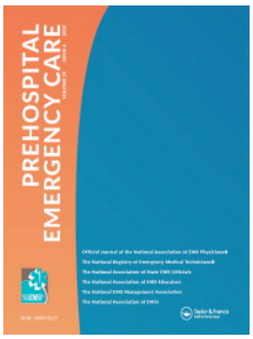

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Current Emergency Medical Services Systems Approaches to Refusal of Assessment, Treatment, or Transport: Examination of Statewide Protocols

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ABSTRACT

Objectives: Many emergency medical services (EMS) 9-1-1 activations result in patients declining evaluation, treatment, or transport to the emergency department (ED). Assessment of a patient's decision-making capacity to refuse and taking appropriate actions based on that are critical elements of EMS practice. However, EMS clinician approaches in this area are under-studied, and variation may exist. As EMS practice is highly protocolized, our goal was to examine all publicly available United States (U.S.) state protocols and describe their guidance around refusals.

Methods: We used a structured, multi-step content analysis and published expert recommendations on managing refusal of care in health care settings to identify 35 specific elements within five domains of prehospital refusal management: decision-making capacity assessment, risk assessment, persuasion, escalation to medical oversight, and documentation. We systematically and comprehensively reviewed 34 state protocols and a U.S. national protocol for the presence of these elements.

Results: Among 34 state protocols examined, 24% (8) had no guidance on refusal, with 18% (6) including at least some guidance in all domains. Among states with any guidance on refusal, we found a median of 15, a mean of 15, and a range of 5–25 elements included. Three states (9%) discussed all four components of decision-making capacity. Seven (21%) emphasized assessing risk of a severe medical emergency when considering refusal. Guidance on persuasion for high-risk patients was included in 13 (38%). Escalation to direct medical oversight was present in 20 (59%). Only 21 (62%) of protocols provided specific documentation guidelines. Notably, guidance was identified in state protocols that is inconsistent with expert recommendations for management of refusal in the ED. Checklists were included in 4 (12%).

Conclusions: Substantial variability exists among state protocols regarding patient refusal guidance. Few protocols address high-risk patients, provide strategies for persuasion, or include checklists for proper management. Standardizing and expanding protocols may enhance EMS care.

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Introduction

When emergency medical services (EMS) agencies and clinicians respond after 9-1-1 activation, it is not uncommon for patients to initially refuse evaluation, treatment, or transport to an emergency department (ED) (1–3). Patients may refuse care for various reasons, including but not limited to symptom improvement, intoxication, fear/mistrust of the health care system, and poor understanding of the severity of their illness or injury (4,5). While most patients will not have a poor outcome if not treated or transported, some may be experiencing a life-threatening emergency.

Assessing patients who initially refuse treatment or transport in the prehospital setting requires determining whether the patient has the capacity to make this decision. To effectively do this, EMS clinicians must consider the risks of a poor outcome if a patient does not receive treatment and/or transport to the ED and communicate those risks to the patient. For patients at high risk, EMS clinicians may attempt to persuade them to accept treatment/transport without being coercive. In some cases, if a patient continues to refuse, EMS clinicians may escalate to direct medical oversight for assistance and guidance. Ultimately, if the patient continues to refuse and is deemed to have the capacity to make this decision, the refusal must be documented appropriately and comprehensively.

This represents a critical and sometimes very challenging evaluation that EMS clinicians must make commonly. It is

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essential to respect the rights of a patient with the capacity to make an unsafe decision while safeguarding those with impaired decision-making abilities. Extensive expert guidance exists on optimal approaches for ED clinicians in assessing the capacity to refuse care and managing discharges against medical advice (6–14). In fact, assessing decisional capacity is considered an essential skill for emergency physicians (6).

Little research has explored the approaches to refusal currently recommended in the prehospital setting. The objective of the current study was to examine publicly available state and national EMS protocols to describe the approach to refusals recommended by state EMS medical directors.

