *how* to assess and document a patient's mental status.

Although we think we know what present mental capacity is when we see it, we often are at a loss when we try to document it in legally sufficient terms. We have been taught to use expressions such as "A & A & O x 4" to document that the patient was awake, alert and oriented to person, place, time and event. But when we examine that expression, we soon see that it is merely a series of conclusions. True, they are conclusions based on observations and interactions with the patient, but unless we document facts to support those observations we have no documented basis for our conclusions. It's

likely that if we are asked years later in court or in a deposition, what was “A & A & O x 4” based on, we would have no memory of the specific facts. Therefore, the only way to ensure we’re not embarrassed in court (or worse) is to document sufficient facts to back up our conclusions.

## Consent

Adult patients present few complications with regard to consenting to EMS treatment. A provider is burdened only with determining whether or not an adult patient possesses the present mental capacity to make a rational health care decision. If the patient personally consents there’s no problem. In emergency situations, especially when an adult patient is unable to respond, lack of informed consent usually doesn’t change treatments and practices because we treat those patients under **implied consent**. The same holds true for minors when they have a potentially life-threatening condition. When emergency circumstances are not present, options become less clear. For example, the patient may be subject to **substituted consent**. In this case, another person legally consents for the patient, as in minors, incapacitated patients, incarcerated patients and those determined by courts to be legally incompetent.

## Refusal

Legal problems for EMS providers more frequently arise when a patient wants to *refuse* treatment and transport. A refusal must always be an informed refusal—one in which the patient understands and appreciates the nature and quality of the illness or injury, knows the consequences of refusal and has the reasoning ability to make a rational health care judgment after weighing all the factors. Otherwise, litigants may be able to bring a lawsuit against the provider for damages resulting from not treating the patient.

Allowing a patient to refuse treatment without having a clear picture of his or her mental status and function is asking for trouble. And once you do have a clear picture of the patient’s mental status and function, your determination to allow refusal can be questioned unless you have documented sufficient factual evidence to demonstrate that the patient has the present mental capacity to:

- Understand and appreciate the nature and quality of his condition

## Objectives

- Define informed consent.
- Distinguish between documenting facts and stating conclusions.
- Document an informed refusal.
- Conduct a short mental status exam.
- Determine a patient’s present mental capacity.

- Understand and appreciate the possible consequences of refusing treatment and transport
- Make a rational decision about his health care after weighing all the factors

Unless you document each of those factors in statements of fact, not observed conclusions, the refusal may not hold up if challenged in court.

## Documenting refusals

Learning to adequately document a patient care report requires first knowing what things to look for and do while evaluating the patient. Expressions such as “patient was in his right mind” or “patient understood the consequences of refusal” are mere conclusions, even when based on trained observation. You must include facts to back up those conclusions, which will provide a basis for your actions if they are questioned in the future. The next section will explain how to determine and write those facts.

Refer back to the May/June 2009 issue of Texas EMS Magazine for a review of the differences between legal competency and present mental capacity to make a health care decision. Remember that legal competency is a legal determination, not a medical determination.

## Mental status evaluation

Mental status evaluation is explained in countless resources in journals, in textbooks and on the Internet. An excellent, short and to-the-point article in eMedicine Online by Guy E. Brannon, MD, gives a great overview of the assessments for evaluating a patient’s mental status.<sup>1</sup>

The evaluation begins with observing the patient based on the following cues.

- **Personal appearance**—Notice the level of the patient’s personal hygiene. Is she dressed in appropriate clothing for the season or the occasion?

