BY ORDER OF THE COMMANDER
59TH MEDICAL WING

59TH MEDICAL WING INSTRUCTION
51-302

6 NOVEMBER 2020

Law

INFORMED CONSENT AND REFUSAL OF CARE

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AFLOA/JACC-MLFSC

Certified by: 59 MDSG/CC
(Colonel Terence Cunningham)

Supersedes: 59 MDWI 51-302, 11 April 2017

Pages: 14

This instruction implements Air Force Policy Directive 51-3, *Civil Law, Acquisition Law and Litigation.* This instruction establishes 59th Medical Wing (MDW) policy and procedure regarding informed consent for medical treatment and surgical procedures. Personnel should consult AFI 44-172, *Mental Health*, AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*, and AFI 40-301, *Family Advocacy Program*, for guidance on informed consent in Mental Health, Alcohol and Drug Abuse Prevention and Treatment, and Family Advocacy contexts. This instruction applies to all personnel assigned, attached, or under contract to the 59 MDW, except for personnel working at the Brooke Army Medical Center. This instruction does not apply to the Air National Guard or Air Force Reserve. **Note:** This instruction requires the collection and maintenance of information protected by the Privacy Act of 1974 authorized by Title 10, United States Code, Section 8013. Privacy Act Systems of Records F044 AF SG D, *Automated Medical/Dental Record System*, and F044 AF SG E, *Electronic Medical Records System*, apply. Collected information is "For Official Use Only." Requests to release Privacy Act information to persons or agencies outside the DoD must be in accordance with (IAW) AFI 33-332, *Air Force Privacy and Civil Liberties Program*, DoDM 5400.7_AFMAN 33-302, *DoD Freedom of Information Act (FOIA) Program*, and DoDM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs.* Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the AF Form 847, *Recommendation for Change of Publication*. The authority to waive requirements is the publication approval authority. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW Air Force Manual (AFMAN) 33-322, *Records*

Management and Information Governance Program, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS).

SUMMARY OF CHANGES

This publication has been revised. This rewrite of 59 MDWI 51-302 includes updated references.

1. Air Force Policy on Informed Consent. As prescribed by Texas State Law and AFI 44-102, *Medical Care Management*, the treating healthcare provider (this includes a resident or fellow with the oversight of the attending provider) is responsible for obtaining and documenting informed consent. "Treating healthcare provider" is defined as the provider with primary responsibility for the procedure or healthcare service to which the patient is consenting. This includes responsibility for informed consent discussions with patients, written disclosures, fully completed consent forms, and entries in the patient's medical or dental records [Standard Form (SF) 509, *Medical Record – Progress Notes;* SF 600, *Health Record – Chronological Record of Medical Care*; or SF 603, *Chronological Record of Dental Care* and/or SF 603A *Chronological Record of Dental Care-Continuation* or equivalent electronic records].

2. Procedures Requiring the Use of a Written Consent Form. Air Force policy allows each military treatment facility (MTF) to determine which procedures do and do not require documentation of informed consent in light of standard medical practice and relevant state laws. This is necessary because liability in medical malpractice cases under the Federal Tort Claims Act is determined IAW the substantive law of the state where the alleged negligence occurred. **Note:** This instruction does not apply to consent to withhold or withdraw life-sustaining treatment from patients with terminal or irreversible conditions. 59th Medical Wing Instruction (MDWI) 44-150, *Advance Directives and End-of-Life*, governs those conditions.

2.1. Texas Statutory Lists. Pursuant to state statutory authority (Tex. Civ. Prac. & Rem. Code § 74.102), the Texas Medical Disclosure Panel publishes and updates a list of procedures requiring written informed consent, as well as the specific risks which must be disclosed. It is codified in 25 Tex. Admin. Code § 601.2, *Procedures Requiring Full Disclosure of Specific Risks and Hazards--List A.* If practitioners comply, there is a presumption that the legal duty to provide informed consent has been satisfied. If they fail to comply, there is a presumption that there has been a "negligent failure to conform to the duty" to provide proper informed consent. The panel has also published a list of procedures not requiring the use of a written informed consent form, available at 25 Tex. Admin. Code § 601.3, *Procedures Requiring No Disclosure of Specific Risks and Hazards--List B.* Caveat: Procedures not included on either list continue to be governed by standard medical practice; see **paragraph 2.3** of this instruction. Lists A and B under the 25 Tex. Admin. Code §§ 601.2 and 601.3 can be found at site: **https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=7&ch=601&rl=Y**