Methods

We comprehensively analyzed publicly available official statewide EMS protocols and the National Association of State Emergency Medical Services Officials (NASEMSO) National EMS Model Guidelines. To identify protocols, we used EMSprotocols.org, United States (U.S.) state EMS websites, and published lists (15). All protocols included in the analysis were accessed in June 2024. We included all mandatory or model statewide EMS protocols for basic life support and advanced life support levels. Only documents labeled as "protocols," "guidelines," "procedures," or otherwise indicated for clinician use in the field were included in the search; policy statements, training documents, public advisories, and other miscellaneous documents were excluded. We did not include county, city, or regional protocols. If multiple current statewide protocols were available for a single state, we examined the one containing the most information about refusal of care. For states that do not have publicly available protocols, we searched online to check whether they reported using the National EMS Model Guidelines. This approach is similar to prior research using state EMS protocols (15,16). We examined the National EMS Model Guidelines separately, given that five states reported using them. Because these national guidelines are a nationally developed set of recommendations intended for broad adaptation, rather than a state-specific protocol, they were included in our tables for comparison but not incorporated into the total percentages for state protocols.

Through a structured, multi-step content analysis, we created a novel tool to facilitate a structured, comprehensive, and reproducible description and comparison of state protocols. To do so, we attempted to break down the approach to management of patient refusal into domains and each domain into elements that could be described as present or absent in each protocol. The authors developing the tool included a multidisciplinary group with experience and expertise in capacity assessment, EMS medicine, emergency medicine, and geriatrics. The tool was created and refined through a consensus process over several meetings.

Before developing this tool, the authors carefully reviewed the extensive, published expert guidance (6–14,17) on the management of refusal in the ED and other health care settings. This published guidance includes that: (1) decision-making capacity is defined as the ability to understand the risks, benefits, and alternatives to the proposed treatment, (2) capacity is decision-specific (a patient may simultaneously have the capacity to make one decision and not another), and (3) while a patient's dementia or a previous determination of incompetence by a court may be incorporated into an assessment of decision-making capacity, neither exclusively determines whether they have the capacity to make medical decisions. To have the capacity to make a specific decision (for example, the decision to refuse EMS assessment, care, or transport), a patient must demonstrate (1) an understanding of relevant information, including risks/benefits, (2) an appreciation of their medical situation, (3) a logical/rational process of coming to the decision, and (4) the ability to communicate a clear and consistent choice over time.

We reviewed all protocols obtained using this novel tool and described the percentage of protocols that include information about each of the domains and elements. We also noted, categorized, and summarized guidance within statewide protocols, particularly around the assessment of decision-making capacity, that was inconsistent with expert guidance for refusal in the ED. This project was evaluated by the Weill Cornell Institutional Review Board and determined to be exempt.

Results

State Protocols

We found and reviewed 34 publicly available state protocols and the National EMS Clinical Guidelines. Of the state protocols, 17 were "mandatory," which EMS clinicians must follow, and 17 were "model," which serve as recommended guidelines. Among the 17 remaining states that did not have a publicly available protocol, 5 reported using the National EMS Model Guidelines. Details of this protocol search are shown in Figure 1. Online Supplemental File Table 1 includes links to access the publicly available protocols. The National EMS Model Guidelines are presented separately for comparison in Table 1 and were not incorporated into the total percentages. The total number of elements included within the National Guidelines is also shown in Supplemental File Table 3.

Tool to Facilitate Description and Comparison

To develop the evaluation tool, we used a structured, multi-step content analysis approach. This process began with two independent reviewers (RB, JL) conducting a directed content analysis of existing literature, which included expert guidance on capacity assessment, previously validated EMS refusal checklists, and refusal management in emergency care settings (6–14,17). Each reviewer independently extracted candidate elements that reflected essential components of capacity evaluation, risk assessment, persuasion, escalation, or documentation from the source material.

