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Against Medical Advice: When Should You Take “No” For An Answer?

How much information should be presented to patients prior to allowing them to leave the ED against medical advice? How should we assess the competence of a patient to make such a decision? When can the emergency physician forcibly treat a patient who is not actively suicidal or homicidal? These questions and others will be explored during this course, addressing the ethical and legal complexities of patients who refuse medical care. The effects of intoxication, altered mental status, age, and other barriers to capacity will be discussed. The appropriate use of restraints, both physical and pharmacological, will be identified. Documentation and medicolegal risks of allowing patients to refuse medical care will also be addressed.

- Demonstrate the ethical foundations of informed consent and informed refusal.
- Discuss criteria of informed refusal.
- Explain the sliding scale of decisional capacity, weighing patient capacity and risk.
- Identify processes of decision making when a patient refuses care, based on case discussions.

TH-258
Thursday, October 30, 2008
9:00 AM - 9:50 AM
McCormick Place - Lakeside Building

(+)No significant financial relationships to disclose

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Overview of Medical Legal Issues

Patients who leave the emergency department against medical advice (AMA) constitute one of the highest liability encounters for emergency physicians. These patients suffer increased morbidity and mortality, complain frequently, and sue the physician and hospital nearly 10 times as often as the typical ED patient. About one in 300 AMA cases result in litigation, versus the usual rate of one in 20-30,000 ED visits (or maybe one in 5,000 if you're from south Florida). There is no question that AMA is a high risk issue, but it should surprise no one. What generates lawsuits? Anger coupled with an adverse outcome. Individuals who leave AMA are usually inherently angry or disgusted with their providers, and foregoing recommended treatment frequently leads to unfavorable results.

AMA cases are difficult for the emergency physician because of the tension between a patient's constitutional right to refuse medical care and the physician's duty to protect those patients who aren't medically competent to refuse necessary emergency treatment. Alcohol or drug intoxication, altered mental status, and suicidal ideation, just to name a few conditions, often render a patient incapable of deciding the course of their care in the ED. In these circumstances they lose their right of self determination.

Your guiding principle in determining whether a patient is medically competent to refuse indicated medical care should be 'When in doubt, act in the best interests of the patient and worry about the legal consequences later.' Which would you rather defend to a jury and the (surviving) spouse: 'I was very concerned that Mr. Smith would go home and die and leave his 4 kids without a father, and I didn't think he fully understood the consequences of his actions, so I kept Mr. Smith to treat his 3rd degree heart block'; or 'he seemed rational and he refused my help, even though I told him he could die? The **'when in doubt rule'** for the emergency physician in these circumstances should always be 'when in doubt, don't let 'em out!'"

Refusal of Medical Care - Definitions

There are essentially three scenarios in which patients leave the emergency department refusing examination or treatment.

1. LBE. First, some patients simply pick up and leave, unknown to anyone affiliated with the hospital. If witnessed, the patient does not respond to requests to stay for the examination or to discuss the issues with the hospital staff. Hospitals generally refer to these as patients who "left before examination" (LBE) or "left without being seen" (LWBS).

2. Elopement. The second scenario, termed 'elopement', is really a variation of an LBE – patient's leave the ED after some element of testing has been conducted, such as u/a, UPT, blood analysis, or x-rays, ordered under nursing triage protocols or by the emergency physician, but before the test results are known and can be communicated to the patient. This scenario is often evidenced by the 'empty gown sign'; the hospital gown is discovered in the patient's room but the patient has vanished.

3. AMA. In the third scenario the hospital is aware that the patient is about to leave and the emergency physician has a meaningful opportunity to interact with the patient before the patient leaves. Physicians and hospitals generally refer to this as "leaving against medical advice (AMA)."

Table 1. Common Errors Found in ED 'LBE' and 'AMA' Lawsuits.