2.1.1. Medical Law Consultant (MLC) Responsibilities. The MLC will review 25 Tex. Admin. Code §§ 601.2-601.3, List A and List B procedures, on a bi-annual basis and provide 59 MDW/SGH a list of any changes to List A and List B. The 59 MDW/SGH

will then provide any changes in List A and List B to the clinics/sections which may be affected by the changes.

2.2. Forms to be used:

2.2.1. To obtain a patient's informed consent before administering certain types of anesthesia or perioperative pain management (analgesia), use 59 MDW Form 164, *Disclosure and Consent – Anesthesia and/or Perioperative Pain Management (Analgesia)* or equivalent computer generated form (i.e. ESSENTRIS). This applies to general, epidural, spinal, and regional block anesthesia, as well as deep sedation and moderate sedation (conscious sedation) and equivalent forms of analgesia. It does not apply to local or other forms of regional anesthesia or analgesia. 2.2.1.1. Pursuant to 25 Tex. Admin. Code § 601.9, Spanish language version of the form is available for use, the local version of which is 59 MDW Form 163, *Revelacion Y Consentimiento – Anestesia y Control de Dolor (Analgesia) Perioperatorio.*

2.2.2. For List A procedures other than the types of anesthesia and perioperative analgesia that require the use of 59 MDW Form 164, use 59 MDW Form 1202, *Disclosure and Consent for Medical and Surgical Procedures* or equivalent computer generated form (i.e. ESSENTRIS). Sections may create overprints on 59 MDW Form 1202 for List A procedures. Overprints must be reviewed by the 59 MDW Forms Manager prior to use. Ensure that all the specific risks which must be disclosed per List A are included in the overprint. Alternatively, a section may attach List A to 59 MDW Form 1202, circling the proposed procedure and associated risks and having the patient sign and date it as well.

2.2.2.1. Pursuant to 25 Tex. Admin. Code § 601.4, Spanish language version of the form is available for use, the local version of which is 59 MDW Form 1201, *Consentimiento Medico Informado*.

2.3. Risks Which Must Be Disclosed. List A establishes minimum levels of disclosure required to ensure statutory protection. Disclosures must be discussed with the patient as part of the informed consent briefing for any List A procedure and listed in the applicable form: 59 MDW Form 1202 or 59 MDW Form 164. If the medical staff or an individual practitioner determines that more risks should be disclosed than what the state requires for List A procedures, or the use of the informed consent form is appropriate for a procedure on List B, or for a procedure not included on either list, they may do so. When providing informed consent on a non-List A procedure, the provider should give the patient the information, including the risks, benefits, and alternatives to the treatment, which would allow a reasonable person to make a rational decision.

2.4. Research Consents. Consent forms to document consent for participation of human subjects in research studies are governed by DODI 3216.02_AFI 40-402, *Protection of Human Subjects and Adherence to Ethical Standards in Air Force Supported Research*. The 59 MDW Institutional Review Board must approve all consent forms to be used in research on human subjects. Any questions should be directed to the 59th Clinical Research Division (SGVU) Director.

3. Documenting Informed Consent.

3.1. Except as otherwise provided for in this instruction, the form used at 59 MDW for all medical and surgical procedures requiring a written consent is the 59 MDW Form 1202, or equivalent computer generated form (i.e. ESSENTRIS or iMed). The Spanish language version of the form, 59 MDW Form 1201, is available for use if needed. For anesthesia and/or perioperative pain management (analgesia), 59 MDW Form 164, or equivalent computer generated form, must be used. See **para 3.5** of this instruction. The Spanish language version of the form, 59 MDW Form 163, is available for use if needed. The patient record must include a complete and accurate informed consent for each operative or invasive procedure to be performed. If corrections are required, a new consent form must be completed. Printed copies of computer generated forms (ESSENTRIS or iMed) may not be altered. Outpatient procedure consent forms are uploaded into HAIMS. Ambulatory surgery procedure consent forms are maintained with the ambulatory procedure record.