The preliminary lists yielded a combined pool of 45 unique elements and were presented to the full multidisciplinary author group, which included EMS physicians and directors, geriatricians, and emergency medicine physicians. Over multiple meetings, the group iteratively reviewed,

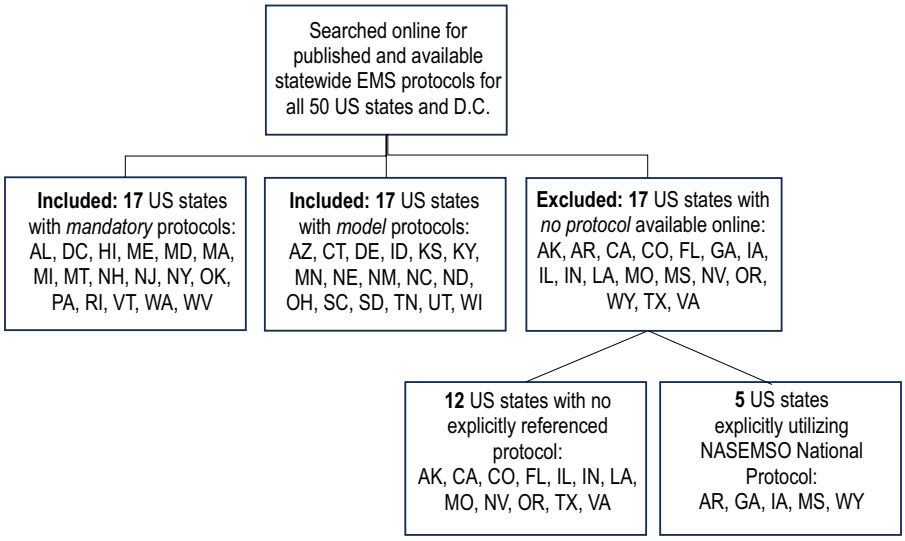

Figure 1. Categorization of Statewide EMS Protocol Availability for Managing Patient Refusals in National and State Guidelines: Mandatory, Model, and Unavailable Protocols.
Abbreviations: EMS, emergency medical services; U.S., United States; NASEMSO, National Association of State Emergency Medical Services Officials.
Based on publicly available statewide EMS protocols as of June 2024.
States were classified as having mandatory (required), model (recommended), or no protocol. States referencing only the National EMS Model Guidelines are listed separately.

categorized, and refined each element, narrowing the list through structured discussions. Consensus was reached instead of voting. Elements were retained if the group determined they were (1) actionable by EMS clinicians in the field and (2) aligned with best practices for refusal management in emergency settings. This process resulted in the final tool of 35 elements organized across 5 domains. While the tool has not yet undergone formal external validation, it was developed based on extensive prior experience in emergency medical settings and using structured content analysis to enhance reproducibility and comprehensiveness.

The five domains were: (1) determining decision-making capacity, (2) assessing risks of a poor outcome if a patient does not receive treatment and/or transport to the ED, and explaining those risks to the patient (3) attempting persuasion without being coercive when appropriate, (4) escalating to direct medical oversight for assistance and guidance, and (5) appropriately and comprehensively documenting refusal. Within each domain, 17 elements were included for assessing capacity, 6 for assessing risk, 2 for attempting persuasion, 3 for considering escalation, and 7 for documenting refusal. This tool is shown in Figure 2.

Two authors (RB, JL) independently reviewed each protocol and recorded their findings for the presence or absence of each element in a Microsoft Excel file. All discrepancies were resolved by consensus through discussion between the two reviewers and a third author (TR). A comprehensive description of how we used this tool to assess the presence or absence of elements is included in Online Supplemental File Figure 1.

Description and Comparison of State Protocols

Of the 34 publicly available US state protocols examined, 8 (24%) did not include any guidance on the management of refusal. These were Kansas, Kentucky, Minnesota, Montana, North Dakota, South Carolina, Utah, and Washington. The percentage of mandatory and model state protocols that included each of the 35 elements within the 5 domains we identified is shown in Table 1.

