

Refusal of Emergency Medical Treatment: Case Studies and Ethical Foundations

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Informed consent is an important component of emergency medical treatment. Most emergency department patients can provide informed consent for treatment upon arrival. Informed consent should also be obtained for emergency medical interventions that may entail significant risk. A related concept to informed consent is informed refusal of treatment. Patients may refuse emergency medical treatment during their evaluation and treatment. This article addresses important considerations for patients who refuse treatment, including case studies and discussion of definitions, epidemiology, assessment of decisional capacity, information delivery, medicolegal considerations, and alternative care plans. [Ann Emerg Med. 2017;■:1-8.]

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CASE STUDIES

Case 1: “I Know My Rights!”

A 24-year-old man was brought to the emergency department (ED) in police custody for psychiatric evaluation. His mother called 911 because he was hearing voices and threatening to shoot her. He reportedly had a history of schizophrenia and had not been receiving his medications. On arrival, he was attempting to leave the ED. “Let me go! I know my rights!”

Case 2: Intoxication

A 25-year-old woman presented to the ED with a forehead laceration. She had fallen down a flight of stairs at home. She appeared intoxicated and could not provide any additional historical information because of altered mental status. She demanded to leave the ED and attempted to walk out.

Case 3: Out-of-Hospital Refusal of Treatment

A 50-year-old man with insulin-dependent diabetes mellitus presented with altered mental status. Relatives called 911 because of unresponsiveness. Out-of-hospital providers obtained a fingerstick glucose reading of 35 mg/dL. He was treated with intravenous dextrose 50% and became awake and alert. He then refused transportation to the ED.

Case 4: “I’ll Be All Right”

A 45-year-old man presented “feeling sick.” He had a history of end-stage renal disease and had missed dialysis for 1 week because of lack of transportation. Vital signs and pulse

oxygenation values were normal. Laboratory study results were notable for a potassium level of 7.4, blood urea nitrogen level of 88, and creatinine level of 9.9. A chest radiograph showed pulmonary congestion. After recommendation for hospital admission and dialysis, the patient stated, “Let me go home. I’ll be all right.”

Background

Among ED visits, it has been estimated that approximately 1% to 3% of patients leave against medical advice.¹⁻⁴ Approximately 500,000 patients per year in the United States are discharged against medical advice. Patients who leave against medical advice have a higher rate of repeated ED visits, hospital admissions, and mortality.⁵⁻¹² From the 148,810 discharges from Montefiore Medical Center in Bronx, NY, 2.4% of patients were discharged against medical advice, and they had a higher 30-day mortality (odds ratio 2.05) and higher 30-day readmission (odds ratio 1.84).⁸ Among the 857 patients of 31,252 who were discharged against medical advice from the Johns Hopkins University Emergency Department, 4.4% had a return to the ED for an emergency hospitalization at 30 days. This percentage was much higher than the 2.2% of patients who left without being seen, 0.6% of patients who were admitted, or 0.1% of patients who were discharged without leaving against medical advice.²

The risk of leaving against medical advice becomes even greater when specific diseases are examined. Patients with asthma who were discharged against medical advice were 4 times more likely to be readmitted with asthma.¹³ Patients

were 60% more likely to die after a myocardial infarction when they were discharged against medical advice.¹⁴ A study looking at patients discharged against medical advice postdischarge revealed that 75% of them had improved or abated symptoms and did not plan to return.⁹

Several patient factors are associated with higher incidence of leaving against medical advice: male sex, younger age, alcohol use, illicit substance use, weekend treatment, Medicaid insurance, no medical insurance, and treatment on welfare check day.^{3,15,16}

DEFINITIONS

Left without being seen refers to patients who never encounter the provider before leaving the ED. Left without being discharged refers to patients who leave the ED after some aspect of evaluation but without a conversation about refusal of treatment. Against medical advice refers to patients who request to leave the ED before completion of their diagnostic studies or treatment and are designated by the provider as making such a decision against medical advice.

