Against Medical Advice

Autonomy Versus Safety

MedPro Group
a Berkshire Hathaway company

Speaker bio

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Gordon has more than 35 years of experience working in clinical practice, hospital administration, risk management, and consulting. His extensive clinical leadership includes nursing supervision in both home care and acute care hospital facilities. In home care facilities, he led the development of fee-for-service programs. In acute care hospital facilities, he served as a lead developer, clinical coordinator, and instructor of the electronic medical records system. He also advanced to director of risk management in a multihospital integrated health system.

Gordon provided risk management consulting services, including program development, education, risk reduction, survey development, and regulatory compliance (including EMTALA and HIPAA), in previous positions. He also developed risk benchmarking between facilities and a best policies repository for insured physician groups and hospitals.

Gordon received a bachelor of science degree in nursing from Youngstown State University. He is a registered nurse in the state of Ohio. He is a member of the American Society for Healthcare Risk Management, the Pennsylvania Association for Health Care Risk Management, and the West Virginia Society for Healthcare Risk Management.

Gordon also has served in leadership roles in the Ohio Society for Healthcare Risk Management. Additionally, he is a certified professional in healthcare risk management, and he is a Fellow of the American Society for Healthcare Risk Management.

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Objectives

At the conclusion of this program, participants should be able to:

- Discuss the competing interests of autonomy and safety
- Describe the foundation for informed consent
- Reinforce the informed consent/informed refusal process and documentation
- Identify what constitutes against medical advice (AMA)
- Discuss “leaving AMA” prevention methods and documentation

Overview

Prevalence of against medical advice (AMA)

All statistics are hospital based

2% of all hospital discharges

Comorbidities increase chances of re-admission and increased healthcare costs

- Asthma – 4 times more likely to be readmitted to emergency department within 30 days
- General medical patients – 7 times more likely to be readmitted within 15 days with same diagnosis
- Acute myocardial infarction – 40% higher mortality or readmission for myocardial infarction or unstable angina for up to 2 years
  - Other studies
    - 15.7% mortality at 1 year (Virginia Academic Facilities)
    - 19% mortality at 6 months (VA)
- Cost – 56% higher than from initial admission

Alfandre, D.J. (2009, March). "I'm going home": Discharges against medical advice. *Mayo Clinic Proceedings, 84*(3):255-260. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2664598/

Self-determination and autonomy

Self-determination = right to choose

Autonomy = self-governance/freedom/ independence

- Roots in the American and French revolutions
- Justice, liberty, and freedom from authoritarian rule

Self-determination and autonomy (continued)

USLegal, Inc.

Patient “autonomy” or self-determination is at the core of all medical decision-making in the United States. It means that patients have the right and ability to make their own choices and decisions about medical care and treatment they receive, as long as those decisions are within the boundaries of law. There is a legal presumption that they are fit and competent to make those decisions until a court determines otherwise.

Medical paternalism

Physician's duty to promote patient welfare

Medical expertise = physician knows what's best

Societal expectations = patient compliance

Kilbride, M.K., & Joffe, S. (2018, November 20). The new age of patient autonomy: Implications for the patient-physician relationship. *JAMA, 320*(19): 1973-1974. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6988779/

Patient rights

- 1950s changing attitudes – patient rights
- 1980s shared decision-making
- Societal expectations = patient compliance
- Today – patient-centered and patient-directed care

Kilbride, M.K., & Joffe, S. (2018, November 20). The new age of patient autonomy: Implications for the patient-physician relationship. *JAMA, 320*(19): 1973-1974. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6988779/

Patient autonomy

MedicineNet definition

The right of patients to make decisions about their medical care without their health care provider trying to influence the decision. Patient autonomy does allow for health care providers to educate the patient but does not allow the health care provider to make the decision for the patient.

