InFocus

Discharging Psychiatric Patients Against Medical Advice

By James R. Roberts, MD

Author Credentials and Financial Disclosure: James R. Roberts, MD, is the Chairman of the Department of Emergency Medicine and the Director of the Division of Toxicology at Mercy Catholic Medical Center, and a Professor of Emergency Medicine and Toxicology at the Drexel University College of Medicine, both in Philadelphia.

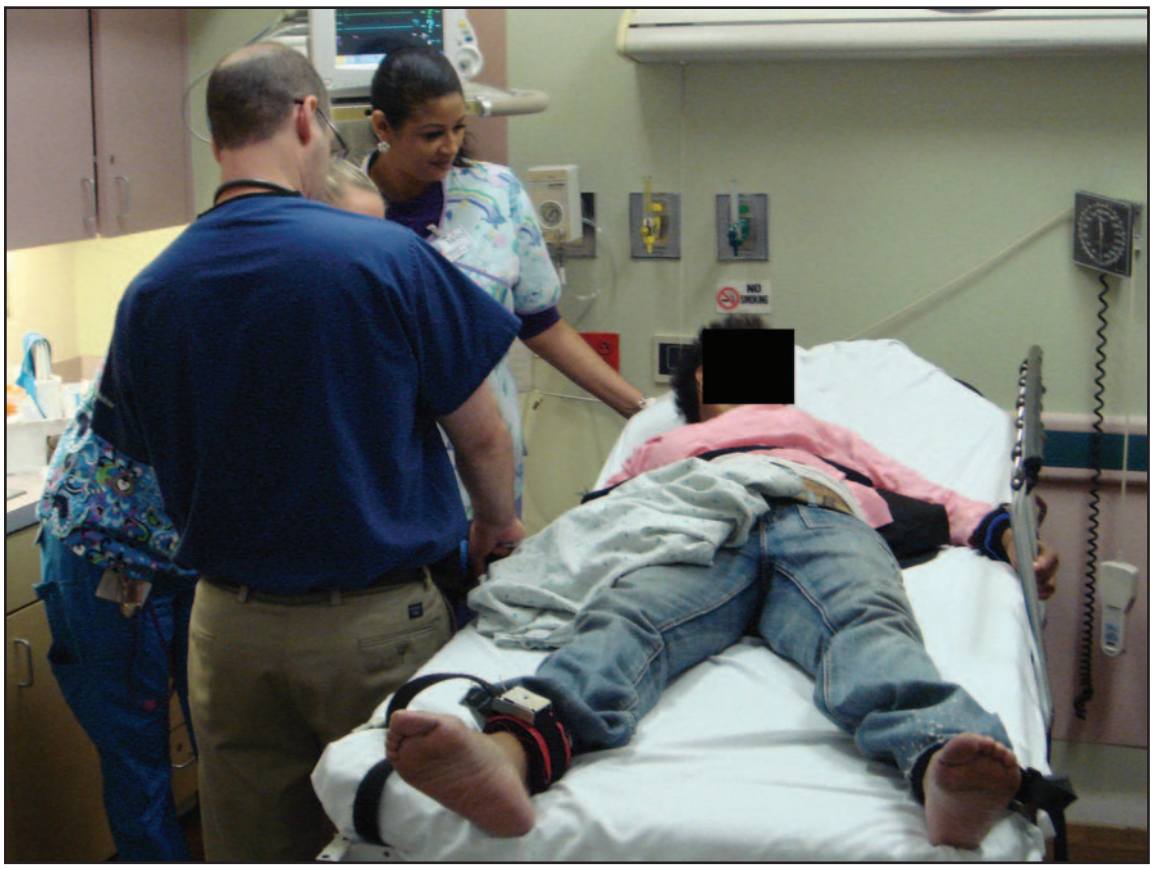
Dr. Roberts has disclosed that he is a member of the Speakers Bureau for Merck Pharmaceuticals. All other faculty and staff in a position to control the content of this CME activity have disclosed that they and their spouses/life partners (if any) have no financial relationships with, or financial interests in, any commercial companies pertaining to this educational activity. Lippincott CME Institute, Inc. has identified and resolved all faculty and staff conflicts of interest regarding this educational activity.