DECISIONAL CAPACITY

Decisional capacity (decisionmaking capacity) is essential to patients' autonomous medical decisionmaking. The assessment of decisional capacity is an essential skill for emergency physicians. The burden of proof is on the physician to determine whether the patient possesses appropriate decisional capacity. Patients who do not possess it should not be allowed to refuse necessary medical treatment until decisional capacity is restored. There may be significant variation in providers' assessment of decisional capacity,¹⁷⁻¹⁹ which underscores the need for a better understanding of decisional capacity and its assessment in the ED environment.

Capacity is composed of 4 essential elements: understanding, appreciation, reasoning, and expression of choice.²⁰ Thus, an individual must be able to understand the information delivered, appreciate how to apply it to his or her own situation, reason to make an appropriate decision, and communicate that choice (Figure 1).

Assessment of capacity is an essential component of medical decisionmaking. It should occur during every patient encounter and may often be assessed through routine communications and interactions.

Capacity is dynamic and task specific.²¹ Individuals may have impaired capacity from a reversible condition at one point and may have full decisional capacity when the condition has resolved. For example, an intoxicated patient may lack capacity while intoxicated, but regain full decisional capacity after intoxication has resolved. When patients in the ED refuse recommended diagnostic tests, treatments, or

<p>Understanding (ability to receive information)</p> <p>Appreciation (ability to process information and apply it to one's circumstances)</p> <p>Reasoning (ability to deliberate)</p> <p>Expression of choice (ability to make and articulate a decision)</p>

Figure 1. Elements of decisional capacity.

disposition decisions, there should be consideration for the spectrum of potential outcomes from the patient's choice, based on the seriousness and severity of the condition.²² One study identified the concept of capacity as decision specific and as the most important concept for education of health care providers in regard to decisional capacity.²³ For example, a patient may have decisional capacity to agree to or refuse sutures for a simple laceration, but may lack capacity to weigh the risks and benefits of high-risk surgery.

There are multiple clinical conditions that may impair capacity, including cognitive disorders, neurologic disorders, education level, alcohol intoxication, substance abuse, psychosis, pain, anxiety, or any other condition that impairs ability to make an authentic choice.²⁴⁻²⁷ Although age alone is not associated with impaired capacity, cognitive disorders are the primary cause of incapacity in the elderly.²⁸

Establishing capacity and its relation to the patient's baseline capacity is essential before a patient refuses treatment. It may be helpful to gather additional information from relevant sources, with the patient's permission. Such sources may include family, friends, primary care provider, or other individuals familiar with the patient's baseline level of functioning. Other hospital resources may also be helpful, including social work, pastoral care, risk management, or ethics committee, when available.

Determining whether the patient's decision is appropriate is an important concept. A patient may have a legitimate difference of opinion about a proposed intervention and how it fits with his or her goals of medical therapy. However, a decision that is irrational and does not demonstrate understanding or reasoning in regard to the intervention may be evidence of impaired decisionmaking capacity.

As a supplement to clinical assessment, there are several tools proposed to aid in the assessment of decisional capacity, particularly in high-risk settings. There is insufficient evidence to establish a single tool as a valid criterion standard for assessment of capacity, and the use of any of these assessment tools represents only a part of the clinical assessment of capacity.²⁹⁻³³ There is significant variability in the clinical application of assessment tools for the assessment of capacity.³⁴ Examples of assessment tools that may be used

as information to aid in the assessment of capacity include the Mini Mental State Examination; Montreal Cognitive Assessment; MacArthur Competence Assessment Tool for Treatment; Competency Interview Schedule; Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory; Hopkins Competency Assessment; Mini-Cog; Aid to Capacity Evaluation; and Capacity Assessment Tool (Table).³⁵⁻⁴³

When a patient lacks capacity, a surrogate decisionmaker or applicable advance directive should be identified. State law varies in regard to surrogates. Some states require a legally appointed surrogate, and others designate a hierarchy of surrogates, often including spouse, adult children, or parents. For example, the 2010 Family Health Care Decisions Act in New York describes the following hierarchy: (1) an MHL Article 81 court-appointed guardian (if there is one); (2) the spouse or domestic partner (as defined in the act); (3) an adult child; (4) a parent; (5) a brother or sister; or (6) a close friend (as defined in the act).⁴⁴ If no surrogate is readily available, medical interventions should be undertaken, using the standard of what a reasonable patient would desire under those circumstances.