Among all state mandatory and model protocols, 25 (74%) included at least one of the 17 elements associated with determining decision-making capacity. No states included all 17 elements, and 3 state protocols (9%) included guidance on the assessment of all 4 components of decision-making capacity. These were Arizona, North Carolina, and West Virginia. In assessing the risk of a poor outcome, seven states (21%) emphasized assessing the risk of a severe medical emergency when patients refuse care or transport. Only 1 state (3%, New York) mentioned advanced age (≥65) as an explicit criterion, while dementia or cognitive impairment was not explicitly mentioned in any. Thirteen state protocols (38%) provided guidance for EMS clinicians on how to persuade reluctant patients at high risk for serious medical conditions to accept care/transport. Escalation to direct medical oversight was present in 20 states (59%). Only 21 protocols (62%) provided guidelines on specific items that should be included in the documentation. Recommendations on further counseling for those who refuse care or transport were present in 17 states (50%). Only 4 state protocols (12%, Maryland, Michigan, Pennsylvania, and Vermont) included a checklist to identify high-risk cases, protocolize management, and facilitate structured documentation.

Overall, 6 state protocols (18%) included at least one element from each of the five domains. For states with a refusal protocol, we found a range of 5–25 of the 35 elements included, with a median of 15.

The National Guidelines, examined separately, included 15 of the 35 assessed elements (43%), spanning only 3 of the 5 domains: determination of decision-making capacity, escalation to direct medical oversight, and documentation of

	Determining decision-making capacity
1	Word "capacity" used within protocol
2	Definition of "capacity" provided
	Inclusion of element(s) of "capacity" to guide assessment
3	Understanding of relevant information including risks/benefits
4	Appreciation of the situation
5	Demonstration of logical/rational process of coming to refusal decision
6	Ability to communicate a clear and consistent choice over time
7	Importance of attempting to overcome language/communication barriers included
8	Inclusion of any clinical circumstances that preclude accepting refusal
	Inclusion of specific clinical circumstances that preclude accepting refusal
9	Suicidal ideation
10	Not alert/oriented to self, time, place
11	Intoxication
12	Altered mental status/level of consciousness
13	Head injury
14	Acute psychiatric condition (other than suicidal ideation)
15	Hypoxemia
16	Abnormal vital sign(s) (other than hypoxia)
17	Abnormal/reduced Glasgow Coma Score
	Assessing risks of a poor outcome if a patient does not receive treatment and/or transport to the ED and explaining those risks to the patient
18	Discussion of consideration of risk for severe medical emergency among patients refusing care/transport
	Inclusion of specific criteria other than EMS clinician gestalt to assess for risk of severe medical emergency among patients refusing care/transport
19	Any
20	Abnormal vital signs
21	Specific chief complaints (e.g. chest pain, shortness of breath)
22	Advanced age (≥65)
23	Dementia/cognitive impairment
	Attempting persuasion without being coercive when appropriate
24	Inclusion of encouragement for EMS clinicians to attempt to persuade patients refusing who are at high risk for severe medical emergency to accept care/transport
25	Inclusion of specific strategies/techniques to attempt to persuade patients refusing who are at high risk for severe medical emergency to accept care/transport
	Escalating to direct medical oversight for assistance and guidance
26	Recommendation to involve/escalate to direct medical oversight in at least some refusals
	Inclusion of specific criteria to involve/escalate to direct medical oversight beyond EMS clinician concern
27	Dementia/cognitive impairment
28	Advanced age (≥65)
	Appropriately and comprehensively documenting refusal
29	Inclusion of the need for EMS clinician to document assessment for accepted refusal
30	Any guidance/guidelines about specific elements of documentation necessary for accepted refusal
31	Inclusion of the need for EMS clinician to document that they have explained to patient risks and benefits of refusing care/transport necessary for accepted refusal
32	Recommendation that patients refusing care/transport sign standardized refusal form
33	Inclusion of an information sheet about refusal that should be given to patient who refuses care/transport
34	Inclusion of a checklist to identify patients refusing care/transport who are at high risk for severe medical emergency, protocolize management, and facilitate structured documentation
35	Recommendations about additional counseling for patients who refuse

Figure 2. Elements of Guidance for Emergency Medical Services (EMS) Clinicians about Managing Patient Refusal of Care/Transport that may be Included in Protocols.
Abbreviations: EMS, emergency medical services; ED, emergency department.

refusals. They incorporated the inclusion of some specific clinical circumstances that may preclude accepting refusal and guidance around documentation, but omitted others, such as assessing the risk of a poor outcome, strategies for ethical persuasion of high-risk patients, and the use of structured checklists. Included elements are detailed in Table 1 and Supplemental File Table 4, with total counts shown in Supplemental File Table 3.