Learning Objectives: After completing this CME activity, the physician should be better able to:

1. Assess the issues concerning discharge against medical advice (AMA) in psychiatric patients.
2. Evaluate the Tarasoff ruling issues.
3. Formulate objectives to minimize problems with psychiatric AMA patients.

Part 3 in a Series

Patients' Rights and Psychiatrists' Duties: Discharging Patients Against Medical Advice
Gerbasi JB, Simon RI
Harv Rev Psychiatry
2003;11(6):333



It's difficult to keep a psychiatric patient in the hospital against his will. For an EP to respond to this higher calling, it takes patience, understanding, the correct paperwork, and a lot of time and effort to jump through the hoops to obtain even temporary involuntary commitment. Your best efforts are easily thwarted by a savvy or manipulative patient and an impersonal legal system bent on preserving individual autonomy. Contrary to the public's naïve beliefs, drug and alcohol problems are not grounds for involuntary commitment. If a patient tells you he is going to kill his neighbor who won't return his lawnmower, brush up on Tarasoff issues discussed in the table before allowing him to leave your ED.

There is no universal standard of care for ED AMA discharges. Some patients leave AMA because they have minimal problems, and don't want to wait. Others have inscrutable social or personal issues, but sick and mentally ill individuals also abscond. Patients who leave AMA often end up back in the ED in worse shape, and the financial repercussions can be immense.

Psychiatric patients pose unique challenges, but after reading this article, emergency physicians should be better able to assess the issues concerning AMA discharge in psychiatric patients, evaluate the Tarasoff ruling concerns, and formulate objectives to minimize problems with psychiatric AMA patients.

Psychiatrists' problems with patients leaving AMA from an inpatient service are clearly reminiscent of ED practice. It is certainly no secret that psychiatric inpatients are discharged AMA at a high rate compared with the general medical population. On average, 17 percent of psychiatric patients initially admitted voluntarily will subsequently leave AMA. (*Mayo Clin Proc* 2009;84[3]:255.) Patients who leave AMA are more anxious, hostile, and aggressive than their counterparts who remain in the hospital until discharged. Psychiatric patients are motivated to leave the hospital by mistrust, denial, fear, paranoia, or irrational dissatisfaction with their treatment. Omnipresent financial issues can be most problematic.

The authors highlight a 32-year-old man admitted to a psychiatric unit because of a drug overdose. The HMO denied financial benefits after a few days because hospitalization was no longer deemed necessary for medical or psychiatric reasons. The patient still had psychiatric issues, however, and the physician and staff did not think he was ready for discharge. When the patient was informed that he would be responsible for the hospital bills, he demanded to leave. This highlights a common conundrum when a mentally ill patient demands to leave the hospital AMA. There is often insurmountable divergence among the patient's rights and autonomy, patient safety, and a physician's duty to treat.

While admission may be voluntary at first or involuntary for a limited time, it's difficult to keep patients in the hospital for prolonged periods of time if they do not agree with medical decisions. Lengths of stay barely supported by insurance companies do not include weeks of therapy that enable acutely psychotic patients to fend for themselves. The structured, controlled hospital environment is much more important to psychiatric patients than it might be for those with medical problems. Outpatient services and support for psychiatric patients can be abysmal, difficult to orchestrate in a timely way, and impossible to achieve if the patient is not motivated or cooperative. The patient's decision to leave can be impulsive, irrational, and made on the spur of the moment over minor issues. For precipitous decisions, there is little one can do logistically.

