Foundations III Curriculum
Guided Small Group Experience

Ethics
"Decision Making Capacity and Against Medical Advice"

- **Agenda and Learning Objectives**
  - Case Part I - Decision Making Capacity (20 min)
    - Define capacity versus competence
    - Identify the components of a capacity determination
    - Discuss commonly encountered clinical scenarios in the Emergency Department that may influence an evaluation of capacity
  - Case Part II - Against Medical Advice (20 min)
    - Discuss the importance of capacity in AMA discharges
    - Identify best practices and professional obligations for AMA discharges
  - Case Conclusion (10 min)
    - Review Session Teaching Points

- **Note to Facilitators**

This session covers the topics of capacity and AMA as part of the ethics unit. Is covers commonly encountered scenarios in the ED such as patients presenting after nalaxone administration and refusing care as well as intoxicated patients with head trauma refusing head CT. Pediatric guardianship and decision-making will be covered separately. Other than reviewing these materials, there are no other special preparations for this session and there are no special activities during this session. It is strictly a question guided large group discussion.

- **Case Part I - Decision Making Capacity (20 min)**

DB is a 25-year old male with a history of heroin abuse and depression. He was brought in to the ED by EMS after being found in a bathroom of a restaurant unresponsive. He was given naloxone by EMS and you can hear him over the radio awake and arguing with the paramedics about transfer. When he arrives, he is tachycardic to the 130s and hypotensive with a blood pressure of 95/45. He is awake, alert with a normal mental status other than being argumentative. You would like to start an IV for IVF and get an EKG due to his vital signs abnormalities but he refuses saying "I don't have insurance and this is going to be really expensive. I'm fine!"

- **Discussion Questions with Teaching Points**
  - **What is capacity and how is it different than competence? What are the components of capacity? How do you determine if DB has the capacity to refuse care?**

- Competence is a formal decision made by the courts regarding a person's long-term ability to make medical decisions
- Capacity is a clinical decision made by a physician at bedside regarding the ability of a patient to make an informed decision regarding their current medical care
- Capacity is highly situational and time dependent (e.g. someone may have capacity one day and not the next)
- There are 4 components necessary for a person to have medical decision-making capacity:
  - Able to understand the relevant information
  - Able to appreciate the situation and its consequences
  - Able to reason through treatment options
  - Able to communicate a choice
- The standard is what a "reasonable" patient would understand of the information given to them → though subjective this is a common legal standard
- Any physician can make capacity decisions and it is a core skill for EM physicians in particular
- If you are unsure of your capacity determination for a particular case, it is appropriate to ask for a second opinion or "capacity consult" from another physician (EM, psychiatry or other)

- **Is capacity the same for each medical decision or is it a "sliding scale"?**
  - Most ethicists consider capacity a sliding scale
  - The capacity bar for refusing lifesaving surgery is much higher than say, for refusing sutures
  - Capacity can also wax and wane depending on mental status → this is especially true in older patients with dementia
  - The concept of a "sliding scale" was outlined and endorsed by the Presidents' Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982)

- **In this case, what historical feature must you take into account and evaluate further before being able to make a capacity determination?**
  - DB has a history of psychiatric disease and depression so you must make sure that he is not actively depressed or suicidal to ensure that is not unduly influencing his decision making
  - There is controversy over whether suicidal action is ever rational (i.e., can you be rational if you are suicidal?) → this is a difficult question with no clear-cut answer
  - However, drug abuse alone or a history of depression does not preclude you from having capacity

- In the particular case of heroin overdose and naloxone, most ethicists do not believe it is ethical to simply wait for the patient to lose capacity as the naloxone wears off and then force care on them after they have already refused while in a state of full capacity

- **What should you document in the chart when making a capacity evaluation?**
  - The four elements listed above:
    - Ie **"**It is my medical opinion that DB appears to currently have capacity to refuse care. He is alert, able to reason through the information I am providing him and seems to understand the serious risks of refusing care up to and including death. He is able to communicate his refusal to me and does not appear to be actively suicidal or have worsening depression influencing his decision-making capacity."