Table 1. Inclusion of elements of guidance for emergency medical Services (EMS) clinicians about managing patient refusal of care/transport within statewide EMS protocols ($n = 34$) and the national EMS model Guidelines ($n = 1$).

Determining decision-making capacity	Total %, ($n = 34$)	Mandatory %, ($n = 17$)	Model %, ($n = 17$)	National EMS ($n = 1$)
Word "capacity" used within protocol	59	59	59	100
Definition of "capacity" provided	53	59	47	100
Inclusion of component(s) of "capacity" to guide assessment				
Understanding of relevant information including risks/benefits	53	59	47	100
Appreciation of the situation	50	59	41	100
Demonstration of logical/rational process of coming to refusal decision	12	6	18	0
Ability to communicate a clear and consistent choice over time	9	6	12	0
Importance of attempting to overcome language/communication barriers included	32	41	24	100
Inclusion of any clinical circumstances that preclude accepting refusal	65	76	53	100
Inclusion of specific clinical circumstances that preclude accepting refusal				
Suicidal ideation	59	71	47	100
Not alert/oriented to self, time, place	44	53	35	100
Intoxication	50	59	41	100
Altered mental status/level of consciousness	35	47	24	0
Head injury	32	41	24	0
Acute psychiatric condition (other than suicidal ideation)	29	35	24	100
Hypoxemia	15	12	18	0
Abnormal vital sign(s) (other than hypoxia)	12	18	6	0
Abnormal/reduced Glasgow Coma Score	9	6	12	0
Assessing risks of a poor outcome if a patient does not receive treatment and/or transport to the ED and explaining those risks to the patient				
Discussion of consideration of risk for severe medical emergency among patients refusing care/transport	18	29	6	0
Inclusion of specific criteria other than EMS clinician gestalt to assess for risk of severe medical emergency among patients refusing care/transport				
Any	18	29	6	0
Abnormal vital signs	18	29	6	0
Specific chief complaints (e.g., chest pain, shortness of breath)	18	29	6	0
Advanced age (≥65)	3	6	0	0
Dementia/cognitive impairment	0	0	0	0
Attempting persuasion without being coercive when appropriate				
Inclusion of encouragement for EMS clinicians to attempt to persuade patients refusing who are at high risk for severe medical emergency to accept care/transport	38	53	24	0
Inclusion of specific strategies/techniques to attempt to persuade patients refusing who are at high risk for severe medical emergency to accept care/transport	15	24	6	0
Escalating to direct medical oversight for assistance and guidance				
Recommendation to involve/escalate to direct medical oversight in at least some refusals	59	76	41	100
Inclusion of specific criteria to involve/escalate to direct medical oversight beyond EMS clinician concern				
Dementia/cognitive impairment	12	18	6	0
Advanced age (≥65)	6	12	0	0
Appropriately and comprehensively documenting refusal				
Inclusion of the need for EMS clinician to document assessment for accepted refusal	71	76	65	100
Any guidance/guidelines about specific elements of documentation necessary for accepted refusal	62	71	53	100
Inclusion of the need for EMS clinician to document that they have explained to patient risks and benefits of refusing care/transport necessary for accepted refusal	62	76	47	100
Recommendation that patients refusing care/transport sign standardized refusal form	50	71	29	0
Inclusion of an information sheet about refusal that should be given to patient who refuses care/transport	6	6	6	0
Inclusion of a checklist to identify patients refusing care/transport who are at high risk for severe medical emergency, protocolize management, and facilitate structured documentation	12	24	0	0
Recommendations about additional counseling for patients who refuse	50	65	35	100

EMS: emergency medical services; ED: emergency department.
Shaded areas represent the five key domains of refusal management.