Medicine.net. (2021, June 3). *Medical definition of autonomy, patient*. Retrieved from https://www.medicinenet.com/autonomy_patient/definition.htm

Informed consent and informed refusal

Patient autonomy and informed consent

Patient right

- Capacity and competency

Sufficient information

Without coercion

Risks, complications, benefits, and alternatives

- Including the alternative to do nothing and the accompanying consequences of doing nothing

Centers for Medicare & Medicaid Services

Information must be specific to the patient

The right to make informed decisions means that the patient or patient's representative is given the information needed in order to make "informed" decisions regarding his/her care. Interpretive Guidelines §482.13(b)(2)

Consent must be executed by the patient in writing

- ***Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.*** Interpretive Guidelines §482.24(c)(4)(v)

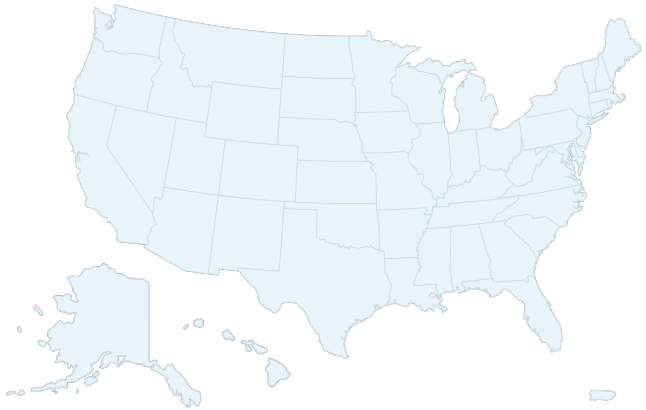
State-specific informed consent

Check with counsel

Statutes

Administrative law

Case law



Responsibility for informed consent

Provider

- Generally, this is a nondelegable duty.
- Individual performing the procedure is obligated to conduct the consent discussion.

Staff

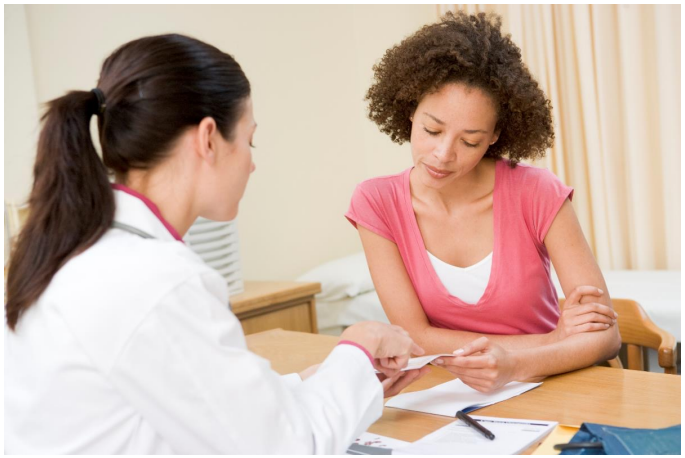
- Staff may reinforce the information shared by the provider.
- Staff may provide supplemental educational information, resources, etc.