3.2. Transfusion of Blood and Blood Components. Transfusion of blood and blood components is a List A procedure. Therefore, 59 MDW Form 1202 is also used to document consent for the transfusion of blood and blood products. The 59 MDW only offers emergency release blood for the Family Emergency Center (FEC) and Operating Room (OR)/Post Anesthesia Care Unit (PACU). Policy/procedures for consent and administration of blood transfusion are outlined in 59 MDWI 44-107, *Blood Products*.

3.3. Storage and Release of Surgical Specimens. Include the following statements on 59 MDW Form 1202:

3.3.1. "I understand that any surgical specimens, to include orthopedic hardware and prosthetic devices, that are removed from me during the above-named procedure will be disposed of after 30 days from removal. I further understand that if I wish to retain these items, I must notify the above-named provider at the time of signing this surgical consent, and that failure to do so may result in these items being destroyed."

3.3.2. "Retain Specimen _____ Destroy Specimen _____ (Pt initial)."

3.4. Immunizations. Refer to AFI 48-110, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases*, for consent requirements for administration of vaccines in Investigational New Drug status.

3.5. Anesthesia. Note that all procedures requiring epidural, general, regional block, spinal anesthesia, as well as deep and moderate sedations are included on List A. However, Texas law requires a separate disclosure and consent form for anesthesia and/or perioperative pain management (analgesia), the local version of which is 59 MDW Form 164.

3.6. Informed Consent Discussion. The patient's attending provider will conduct the informed consent discussion with the patient and note the discussion in the medical record. The note should indicate that the patient understood the discussion. If desirable, the provider may have the patient sign the record to acknowledge the discussion. The discussion with the patient will include:

3.6.1. The patient's proposed care, treatment, or services.

3.6.2. The potential benefits, risks, and side effects of the patient's proposed care, treatment, or services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.

3.6.3. Reasonable Alternatives to the Patient's Proposed Care, Treatment or Services. This discussion should encompass the risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, or services.

3.6.4. Any circumstances under which information about the patient must be disclosed or reported (e.g. reportable diseases).

3.7. Involving Family in Care Decisions. Providers should involve the patient's family in care, treatment, or services decisions when appropriate, to the extent permitted by the patient (or surrogate decision-maker), and in accordance with law and regulation.

3.8. Responsibility for Documenting Informed Consent. The patient's attending provider must counsel the patient, obtain informed consent, and document the counseling in the patient's medical record. If the counseling provider will not be performing the procedure, the consent form must also list the name(s) of the provider(s) performing the procedure. Except for limited, minor, routine procedures not requiring a physician's supervision or authorization to carry out, a physician's assistant, medical student or nurse practitioner may not perform the patient counseling or obtain the patient's informed consent. The practitioner performing the procedure must ensure proper documentation and completion of any informed consent form as well as documenting the proper entry in the patient's record.

3.9. Fill in All Blanks. In completing any informed consent form, all blanks must be filled in appropriately. Use plain English (lay terms) to describe the patient's condition and the procedure(s) to be performed.

3.10. Signatures. Informed consent forms must be signed by the patient, by the patient's legal guardian, by another individual appointed to make treatment decisions by the patient through a Medical Power of Attorney, or by another person legally authorized to consent for the patient (see **paragraph 4**). The forms must be signed by a witness who is not a member of the operating team or the patient's family. The forms must also be signed by the attending physician, dentist, or practitioner. A resident or fellow may obtain and sign informed consent under the supervision of the attending physician, dentist or other provider. The witness signature affirms that the witness observed the patient sign the consent form; however, the witness need not be present for the informed consent discussion between the patient and the counseling practitioner. If the patient's status or mental condition renders the patient unable to give intelligent informed consent, consent must be obtained from the patient's legal guardian or other person legally authorized to consent for the patient (see **paragraph 4**). If the incompetent patient has a terminal or irreversible condition, refer to 59 MDWI 44-150 for procedures used to have treatment decisions made by next of kin.