- **If someone lacks capacity and is refusing care, what can you (or should you) do?**
  - It depends on the severity of the condition for which care is being refused → what you do will likely hinge on your evaluation of the risks of refusal
  - If it is something non-life or limb threatening (ie sutures), you can likely let the patient refuse
  - If it is immediately life or limb threatening, you ***may*** need to provide care against their will up to and including chemical or physical restraints
    - A good example of this is an intoxicated patient who lacks capacity due to intoxication refusing a head CT after a head injury → you must decide how concerned you are about pathology as your level of concern will determine if you override their refusal
    - If you are truly worried about a potentially life or limb threatening injury you may need to provide care against their wishes and may have to use chemical sedation in order to achieve this
    - If your suspicion is low, it is likely not ethically defensible to force care on them
  - This is obviously a very tricky situation so call the hospital lawyers, ethicists and risk management office as soon as possible when a situation like this occurs!

- **Case Part II - Against Medical Advice (20 min)**

Several minutes later DB becomes somnolent again and requires another dose of naloxone (intranasal as you still don't have an IV). When he wakes up, he is angry and requesting discharge. You recommend observation in the ED for some time given his need for repeated doses of naloxone but he refuses. He states "I know the risks, I've been using for a long time, and I want to go home. Please let me sign AMA."

- **Discussion Questions with Teaching Points**
  - **What is the first thing you must assess in order to discharge someone AMA?**
    - Capacity

  - These are high risk encounters for both yourself and the patient so make sure you document your capacity ***and*** AMA discussions
  - A study of charts found that only 4% of them included appropriate documentation (most often lacking benefits of treatment discussion) and only 22% included a capacity assessment (Shaefer and Monico)

- **Per EMTALA, what are you obligated to discuss with the patient prior to allowing an AMA discharge?**
  - A discussion of the risks of refusing care and the benefits of accepting care
  - Think of it as an informed consent discussion

- **Do you need to have the patient sign the AMA form?**
  - Not necessarily but some states give extra legal protection if the form is signed (or the physician signs the form stating the patient or surrogate refused to sign)
  - The most important protection you have is documenting your capacity ***and*** AMA discussions

- **Does insurance cover AMA discharges?**
  - Yes
  - This is a commonly held myth (up to 50% of MDs believe it) but based on several audits of bills from a multitude of insurance companies, it is not true

- **What should you do about after care (i.e. prescriptions, follow up appointments etc) for AMA discharges?**
  - Physicians are still typically considered ethically and professionally responsible to provide and facilitate follow-up care
  - This includes prescriptions and assistance with appointments
  - The stipulation is that this care doesn't encourage a patient to leave AMA
  - There is no data that this care translate to greater legal liability and is clearly in the best interest of the patient

❖ **Case Conclusion and Summary (10 min)**

Given DB's history of depression, you evaluate for worsening depression or suicidal ideation influencing his capacity and find none. You determine that DB has capacity to refuse care and leave AMA. He states his reasons for leaving are financial and that he will stay with a friend who has naloxone and follow up with his counselor. You offer him transfer to drug rehab and he also declines stating "I'm not ready to dry out." You discuss the risks of leaving and the benefits of getting treated and he still requests discharge. You request DB signs the AMA paperwork, which he does, and you document your conversation in the chart. You discharge him with drug rehabilitation resources, a prescription for intranasal naloxone and a request to return to the ED if he changes his mind.

- **Case Teaching Points Summary**
  - Decision Making Capacity
    - Capacity requires four conditions to be met
      - Able to *understand* the relevant information
      - Able to *appreciate* the situation and its consequences
      - Able to *reason* through treatment options
      - Able to *communicate* a choice
    - EM physicians should be experts at capacity evaluations but may ask for a second opinion as needed (either from another EP or a psychiatrist)
    - It is important to document the elements of capacity in the chart
    - Capacity is a sliding scale depending on the consequences of the decision being made and may fluctuate with time
    - Mental illness and/or substance abuse does not preclude capacity though active depression and/or suicidality may influence capacity
  - Against Medical Advice
    - Leaving AMA requires a patient (or surrogate) to exhibit capacity
    - EMTALA requires us to discuss both the risks of refusing care *and* the benefits of treatment
    - Both a capacity evaluation and documentation of an AMA discussion should be included in the medical chart for AMA discharges
    - Insurance companies *do* pay for medical bills ending in an AMA discharge
    - You are still obligated to provide discharge care so long as it does not encourage the AMA discharge