Patient Rights

Voluntary admissions comprise approximately three-quarters of the 1.6 million admissions to psychiatric facilities in this country. The voluntary admission procedure is the most desirable and commonly used in many hospitals. Many practical and logistical external pressures are placed on psychiatric patients from numerous sources — family, police, lack of shelter or personal resources, and winter weather. An involuntary admission usually has to meet relatively standard requirements: The patient must be a danger to himself or others or is unable to care for himself. This is often a gray area, subject to much physician and court interpretation, and certainly open to patient manipulation.

Even when involuntary commitment criteria are clear cut, the incarceration is limited (72-120 hours) without some sort of complicated and time-consuming judicial review. Few hospitals have the resources to routinely obtain or enforce prolonged involuntary admissions in a complex overburdened court system. Often physicians' good intentions are thwarted when the initially psychotic

or dangerous patient appears to have seen the error of his ways, and is no longer an obvious threat. Because extended involuntary commitment requires a physician to provide formal and detailed documentation about the actual involuntary commitment, and almost always a cumbersome court appearance, it's easy to rationalize and move on to the more pressing case.

The neophyte clinician might assume there is a legal consensus that a mentally ill patient cannot give informed consent simply because he has a psychiatric diagnosis. This is not true. Patients are, by judicial law, considered competent until proven otherwise. This is true even of the schizophrenic or bipolar patient who was found wandering around talking to himself. Many psychiatric patients do not acknowledge their problem, and it's easy for the family also to be in denial. Once in the system, the psychiatric patient often quickly learns tactics and behavior to appear competent enough to leave. A person who voluntarily seeks admission is usually assumed to possess the mental capacity to understand the nature and implications of that decision, and therefore would be capable of leaving at will and understanding the risks of that. Essentially, a voluntarily admitted patient must be mentally competent, or he would not have opted for admission in the first place.

Harsh realities encourage voluntary admission with hope of facilitating treatment. Even if patients meet involuntary hospitalization criteria, many physicians prefer to make the admission voluntary because it involves fewer stigmas to the patient and certainly less paperwork and personnel effort. A voluntary psychiatric admission is less coercive, often avoids an adversarial relationship between the doctor and the patient, allows the patient to acknowledge a desire for help, and increases patient involvement and personal responsibility for his disease. Essentially, he has bought into the treatment plan. A voluntary admission respects individual autonomy, and it is clearly the best scenario.

AMA Discharges

Current law has great concern for protecting patients' rights, and psychiatric patients are included in this mandate. When one tries to balance mental health law with clinical care, the physician's intentions often compete with the patients' rights to refuse such care.

Psychiatrists have a duty to provide competent patient care. From a psychiatric standpoint, the clinician must first assess whether the patient who wants to leave is a candidate for involuntary commitment. Secondly, the physician must inform the patient, following procedures similar to the medical service, of any consequences of AMA discharge. The clinician must assess and document that the patient is able to understand that information. This may be readily accomplished on a medical service, but in a psychiatric milieu can be daunting.

Involuntary Commitment

The bottom line for an AMA request from psychiatric patients boils down to two options: release the patient voluntarily or proceed with involuntary commitment procedures. The general test of involuntary hospitalization requires the presence of mental illness and that the patient is either a danger to himself or others or is unable to care for himself. Often these decisions have to be made with minimal clinical data, a hostile milieu, and under a specific timeframe. A cornerstone is an assessment for violence. Most state courts provide immunity to clinicians who, after a properly documented evaluation, decide to hold a patient against his will as long as they have demonstrated that the patient is a danger or unable to care for himself. These authors believe that it is best to assume that the risk of the physician being sued for false imprisonment is minimal. Certainly that risk of litigation is much less than the risk assumed when discharged patients inflict violence on themselves. Malpractice suits that allege negligence because a patient is prematurely released and subsequently harms himself or others are common. It is extremely uncommon