- **Social interactions**—How does the patient interact with others? Is she connected or distant?
- **Eye movements**—A patient who avoids looking at you may be shy, frightened, embarrassed or distracted. If the patient is distracted, find out why.
- **Body language**—Body language and movement can display mannerisms often seen in patients suffering from the effects of mental illness or drug use. These mannerisms can include twisting or playing with one's hair, jaw clenching and teeth grinding, akathisia (inability to sit still), foot tapping, clucking, pacing or restlessness.
- **Speech**—Speech patterns may indicate a confused state, an agitated state, a depressed state or an inability to associate thoughts and words.
- **Affect**—Affect describes the patient's immediate emotional state or mood, which is felt by the patient and can be observed by others. Abnormal excitement or the opposite can indicate a number of problems with present mental capacity.
- **Thought processes**—Ask yourself whether your patient is "connected" to your interview and assessment. How is she answering your questions? Are the answers appropriate or inappropriate? Can she concentrate on one subject, or does she frequently jump from one thing to another? Inability to focus on a subject for more than a few seconds indicates the patient may not be able to rationally weigh a treatment decision. Memory is another thought process to test. Short term memory is particularly vulnerable, and if the patient cannot remember the events that led up to your being summoned, a red flag about present mental capacity should go up.

### **Document mental status**

After observing the patient for a minute or so you should begin to have some idea of the patient's present mental capacity. If the patient looks, talks and acts appropriately, and he is

consenting, there's no problem—treat the patient.

If the patient looks, talks and acts appropriately and is considering refusal, then you must decide upon a course of action. First, establish enough basic facts to determine whether he's *able* to refuse; do that by engaging him in conversation and gathering essential data. Ask his name, the location and time/events questions, but instead of simply writing "A & A & O x 4," write out notes about his actual answers in quotation marks. For example, you would write:

Name: "David Dalworth"

Place: "Bathroom of my house"

Time: "Thursday night"

Month: "February"

Date: "12th or 13th"

Event: "slipped getting out of the shower and landed on my tailbone"

Let's assume that you are satisfied that the individual's answers are correct. So far, so good. Next determine whether any of the following statements, which may be preprinted on the refusal form, apply to the patient.

- 18 years or older
- Emancipated minor (less than 18 years of age, living away from parents and financially self-responsible)
- Married minor
- Minor in the military

**NOTE:** A pregnant minor must still have adult consent unless she fits within one of the listed exceptions.

If *any one* of the above items is checked, the person qualifies as an adult and may consent for himself.

The answers so far indicate that the patient is an alert and oriented adult who wishes to refuse treatment. You should next check for red flags that would indicate the need for a mental status exam. **All items in the following list must apply** to the patient before he can be allowed to refuse without further inquiry.

- No altered level of consciousness (LOC) or history (Hx) of altered LOC during the previous six hours
- No suicide attempt or threat (See "Suicide and mental capacity" box for details.)
- No evidence of cerebral hypoxia
- No severely altered vital signs per protocol
- No irrational actions or decisions observed
- No obvious potentially life- or limb-threatening condition related to this call

- No evidence that patient is under psychiatric hold per physician
- No evidence of alcohol consumption (ETOH)
- No evidence of drugs affecting LOC
- No other signs of altered mental status<sup>2</sup>

**If any one of those items cannot be verified or cannot be checked off based on your observation of and conversation with the patient or other witnesses, then you should perform a mental status exam.**

#### **Suicide and mental capacity**

A suicide threat or attempt *automatically* indicates lack of mental capacity. A Texas law enforcement officer may arrest a patient who threatens or attempts suicide under Texas Health and Safety Code Chapter 573.<sup>3</sup> That statute also covers other mentally ill patients and a similar statute allows an arrest for chemical dependency. Remember though, only a law enforcement officer can make these arrests.

If all of the above items *can* be checked off, go on to the next task: Inform the patient of the possible consequences of refusal of treatment and transport to a hospital. A good general statement is: “You may have a medical condition or injury that is not apparent to you now and can only be determined by a doctor’s examination, possibly with X-rays, CT scan, laboratory tests and other procedures that we cannot do for you here.” Then add specific items as appropriate, such as, “Paramedic 327 said, ‘You may be bleeding internally and could get worse,’ or ‘You may be having a problem with your heart that could cause serious problems for you.’” There’s no need to threaten or frighten; the object is to educate. Remember, adults *do* have a right to refuse treatment if they have the required present mental capacity. Not every patient must be transported.

Finally, ask the patient to repeat to you what he understands his condition to be and what you’ve told him. On the patient care report, you would write the patient’s response word-for-word and include quotation marks: “I might be having a heart attack and I guess I ought to see my doctor.”