3.10.1. Consideration of the decisional capacity of the patient to sign the consent is the responsibility of the provider obtaining the consent (see **paragraph 8.2.5**).

3.10.2. If the patient had been medicated prior to signing the consent, the practitioner obtaining consent shall consider the effect of the medication on the patient and document the tests and results of the tests used to determine the patient's capacity. If the patient's

capacity has been temporarily diminished, the procedure will be postponed until the effects of the medication have dissipated, the patient's capacity restored, and informed consent obtained.

3.11. Include Additional Risks or Information on the 59 MDW Form 1202. For procedures where the practitioner desires to document procedures, risks, or alternatives more extensively than the space in the 59 MDW Form 1202 permits, the practitioner should attach an additional page, clearly annotate that the additional information as a continuation of the 59 MDW Form 1202, and have the patient sign and date it at the bottom.

4. Surrogate Consent for Adult Incapacitated Patients.

4.1. An incapacitated patient is one who lacks the ability to communicate a decision, understand the illness and prognosis on at least a basic level, understand the nature and consequences of treatment options, and/or use a rational thought process. Threshold levels of capacity are fluid and thus vary with the individualized risk/benefit ratios encountered. Consideration of the decisional capacity of the patient to sign the consent is the responsibility of the provider obtaining the consent.

4.2. Except for the excluded categories of treatment and excluded circumstances listed below in **paragraph 4.6** and its subparagraphs, a competent adult surrogate, in order of priority listed below, can consent to treatment on behalf of an incapacitated adult patient using the following rules. If the patient is incapacitated and has no guardian appointed by the court and has not designated a decision-maker through a Medical Power of Attorney, surrogates in the following order of priority may consent:

4.2.1. The patient's spouse;

4.2.2. An adult child of the patient who has the consent of all other qualified adult children of the patient to act as the sole decision maker;

4.2.3. A majority of the patient's reasonably available adult children;

4.2.4. The patient's parent(s);

4.2.5. The individual clearly identified by the patient to act for him/her before the patient became incapacitated;

4.2.6. The patient's nearest living relative; or

4.2.7. A member of the clergy (contact Medical Law at (210) 292-7808 before using a member of the clergy for a surrogate). **Note:** If the surrogate is also a 59 MDW employee, consult with Medical Law prior to obtaining consent.

4.3. A reasonably diligent inquiry must be made to locate the highest priority surrogate before a lower priority surrogate may give consent. The inquiry efforts must be detailed in the patient's medical record.

4.4. The patient's attending provider must fully describe the basis of the patient's incapacitation in the medical record, as well as the proposed medical treatment. The surrogate will be given a full informed consent discussion, as the patient would normally receive. The attending provider shall record the date and time of the surrogate consent and sign the patient's medical record.

4.5. The surrogate will make consent decisions based upon what the patient would desire to the extent known. The surrogate shall sign the appropriate consent form for the proposed treatment. **Note:** A surrogate decision-maker's consent to medical treatment that is not made in person will be reduced to writing in the patient's medical record, signed by the provider receiving consent, and countersigned in the patient's medical record or on an informed consent form by the surrogate as soon as possible. Providers should first address the feasibility of securely electronically transmitting the informed consent document between locations.

4.6. Surrogate consent may not be used for the following categories of treatment:

4.6.1. Voluntary inpatient mental health services;

4.6.2. Electro-convulsive treatment;

4.6.3. Procedures Performed for the Purpose of Sterilization. No individual may consent to a procedure to be performed on another for the purpose of sterilization, nor may a Texas court order anyone to be sterilized. See *Frazier v. Levi*, 440 S.W.2d. 393 (Tex. Civ. App. 1969). This applies even when the patient is a minor or is an incapacitated adult.

4.6.4. For adult inmates, surrogate consent may not be used for psychotropic medication, involuntary inpatient mental health services, or psychiatric services calculated to restore competency to stand trial.

4.7. Surrogates may not appoint another person to make treatment decisions for the patient. Surrogates shall also not be used when a competent adult has been named by the patient as the patient's agent in a Medical Power of Attorney.