Discussing and documenting risks, benefits, and alternatives

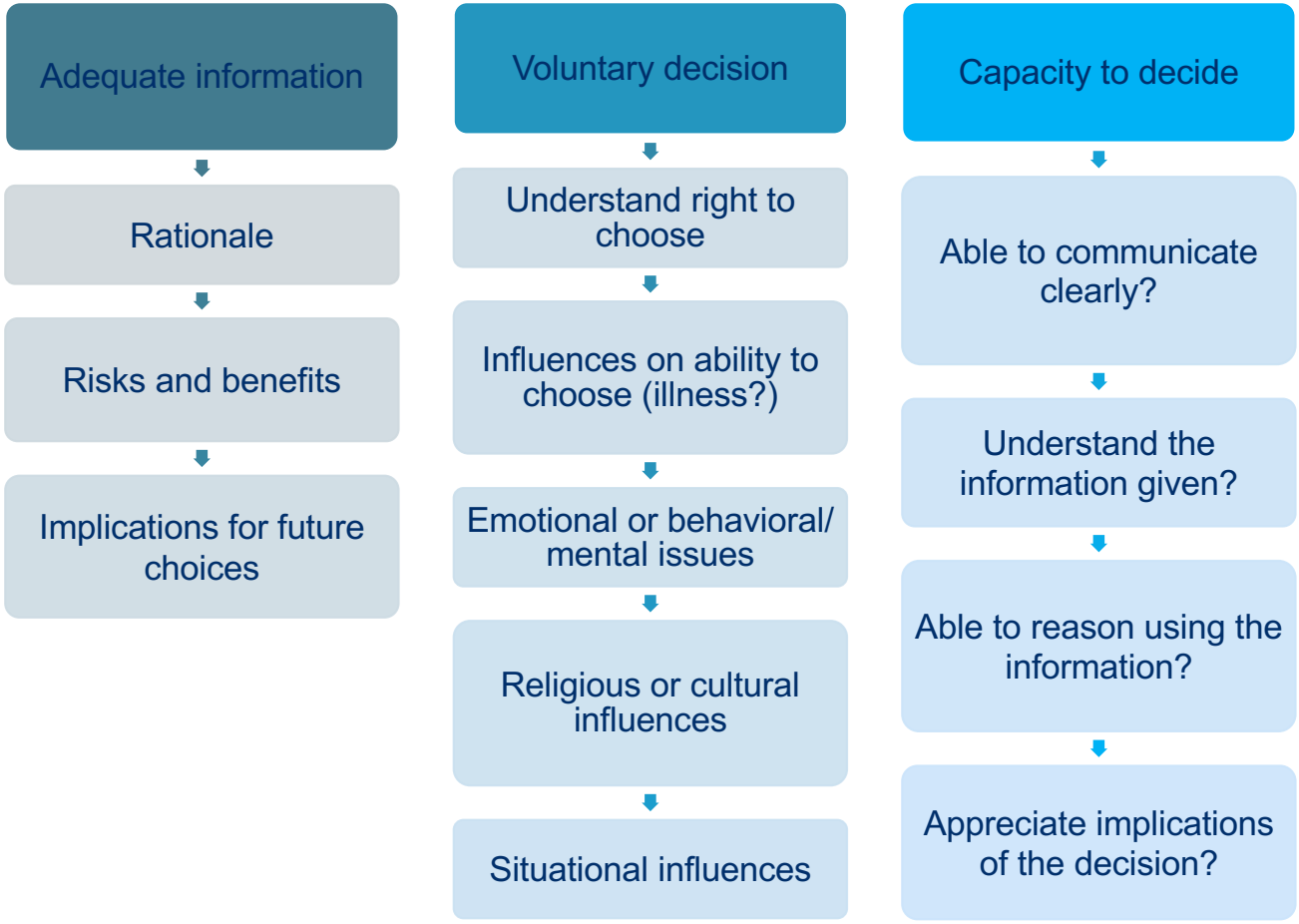
Discussion of the risks, benefits, and alternatives/ options as well as the risks of withholding treatment

An opportunity for the patient to ask questions and receive answers to their satisfaction

Documentation in the patient's health record of all of the above details



Considerations in consent



Roberts, L.W. (2002). Ethics and mental health research. *Psychiatric Clinics of North America, 25*(3):525-545. Retrieved from https://pubmed.ncbi.nlm.nih.gov/12232968/

Documentation of the informed consent discussion

The quality, not the quantity, of the documentation is important

- Entry should be objective, factual, and concise

Record essential elements: RBAC

- Risks
- Benefits
- Alternatives
- Consequences of doing nothing

Document patient's understanding

Note questions that the patient asked

- How were these questions answered?
- Was the patient satisfied with the responses?

Other considerations

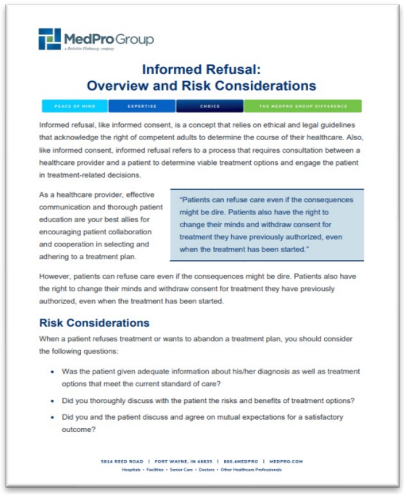
- Mention educational pieces given to the patient to reinforce consent process
- Document patient refusal of proposed treatment and reasons given

Informed refusal: overview and risk considerations

Inform the patient of the risks associated with transitioning care or not seeking care elsewhere:

- Fewer treatment options if condition deteriorates
- Decreased opportunity for a successful outcome
- Increased possibility of complications
- Remaining treatment options might be more expensive

Consider asking the patient to sign an informed refusal statement



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Informed Refusal:
Overview and Risk Considerations

Informed refusal, like informed consent, is a concept that relies on ethical and legal guidelines that acknowledge the right of competent adults to determine the course of their healthcare. Also, like informed consent, informed refusal refers to a process that requires consultation between a healthcare provider and a patient to determine viable treatment options and engage the patient in treatment-related decisions.

