

# Capacity? Informed Consent; Informed Discharge? Uncertainty!

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## SEE RELATED ARTICLE, P. ■■■.

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The American College of Emergency Physicians Ethics Committee has drafted a primer on the care of gravely compromised emergency department (ED) patients with complex disease, using case examples to assist us in improving emergency care.<sup>1</sup> In our opinion, the 4 case studies presented are exceptionally complicated. Emergency physicians evaluate a small but challenging group of patients with uncertain decisionmaking capacity who want to leave the ED against medical advice. When the decision is complicated and capacity uncertain, making a decision may require not only discussion with the patient but also with other members of the emergency medical team, consultants (psychiatrists, social workers, and hospital lawyers), and family and friends when available and permitted by the patient. Additionally, a period of observation may be necessary. Individuals reading this editorial may render different judgments, given the limited information presented in these brief case vignettes, the complexity of the cases, and the readers' lack of personal contact and communication with the patient, medical team members, and consultants.

In this editorial, we discuss our evaluation of the cases. Our approach differs from that of the authors, and we present our reasons for these differences. We believe that none of the 4 patients presented would have been able to offer informed consent for care. None of the 4 patients could easily demonstrate decisionmaking capacity. All 4 cases managed as described would have been gravely compromised by clinical uncertainty, and the information available was inadequate to permit informed discharge.

Our role as physicians is to be our patients' stewards, and every patient who crosses the threshold of our facilities becomes our responsibility both ethically and legally. What is clear is that we often do not adequately discuss the patient's needs and concerns and document our concerns, thoughts, and strategies while considering an unwanted

discharge. What is less clear is how to make these assessments in the first place. In reality, capacity is a complex calculation involving a patient's mental status, cognitive ability, culture, education, health literacy, and ability to articulate the issues of concern. Although the authors of the accompanying article do offer a framework about to how to proceed in these scenarios, there is exceptional difficulty in achieving adequate decision analysis.

Although some patients likely have capacity to sign out against advice or walk out of the ED, it is incumbent on us to ensure that we concentrate on mitigation, redirection, and education, rather than the process of documenting a refusal with an against-medical-advice form that provides limited legal protection, and certainly no benefit to the patient.

Our goal should be to reduce harm by minimizing the number of patients who sign out against medical advice and left without being discharged by increasing communication, satisfaction, and efficiency. And for patients who do wish to leave against medical advice and left without being discharged, we must recognize the potential perils of these decisions and work diligently to investigate whether such a decision is truly in the patients' best interest. Does the authors' report apply to all of us in the largest academic centers and the smallest rural hospitals? Is the staffing adequate when the eyes are only yours and the single nurse's as opposed to those of an emergency physician, a registered nurse, a resident, a social worker, a psychiatrist, a patient advocate linguistically and culturally prepared, and hospital security, and when there is time and space to render care?

Providing the time-intensive observation, sensitive communication, and counseling that are necessary to make such a critically important decision is often most difficult in low-volume EDs, many of which are located in more rural areas. This setting presents a challenge to the single physician and nurse who may be the only professionals with the knowledge, training, and experience to assess capacity. Physicians practicing in such hospitals need to

work with hospital leadership to develop strategies and plans to deal with these infrequent but potentially dangerous situations.

When family and friends are available and patients are willing, involving surrogates and informants early and often is of significant utility to help both mitigate potential discharges against medical advice and establish capacity. The use of screening tools to determine capacity as described in the article<sup>1</sup> is validated in small studies on patients with alcohol use disorder, and although the screens are somewhat time intensive, they offer a layer of increased security against inappropriate discharge.

Some patients clearly understand the risks of refusal of treatment, and we may fully agree that this might be an acceptable decision for an individual. Many patients who leave against medical advice do not understand the risks of refusal; others fear the costs (socioeconomic and insurance status), fear health care, fear repetition of a previous negative experience, lack health literacy, or have subtle consciousness-altering disorders that are neuropsychiatric, toxic metabolic, or infectious in nature. All efforts should be made to comfort, console, and counsel these patients to reach a negotiated means of achieving essential effective care and at the least of achieving a relatively safe discharge against medical advice.

In emergency medicine, we make hundreds, if not thousands, of decisions per hour. It is tempting to set up a framework for processing these often time-consuming issues to allow us to simply execute our “decision tree” and move on to the next patient or crisis. But decisions made rashly are often poor ones, and sometimes in the absence of complete information, a little more time can be of inestimable benefit: time to gather more information, time for a patient to reconsider leaving, time for the ethanol concentration to diminish and permit an improved quality of discourse and thought.

Although case presentations and commentaries can be useful, these brief vignettes are of limited value in distilling this subtle and complex part of medicine. Screening and working with patients who attempt to leave against medical advice and leave without being seen are some of our most perplexing tasks and responsibilities. Attempting to address the topic effectively in one-paragraph vignettes gives it inadequate attention and depth.