4.8. In situations where the patient has capacity, but is not physically able to sign the informed consent document, using a surrogate is not appropriate. In such situations, the provider should engage in the full consent discussion with the patient and obtain the patient's consent verbally or, if patient is unable to speak, through other demonstrable means. The provider must document this consent in the medical record. Additionally, the patient should be provided with the standard appropriate written informed consent document. An additional witness not directly involved in the patient's care and not otherwise acting as a witness for the informed consent document should sign "for" the patient, by writing and signing the following where the patient would ordinarily sign the informed consent document: "Signed for (Patient's Name) due to patient's physical inability to sign. Patient indicated to me (she/he) understood the content of this document and wished for me to indicate (her/his) consent by signing this document on (her/his) behalf. [Witness' Signature] [Printed Witness' Name] [Date and Time]" If any questions arise using this procedure, contact Medical Law at (210) 292-7808.

5. Obtaining and Documenting Informed Consent for Treatment of Minors. See 59 MDWI 44-121, *Treatment of Minors*.

6. Emergencies. In an emergency situation as described below, consent is implied by law and no form needs to be signed. Consent for emergency care of an individual is not required if:

6.1. The individual is unable to communicate because of an injury, accident, or illness, or is unconscious and suffering from what reasonably appears to be a life-threatening injury or illness;

6.2. A court orders the treatment of an individual who is in an imminent emergency to prevent the individual's serious bodily injury or loss of life (in such case, contact the Medical Law Consultant if time permits or as soon thereafter as possible); or

6.3. The individual is a minor who is suffering from what reasonably appears to be a life-threatening injury or illness and whose parents, managing conservator or possessory conservator, or guardian is not present. This exception applies only to the extent necessary to preserve the patient's life or health and to stabilize the patient's condition.

7. Duration of Effective Informed Consent.

7.1. The consent form will generally remain effective until:

7.1.1. It is revoked by the person giving consent.

7.1.2. The patient's condition changes.

7.1.3. A different procedure is contemplated

7.1.4. The risks associated with the procedure change.

7.1.5. the procedure is completed.

7.2. 59 MDW's policy is that written patient consent forms are valid for 60 days provided the patient's condition, the type of procedure and the risks do not change. If the procedure occurs 30 or more days after the date of the initial consent, the provider performing the procedure will document on the SF 509 that the initial consent still applies and the patient's medical condition, the procedure, and the risks remain the same. If there is any question, contact Medical Law for assistance.

7.3. In the event one of the above factors necessitates a new consent form, the provider must have another informed consent discussion with the patient and a new form must be re-executed in its entirety (see **paragraph 3**). The original form will be kept in the chart along with later forms for the purpose of detailing a complete history of patient care.

8. Patient Refusal of Diagnostics or Treatment, Including Blood or Blood Products, and Leaving Against Medical Advice.

8.1. Release From Treatment Against Medical Advice (AMA).

8.1.1. Policy. All patients and immediately available family members must be informed about the risks involved in leaving the facility AMA. Staff members are responsible for preparation of appropriate documentation for inclusion in the medical record of the risks explained, the circumstances involved with a patient's decision to withdraw from treatment at the 59 MDW, the patient's or family member's decision, and any other pertinent information.

8.1.2. Active duty patients may not be released AMA without coordination with the individual's commander. The patient will be reported as missing from the facility immediately to his or her commander if the individual departs the facility, and reported absent without leave after a 24-hour absence. In addition, active duty members who

refuse required medical care may need to be evaluated by a Medical Evaluation Board. See AFMAN 41-210, *TRICARE Operations and Patient Administration*, paragraph 4.60.8.

8.1.3. Patients leaving AMA who have physically or verbally abused wing personnel may be considered for denial of further treatment on a case-by-case basis. All wing personnel are encouraged to complete an electronic Patient Safety Report. This Patient Safety Report can be completed by accessing the "Patient Safety Reporting" icon found on all 59 MDW personnel's computer desktop. It will also be found at **https://patientsafety.csd.disa.mil/**.