❖ **Facilitator Background Information**

Capacity and Competence

The foundation of medical decision-making in modern, Western medical ethics centers primarily on the primacy of an individual's autonomy in directing their medical cares – this being balanced with the other bioethical principles (an approach introduced and outlined in the seminal work by Beauchamp and Childress in 1985, Principles of Biomedical Ethics). While historically the paternalistic style of medicine focused on a physician's assessment of the balance of beneficence and non-maleficence, the modern empowerment of the patient as the appropriate judge of this balance, as an expression of respect for patient autonomy on an individual-by-individual basis, has placed an important duty upon the physician to manage and assess the patient's decision-making capacity.

Pragmatically, clinicians do not formally assess medical decision-making capacity at every patient encounter. While informal assessments based on global impressions often suffice, identifying scenarios that should trigger a formal assessment, and a structured approach to it, is ethically and legally prudent. Such triggers might include (1) patients with obviously impaired mental status and (2) decisions with potentially serious or life-threatening ramifications. A structured approach to this ethical decision is the goal of this session.

Definitions:

"Competence" = A legal determination made by a judge in a court

"Decision-making capacity" = A medical assessment made by a physician at the bedside.

To a large degree this distinction is semantic and inadvertently interchanged by medical professionals. The relevance in this distinction is the following: "Decision-making capacity" is a much more flexible and adaptable pronouncement that depends heavily on the situation, the particular medical decision, and potential consequences. Generally speaking, the criteria for establishing medical decision-making capacity are as follows:

1. Able to *understand* the relevant information
2. Able to *appreciate* the situation and its consequences
3. Able to *reason* through treatment options.
4. Able to *communicate* a choice

Notably, the *communication* need not be verbal. Importantly, the *understanding*, *appreciation*, and *reasoning* are largely dependent on the content of the medical decision (e.g. it takes a different degree of capacity to decide between deciding to treat AOM versus tPA for a stroke). This "sliding-scale" approach is outlined and endorsed by the Presidents' Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982). When the assessment of medical decision-making capacity is sufficiently unclear to the treating physician, seeking a second clinician's evaluation is

appropriate. The specialties most often called upon to contribute to this kind of assessment are psychiatry and neuropsychology.

Against Medical Advice

Patients choosing to leave against medical advice (AMA) constitute ~1-3% of patient encounters in the ED; these patient encounters are over 10 times more likely to result in a lawsuit. Similar to properly informed consent, a patient requesting to leave the ED "Against Medical Advice" (AMA) requires a processes of assessment and communication; the paper form is considered a type of evidence that this discussion took place and contained the appropriate content but should not suffice to detail the content of the discussion. Like "informed consent," allowing a patient to leave AMA primarily includes assessing decision-making capacity, which depends in part on the potential ramifications of the ill-advised choice.

EMTALA stipulates that the provider is to discuss "the risks and benefits to the individual of such examination and treatment" in addition to the examination and treatment that were provided. In an audit of charts of AMA encounters, only 4.1% met this standard. The most common deficiency is discussing with patients the benefits of treatment. Only 22% of charts specifically noted that the patient demonstrated decision-making capacity.

Similar to informed consent, AMA forms carry some legal weight in some states. This is in contrast to other states where the form is considered too "generalized" to offer much legal protection or proof that an appropriate AMA conversation was had. Consider documenting the conversation in the chart if there are extenuating or other unusual circumstances.

After the patient's decision to leave AMA has been made and respected, physicians are still typically considered ethically and professionally responsible to provide and facilitate prescriptions and follow-up appointments (with the stipulation that this care doesn't encourage a patient to leave AMA). There is no evidence to suggest that these cares translate to greater legal liability.

- **References**
  - **Author:** Dr. Natasha Wheaton
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