"Against Medical Advice" (AMA), Refusal of Transport, and Informed Consent

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Here are some notes I've taken about the issue of informed consent. This is directly related to the ED—where most of the case law about informed consent in emergencies originates—but also applies to EMS and SAR situations.

As one lecturer put it, AMA or refusal of transport or refusal of care needs the following documented on the chart:

1. **CAPACITY**: patient has the capacity (competence) to sign out
2. **TOLD**: attending told patient of the diagnosis
3. **WHAT ELSE**: What other reasonable alternatives can the patient pursue?
4. **OUTCOME**: What might be the outcome if the patient signs out AMA?
5. FAMILY: You have involved the family, if any, in the AMA process; have them sign chart, if possible.

And, quoting from Emergency Department Law 1993;4(23), p. 8-7, relating to questions I posed after a particularly difficult night, with 2.5 inappropriate AMA discharges from our hospital:

"...What are the attendant duties and liabilities of medical restraint in the following not so atypical scenario? An elderly man is brought to the Ed by his family. When asked what the problem is, the man reveals no specific medical complaints except for 'being sick.' The man recalls something about throwing up blood, but says that it happened 'several days ago.'

"The patient's vital signs are unremarkable, as is his physical exam, except for some mild epigastric tenderness. His stool is hemetest negative and his blood pressure shows no orthostatic instability. His answers to questions reveal no evidence of any overt psychiatric illness, but he is disoriented as to place and time.

"According to the family and medical records, the patient had recently been admitted to the hospital with the diagnoses of alcohol intoxication, pancreatitis, and an upper GI bleed. He had been scheduled to be transferred to an alcohol detoxification center in three days. However, he had signed out from the hospital "Against Medical Advice" just three hours earlier.

"The patient had walked about a block from the hospital, where he had been found collapsed in a snowdrift, confused and unable to walk. [by his family --KC] The cause of the confusion was not clear to the examiner, but it appeared to be alcohol withdrawal. [or the benzodiazepines he'd been given --KC]

"During the process of re-admitting the patient to the hospital, his family expressed great concern that the patient had been allowed to leave the hospital, since he could have died of exposure. They expressed willingness to sign psychiatric commitment papers, but the emergency physician did not feel that the patient had any primary psychiatric problems. [N.B. -- in Pennsylvania, alcohol-related problems are specifically excluded from the reasons you can use to involuntarily commit someone. --KC]

"Should the patient be restrained in this situation? What are the legal risks and liabilities?

"ANALYSIS: The analysis of any patient's situation should always begin with establishing what course of action is likely to promote his or her good health. In this case, wandering aimlessly in inclement weather was obviously not to the patients' advantage.

"If weather is not a factor, is the patient able to care for his medical condition? Is he or she able to obtain and take medications and food? IS there someone willing to assist the patient? If there would be any doubt by a reasonable person [and those of us who work in the ED know this is an entirely fictional legal construct --KC] as to the patient's ability to care for him- or herself, at least there is a proper motivation to intervene. While the analysis does not stop here, this alone should be enough to defend against a charge of false imprisonment.

"In fact, there may be liability if you do not act on the patient's behalf. In an emergency condition where the patient is unconscious, the patient has the right to presume consent to treatment. Failure to do so would undoubtedly result in a claim of negligence.

"For example, one hospital found itself liable for the wrongful death of an intoxicated patient who had presented to the emergency department requesting help for this drinking problem. After making his request, the patient left the ED with another alcoholic and was struck by a car while attempting to cross a nearby highway. A court later found that once the patient present asking for assistance, the hospital had the duty to comply with that request until he regained the capacity to protect himself.

"It is true that a physician must have the patient's consent for treatment, but consent is presumed when the patient is incompetent, then the right or responsibility to restrain a patient is determined by whether or not he or she has the ability to make an informed decision. The test is the same whether the patient is a Jehova's Witness who refuses life-saving blood or the fearful elderly person who refuses life-sustaining protective measures. If they lack capacity to make a truly informed decision, the physician is permitted, even obligated, to presume consent to treatment that is in the patient's best interest.