8.2. *Provider Responsibilities.*

8.2.1. *Inform the patient or sponsor about any risk that may occur if the patient departs AMA. For guidance in unique or difficult situations, seek advice from the Patient Administration Division, Medical Law Office, flight commander, medical director, and/or group Chief of the Medical Staff. Document the information given to the patient regarding risks associated with AMA actions in the medical records.*

8.2.2. *Have the patient or sponsor complete 59 MDW Form 172,* Release from Responsibility Upon Departure Against Medical Advice, *when patient or sponsor desires release from treatment AMA. The form must be completed and signed by the patient or patient's sponsor, the attending provider, and a witness. Ensure that two copies are made, with one copy being given to the patient or sponsor and the other copy being placed in the patient's medical records.*

8.2.3. If the patient or the patient's sponsor refuses to complete 59 MDW Form 172, the provider and witness complete the form and add a statement that the patient refused to sign.

8.2.4. Document the patient's AMA information in the electronic medical record, SF 600, or SF 558, *Medical Record – Emergency Care and Treatment Record* (ETR), for FEC patients. All entries must be dated, timed, stamped, and signed by the provider. Also, complete an electronic Patient Safety Report.

8.2.5. When the patient and sponsor refuses to sign the release from responsibility statement, the provider must document on the SF 600, electronic medical record, or the ETR the following information:

8.2.5.1. Why the patient chose to sign out AMA.

8.2.5.2. Counseling given to patient and sponsor on the risks that may occur from signing out AMA.

8.2.5.3. A statement that the patient and sponsor refused to sign the release from responsibility statement.

8.3. Procedures.

8.3.1. When a provider deems a diagnostic procedure or treatment necessary for the care of the patient, and the patient refuses the procedure or treatment, the refusal should be identified at the earliest possible opportunity and promptly annotated in the patient's medical record so that all providers have access to the information, alternatives can be

explored, and the patient can be properly managed. AF Form 1864, *Perioperative Nursing Record,* is a vital document that is used to communicate the patient's wishes to the Surgical Team, as well as serve as a very important Quality Assurance document. AF Form 1864, once completed, needs to be placed in the patient's medical record.

8.3.2. The 59 MDW only offers emergency release blood for the FEC and OR/PACU. Policy for administration of emergency release blood are outlined in 59 MDWI 44-107, *Blood Products*.

8.3.3. If, after a full discussion of risks, benefits, and alternatives, the patient still refuses to allow the administration of blood or blood products that may be necessary for safe surgical care, the patient will not undergo the surgery at a 59 MDW facility. The patient may be referred elsewhere for care.

8.4. Obtain Informed Refusal. If the provider is willing to accept the patient, then informed refusal should be obtained. The provider should explain to the patient the increased risks caused by the refusal of blood or blood products, to include significant hemorrhage, life-threatening hemorrhage, and death. The medical record must clearly reflect the patient's insistent refusal of the specific therapy even in light of the potential complications discussed. A note to this effect should be co-signed by the patient in addition to the refusal notation on the informed consent document. **Note:** In the case of active duty members, the provider should also discuss with the patient and document in the note the patient was advised the refusal may impact the patient's continued military service, result in the patient's evaluation by a Medical Evaluation Board, and may affect any potential disability rating.

8.5. Guidance for Specific Patient Categories.

8.5.1. Obstetric Patient. 59 MDW may support routine outpatient prenatal care, radiology, and medical care to include services at the FEC. The 59 MDW does not provide invasive outpatient OB services, surgeries, elective blood transfusions, or inpatient services. OB patients presenting to the 59 MDW and requiring these services are transferred to a higher level of care. Emergency release blood products are limited to the FEC and OR/PACU and follow 59 MDWI 44-107 guidance. OB patients requiring emergency release blood would be immediately transferred to a higher level of care. OB patients declining emergent, lifesaving procedures or blood transfusion, would be addressed per our AMA policy and be transferred to a higher level of care to readdress the indications for treatment. The Medical Law Consultant and 59 MDOG or 59 MDW Chief of the Medical Staff may be contacted for issues that cannot be resolved to determine need for an ad hoc ethics function.

8.5.2. Emergency Treatment of Competent Adults. In cases presenting as bona fide emergencies, the patient is transferred emergently to the nearest facility equipped to render necessary care. Once an adult patient's desires are known, these desires must be followed. If the patient chooses to not comply with the recommended treatments, the director of the appropriate service should be involved in attempting to secure providers who will accept care of the patient with the noted restriction.