MEDICOLEGAL CONSIDERATIONS

The legal principle of informed consent regulates the interaction between emergency physician and patient.⁴⁵ Explicit consent may not be required during an emergency, but the elements of the emergency privilege, ie, exception of the requirement to obtain consent, which include a presumption of consent by a reasonable person, are narrow.⁴⁶ The emergency physician should still inform the patient, if possible, of the specifics of the intervention. If

the patient has the capacity to make a medical decision or a legally authorized decisionmaker is available, then the emergency exception would not apply.

Although patients have the legal right to refuse even life-sustaining medical treatment,⁴⁷ patient refusal comes with legal obligations for the emergency physician. When a patient with decisionmaking capacity refuses recommended medical interventions, the physician has the duty to inform the patient of the consequences of that refusal. The only exception to this is if the patient refuses the information, waiving the right to be informed of the consequences.⁴⁸

Legal risk to emergency physicians can result from forced treatment. However, the more common risk results from patients who refuse medical treatment and are injured or die because of the refusal. Their survivors may claim that the patient either was unable to make the decision to refuse and should have been detained and treated against his or her wishes or was inadequately informed about the consequences of refusal.⁴⁹

When there is an unanswered question about decisionmaking capacity, the emergency physician is faced with the dilemma of which scenario is in the best interest of the patient and thus would be more likely to be able to be defended: one in which the patient was detained so that decisionmaking capacity could be determined, or one in which the patient was allowed to leave and encountered injury or death as a result, when evidence of the patient's ability to be able to make this decision was not ascertained. The emergency physician should weigh the risks of detention until a capacity determination can be made against the risks of allowing the patient to leave.

Emergency physicians may face liability when intoxicated patients who lack decisional capacity leave while still impaired (without a responsible caretaker), posing an

Table. Examples of standardized tests for the assessment of decisional capacity.*

Test	Abbreviation	Assessment Time, Minutes	Interobserver Reliability	Score	Comments
Mini Mental State Examination	MMSE	7–15		0–30	Cognitive questions in 5 domains
Montreal Cognitive Assessment	MoCA	15–20		0–30	Cognitive questions in 9 domains
Hopkins Competency Assessment	HCAAT	10	0.95–0.99	0–10	Six questions about an essay
MacArthur Competence Assessment Tool for Treatment	MacCAT-T	15–20	0.75–0.99		Semistructured interview
Competency Interview Schedule	CIS	Variable	0.96		15-item structured interview
Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory	SICIATRI	20			12-item structured interview
Capacity Assessment Tool	CAT	Variable			Semistructured interview in 6 broad categories
Aid to Capacity Evaluation	ACE	10–20	0.9		Medical-decision-specific questions in 7 domains
Composite Screening Examination	Mini-Cog	3–4		0–3	Cognitive questions in 3 domains

MMSE, Mini Mental State Examination; MoCA, Montreal Cognitive Assessment; HCAAT, Hopkins Competency Assessment; MacCAT-T, MacArthur Competence Assessment Tool for Treatment; CIS, Competency Interview Schedule; SICIATRI, Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory; CAT, Capacity Assessment Tool; ACE, Aid to Capacity Evaluation.

*This table shows some examples of assessment tools. There is insufficient evidence to recommend a single specific test as the most valid standard for the assessment of decisional capacity. Assessment tools represent only one part of the clinical assessment of decisional capacity.

imminent risk of harm to themselves or others⁵⁰; for example, by driving an automobile while intoxicated. However, a recent New York appellate case supported the right of intoxicated patients who voluntarily come to the ED to leave when they are not an imminent danger to themselves, even if they later are injured. In *Kowalski v St. Francis Hospital and Health Centers*,⁵¹ a patient who showed signs of severe intoxication presented to the ED for detoxification. His blood alcohol level was 0.369. While in the waiting area for the transport van to take him to the detoxification center, the patient left the ED. He was hit by a car within 2 hours and severely injured. The plaintiff alleged that the defendant emergency physician should have detained him against his wishes to leave to prevent harm. The New York Court of Appeals held in a divided opinion (5 to 2) that the emergency physician did not owe a duty to the patient to confine the patient against his will, nor did the emergency physician have a duty to use the mental health statute to confine him as an immediate danger to himself. This New York case was one in which the patient presented voluntarily (ie, not in the custody of law enforcement because of a determination of potential harm to self or others), and it is not controlling in other states' jurisdictions, in which the duty of care may require protecting the intoxicated patient and others at risk. Emergency physicians are advised to consult with their risk managers about the best course of action in their jurisdiction.