Continued on next page

Unsolved Dilemmas in Treating Psychiatric Patients

- Patients have the right to refuse treatment (including surgery or life-saving treatment) even when the treatment is clearly in their best interest.
- A psychiatric diagnosis does not automatically render a patient incompetent or incapable of refusing medical care.
- Competence, not incompetence, is assumed unless proved otherwise.
- Criteria for involuntary commitment are limited to a clear danger to self or others or inability to care for oneself.
- Drug abuse or alcohol dependence do not in themselves provide criteria for involuntary commitment.
- Most involuntary commitment laws expire in a few days (72-120 hours) unless pursued in court.
- Most common allegations of negligence against physicians are failure to prevent patients from leaving the hospital, failure to invoke involuntary commitment, and failure to protect endangered third parties.
- Endangered third parties must be notified of an AMA discharge or if a patient has made credible threats against them. Patient confidentiality and HIPAA laws do not hold in this case.
- Patient confidentiality issues should not keep the physician from informing family and other interested parties of a bona fide AMA discharge. Most families do not understand mental health laws, and expect that the hospital will do the right thing or keep the obviously distressed patient safe for his own good.

Initiating Involuntary Commitment

Involuntary commitment is an application for emergency evaluation and treatment for a person who is dangerous to himself or others due to mental illness. Danger to self has to be shown by establishing within the previous 30 days that:

- The person would be unable to satisfy his need for nourishment, personal or medical care, shelter or self-protection, or safety without the care, supervision, and assistance of others, and death or serious physical debilitation would occur within 30 days unless treatment was provided.
- The person has attempted suicide or the person has made threats to commit suicide and committed acts to bring about those threats.
- The person has mutilated himself or has made threats to mutilate himself, and he has committed acts to bring about those threats.
- The person has shown danger to others by inflicting or attempting to inflict serious bodily harm on another or has threatened serious bodily harm and has committed acts to bring about the threat to commit harm to another.

Because this commitment is involuntary, it may require the assistance of family, crisis professionals, police, ambulance, and any other person involved in the crisis. A petitioner is required to sign the request and possibly appear at a hearing. The petitioner must have firsthand knowledge of the dangerous conduct and be willing to go to an emergency department or the Office of Behavioral Health (OBH) to sign the commitment form.

The petitioner also may be required to testify at a hearing about the dangerous conduct that he witnessed. A police officer or a doctor has the authority to initiate involuntary commitment without prior authorization from the OBH delegate.

Once involuntary commitment is authorized, the individual will be taken to an emergency department by the police or ambulance for physician evaluation to determine if he should be admitted for involuntary psychiatric inpatient treatment. If admitted, he may be kept no longer than 120 hours unless a petition for Extended Emergency Involuntary Treatment is filed by the hospital.

AMA

Continued from previous page

for patients to successfully sue for false imprisonment.

A number of risk factors should prompt the clinician to opt for involuntary hospitalization. These include a recent discharge or multiple discharges from a psychiatric hospital, a definite plan for violence or suicide, substance abuse, a recent significant personal loss for the patient, panic attacks, acute anxiety, and insomnia. Some issues, like anxiety and insomnia, can be treated as outpatients.

For more than 100 years, the American medical system has supported the concept that every adult of sound mind has the right to determine what shall be done with his own body. Competent patients have the right to refuse treatment even when eschewing interventions in their best interest, even life-saving ones. Even psychiatric patients, if they are deemed to be competent, have a right to refuse treatment, including antipsychotic medications and hospitalization. If a psychiatrist thinks a patient should take antipsychotic drugs, he can rarely be forced to if he is truly competent. Often a family member may be able to encourage the patient to continue with hospitalization when the physician has failed. Having a non-physician patient advocate in the hospital is extremely valuable in promoting patient trust and cooperation. (*Psychiatr Serv* 2006;57[8]:1192.)