8.5.3. Emergency Treatment of Minors. A minor is defined as an unemancipated individual under the age of 18. Absent specific evidence of emancipation (such as marriage or entry into the military), health care providers may properly assume that a

person under 18 is a minor and therefore legally precluded from either consenting to or refusing care in many situations. If there is a question regarding emancipation, contact the Medical Law Consultant. While parents and guardians generally have wide latitude in making health care decisions for their children, this is not the case when the refusal to seek or consent to care will, within a reasonable medical certainty, result in either the child's death or in great bodily harm. In these limited situations, providers may provide diagnostics and treatment to stabilize the child without the consent and over the objection of the child, parent or guardian. Every effort must be made to minimize the use of blood products and to contact Child Protective Services (CPS) in order to obtain a court order establishing a new medical consenter. The CPS 24-hour hotline number is 1-800-252-5400. The Medical Law Consultant and a Social Worker must be contacted at the earliest opportunity. During these situations, documentation of the care provided and the attempts to contact CPS, the Medical Law Consultant and a Social Worker is critical and therefore should be clearly documented in the record. See 59 MDWI 44-121 for further information.

8.5.4. Active Duty Patients. For those individuals refusing diagnostics or treatment, including blood transfusion, the guidelines outlined above in **paragraphs 8.3** and **8.4** will apply. In the event that the necessary providers cannot be located for the particular medical care needed, required services may be obtained from another Uniformed Services Treatment Facility, the Veteran's Administration, or from civilian sources. Refer these patients to the Health Benefits Advisors, Managed Care Office for assistance.

8.5.5. Incapacitated Patients. If there is a possibility of delirium, dementia, or a mental condition that would impair a patient's ability to give or understand informed consent or to refuse appropriate medical care, a determination of the decisional capacity is indicated. Consideration of the decisional capacity of the patient is the responsibility of the physician who would be obtaining the consent. If the provider desires, a request for the evaluation of decision-making capacity can be made through the Mental Health Consult/Liaison Service. The consult service will render an opinion as to the individual's capacity. After duty hours, the psychiatry on-call resident can provide an initial assessment with recommendations, with staff supervision provided as soon as is necessary/possible.

8.5.5.1. Incapacitated Patients Who Have Executed a Medical Power of Attorney. The agent named under the Medical Power of Attorney may make treatment decisions for the incompetent. (See 59 MDWI 44-150) However, if the patient indicates he wants the treatment over the objection of the agent, the patient's desires will be followed. If the agent refuses treatment on behalf of a patient who does not have a terminal or irreversible condition as defined in 59 MDWI 44-150, seek assistance from the Medical Law Office. Legal intervention may be required.

8.5.5.2. Incapacitated Patients Who Have Not Executed a Medical Power of Attorney. Persons identified in section 4.2. of this policy may make treatment decisions for the patient. However, if the patient indicates he wants treatment over the objection of the surrogate, the patient's desires will be followed. If the surrogate refuses care on behalf of the incompetent patient and the patient does not have a terminal or irreversible condition as defined in 59 MDWI 44-150, contact Medical Law. Legal intervention may be required. **Note:** Certain care and treatment may not

be removed from patients who have terminal or irreversible conditions. Issues pertaining to life-sustaining care are also not addressed in this instruction. See 59 MDWI 44-150. Additionally, decision-makers for incompetent patients with those diagnoses are different from those who can consent to treatment for other patients.

8.6. Conflict Resolution. Every case should be individually evaluated and the best resolution possible achieved through a spirit of cooperation and mutual respect between the patient, patient surrogates, and health care providers. Communication and coordination will resolve most, if not all, issues. In instances where a conflict cannot be resolved, the provider should contact the MLC at (210) 292-7808. The MLC will provide guidance to the provider and the patient or patient's surrogate. If the conflict still cannot be resolved, the Executive Committee of the Medical Staff (ECOMS) will convene an ad hoc ethics function, which will include an MLC and a Chaplain as voting members, to make recommendations.