As a healthcare provider, effective communication and thorough patient education are your best allies for encouraging patient collaboration and cooperation in selecting and adhering to a treatment plan.

"Patients can refuse care even if the consequences might be dire. Patients also have the right to change their minds and withdraw consent for treatment they have previously authorized, even when the treatment has been started."

However, patients can refuse care even if the consequences might be dire. Patients also have the right to change their minds and withdraw consent for treatment they have previously authorized, even when the treatment has been started.

Risk Considerations

When a patient refuses treatment or wants to abandon a treatment plan, you should consider the following questions:

- Was the patient given adequate information about his/her diagnosis as well as treatment options that meet the current standard of care?
- Did you thoroughly discuss with the patient the risks and benefits of treatment options?
- Did you and the patient discuss and agree on mutual expectations for a satisfactory outcome?

MedPro Group. (2022). *Informed refusal: Overview and risk considerations*. Retrieved from https://www.medpro.com/documents/10502/2820774/Article_Informed+Refusal_Overview+and+Risk+Considerations_MedPro+Group.pdf

Informed refusal considerations

Right to refuse/change mind

Follow the informed consent process

- Was adequate information provided?
- Did you discuss the risks, benefits, and alternatives/options?
- What is a satisfactory outcome to the patient?
- Did the patient ask questions?
- What is the patient's reason for the decision? Do we know? Did we ask?
- Execute a form with the patient's signature

Documentation of the informed refusal discussion

Document the patient's refusal

- Document in the patient's health record
  - Patient reservations or concerns
  - Other obstacles
  - Discussion of consequences without proposed treatment
- Patient attestation
  - Akin to a consent form
  - List proposed benefits
  - List potential risks in deciding against treatment
  - Note patient's opportunity to ask questions/receive answers

Revocation/withdrawal

- Revocation/withdrawal of prior consent is the patient's right
- Provider must comply unless treatment or procedure has begun; to stop would put the patient at further risk

Against medical advice

Refusal of treatment	
Refusal of continued treatment	
Refusal of course of treatment	
Potentially	Altering course of treatment without consulting physician
	Changed their mind
	No show
Leaving monitored medical care before discharge	
Other	

De-escalation strategies

Case study

60-year-old man elopes from skilled nursing facility; found dead outside	
Medical history included depression, substance abuse, numerous back surgeries; on disability	
Admitted to skilled nursing facility for IV antibiotics after removal of brain abscess	
Alert and oriented to person, place, and time, no dementia, but history of behavioral issues including suicidal ideation, aggression, anger, and assault	
At admission	Not deemed an imminent threat to self or others but had issues with impulsivity
	Positive risk for elopement (history of AMAs), but no preventative measures put in place
Two weeks later at 9:30 p.m. patient was missing. Police were notified and they searched to no avail.	
Two weeks after patient went missing he was found dead behind facility	
Health records were altered by staff	
Case closed with indemnity in the mid-six figure range and expenses in the low-six figures	

Reasons some patients wish to leave before being discharged

Why do they want to leave before discharge?