In case 1, the paucity of information provided leads to a situation in which experienced providers would think that they did not have sufficient information to judge the patient’s capacity for a safe assessment for discharge. A safe discharge against medical advice for a psychiatric complaint is an inherently risky proposition, and a proper evaluation would have to include collateral communication, an

assessment of cognitive function, and a complete inventory of suicide and homicide risk factors. Although this is alluded to in the recommended resolution, the presentation might initially appear as though this were a simple and easily resolved matter, which it is not.

In case 2, assessing the risk factors of refusal for the young intoxicated patient is more complex than is suggested. The level of impairment varies significantly among individuals with similar concentrations of ethanol or other toxins. A careful history using a standard assessment tool<sup>2,3</sup> can be helpful, but ultimately the balance of autonomy versus the need to protect patients with a potentially significant injury when judgment is impaired is very difficult. Although the “right answer” will vary according to the individual scenario, we argue that the threat to safety outweighs the loss of liberty or autonomy for patients who present with traumatic injuries in the presence of ethanol.

In case 3, given the scenario as presented, the idea that a rushed decision in the field, in the absence of an emergency physician evaluation, is appropriate is deeply troubling. Patients with transient hypoglycemia can certainly still be impaired (posthypoglycemic alteration in consciousness) even after initial dextrose supplementation. In addition, no information was offered in regard to the absence of ethanol or substance use, intentional overdose, or the use of a sulfonylurea or long-acting insulin. The presence of any of these factors in hypoglycemic patients could easily predict reoccurrence of hypoglycemia after emergency medical services personnel have left.

In case 4, although the authors outline the multiple potential risks to a discharge against medical advice, the brevity of the outlined concerns might lead some caregivers to fail to recognize the underlying reality that this is not a simple and rapidly accomplished assessment. This patient had immediate life-threatening hyperkalemia, and the assessment of health literacy and potential presence of suicidal intent, profound depression, or uremic encephalopathy need consideration.

Although there is some medicolegal risk involved in holding a patient against his or her will, in most cases this should not be necessary. When we firmly and warmly explain to our patients that we as clinicians do not believe it is safe for them to leave, most will comply. For those who do not, we are personally much more comfortable standing in front of a judge explaining why we kept a patient in our ED for a few hours against his or her will because we were concerned he or she might die if released, based on our clinical judgment and experience, than explaining why we let a patient leave only for him or her to be injured or die. As a corollary, studies have shown that patients who leave

against medical advice and left without being discharged have higher rates of ED revisitation and admission on revisitation.<sup>4,5</sup>

When we fail to get it right the first time, there are often grave consequences for our patients.

One of the primary aims of the article could have been to explore creative strategies to minimize against medical advice and left without being discharged protocols, yet that opportunity was missed. We believe the best message for emergency physicians is that as clinicians we should use all our skills and wisdom to minimize experiences involving leaving against medical advice and left without being discharged. These patients may have grave toxic metabolic, psychiatric, or traumatic causes for their lack of compliance and decision to refuse care. When we assess these patients with complex disease, we have bidirectional uncertainty because of the multifactorial gaps between providers and patients that create unique challenges in achieving the goals we share with our patients.

Our privilege is to care for the critically ill and injured. When our patients reject our efforts, we must consider whether we have failed—we must decide if we are compromised in our efforts, discriminatory, insulted by disrespect, concerned about a failed relationship, or angry. We cannot allow these factors to limit our creative abilities to care for these patients who need us desperately. These are our patients; their quality care is our goal.

It is our belief that these case studies are so well crafted and so neat that they fail to depict the complexity of medical care in the ED. They fail to demonstrate that there are no shortcuts to ensure adequate capacity with a high level of certainty and that, absent that high level of certainty, we cannot permit any of these patients to refuse care. Emergency physicians must acknowledge that oftentimes we do not know these patients, and without essential information from family or significant others, we are very limited in our ability to accurately assess many of them without more observation and evaluation. We believe

that the authors would serve our patients and our medical principles better to offer the reader more creative strategies to achieve quality care. These cases necessitate more time, more people, and more energy, and require holding these patients against their will in the ED until a greater level of certitude of capacity and a pathway to safety are established.

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## REFERENCES

1. Marco CA, Brenner JM, Kraus C, et al. Refusal of emergency medical treatment: case studies and ethical foundations. *Ann Emerg Med*. 2017; <http://dx.doi.org/10.1016/j.annemergmed.2017.04.015>.
2. McCormack RP, Williams AR, Goldfrank LR, et al. Commitment to assessment and treatment: comprehensive care for patients gravely disabled by alcohol use disorders. *Lancet*. 2013;382:995-997.
3. McCormack RP, Gallagher T, Goldfrank LR, et al. Including frequent emergency department users with severe alcohol use disorders in research: assessing capacity. *Ann Emerg Med*. 2015;65:172-177.e1.
4. Hwang SW, Li J, Gupta R, et al. What happens to patients who leave hospital against medical advice? *CMAJ*. 2003;168:417-420.
5. Baptist AP, Warrier 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.