9. Staff Rights: Exclusion from Certain Aspects of Patient Care/Treatment .

9.1. Each health care provider, including but not limited to physicians, nurses, and medical support personnel, may request not to engage in any form of health care which they personally feel is unconscionable, immoral or unethical. Reasonable efforts will be made to replace the objecting provider. At no time will a patient be left without a health care team. The initial healthcare provider will continue care of the patient until the transfer to another provider has been completed. The patient's safety will take precedence over health care providers' request not to engage in health care. See also 59 MDWI 41-206, *Patient Rights.*

9.2. If the care required by the patient will necessitate support personnel in addition to the primary provider, then that provider must ensure the availability of other individuals willing to participate in the care. For instance, if the patient is undergoing an elective surgical, invasive procedure, such as liver biopsy or balloon angioplasty, acquisition of a support team (to include both physician and nursing services, all of whom are willing to participate in the patient's treatment) for potential anesthesia and surgical support must be prearranged. In elective cases, this should be done by a formal consultation to the individual service from which support is requested, the consult being initiated at least 72 hours before the procedure is planned.

9.3. Support staff unwilling to participate. The inability of the ancillary support services to identify individuals willing to participate in this care may necessitate disengagement by the MTF for that particular medical problem. In this event, the provider will work with the Health Benefits Advisor located in Managed Care to assist the patient in transfer of care into the civilian sector or to other Uniformed Services Treatment Facilities which can and are willing to provide the service. Until transfer of care occurs, the patient will continue to receive, at a minimum, safe, non-elective care.

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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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DoDM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Program,* 13 March 2019

5 U.S.C. § 552a, *Privacy Act of 1974*

AFPD 51-3, *Civil Law, Acquisition Law and Litigation,* 28 November 2018

AFI 33-332, *Air Force Privacy and Civil Liberties Program,* 12 January 2015

AFI 40-301, *Family Advocacy Program,* 16 November 2015

AFI 44-102, *Medical Care Management,* 17 March 2015

AFI 44-105, *The Air Force Blood Program,* 10 January 2019

AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*, 18 July 2018

AFI 44-172, *Mental Health*, 13 November 2015

AFI 48-110, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases*, 7 October 2013

AFMAN 33-322, *Records Management and Information Governance Program,* 6 March 2020

AFMAN 41-210, *TRICARE Operations and Patient Administration,* 10 September 2019

AFMAN 47-101, *Managing Dental Services,* 25 July 2018

59 MDWI 44-107, *Blood Products*, 29 August 2019

59 MDWI 44-121, *Treatment of Minors,* 4 October 2019

59 MDWI 44-150, *Advance Directives and End-of-Life,* 17 July 2019

59 MDWI 41-206, *Patient Rights and Responsibilities*, 17 July 2019

Texas Civil Practice & Remedies Code § 74.102

Title 25, *Texas Administrative Code*, § 601.2 and 601.3, 31 May 2016

Prescribed Forms

59 MDW Form 163, *Revelacion Y Consentimiento – Anestesia y Control de Dolor (Analgesia) Perioperatorio*

59 MDW Form 164, *Disclosure and Consent – Anesthesia and/or Perioperative Pain Management (Analgesia)*

59 MDW Form 172, *Release from Responsibility Upon Departure Against Medical Advice*

59 MDW Form 1201, Divulgacion *Consentimiento Medico Informado*

59 MDW Form 1202, *Disclosure and Consent - Medical and Surgical Procedures*

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

AF Form 1864, *Perioperative Nursing Record*

SF Form 509, *Medical Record – Progress Notes*

SF Form 558, *Medical Record – Emergency Care and Treatment*

SF Form 600, *Medical Record – Chronological Record of Medical Care*

SF Form 603, *Health Record – Dental*

SF Form 603A, *Health Record – Dental – Continuation*

Abbreviations and Acronyms

AMA—Against Medical Advice

CPS—Child Protective Services

ECOMS—Executive Committee of the Medical Staff

ETR—Emergency Treatment Record

FEC—Family Emergency Center

IAW—In Accordance With

MDW—Medical Wing

MDWI—Medical Wing Instruction

MLC—Medical Law Consultant

MTF—Military Treatment Facility

OR—Operating Room

PACU—Post Anesthesia Care Unit

SF—Standard Form