Informed Refusal: A Review

Most healthcare providers know that a patient's signature on an informed consent document may not automatically make the consent valid. The same is true of informed refusal. Both of these concepts rely on ethical and legal guidelines that acknowledge the right of competent adults to determine the course of their healthcare.

The decision-making process requires consultation between the healthcare provider and the patient to determine the best treatment option and to ensure that the patient has been a partner in selecting the appropriate treatment. A signature merely documents the occurrence of this process; without the consultation, the signature means nothing.

Patient education and documentation are the provider's best allies for gaining a patient's cooperation in selection of a treatment plan. However, a patient can refuse care even if the consequences might be dire. When a patient refuses urgent care, the provider should scrupulously document his or her efforts to explain the risks associated with lack of treatment.

When the patient has made known his or her decision to refuse treatment, the provider or staff member should document the information directly into the patient's record. He or she may ask the patient to sign and date the entry. These notes should include the patient's diagnosis, the recommended treatment, and the risks that might occur if the condition isn't treated. The risks might include:

- Fewer treatment options as the condition deteriorates
- Less opportunity for the healthcare provider to affect a successful outcome
- The increased possibility of complications
- Remaining treatment options that are more expensive that the treatment that was initially recommended

Patients also have the right to change their minds and withdraw consent for treatment they have previously authorized, even when the treatment has already been started. When a patient refuses treatment or wants to abandon a treatment plan, the provider should carefully document the decision using the framework of informed refusal. Documentation should include the following considerations:

- Was the patient given adequate information about the diagnosis and treatment options that meet the current standard of care?
- Were the risks and benefits of treatment options discussed with the patient?
• Did the provider and patient discuss and agree upon their mutual expectations for a satisfactory outcome?

• Was the patient encouraged to ask questions and voice his or her concerns? Were these questions and concerns addressed to the patient’s satisfaction?

• Did the provider ask for the patient’s reason for the decision? Knowing the patient's reason for refusal, the provider can sometimes propose an acceptable alternative that the patient will accept.

• Did the provider document his or her explanation of the risks associated with refusal of treatment? If the provider opts to use an informed refusal form, the patient should be given a copy of the signed document, and the original should be retained in the patient's file. The form should include:
  o The diagnosis.
  o Treatment options and the treatment plan the patient elected, as well as risks and benefits associated with each.
  o Acknowledgement that the patient refused or terminated treatment.
  o Specific risks that might occur if the patient doesn’t receive care, and acceptance of the risk on the part of the patient.
  o The patient’s signature (if he or she agrees to sign).

Although it is not always necessary for the patient to sign an informed refusal statement, the request forces the patient to acknowledge the seriousness of the untreated condition. Many patients sign; some refuse. In the event of refusal, the provider should document that the patient was asked to sign the statement and would not do so.

Some providers like to have a witness present when a patient refuses needed care. When an employee has been asked to witness the informed refusal process, he or she should sign the record and date the signature — whether the patient agrees to sign or not.

By refusing urgently needed care, a patient might increase his or her risk of injury and possibly increase the healthcare provider’s liability risk. Under these circumstances, some providers feel that they have no other choice but to formally withdrawal from the patient’s care. Other providers continue to see and treat such patients, with the hope that the patient may change his or her mind or that, if the patient's condition deteriorates, emergent care can still be initiated.

If the provider decides to withdraw from the patient’s care because of the refusal, a discussion should take place, if possible, before the formal discharge process occurs. The patient should know that the provider feels strongly enough about the needed treatment that he or she may withdraw rather than stand by as a witness to the deterioration of the patient’s condition.
Having decided to withdraw, the provider should formalize the notification with a discharge letter, giving the patient adequate time (generally 30 days) to find another practitioner. The letter should be sent to the patient via certified mail with return receipt requested, and an additional copy should be sent through first class mail. Copies of the letter should be maintained in the patient’s file.

When a patient refuses care, the healthcare provider needs to ensure that the patient understands the risks that may result from the decision, and that this warning is thoroughly documented. When in doubt about how to handle a patient’s refusal of treatment or withdraw from a treatment plan, the provider should contact a risk management expert.