"*The legal capacity to consent or refuse consent can be reasonably determined by a four-prong test:*

"*- Does the patient understand the relevant information?*

"*- Does the patient have the ability to manipulate the information?*

"*- Does the patient have the ability to make and communicate a choice?*

"*- And finally, can the patient put all of these together to appreciatethe situation and its consequences?*

"The first test is one of simple understanding. If the patient cannot understand the danger, those that [sic] do have an obligation to protect him. Asking a patient to paraphrase what has been told to him can help assess this understanding better than asking him to simply regurgitate information. If a person is disoriented, it is hard to support a conclusion that they appreciate a personal danger

"To determine whether a patient can successfully manipulate information, it is helpful to ask the patient about hypothetical situations based on what a rational person would do. In this way a person with normal capacity, but differing values, can demonstrate that understanding.

"The third prong looks to whether the patient can make decisive choices. Differing responses within short periods suggest that the patients' capacity to organize his thoughts and choose a course of action is confused and unstable. [see Addendum below --KC] Patients who repeatedly change their minds should be protected until their decision-making process is stabilized.

"The last prong entails the ability to appreciate the outcomes of their behavior and give reasons for their choices. The goal is to evaluate the patients' ability to do this, not to make value judgments based upon the choices.

"The bottom line is exactly where we started. What is the best thing for the patient's health? If restraining a patient is the best way to ensure that outcome, then proceed with such, observing the normal precautions.

"The advice to treat the patient as you would your own mother is a good guideline. The legal risk of behaving in this manner is one well worth taking." [from Mark Plaster, M.D., J.D., FACEP]

[Addendum: on this same shift, another family brought in a woman, against her will, who also had just signed out AMA and found by the family in a bar drinking. She was alert, seemingly able to give a good history, smiling, cooperative, and ready to sign out again AMA. I was ready to let her, until I talked to the family, who said she had been nearly dead of hepatorenal syndrome, had severe liver failure, and had been told that if she drank again she would die. When I went back to her, she was still alert, smiling, and a good historian, but with a completely different history. She remembered nothing about having liver failure, or hepatorenal syndrome. She was a classic Korsakoff's glib confabulator. I admitted her against her will, on the grounds that based on her poor memory she wasn't capable of informed consent to an AMA. I called the magistrate for a restraining order.]

[Addendum #2. A couple of hours before the end of my shift (which by this time I thought would never end) one of our (excellent) third-year internal medicine residents called me from the floor. He said his internal medicine attending had told him to let his patient sign out AMA but he had some questions and wanted to consult me first. (Nice when even the residents on the other services consult the emergency medicine attendings for advice.) I asked what the patient's medical problem was. He said DTs. I asked if the patient was hallucinating. He said yes. Only raising my voice a little (I was very proud of this at the time) I told him that, not to mention suing him for malpractice, I would personally strangle him if he let the patient sign out AMA. I explained the above and he called the magistrate. I suspect that by this time the magistrate was ready to strangle ***me***.]

Additional note: it is ***not*** necessary for medical professionals to call a magistrate except in exceptional circumstances, as when a family member, staff member, or the person's lawyer contests the restraint. Note also that a drunk or otherwise incapacitated patient saying ***"I'll sure your ass!"*** or ***"I wanna call my lawyer"*** does ***not*** require you to call either the magistrate or the person's lawyer. (I have often considered letting drunks call their lawyers—after all if ***we*** have to deal with obnoxious drunks, why not their lawyers, too? But I've never done it.

Final note: when teaching residents about AMAs, I always use the above stories to point out the following (view with nonproportional font):

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|------------people who want to sign out AMA------------------|

|-people to let sign out AMA-| |-people to commit-| |---*****---|
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***** means there are people who want to sign AMA who don't meet the criteria for involuntary commitment, but who still shouldn't leave. Most are drunks who we just tell to shut up until they're sober; many threaten to sue and we just say "see you in court, shut up and behave." (Most apologize when they're finally sober and able to leave.) Ones that are more complex get "medical restraint." And if needed, a restraining order from a local magistrate who rules (legally) on their competence to sign out AMA.