Malpractice Liability

While conforming to the nuances and vagaries of a highly detailed AMA discharge may confer some legal protection on the physician, it is not a free pass to legal immunity. In general, court rulings hinge on whether the doctor had a duty to forcibly commit the patient or to release him AMA. If the discharging physician can show in the medical record that the patient's ability to make an informed decision was done competently, an AMA discharge is generally protective for malpractice claims. If a patient is deemed competent and demands to leave the hospital, the physician is obligated to inform him of the possible consequences and allow the patient to exit, provided the patient is not a danger to himself or others or unable to care for himself.

Financial Disincentives

Some payors will limit payment for psychiatric services after a certain length of time. Using obviously sneaky tactics, the payors are not actually denying care; they just won't pay for it. Blaming them for failure to pay will not provide a viable defense. It is the treating physician, not the insurance company, who is responsible for crafting interventions and deciding when discharge is appropriate. Courts have held that physicians have a duty to be patient advocates, so most hospitals opt to continue to treat patients even if insurance or patient payment is denied.

If a patient does leave the hospital AMA, the psychiatrist should consider informing family members or significant others. See the table outlining the Tarasoff ruling.

Comment: The ubiquitous dilemmas of this are crystal clear, as is the system's failure to make things easy. The next time you are having a bad day dealing with psychiatric patients, have some empathy for your psychiatric colleagues. Most of us merely sign the involuntary commitment form of the overdose- or suicide-prone patient, institute a one-on-one by taking a much needed tech out of circulation, and let the psychiatrist deal with it after any medical situations have been stabilized. In psychiatry, the hard work begins after the ED visit.

When the patient's rights to autonomy and self-directed care come into direct conflict with the true need for psychiatric treatment, all involved are smack in the middle of a horrific, if not no-win, situation. Always looming overhead is potential litigation for premature discharge, failure to warn a third party about potential violence toward them from your patient, or the overriding financial issues. The deck is clearly stacked. It's not easy to prove incompetence on the medical record or to complete all the necessary steps to support a continued involuntary commitment. Want to spend all day in mental health court, only to have the case continued?

There is no easy answer. It is clear that psychiatric patients are prime candidates for bad outcomes if they are discharged AMA. They know the system, are a crafty lot, and can be intolerably annoying and hostile, especially when substance abuse is involved. It should be a rare case where an AMA discharge of bona fide psychiatric issues is orchestrated by the EP. Paranoid schizophrenics do push people in front of subways after God told them to. We should be thankful for psych crisis and those who staff it.

There is no magic way for anyone to predict who will commit suicide, and any patient who really wants to kill himself will succeed at some point. Bipolar patients, while often impossible to deal with in the ED,

Tarasoff Ruling: Duty to Warn and Protect Third Parties

All physicians should be aware of the Tarasoff case. It is law in most states, but interpretations vary widely. The intent of the 1976 statute was to protect potential victims from harm, the implied principle being that the safety of society outweighs the benefits of maintaining patient confidentiality. This statute applies primarily to psychotherapy, but might be applicable in the ED.

This California case involved a patient who told his therapist that he planned to kill Tatiana Tarasoff, who had spurned his romantic gestures. The therapist informed authorities, who found no credible danger, and did not institute specific preventive or commitment actions. Ms. Tarasoff was not informed or warned of the threats. The patient killed Ms. Tarasoff, carrying out the threat conveyed to the therapist. The case was reviewed by the California Supreme Court, resulting in a complicated ruling, and a precedence that further clouds all of the issues. Since then, other states have tried to clarify this problem, but jurisdictions and psychotherapists vary widely in their approach.

If you hear a psychiatric patient state that he is going to kill a police officer, his neighbor, or his lover or spouse when he leaves, it is your duty to inform that individual and authorities that such a threat was made if involuntary commitment is not pursued. HIPAA rules do not apply, but this is a complicated issue. A real threat of violence should preempt concern about maintaining patient confidentiality or preserving patients' rights to participate in medical decision-making, but the clinician is truly in a tricky situation. The act of informing a third party and the authorities is unfamiliar to most EPs. If a patient is violent or expressing intent to harm someone else, keep him in the hospital by whatever means possible, and seek help.