PRACTICAL CONSIDERATIONS

Resolution of a conflict between a provider, who wishes to provide the best possible medical care, and the patient, who knows his or her goals and values best, may require trust, communication, and compromise.⁵² Enhancing the patient-physician relationship and developing trust may mitigate prevention of this conflict. Mitigating the conflict may require negotiation and compromise to arrive at a treatment plan that will optimally benefit the patient.

The appropriate management of a patient who wishes to refuse medical care includes determination of decisionmaking capacity; negotiating to encourage compliance; discharge planning, including the best treatment alternative; and documentation. One approach to the patient who leaves against medical advice is the framework "assess, investigate, mitigate, explain, and document."⁵³

DELIVERY OF INFORMATION

The physician has a duty to communicate diagnosis and treatment options to the patient in understandable terms. It is important that the treating provider give patients the necessary

information to allow their autonomous decisionmaking. Relevant information includes that which is material to the decision and should include the diagnosis, recommended treatment, risks and benefits, expected outcome, and reasonable alternatives, including doing nothing.⁵⁴

Manipulation or coercion of any type should be avoided. Undue threats of poor outcome, abandonment, or anger are not helpful to improving patient outcomes. A common misconception is that insurance will not pay for visits in which a patient left against medical advice.⁵⁵ Not only is this untrue but also quoting such misinformation may in fact be a form of economic coercion.

ALTERNATIVE CARE PLANS

Patients may have a variety of reasons for choosing to leave the ED against medical advice. Communication in regard to the patient's perspective and reasons for refusal of treatment is essential to addressing their individual concerns. The experience of illness and medical treatment may be emotionally distressing for some patients. For some patients, this may be a fear of the health care system or diagnosis that can be resolved by enlisting other family members or a trusted primary care physician into the discussion. Patients may be responsible for the care of children, ill or disabled family members, or pets and unable to arrange acceptable alternative care. For some patients, financial concerns may influence their decision. Patients may not be able to afford the time away from employment because of the risk of losing either their job or hourly wages. Communication and shared decisionmaking are important in addressing the patient's individual concerns.

Often a reasonable course of action can be negotiated with patients. For example, perhaps the patient is unwilling to be hospitalized for symptoms of chest pain but urgent outpatient cardiology follow-up can be arranged. In the event that the patient still chooses to leave, every effort should be made to provide him or her with appropriate discharge instructions at an appropriate health education level, including their current results, the recommended course of care, follow-up care, and encouragement to pursue further medical care or return to the ED. This may also include providing appropriate prescriptions and instructions.

DOCUMENTATION OF ESSENTIAL ELEMENTS

Documentation of an encounter in which a patient refuses treatment should include several essential elements (Figure 2).⁵⁶

One study demonstrated that documentation of elements of refusal of treatment is often suboptimal. In this

<p>Assessment of decisional capacity</p> <p>Delivery of information including the proposed intervention and risks of refusal</p> <p>Delivery of information including alternatives to the proposed intervention</p> <p>The patient's understanding of risk and voluntary decision</p> <p>Discharge instructions, including follow-up care</p> <p>Invitation to return for care at any time</p>
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Figure 2. Documentation of refusal of care.

study, minimal standards according to the Emergency Medical Treatment and Labor Act, which applies to unstable patients, were met in only 17 charts (4.1%). Decisional capacity was documented in only 22% of charts.⁵⁷

Proper documentation of leaving against medical advice can confer medicolegal protection in 3 potential ways. It can define termination of the legal duty to treat the patient, create the defense of assumption of risk by the patient, and create evidence of the patient's refusal of treatment.⁵⁸

Many institutions use specific forms for discharges against medical advice. There is no evidence that these documents improve patient care or provide medicolegal protection. In fact, they often do not demonstrate the essential elements of refusal of treatment, including meaningful communication.⁵⁹ Although many of the forms for leaving against medical advice state that the patient waives his or her right to litigate for any of the injuries that he or she may experience from the refusal of medical treatment, courts may find this waiver invalid and a violation of public policy. Although the form may not confer legal protection, it may be entered as evidence that there was an attempt by the emergency physician to persuade the patient to accept treatment and inform the patient of the risks of refusal, and it lists the names of witnesses to this conversation. Thus, these forms may be helpful for evidentiary reasons. However, such paperwork may appear defensive or coercive, may contribute to an antagonistic relationship, and may add to the distrust and stigmatization dividing patient from physician.