- Failure to adequately document that the patient couldn't be found or left of their own free will prior to the medical screening examination (MSE).
- Failure to review the charts of patients who leave before the MSE or follow-up on significant triage findings.
- Failure to review or follow-up on the laboratory tests or x-rays of patients who elope.
- Failure to involve the emergency physician when patients leave the department AMA.
- Failure to insist that the patient sign the AMA form, and instead 'discharge' the patient without documenting the patient's refusal to follow the recommended treatment plan, which includes diagnostic tests, such as an LP, as well as admission.
- Failure to correctly complete the AMA form or have it witnessed.
- Failure to adequately inform the patient of the risks of leaving which are specific to the patient's chief complaint.
- Failure to ascertain the patient's capacity to make informed medical decisions and adequately understand the ramifications of refusing the recommended treatment, and/or documenting such in the medical record.
- Failure to appropriately document the AMA process in the medical record.
- Failure to involve the family before allowing the patient to refuse care.

Table 2. ‘Must Do’ Action Items in the Management of AMAs.

1. LBEs

- Check the waiting room 3 times and page the patient overhead at least once; document all attempts to find the patient.
- The emergency physician should review the chart *in real time* to ascertain if the patient should be contacted to return to the ED.

2. Elopement cases

- The emergency physician should review the chart and any tests ordered by the nursing staff under protocol, or by the physician, such as x-rays, U/As, urine pregnancy tests, blood counts, or serum chemistries *in real time*.
- When indicated, the emergency should contact the patient regarding the results of the tests, and always document the review of the tests, any attempts to reach the patient, and any instructions given to the patient.

3. AMA cases

- The emergency physician must be involved.
- The family and the patient’s personal physician should be involved whenever possible.
- The risks and benefits explained to the patient must be specific to the patient’s condition; ‘you could die’ alone is too generic.
- Explain any alternative treatments to the patient.
- Ascertain the patient’s capacity to make informed medical decisions: ‘When in doubt, don’t let ‘em out!’
- Have the patient and at least one witness sign the AMA form.
- If the patient refuses to sign the AMA form, a member of the hospital staff should sign the form stating that the patient refused to sign the form.
- Still provide the best possible treatment within the scope allowed by the patient, including antibiotics and analgesics when warranted.
- Provide appropriate discharge instructions and welcome the patients to return to the ED at any time if they change their mind and wish to accept your recommended care.
- Document your discussions with the patient, the risks explained, and the patient’s medical decision-making capacity and understanding of the ramifications of leaving AMA in the medical record.

AMA References and Resources

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ACEP 2008 AMA Lecture □

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Every human being of adult years
and sound mind has the right to
determine what shall be done to his
body.

Justice Cardozo, 1914

Objectives

- Informed consent/refusal
- Decision making process
- Medicolegal risks
- Specific situations
- Avoid grief – our goal

Doctrine of Informed Consent

- **Creature of state law**
- **Standards of disclosure**
- **Elements of disclosure**
- **Process v. signature**
- **“Failure to provide full disclosure”**

Informed Consent

- **Competent adults**
- **Incompetent adults**
- **Accompanied minors**
- **Unaccompanied minors**
- **Others**

IC – Competent Adults

- **General rule**
- **Expressed consent**
- **Implied consent**

Consent for Procedures

- ED v. OR procedures
- RN v. MD
- Written and signed v. oral
- Process not a signature
- Alcohol or narcotics issue

IC – Incompetent Adults

- Who has authority to consent?
- Implied consent – Emergency Doctrine
- Federal law preemption
- ETOH intoxication – blood levels
- ‘When-in-doubt rule’

Accompanied Minors

- General rules
- Creatures of state law
- Role of the parent, legal guardian
- Minor’s consent alone sufficient

Unaccompanied Minors

- **Federal law preemption - EMTALA**
- **State's 'Emergency Doctrine'**
- **Minor's consent alone sufficient**
- **Consent never an issue**
- **Common sense – Mark Twain**

EMTALA - 'Request for Examination or Treatment'

- **By patient**
- **By family**
- **By babysitter**
- **By police**
- **By anyone**
- **By word or by deed**

Consent for a MSE

- **No EMC required – purpose of MSE**
- **No parental consent required**
- **Never delay examination of child**

Consent for Stabilizing Treatment or Transfer

- Determine EMC exists
- No parental consent required
- Delay is error
- Obtain consent after MSE/stabilize