An AMA discharge does not negate the physician's obligation to protect third parties. If an AMA discharge is planned, even without issues of potential third party harm, it may be best always to tell interested parties about the AMA process. Despite HIPAA and litigation risks, this seems prudent. Relatives and the general public usually assume that you will not cavalierly release a troubled, dangerous, or psychotic individual, and believe you have the authority and ability to hold them and even force treatment "for his own good." This is certainly easier said than done.

All EPs should research this important but complicated issue; it's far too involved for a brief summary here. Googling the name "Tarasoff" will yield many documents, including one from *Public Health Law and Ethics*, which can be accessed at http://bit.ly/Tarasoff. If you are confronted with this situation, get some help from hospital legal counsel and a psychiatric consultant before proceeding. An erudite analysis by a physician who is also a lawyer can be found in the *Journal of the American Academy of Psychiatry and the Law* (2002;30[3]:417).

The American Psychiatric Association's Principles of Medical Ethics (http://bit.ly/APAethics) allow psychiatrists to reveal confidential information if another person is at significant risk of danger. (For details, see *Psychiatr Serv* 1996;47[11]:1212, www.stanford.edu/group/psylawseminar/Tarasoff.Greene.htm, and www.apa.org/monitor/julaug05/jn.aspx.)

Click and Connect! *Access the links in this table by reading it on* www.EM-News.com.

are at greatest risk of successful suicide so be careful. Should something happen to them when they are discharged, the obvious retort is: "He was a psychiatric (or drug-addicted or alcoholic) patient, how could he understand or be competent to leave your ED?" The public has its head in the sand about many psychiatric issues, including involuntary commitment laws. Not that drug and alcohol issues are not clear-cut psychiatric issues, but there is even less one can do for these hapless folks unless they cooperate.

Risk Factors for an Untoward Outcome* in the Psychiatric AMA Patient

- Recent prior psychiatric admission.
- Recent significant personal loss (spouse died, divorce, lost job).
- Substance abuse.
- Panic attacks.
- Acute anxiety.
- Global insomnia.
- Prior AMA discharge resulting in violence to self or others.

* Suicide attempt; violence to self or others.

EPs usually see the worst of the problem: the noncompliant, addicted, homeless, or totally incurable patients who drain one's patience and the hospital's resources. It's difficult for anyone to obtain competent ongoing psychiatric care when he is rich and famous, let alone psychotic and penniless, so the ED is the end of the social funnel for many. Enlisting family members (unfortunately, many shy away), cajoling, bargaining, providing food and medications, threatening drug withdrawal, and offering a variety of creature comforts only go so far with some psychiatric patients. The naïve public likes to believe that something can be done to save psychiatric patients from mental anguish and self-destruction: "Just get him some help and on medication." Someone, please, show me that magic formula.

Click and Connect! *Access the links in this article by reading it on* www.EM-News.com.

CME Participation Instructions

To earn CME credit, you must read the article in *Emergency Medicine News*, and complete the evaluation questions and quiz, answering at least 80 percent of the questions correctly. Mail the completed quiz with your check for $12 payable to Lippincott Continuing Medical Education Institute, Inc., Two Commerce Square, 2001 Market St., Third Fl., Philadelphia, PA 19103. Only the first entry will be considered for credit, and must be received by Lippincott Continuing Medical Education Institute by August 31, 2011. Acknowledgment will be sent to you within six to eight weeks of participation.

Lippincott Continuing Medical Education Institute is accredited by the Accreditation Council for Continuing Medical Education to provide medical education to physicians. Lippincott Continuing Medical Education Institute designates this educational activity for a maximum of *1 AMA PRA Category 1 Credit.*™ Physicians should only claim credit commensurate with the extent of their participation in the activities.

August 2010
Questions:

1. In assessing AMA discharge in psychiatric patients, which of the following is not an impediment to delivering definitive health care?
   - ○ A. Patient autonomy caveats.
   - ○ B. Manipulative patients.
   - ○ Lack of insurance.
   - ○ AMA discharge for competent patients.