Whether or not the patient is willing to sign a form documenting leaving against medical advice, or even if the physician chooses not to designate the discharge as against medical advice, the physician should document the information about risks disclosed to the patient, the evaluation by the physician that the patient has the decisional capacity, and the patient's refusal, and should provide

instructions to the patient about medications and other recommended treatment, and include in the instructions that the patient is welcome to return at any time for treatment. The documentation should also include any witnesses to the conversation. The refusal by a patient to accept medical treatment is a temporal one and does not restrict him or her from returning to the ED for evaluation and treatment.⁶⁰ Although there have been concerns that if the physician offers partial treatment that is not the standard of care, he or she may be at risk for liability, partial treatment may be also be evidence that the physician was willing to provide as much treatment as the patient would allow.⁶¹

CASE RESOLUTIONS

Case 1: "I Know My Rights!"

A 24-year-old man was brought to the ED in police custody for psychiatric evaluation. His mother called 911 because he was hearing voices and threatening to shoot her. He reportedly had a history of schizophrenia and had not been receiving his medications. On arrival, he was attempting to leave the ED. "Let me go! I know my rights!"

Recommended resolution. Assessment of decisional capacity is essential before allowing the patient to refuse medical treatment. This should be accomplished by reassuring the patient that he or she can refuse medical treatment if able to demonstrate decisional capacity. If the physician is uncertain about decisional capacity, it is reasonable to detain the patient to assess it. It may be helpful to obtain consultation from a psychiatrist who specializes in determining decisionmaking capacity in patients with serious mental illness. Emergency psychiatric consultation is warranted in cases in which the patient has active delusions or active psychiatric illness. In some instances, it might be necessary to involuntarily detain a patient who lacks decisional capacity. If necessary, an emergency court order might be requested.

Case 2: Intoxication

A 25-year-old woman presented to the ED with a forehead laceration. She had fallen down a flight of stairs at home. She appeared intoxicated and could not provide any additional historical information because of altered mental status. She demanded to leave the ED and attempted to walk out.

Recommended resolution. Alcohol intoxication is a transient threat to decisional capacity. However, it is not an absolute indicator of absent capacity. A clinical assessment of capacity should be performed in each case and documented. For example, laboratory alcohol measurements often do not correlate with clinical condition. A patient might have an elevated blood alcohol

level but not appear clinically intoxicated, and can ambulate without difficulty, perform tasks, and engage in a discussion of risks, benefits, and alternatives. If capacity is uncertain, a standardized assessment of it may be of additional value. The relative complexity and severity of risks of the medical decision should also be assessed. In this case, assessment of potential head trauma is essential. If significant trauma is ruled out and when the patient has adequate decisional capacity, he or she may refuse sutures. Other extenuating factors should also be considered, including whether the patient has ingested other capacity-altering substances such as recreational drugs or prescription medications that might compound the effect of alcohol on decisional capacity.

Case 3: Out-of-Hospital Refusal of Treatment

A 50-year-old man with insulin-dependent diabetes mellitus presented with altered mental status. Relatives called 911 because of unresponsiveness. Out-of-hospital providers obtained a fingerstick glucose reading of 35. He was treated with intravenous D50 and became awake and alert. He then refused transportation to the ED.

Recommended resolution. This is a case in which the emergency physician can choose to either trust the out-of-hospital providers to relay accurate information about the patient's decisionmaking capacity or assess it themselves over the radio. Most of the time, these patients regain normal sensorium after their hypoglycemic event and can make a reasonable decision to refuse transport to the ED after being informed of the risks and benefits. In this case, it would be important for the emergency physician to confirm that the patient has availability of monitoring and is able to access 911 again if necessary.