Mandatory protocols included a range of 5–25 elements (median 16, mean 16), while model protocols had a range of 6–24 (median 14, mean 13). Model protocols were substantially more likely than mandatory protocols to include elements in assessing risks of a poor outcome if a patient does not receive treatment and/or transport to the ED and explaining those risks to the patient, attempting persuasion without being coercive when appropriate, and escalating to direct medical oversight for assistance and guidance, A detailed breakdown of the inclusion of elements within each of the state protocols is shown in Online Supplemental File Table 4.

In addition to assessing the inclusion of structured elements across protocols, we noted statewide EMS protocols with guidance that was inconsistent with the 35 structured elements developed through expert consensus and recommendations for ED management of refusal (6–14,17). Some states applied a "reasonable person" standard to assess a patient's decision-making capacity, while others equated capacity with being of "sound mind." Additionally, some protocols list dementia as a cause of altered mental status or altered level of consciousness. Details of these and additional inconsistencies with text from state protocols are shown in Table 2.

Table 2. Examples of guidance in statewide EMS protocols not consistent with evaluation tool.

Guidance from EMS Statewide Protocol	Text from Protocol
A patient's capacity is evaluated using a "reasonable person" standard	"A person that denies the need for medical treatment and/or transport, but any reasonable EMS provider can see that a person(s) has an obvious injury or illness, should be considered a patient and treated as such." (*Delaware*)
	"Acting in an irrational manner, to the extent that a reasonable person would believe that the medical capacity to make decisions is impaired…Judgment impaired by severe illness or injury to the extent that a reasonable and medically capable person would seek further medical care" (*Maryland*)
	"Patient consent in these circumstances is implied, meaning that a reasonable and medically capable adult would allow appropriate medical treatment and transport under similar conditions" (*New York*)
	"Acting in an irrational manner, to the extent that a reasonable person would believe that the capacity to make medical decisions is impaired" *(New York)*
Capacity is made synonymous with being of "sound mind"	"An adult is considered to be of sound mind unless he or she is obviously under the influence of drugs or alcohol or has been determined by a judge to be incompetent. If the person is obviously under the influence of alcohol or drugs, or threatens to harm him or herself, yet refuses treatment, contact OLMD and law enforcement if necessary." (*Alabama*)
Patient is determined to be without capacity if the language is not understood	"A patient without decision making capacity would be one who has one or more of the following: an altered mental status or intoxicated, confused, delirious, psychotic, comatose, unable to understand the language, or is a minor, etc." (*Maine*)
Dementia is included as a cause of altered mental status or altered level of consciousness	"No evidence of altered level of consciousness resulting from head trauma, medical illness, intoxication, dementia, psychiatric illness or other causes." (New Hampshire, Connecticut, Massachusetts, Vermont)
	"Continued altered mental status from any cause including altered vital signs, influence of drugs and/or alcohol, metabolic causes (CNS or hypoglycemia), head trauma, or dementia" (Maryland)

EMS: emergency medical services; OLMD: online medical direction; CNS: central nervous system. Based on publicly available statewide EMS protocols as of June 2024.

Discussion

This represents, to our knowledge, the first in-depth analysis of statewide and national EMS protocols concerning patient refusal. These protocols vary significantly in the inclusion of information and guidance about evaluating decision-making capacity, identifying cases at high risk for poor outcomes, persuading reluctant patients, escalating to direct online medical oversight, and documenting such incidents. Notably, 24% of states offer no guidance on handling refusals, and only 18% include at least one element from each of the five domains we examined.

Most importantly, protocols included widely differing approaches to decision-making capacity. Few included guidance about assessment for all four components of capacity that a patient must demonstrate to make a specific medical decision (6–14). This suggests that the approaches to capacity assessment in the prehospital setting are different than those in the ED (18). While variations in pre-hospital and ED care are unavoidable due to resource constraints, further research is necessary to understand how this variation in capacity assessments affects patient outcomes, particularly in high-risk cases.