Appointments	
Obligations	Children
	Animals
	Elderly
	Family
Angry	Dissatisfied with care
	Pain
	Medication reaction
Fear	
Substances	Tobacco
	Narcotics
	Alcohol
Other	

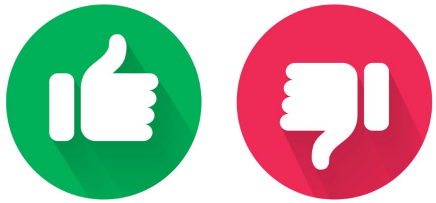
Do’s and don’ts

Do’s

- Assess decision-making capacity
- Apologize for waits/delays/inconveniences
- Enlist family assistance
- Document informed refusal
- Understand details of the AMA

Don’ts

- Ignore the patient
- Blame or berate the patient (noncompliant)
- Just have nurse get AMA form signed
- Express your frustration
- Refuse to provide continuing treatment
- Worry about whether the insurance will pay



MedPro Group guidance

- Don’t permit the patient to “voluntarily” travel to another location for care without signing out AMA or being discharged

Considerations in ambulatory care

Be specific – be sure it is pertinent to patient's condition, care, and treatment

- Example – postoperative patient
  - Increased risk of bleeding
  - Increased risk of nausea and vomiting leading to increased risk of bleeding
  - Increased risk of hypoventilation, leading to pneumonia and hospitalization
  - Increased risk of uncontrolled pain
  - Increased risk infection
  - Increased risk of surgical complications x, y, z
  - All of these lead to increased risk of death
- Why should they have a responsible adult (or a ride)?
  - They may have received medications before, during, and after surgery
  - They may have limited mobility due to surgery
  - Others?

What to do when the patient is angry, belligerent, or violent

Still your patient

What has changed?

What is the cause? Treat it

- Dissatisfied with care
  - Discuss with patient objectively (on your part) – don't get defensive
  - Answer questions
  - Are you too busy for a lawsuit?
- Medication reaction
- Pain
- Mental/behavioral health condition

Use de-escalation techniques

De-escalation strategies

Put safety first

- Ensure the safety of the patient, staff, and others in the area
- Help the patient manage their emotions and distress and maintain or regain control of their behavior
- Avoid the use of restraints/seclusion when possible
- Avoid coercive interventions that escalate agitation

De-escalation strategies

- Respect personal space while maintaining a safe position
- Do not be provocative
- Establish verbal contact
- Be concise; keep the message clear and simple
- Identify wants and feelings
- Listen closely to what the person is saying
- Agree or agree to disagree
- Lay down the law and set clear limits
- Offer choices and optimism
- Debrief the patient and staff

De-escalation strategies (continued)

De-escalation tips for high stress situations

- Be empathic and nonjudgmental
- Respect personal space
- Use nonthreatening nonverbal communication
- Keep your emotional brain in check
- Focus on feelings
- Ignore challenging questions
- Set limits
- Choose wisely what you insist upon
- Allow silence for reflection
- Allow time for decisions

Crisis Prevention Institute training options
https://www.crisisprevention.com/Training-and-Events

Capacity/competency to make decisions

Capacity and competency

Capacity (decision-making capacity) – functional assessment

- The ability to assimilate and understand information, appreciate the ramifications, and rationally formulate a decision based on that information reflecting one's values
  - Alzheimer's/dementia patient
  - Schizophrenic
  - 15-year-old daughter
  - Comatose patient

Competency – in general, it is a quality or state of an individual - legal determination

- Know your state law
- Age of majority
- Guardian

Ten myths about decision-making capacity

1. Decision-making capacity = competency
2. AMA = lack of decision-making capacity
3. There's no need to assess decision-making capacity unless a patient goes AMA
4. Decision-making capacity is all or nothing
5. Cognitive impairment = no decision-making capacity
6. Lack of decision-making capacity is permanent
7. Patients who have not been given relevant information about their condition can lack decision-making capacity
8. All patients with certain psychiatric disorders lack decision-making capacity
9. All institutionalized patients lack decision-making capacity
10. Only psychiatrists and psychologists can assess decision-making capacity

Ganzini, L., Volicer, L., Nelson, W.A., Fox, E., & Derse, A.R. (2004). Ten myths about decision-making capacity. *Journal of The American Medical Directors Association, 5*(4):263-267. Retrieved from https://www.academia.edu/8239866/Ten_Myths_About_Decision_Making_Capacity

Mental incapacity

Physical etiology

- Transient ischemic attack (TIA)/stroke
- Electrolyte imbalance
- Diabetic ketoacidosis

Psychiatric etiology

- Suicidal ideation/homicidal ideation
- Psychosis

Involuntary Hold

- Know your state law
- Duty/standard of care
- Mentally incapacitated + leaving AMA = Elopement
  - Elopement + severe injury/death = Sentinel event
  - EMTALA?