Case 4: "I'll Be All Right"

A 45-year-old man presented "feeling sick." He had a history of end-stage renal disease and had missed dialysis for 1 week because of lack of transportation. Vital signs and pulse oxygenation values were normal. Laboratory study results were notable for potassium level of 7.4, blood urea nitrogen level of 88, and creatinine level of 9.9. A chest radiograph showed pulmonary congestion. After recommendation for hospital admission and dialysis, the patient stated, "Let me go home. I'll be all right."

Recommended resolution. Assessment of decisional capacity is imperative before allowing a patient to refuse medical treatment. This case poses numerous threats to capacity, including uremia, fluid overload, and hyperkalemia. In addition, some patients with chronic medical problems may experience depression or anxiety,

which are additional threats to capacity. Because of the potentially life-threatening medical conditions, assessment and documentation of decisional capacity are imperative. Standardized tests or psychiatric consultation may be helpful to determine capacity. Communication in regard to the reasons for refusal of treatment is essential because some patients with chronic medical problems may have legitimate concerns that can be adequately addressed, such as pain control, comfort, and communications. Negotiations, including family communication, with the patient's permission, may be helpful. Additionally, it is important in discussion with the patient to elicit whether there are underlying motivations (eg, desire to care for a pet at home) that are causing the patient to refuse treatment. The emergency physician and patient might be able to negotiate a plan that meets the patient's goals and clinical needs.

CONCLUSIONS

Informed consent is an important component of emergency medical treatment and demonstrates respect for a patient's autonomous decision. Most ED patients can provide informed consent for treatment on arrival. Informed consent should also be obtained for medical interventions that may entail significant risk. Some patients may refuse emergency medical treatment at any time during their evaluation and treatment (ie, informed refusal, against medical advice, and leaving before evaluation). When patients refuse emergency medical treatment, providers should communicate with the patient about their diagnosis, recommended treatment, risks, benefits, and alternatives to the proposed intervention. Documentation of the refusal of treatment should include an assessment of patient capacity, delivery of information, and the patient's autonomous choice.