Refusal of Medical Care

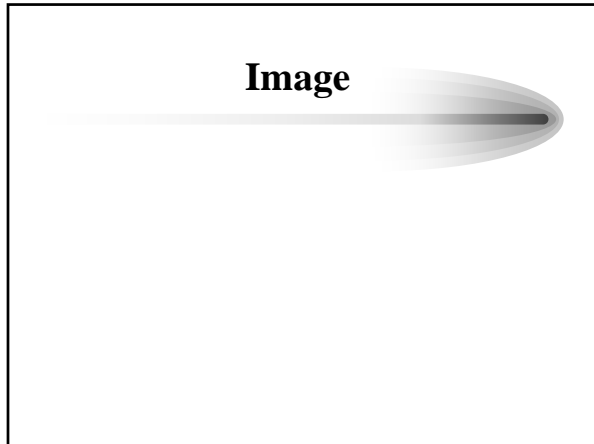
‘A competent adult has a constitutionally protected right to refuse medical care’

US Supreme Court 1990, Cruzan decision

‘Voluntary Withdrawal’

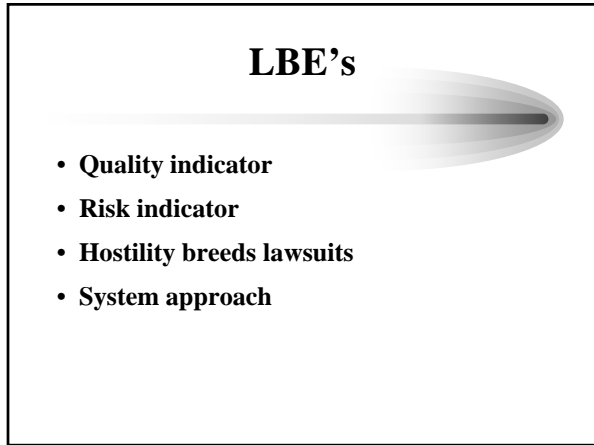
- CMS/OIG Advisory Bulletin
- MSE
- Stabilization
- Refusal of Transfer
- LBE’s & AMA’s now federal law

Image



LBE's

- Quality indicator
- Risk indicator
- Hostility breeds lawsuits
- System approach



Left Before 'MSE'

- Denial of MSE?
- Burden of proof
- Documentation
- Long waits a violation?
- View of government and courts



Against Medical Advice

- Failed relationship
- Communication skill
- Address the problem
- Physician involvement
- ‘Negotiate’; bargain for time

AMA - Elements

- Capacity, competency
- Risks and benefits
- Alternative treatments
- Involve family
- Informed refusal

AMA

- Process v. signature
- Documentation
- Do not punish
- Welcome back

'Voluntary Withdrawal'

- **Inform patient of EMTALA rights**
- **Offer MSE, stabilization, transfer**
- **Explain risks and benefits**
- **Ascertain competence**
- **Written informed refusal**

AMA - Documentation

- **Who can do this?**
- **Clerk, RN, EP?**
- **Patient refuses to sign?**
- **'Offered admission'**
- **Documentation**

Minors Refusing Treatment

- **Minor alone, without parent**
- **Severity of the illness**
- **Not quite the same as consent**
- **Role of the parent, legal guardian**

Parent Refuses Care

- EMC v. no EMC
- Severity of the illness
- Child abuse v. child neglect
- State laws
- Stabilize / Transfer

Override Parental Refusal

- Federal law – EMTALA
- State laws
 - Emergency doctrine
 - Child abuse statutes
 - Confirming medical opinion
 - Court order
- Same as religious objections

Jehovah's Witnesses

- Competent adult
- Incompetent adult – wallet card
- Child

Additional Refusal Scenarios

- Suicidal patients
- Police blood alcohols – refuse MSE
- Violent patient
- Pre-hospital care/transport

Suicidal Patient

- Loose certain rights
- Physician responsible
- ‘State made me do it.’
- Err on patient safety
- Commitment process

Police Blood Alcohol

- Refusal of MSE?
- Implied consent state?
- Consent still necessary
- Search warrant
- Immunity

Combative Patients and Restraints

- **Indications**
- **Documentation**
 - **Incompetence**
 - **Order**
- **Philosophy of Yes!**

Physical Restraint

- **Techniques**
- **Remove tools of harm**
- **Observation**
- **Hospital protocol**
- **JCAHO/MC-COP**
- **Failure to follow own rules**

Documentation

The chart should read like a storybook with only one possible conclusion - yours!