The concept of the "sliding scale" (16,19–24) of capacity, in which the threshold for decision-making capacity increases with the medical risk associated with a decision, is well-established in psychiatry. Although its principles are implicitly applied in prehospital care, such as requiring medical oversight for high-risk cases, explicitly incorporating these concepts in protocols and education could support EMS clinicians in navigating these high-risk refusal scenarios. Many protocols do not provide substantial, structured guidance for EMS clinicians to identify patients at high risk of poor outcomes if not assessed, treated, and/or transported. Only 18% of protocols offer specific criteria (e.g., head injury, chest pain, electrocardiogram abnormality) beyond EMS clinician gestalt (described typically as "suspected serious illness or injury" or something similar). Notably, one characteristic that substantially increases the risk of poor outcomes among patients who refuse is advanced age due to frailty or chronic underlying medical conditions (3,25–28). More than 75% of patients who die within one week of refusing care are ≥65 years old (29). As the aging population continues to grow, EMS is increasingly responsible for providing prehospital care to older adults, who are also more frequently refusing EMS transport (1,30,31). Despite this, only one protocol (New York) includes advanced age as a criterion for high-risk refusals.

Many patients who initially refuse assessment, care, or transport may be ethically persuaded by EMS clinicians. However, only 38% of states provide any guidance on how to do so. Communication techniques that facilitate the ethical persuasion of reluctant patients have been successfully taught to clinicians in other clinical settings (32). State EMS medical directors may consider incorporating these strategies into state protocols and training, tailoring them to the unique challenges of prehospital patient encounters.

Online medical oversight is a resource for EMS clinicians who cannot persuade a high-risk patient to accept assessment, treatment, or transport, or when unsure if a refusal is acceptable. The online medical oversight physician can discuss the care with the EMS clinician and may talk directly to the patient. In one system, 32.3% of all calls from EMS in the field to online medical oversight were for a patient who was refusing (33). More than half (59%) of statewide protocols included a recommendation to involve/escalate to online medical oversight in at least some refusals. Very few, though, included specific guidelines or clinical criteria for this escalation beyond EMS clinician concern. Previous literature suggests that the involvement of an online medical oversight physician often has a positive impact. In 47% of calls in one study, the online oversight physician was able to persuade the patient to be transported (27). This suggests that a key element of online oversight strategy, when involved in assessing and caring for patients who have initially refused, is to attempt to persuade them to accept care.

However, given that direct physician oversight is an expensive and limited resource, more research is needed to understand the specific escalation conditions for its efficient use.

Comprehensive and accurate documentation of the assessment, the care offered, attempts at persuasion, capacity evaluation, and counseling provided when accepting refusals is essential to protecting EMS clinicians and agencies. Substantial potential liability is associated with an accepted refusal in a patient who has a poor outcome soon thereafter (34). Despite this, less than two-thirds of state protocols offer any guidance about documentation of refusals. The complexity of documentation for accepted refusals suggests that using a checklist might be helpful for memory recall and standardization (35). Despite this, only four states (Maryland, Michigan, Pennsylvania, and Vermont) included a checklist as part of their protocols, suggesting a potential missed opportunity. Pennsylvania used a structured checklist that not only documented the key elements but also provided clear thresholds and criteria for factors such as vitals, mental status, and various patient scenarios where direct physician oversight must be contacted.

Limitations

This study has several limitations. We only included published protocols available online, which may not be the most updated versions. We excluded 12 states from this analysis because they did not have publicly available protocols and did not report using the national model guidelines. The states not included (such as California, Texas, and Florida) comprise a substantial fraction of the US population. In this analysis, we included both mandatory and model protocols, which serve different purposes. Mandatory protocols require adherence, whereas model protocols serve as recommendations for counties/agencies to adapt or adopt. The tool we developed to describe and compare state protocols, though based on a structured, multi-step content analysis and the consensus of a multi-disciplinary team with relevant experience and expertise, has not undergone external review or validation. Notably, though more comprehensive, our tool is consistent with the results of a recently published description of critical steps in capacity assessment for physicians providing EMS oversight (17). Additionally, as EMS clinicians' adherence to protocols in clinical practice likely varies, our findings may not reflect actual pre-hospital approaches to patient refusal.

Conclusions

Substantial variability exists among state protocols regarding patient refusal guidance, including assessment of capacity. Few protocols address high-risk patients, provide strategies for persuasion, or include checklists for proper management. Standardizing and expanding protocols may enhance EMS care.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

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