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REFERENCES

- Centers for Disease Control and Prevention. National Hospital Ambulatory Medical Care Survey: 2011 emergency department summary tables. Available at: https://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2011_ed_web_tables.pdf. Accessed January 22, 2017.
- Ding R, Jung J, Kirsch T, et al. Uncompleted emergency department care: patients who leave against medical advice. *J Acad Emerg Med*. 2007;14:870-876.
- Alfandre D. "I'm going home": discharges against medical advice. *Mayo Clin Proc*. 2009;84:255-260.
- Lee C, Cho J, Choi S, et al. Patients who leave the emergency department against medical advice. *Clin Exp Emerg Med*. 2016;3:88-94.
- Gabayan GZ, Asch SM, Hsia RY, et al. Factors associated with short-term bounce-back admissions after emergency department discharge. *Ann Emerg Med*. 2013;62:136-144.e1.
- Gabayan GZ, Sarkisian CA, Liang LJ, et al. Predictors of admission after emergency department discharge in older adults. *J Am Geriatr Soc*. 2015;63:39-45.
- Choi M, Kim H, Qian H, et al. Readmission rates of patients discharged against medical advice: a matched cohort study. *PLoS One*. 2011;6:e24459.
- Southern WN, Nahvi S, Arnsten JH. Increased risk of mortality and readmission among patients discharged against medical advice. *Am J Med*. 2012;125:594-602.
- Glasgow JM, Vaughn-Sarrazin M, Kaboli PJ. Leaving against medical advice (AMA): risk of 30-day mortality and hospital readmission. *J Gen Intern Med*. 2010;25:926-929.
- Yong TY, Fok JS, Hakendorf P, et al. Characteristics and outcomes of discharges against medical advice among hospitalised patients. *Intern Med J*. 2013;43:798-802.
- Geirsson OP, Gunnarsdottir OS, Baldursson J, et al. Risk of repeat visits, hospitalisation and death after uncompleted and completed visits to the emergency department: a prospective observation study. *Emerg Med J*. 2013;30:662-668.
- Jerrard DA, Chasm RM. Patients leaving against medical advice (AMA) from the emergency department—disease prevalence and willingness to return. *J Emerg Med*. 2011;41:412-417.
- Baptist AP, Warrior I, Arora R, et al. Hospitalized patients with asthma who leave against medical advice: characteristics, reasons, and outcomes. *J Allergy Clin Immunol*. 2007;119:924-929.
- Fiscella K, Meldrum S, Barnett S. Hospital discharge against advice after myocardial infarction: deaths and readmissions. *Am J Med*. 2008;120:1047-1053.
- Jeong J, Song KJ, Kim YJ, et al. The association between acute alcohol consumption and discharge against medical advice of injured patients in the ED. *Am J Emerg Med*. 2016;34:464-468.
- Ti L, Ti L. Leaving the hospital against medical advice among people who use illicit drugs: a systematic review. *Am J Public Health*. 2015;105:e53-e59.
- Marson DC, McInturff B, Hawkins L, et al. Consistency of physician judgments of capacity to consent in mild Alzheimer's disease. *J Am Geriatr Soc*. 1997;45:453-457.
- Braun M, Gurrera R, Karel M, et al. Are clinicians ever biased in their judgments of the capacity of older adults to make medical decisions? *Generations*. 2009;33:78-91.
- Sessums LL, Zembrzuska H, Jackson JL. Does this patient have medical decision-making capacity? *JAMA*. 2011;306:420-427.
- Grisso T, Appelbaum PS. *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*. New York, NY: Oxford University Press; 1998.
- Larkin GL, Marco CA, Abbott JT. Emergency determination of decision making capacity (DMC): balancing autonomy and beneficence in the emergency department. *Acad Emerg Med*. 2001;8:282-284.
- Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. *N Engl J Med*. 1988;319:1635-1638.
- Ganzini L, Volicer L, Nelson W, et al. Pitfalls in the assessment of decision-making capacity. *Psychosomatics*. 2003;44:237-243.
- Boettger S, Bergman M, Jenewein J, et al. Assessment of decisional capacity: prevalence of medical illness and psychiatric comorbidities. *Palliat Support Care*. 2015;13:1275-1281.
- Restifo S. A review of the concepts, terminologies and dilemmas in the assessment of decisional capacity: a focus on alcoholism. *Australas Psychiatry*. 2013;21:537-540.
- Kolva E, Rosenfeld B, Brescia R, et al. Assessing decision-making capacity at end of life. *Gen Hosp Psychiatry*. 2014;36:392-397.
- Karlawish J, Cary M, Moelter ST, et al. Cognitive impairment and PD patients' capacity to consent to research. *Neurology*. 2013;81:801-807.
- Boettger S, Bergman M, Jenewein J, et al. Advanced age and decisional capacity: the effect of age on the ability to make health care decisions. *Arch Gerontol Geriatr*. 2016;66:211-217.
- Sturman ED. The capacity to consent to treatment and research: a review of standardized assessment tools. *Clin Psychol Rev*. 2005;25:954-974.
- Appelbaum PS. Assessment of patients' competence to consent to treatment. *N Engl J Med*. 2007;357:1834-1840.
- Dunn LB, Nowrangi MA, Palmer BW, et al. Assessing decisional capacity for clinical research or treatment: a review of instruments. *Am J Psychiatry*. 2006;163:1323-1334.
- Bremault-Phillips SC, Parmar J, Friesen S, et al. An evaluation of the decision-making capacity assessment model. *Can Geriatr J*. 2016;19:83-96.
- Finney GR, Minagar A, Heilman KM. Assessment of mental status. *Neurol Clin*. 2016;34:1-16.
- Lamont S, Stewart C, Chiarella M. Documentation of capacity assessment and subsequent consent in patients identified with delirium. *J Bioeth Inq*. 2016;13:547-555.
- Palmer BW, Harmell AL. Assessment of healthcare decision-making capacity. *Arch Clin Neuropsychol*. 2016;31:530-540.
- Folstein MF, Folstein SE, McHugh PR. "Mini-Mental State": a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*. 1975;12:189-198.
- Edelstein B. Challenges in the assessment of decision-making capacity. *J Aging Stud*. 2000;14:423-437.
- Nasreddine ZS, Phillips NA, Bedirian V, et al. The Montreal Cognitive Assessment, MoCA: a brief screening tool for mild cognitive impairment. *J Am Geriatr Soc*. 2005;53:695-699.
- Grisso T, Appelbaum PS, Hill-Fotouhi C. The MacCAT-T: a clinical tool to assess patients' capacities to make treatment decisions. *Psychiatr Serv*. 1997;48:1415-1419.
- Bean G, Nishisato S, Rector NA, et al. The psychometric properties of the Competency Interview Schedule. *Can J Psychiatry*. 1994;39:368-376.