The Joint Commission. (2021). *Sentinel event data: General information & 2021 update*. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sentinel-event-general-information-and-2021-update.pdf

Federal regulations

EMTALA – refusal of treatment

- Title 42 - THE PUBLIC HEALTH AND WELFARE
- CHAPTER 7 - SOCIAL SECURITY
- SUBCHAPTER XVIII - HEALTH INSURANCE FOR AGED AND DISABLED
- Part D - Miscellaneous Provisions
- Sec. 1395dd - Examination and treatment for emergency medical conditions and women in labor

  (2) Refusal to consent to treatment.

  A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. **The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.**

Federal regulations (continued)

Remember – for EMTALA purposes, a discharge is a transfer

EMTALA – stabilize

- Title 42 - THE PUBLIC HEALTH AND WELFARE
- CHAPTER 7 - SOCIAL SECURITY
- SUBCHAPTER XVIII - HEALTH INSURANCE FOR AGED AND DISABLED
- Part D - Miscellaneous Provisions
- Sec. 1395dd - Examination and treatment for emergency medical conditions and women in labor

  (3)(A) The term “to stabilize” means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility,….

Justia US Law. (n.d.). *1999 US Code Title 42 – The public health and welfare*. Retrieved from https://law.justia.com/codes/us/1999/title42/chap7/subchapxviii/partd/sec1395dd

Special circumstances including elderly and pediatric patients

Mentally incapacitated

Legally incompetent/ incapacitated

Vulnerable populations

Elderly

- Abuse
  - Signs of abuse
  - Disagreement about treatment
  - Failure to provide treatment likely to cause injury
- Reporting requirements – Adult Protective Services

Pediatrics

- Abuse
  - Signs of abuse
  - Failure to provide treatment likely to cause injury
  - Reporting requirements – Child Protective Services

MedPro Group. (2020). *Preventing elder abuse in senior care*. Retrieved from https://www.medpro.com/documents/10502/3019648/Risk+Q%26A_Preventing+Elder+Abuse+in+Senior+Care.pdf; MedPro Group. (2020). *Risk resources: Elder abuse*. Retrieved from https://www.medpro.com/documents/ 10502/2824311/Risk+Resources_Elder+Abuse_MedPro+Group.pdf; Cascella, L. M. (2020). *Addressing potential maltreatment in pediatric patients*. Retrieved from https://www.medpro.com/pediatrics-maltreatment-abuse

Transfer protocols

What to do if your patient needs a higher level of care than you can provide

- Office
- Ambulatory surgery center/Postanesthesia Care Unit
- Emergency department
- Inpatient hospital
- Think about checklists for various transfer types – it's about the outcome
  - Higher level of care
  - Mental/behavioral health evaluations
  - If a patient needs a higher level of care…transport by car would not be standard of care!
- Tools and resources
  - National Highway Traffic Safety Administration – Guide For Interfacility Patient Transfer
  - Pediatrics (Society of Trauma Nurses – useful algorithms and agreement samples)
  - State-specific statutes

National Highway Traffic Safety Administration. (2006, April). *Guide for interfacility patient transfer*. Retrieved from https://www.ems.gov/pdf/advancing-ems-systems/Provider-Resources/Interfacility_Transfers.pdf;
Society of Trauma Nurses. (n.d.). *Inter facility transfer tool kit for the pediatric patient*. Retrieved from https://www.traumanurses.org/inter-facility-tool-kit-for-the-pediatric-patient

Documentation of leaving AMA

Case study

Patient came to the emergency department

Labs and blood cultures collected – initial diagnosis chronic sinusitis

Patient refused spinal tab

Patient left AMA although nothing was documented about the AMA process

No documentation indicated that the physician wanted to admit the patient for sepsis