By following the above steps for documenting a refusal, you will have gathered

enough facts to demonstrate that your conclusion that the adult patient possessed the present mental capacity to make an informed health care decision was based on objective facts.

If even one of the items above can *not* be checked off, perform a brief mental status exam. Probably the best known mental status exam is the one developed by M. F. Folstein and others in 1975.<sup>4</sup> The Folstein exam is a rapid test that measures orientation, registration (memory), attention, calculation, recall and language. The Folstein exam is copyrighted and sold as part of an inexpensive kit; however, there are similar versions available at various websites. In addition, the February 2001 issue of *American Family Physician* includes an in-depth discussion of mental status and also contains a summary of Folstein’s exam.<sup>5</sup>

The Folstein exam quickly tests a variety of cognitive abilities.

- **Alertness and orientation**—the A&A&O questions are asked in detail
- **Registration**—the patient is asked to recall three objects
- **Attention and calculation**—the patient is asked to spell a five-letter word backwards
- **Recall**—the patient is asked to remember the previous three items
- **Language**—the patient is asked to repeat a phrase
- **Ability to respond to verbal commands**—the patient is asked to do something with an object or identify two objects held up, such as a watch and pencil.

The Folstein exam scores these items and then correlates the score to age. Any significant failure should heighten your suspicion that the patient lacks present mental capacity.

No matter what method you apply to assess mental capacity, record the patient’s answers in quotation marks. If your service elects to formulate a unique exam, the medical director should make it part of protocol and indicate a scoring system for you to use in determining whether or not the patient can refuse. The score from this brief mental status exam will help you further document the facts used to determine whether a patient has the present mental capacity to refuse treatment.

## Why we evaluate and document

If you allow a patient who lacks present mental capacity to refuse treatment and transport, you may be held liable for any injury or damages that she suffers. That's a straightforward possibility. However, this is an extremely complex area of the law and there are many approaches that might be used by a plaintiff's attorneys to attempt to hold an EMS provider liable. For example, could you be held liable for damages inflicted by a patient on a third party if you have knowledge of such danger and fail to warn the third party? The answer is unclear, and although there are cases in other states imposing such liability on medical professionals, Texas has not chosen to assert this liability.<sup>6</sup> It's better to avoid such a situation altogether, and proper evaluation and documentation is the key.

The time and effort needed to compile the answers to these questions is always an obstacle. I can only advise that the amounts of time and effort are far less than the time and effort spent with lawyers, depositions and testimony in court would be if you were sued (and much less expensive). Following the procedures outlined here is no guarantee that you won't be sued, but they will go a long way toward influencing a plaintiff's lawyers to make a decision not to sue. If you are sued, you'll stand a much better chance of winning if you have this level of documentation. A bit of preparation, such as photocopying the mental status assessment routine and having it available alongside the patient care report and refusal forms, will save time—you will only have to record the patient's answers or actions.

## Summary

A patient must possess the present mental capacity to understand and appreciate his condition in order to make a rational decision either to **consent to** or **refuse** medical treatment and transport. We determine whether or not the patient has the present mental capacity to make a decision through the process of evaluating the patient. We then we act on our determination and document the assessment. Good legal documentation requires written factual reasons for any conclusions we reached based on the assessment. The conclusion, "the patient was awake, alert and oriented to time, person, place

and event" is documented by writing the patient's exact answers to each question: "My name is John Smith and I am in the living room of my house." When patients exhibit signs or symptoms indicating that they might lack present mental capacity to make a decision, we should perform and document a mental status exam. The written results of that exam will help determine and document the patient's present mental capacity. Documenting present mental capacity then helps avoid liability related to patient consent or refusal.