Documentation

- Determining factor > 80% lawsuits
- Learned art
- Risk driven
- Tell a story

Documentation

- The chart is on trial!
- System - dictation
- Refusal of care form
- Understand the game

Image

Key Concepts

- 'When in doubt rule'
- Never delay minors
- Alcohol confuses everything
- Systems for LBEs/AMAs
- Documentation

Questions?



AMA Forms and References

INFORMED CONSENT TO REFUSE EXAMINATION, TREATMENT, OR TRANSFER

I understand that the hospital has offered: (Check all that apply).

- A. To examine me (the patient) to determine whether I have an emergency medical condition, or
- B. To provide medical treatment or to provide stabilizing treatment for my emergency condition, or
- C. To provide a medically appropriate transfer to another medical facility.

The hospital and physician have informed me that the *benefits* that might reasonably be expected from the offered services are: _____

and the *risks* of the offered services are: _____

Physician Documentation

- The patient appears competent and capable of understanding risks and benefits.
- Alternative treatments discussed with the patient.
- Patient's family involved. Family not available. Patient does not want family involved.

Signature of Physician _____

Patient or Legally Responsible Person Documentation.

- I have declined to have the physician fully explain to me the risks, benefits, and alternatives to leaving the hospital against medical advice. I knowingly and willingly take and assume the responsibility for all risks incurred.
- or**
- The physician has fully explained to me the risks and benefits but I choose to refuse the offered services. I understand that my refusal is against medical advice, and that my refusal may result in a worsening of my condition and could pose a threat to my life, health, and medical safety. I understand that I am welcome to return at any time.

Signature/Patient or Legally Responsible Person _____

Print Name _____ Address _____

City _____ State/Zip _____ Date _____ Time _____

Witness/Signature _____ Print Name _____

The patient or person legally responsible for the patient was offered but refused to sign form after explanation of their rights and the risks and benefits of the services offered.

Hospital representative who witnessed refusal to sign: _____

Date _____ Time _____

PATIENT DENIAL OF REQUEST FOR A MEDICAL SCREENING
EXAMINATION / PHYSICIAN ORDER CONFIRMATION

Under Federal Law, the hospital's emergency department must provide a medical screening exam to determine if an emergency medical condition exists for any individual who requests examination or treatment for a medical condition. At General Hospital, this exam is performed by a physician. If you want to receive a medical screening examination, please tell your nurse. If you do not wish to have a medical screening examination, please check the appropriate statement below and fill out the information requested. Thank you.

I am presenting to the Emergency Department for:

Laboratory test(s) ordered by my physician.

Radiological procedure (x-ray, CT, MRI or nuclear medicine) ordered by my physician.

Forensic examination by the Sexual Assault Nurse Examiner for the criminal justice system.

Scheduled out-patient visit for _____, to see Dr. _____ .

Other _____ .

I do not request a medical screening examination (to determine if I have an emergency medical condition), nor do I request treatment for a medical condition at this time. I understand that the Hospital is willing to provide me with such examination and treatment should I ask for it. Furthermore, I am not asking the Hospital, its personnel or the Emergency Department physician to analyze the laboratory test or radiological procedure results ordered by my physician.

Print Name: _____

Date of Birth: _____ SS# _____

Signature: _____

Parent of Guardian in case of minor: _____

Address: _____

City, State, Zip: _____

Date: _____ Time: _____

Witness: _____

Confirmation of order: (to be completed by clinical staff)

Ordering MD: _____

Test Ordered: _____

Select One: _____ Verbal order called to department
_____ Written order sent with patient

Confirmed by: _____