Patient admitted a couple weeks later with septic emboli causing stroke

Patient died 3 months later

Case closed with indemnity in the mid-six figures

Documentation considerations of leaving AMA

- Think about checklists
- Think about forms to guide documentation
- Criteria - Capacity
  - Cognitive evaluation: oriented, gives appropriate answers, speaks coherently, no slurred speech, no signs of psychosis, no tangential thinking, no auditory hallucinations, no delusional thinking, abstract thought process intact, no homicidal/suicidal ideations, gives rational explanation for wanting to leave
  - Comprehension: aware of condition/diagnosis, Understands: need for further medical attention
  - Clinical impression: decisional capacity intact yes/no
  - Specific risks of leaving before official appropriate discharge
  - Family/significant other engaged to convince patient to stay
  - Offer to engage primary care physician to talk with patient
  - Patient's verbalized reason for leaving
  - Discharge instructions include additional instructions to prevent discussed risks
    - Don't just put – "stay until discharged"
    - Better – call 911, or go/return to the emergency department
    - Note: if patient refuses discharge instructions or to sign form – that must be documented as well

Capacity assessment tools

Mini-Mental State Examination (MMSE)
https://www.ncbi.nlm.nih.gov/projects/gap/cgi-bin/GetPdf.cgi?id=phd001525.1

MacArthur Competence Assessment Tools for Treatment (MacCAT-T)

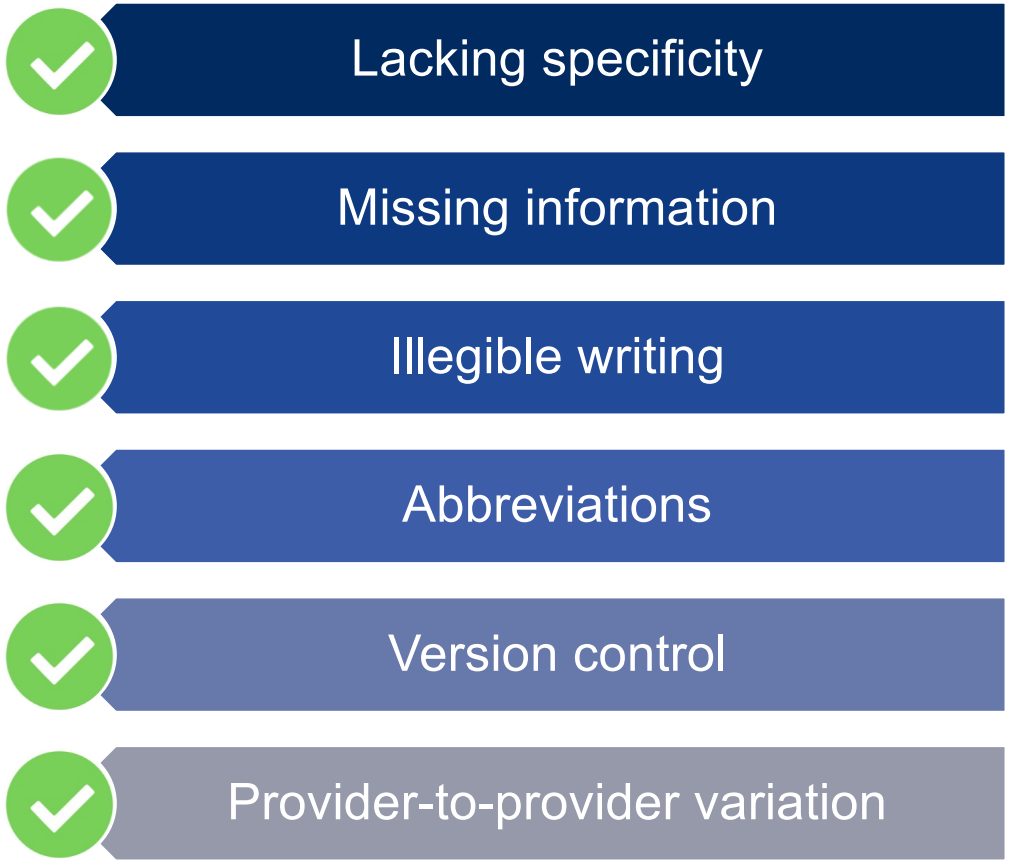
Capacity to Consent to Treatment Instrument (CCTI)

Assessment of the Capacity to Consent to Treatment (ACCT)
https://heartbrain.hms.harvard.edu/files/heartbrain/files/acct_manual.pdf

Hopemont Capacity Assessment Interview (HCAI)