## Notes

1. Brannon GE, MD. Mental status. Available at: [www.eMedicine.com/med/topic3358.htm](http://www.eMedicine.com/med/topic3358.htm). Accessed June 1, 2009.
2. Modified from Plano, Texas, Fire Rescue "EMS Refusal of Service" form.
3. Texas Health and Safety Code, Chapter 573. Emergency detention. Subchapter A. Apprehension by peace officer:

### § 573.001. Apprehension by Peace Officer Without Warrant

- (a) A peace officer, without a warrant, may take a person into custody if the officer:
  - (1) has reason to believe and does believe that:
    - (A) the person is mentally ill; and
    - (B) because of that mental illness there is a substantial risk of serious harm to the person or to others unless the person is immediately restrained; and
  - (2) believes that there is not sufficient time to obtain a warrant before taking the person into custody.
- (b) A substantial risk of serious harm to the person or others under Subsection (a)(1)(B) may be demonstrated by:
  - (1) the person's behavior; or
  - (2) evidence of severe emotional distress and deterioration in the person's mental condition to the extent that the person cannot remain at liberty.
- (c) The peace officer may form the belief that the person meets the criteria for apprehension:
  - (1) from a representation of a credible person; or
  - (2) on the basis of the conduct

of the apprehended person or the circumstances under which the apprehended person is found.

(d) A peace officer who takes a person into custody under Subsection (a) shall immediately transport the apprehended person to:

- (1) the nearest appropriate inpatient mental health facility; or
- (2) a mental health facility deemed suitable by the local mental health authority, if an appropriate inpatient mental health facility is not available.

(e) A jail or similar detention facility may not be deemed suitable except in an extreme emergency.

(f) A person detained in a jail or a

nonmedical facility shall be kept separate from any person who is charged with or convicted of a crime.

Added by Acts 1991, 72nd Leg., ch. 76, §1, eff. Sept. 1, 1991.

Amended by Acts 2001, 77th Leg., ch. 367, §5, eff. Sept. 1, 2001.

4. Folstein MF, Folstein SE, McHugh PR. Minimal state: A practical method for grading the state of patients for the clinician. *Journal of Psychiatric Research*. 1975; 12:189-98.
5. Santacruz KS, Swagerty D. Early diagnosis of dementia. *American Family Physician*. 2001; 63:4. Available at: [www.aafp.org/afp/20010215/703.html](http://www.aafp.org/afp/20010215/703.html). Accessed June 1, 2009.
6. Tarasoff v. Regents, 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 334, 345-7 (1976).

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## Trauma Registry plans stakeholder meetings

Over the years, stakeholders have voiced plenty of concerns about the integrity, usefulness, and viability of the current trauma registry. Now DSHS is assessing the current EMS/Trauma Registry system to try to figure out what can be done. As part of the Trauma Registry Improvement System Assessment (TRISA) Project, DSHS will be conducting

meetings around the state this summer to give stakeholders a chance to tell DSHS what they need. MTG Management Consultants, LLC, a national independent management consulting firm, will be helping with the project and the meetings.

The main goal of the meetings is to collect and document stakeholder requirements so that we can implement the best State EMS/Trauma Registry for the State of Texas, its citizens, and the DSHS stakeholders.

Anyone interested in contributing their opinions for the development of the Texas EMS/Trauma Registry are encouraged to attend. Generally, MTG will meet with EMS providers in the mornings from 8am to 12pm and with hospital providers in the afternoons from 1pm to 5pm, at each location. The last meeting will be held in Austin from 1pm to 5pm and is for anyone who either was not able to attend one of the other meetings or who is not an EMS or hospital provider but who has an interest in the future Registry. (Seven meetings took place in June. Notification for those went out on the listservs.)

Please refer to our website for handout materials as **MTG will not be bringing copies** – [www.dshs.state.tx.us/injury](http://www.dshs.state.tx.us/injury). —Linda Jones

### July 6 Midland / Odessa

Region XVIII ESC Annex  
2700 LaForce Blvd.

Midland, TX  
432-563-5554

Please notify Connie Thompson  
at [txjrac.connie@att.net](mailto:txjrac.connie@att.net) if you plan to attend.



### July 7 El Paso

Border RAC Office  
200 North Kansas St.  
El Paso, TX 79901  
915-838-3202

### July 13 Austin (1 pm – 5 pm)

Texas Department of State Health Services  
1100 W. 49th Street  
Austin, TX 78756  
Room K-100  
512-458-7111, ext. 3131