41. Tomoda A, Yasumiya R, Sumiyama T, et al. Validity and reliability of Structured Interview for Competency Incompetency Assessment Testing and Ranking Inventory. *J Clin Psychol.* 1997;53:443-450.
42. Carney MT, Neugroschl J, Morrison RS, et al. The development and piloting of a capacity assessment tool. *J Clin Ethics.* 2001;12:17-23.
43. Borson S, Scanlan J, Brush M, et al. The Mini-Cog: a cognitive "vital signs" measure for dementia screening in multi-lingual elderly. *Int J Geriatr Psychiatry.* 2000;15:1021-1027.
44. Swidler RN. New York's Family Health Care Decisions Act: the legal and political background, key provisions and emerging issues. 2010. Available at: <https://www.nysba.org/WorkArea/DownloadAsset.aspx?id=26481>. Accessed April 20, 2017.
45. Derse AR, Scheidermayer D. Informed consent. In: *Practical Ethics for Students, Interns, and Residents*, 4th ed. Hagerstown, MD: University Publishing Group; 2015:18-20.
46. Prosser WL, Keeton WP, Dobbs DB, et al. Prosser and Keeton on Torts, 5th Ed. 1984. § 18 Consent: Emergency Privilege pp. 117-118.
47. *Cruzan v Director of Missouri Department of Health*, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990).
48. *Truman v Thomas*, 27 Cal.3d, 285, 165 Cal.Rptr. 308, 611 P.2d 902 (1980).
49. Broida R. Does ED chart leave AMA patient free to claim, "If only I'd known the risks?". *ED Legal Letter.* 2017;29:20-22.
50. Raines RT. Evaluating the inebriated: an analysis of the HIPAA privacy rule and its implications for intoxicated patients in emergency departments. *University Dayton Law Rev.* 2016;40:479-498.
51. *Kowalski v St. Francis Hospital and Health Centers*, 2013 N.Y. LEXIS 1677 (N.Y. Ct. App. June 26, 2013), 2013 WL 3197637, 2013 N.Y. Slip Op. 05437 (2d Dept. July 24, 2013).
52. Simon JR. Refusal of care: the physician-patient relationship and decisionmaking capacity. *Ann Emerg Med.* 2007;50:456-461.
53. Clark MA, Abbott JT, Adyanthaya T. Ethics seminars: a best-practice approach to navigating the against-medical-advice discharge. *Acad Emerg Med.* 2014;21:1050-1057.
54. Maguwaran BG. Risk management for the emergency physician: competency and decision-making capacity, informed consent, and refusal of care against medical advice. *Emerg Med Clin North Am.* 2009;27:605-614.
55. Wigder HN, Propp DA, Leslie K, et al. Insurance companies refusing payment for patients who leave the emergency department against medical advice is a myth. *Ann Emerg Med.* 2010;55:393.
56. Monico EP, Schwartz I. Leaving against medical advice: facing the issue in the emergency department. *J Healthc Risk Manage.* 2009;29:6-15.
57. Schaefer MR, Monico EP. Documentation proficiency of patients who leave the emergency department against medical advice. *Conn Med.* 2013;77:461-466.
58. Levy F, Mareiniss DP, Iacovelli C. The importance of a proper against-medical-advice (AMA) discharge: how signing out AMA may create significant liability protection for providers. *Am J Emerg Med.* 2012;43:516-520.
59. Alfandre D, Schumann J. What is wrong with discharges against medical advice (and how to fix them). *JAMA.* 2013;310:2393-2394.
60. Examination and treatment for emergency medical conditions and women in labor. 42 U.S. Code § 1395dd.
61. Marco CA, Derse AR. Refusal of life saving therapy. In: Jesus J, Grossman SA, Derse AR, et al, eds. *Ethical Problems in Emergency Medicine: A Discussion Based Review.* Wiley-Blackwell; 2012: 89-97.