Others: Tools for testing decision-making capacity in dementia
https://academic.oup.com/ageing/article/47/6/778/5052166

Documentation forms: poor execution



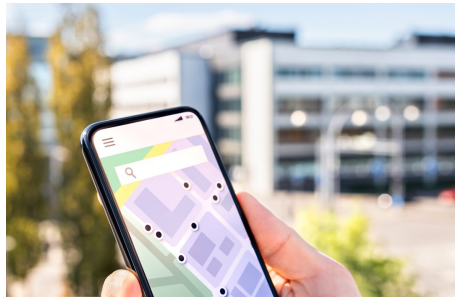
Documenting the path of care from the beginning

- Preoperative information
  - Lay down the law – let patient know expectations and ramifications
- Preoperative screening questions
  - Include questions
    - Are you responsible for any other adults/children/animals when you are home? If yes, who will take care of them while you are recovering?
    - You may need to involve social services, home care, and adult protective services
  - Do you have any appointments or other obligations on the day of surgery? Please do not schedule anything else on the day of surgery
  - Who will stay will you postoperatively? Contact information? (may or may not be necessary depending on surgery and anesthesia)
  - Who will be driving you home? (may or may not be necessary depending on surgery and anesthesia)
- Re-ask those same questions on arrival to the ambulatory surgery center
- You may need to reschedule – and more than once
  - Documentation of failure to follow specific safety instructions is necessary

Responding to noncompliance

So now the patient is discharged and you find out that patient has no ride or drove themself

- Use a checklist or form
  - Always document patient inconsistencies, e.g., if the patient answered they have a designated driver and now they don't
  - Was surgery such that someone else needs to drive?
    - Left foot wart removal under local
    - Excision superficial left leg under local
    - Colonoscopy
    - Total knee arthroplasty



  - Will someone be at home with the patient?
    - No – What are the risks? Document them. Are they sufficient that home care needs are arranged?
    - Yes – Arrange sitter/home care. If patient refuses, follow AMA process
  - Transportation for those who cannot/should not drive
    - Local hospital transportation services
    - Lyft Pass for Healthcare https://www.lyft.com/blog/posts/launching-lyft-pass-for-healthcare
    - Uber Health https://www.uberhealth.com

Follow-up when patients leave AMA

They either sign an AMA form or refuse to sign and leave

So what do you do?

Call the police or don't call the police?

What about HIPAA?

- Is there a clear and imminent danger to the patient or others? Yes – Call!
- If no, should you call? Corporate decision – preoperative patient expectations
- If you do, how much information should you give police?
  - Car license IMPARD DR1VR – driving erratically in parking lot, I think they are going to wreck!

Summary of best practices

Consider all that should be documented

Documentation is key

Document

- All discrepancies – failure to follow patient responsibilities
- All adverse behaviors and de-escalation techniques used
- Consents/Refusals – patient decisions
- Decisional capacity/Competency
- Additional discharge instructions – Be patient specific!
- Procurement of ride
- Have patient sign appropriate forms
  (Leave AMA, no responsible adult)

Providers

- Physicians as well as nurses must be involved

Transfer agreements, protocols, and checklists

- Mental health involuntary evaluation forms

Best practices

Are your policies in place?	
Include:	
Impaired decision-making	
Informed refusal	
Patient accepted treatment	Medications
	Therapies
	Discharge plans
Reporting requirements as applicable	
Documentation requirements	Notes
	Forms

Best practices (continued)

Every situation is different

Consult your legal counsel or risk management professional as needed

MedPro Group resources

Guideline: Managing Nonadherent Patients
https://www.medpro.com/documents/10502/2837997/Guideline_Managing+Nonadherent+Patients.pdf

Informed Refusal: Overview and Risk Considerations
https://www.medpro.com/documents/10502/2820774/Article_Informed+Refusal_Overview+and+Risk+Considerations_MedPro+Group.pdf

Risk Management Review
Physician Fails to Adequately Work Up Atypical Patient, Resulting in Death From Myocardial Infarction

Risk Tips: Managing Nonadherent and Difficult Patients
https://www.medpro.com/documents/10502/3667697/Risk+Tips_Managing+Nonadherent+and+Difficult+Patients.pdf

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