2. A paranoid schizophrenic patient, hospitalized for cutting his wrists, says he is going to kill a neighbor who has been spying on him. What should the emergency physician do?
   - ○ A. Allow AMA discharge if the patient promises not to harm himself or the neighbor.
   - ○ B. Institute involuntary commitment procedures immediately.
   - ○ C. Consider the threat strictly confidential information.
   - ○ D. Allow ED discharge if the patient will take antipsychotic medication.

3. An admitted chronic alcoholic is treated for an accidental heroin overdose, and tells you that he is addicted to narcotics. The overdose is successfully treated with no complications. Which of the following options is possible?
   - ○ A. Involuntary commitment to a psychiatric facility for 72 hours.
   - ○ B. AMA discharge after the overdose is no longer a medical issue.
   - ○ C. Call the family with this information even if the patient protests.
   - ○ D. Involuntary commitment only to an alcohol/narcotic rehabilitation facility.

4. Which of the following will not help formulate objectives to minimize AMA issues with psychiatric patients?
   - ○ A. Enlist the help of a patient advocate.
   - ○ B. Orchestrate a voluntary admission.
   - ○ C. Proceed in a nonthreatening, nonjudgmental manner.
   - ○ D. Limit interventions based on insurance reimbursement.

5. What best describes the Tarasoff ruling?
   - ○ A. Duty to warn a third party of potential harm.
   - ○ B. Patient confidentiality limits disclosure of threats.
   - ○ C. Ability to force use of antipsychotic medications.
   - ○ D. Involuntary commitment for drug and alcohol addiction.

Directions
Your successful completion of this activity includes evaluating it. Please indicate your responses below filling in the blanks or by darkening the circles with a pencil or pen.

Please rate your confidence in your ability to achieve the following objectives, both before this activity and after it: 1 (minimally) to 5 (completely)

	Pre 1	2	3	4	5	Post 1	2	3	4	5
Assess the issues concerning AMA discharge in psychiatric patients.	○	○	○	○	○	○	○	○	○	○
Evaluate the Tarasoff ruling issues.	○	○	○	○	○	○	○	○	○	○
Formulate objectives to minimize problems with psychiatric AMA patients.	○	○	○	○	○	○	○	○	○	○

Please indicate how well the activity met your expectations: 1 (minimally) to 5 (completely)

	1	2	3	4	5
Was effective in meeting the educational objectives	○	○	○	○	○
Content was useful and relevant to my practice	○	○	○	○	○

Please address the practical application of this activity below
How many of your patients may be affected by what you learned from this activity? _____

Do you expect that the information you learned during this activity will help you improve your skill or judgment within the next 6 months? (1-Definitely will not change, 5-Definitely will change) **1** ○ **2** ○ **3** ○ **4** ○ **5** ○

How will you apply what you learned from this activity? (Mark all that apply.)
- ○ In diagnosing patients
- ○ In monitoring patients
- ○ In educating students and colleagues
- ○ To confirm current practice
- ○ For maintaining board certification
- ○ In making treatment decisions
- ○ As a foundation to learn more
- ○ In educating patients and their caregivers
- ○ As part of a quality/performance improvement project
- ○ For maintaining licensure

Please complete these overall activity assessment questions.
Did you perceive any bias for or against any commercial products or devices? Yes ○ No ○
If yes, please explain: _____

Compared with other educational activities in which you have participated over the past year, how would you rate this activity? (1-Needs serious improvement, 5-A model of its kind) **1** ○ **2** ○ **3** ○ **4** ○ **5** ○

Future activities concerning this subject are necessary. (1-Strongly disagree, 5-Strongly agree) **1** ○ **2** ○ **3** ○ **4** ○ **5** ○

My biggest clinical challenges related to this topic are: _____

Please use the space below to provide any additional information that will help the activity planners and faculty evaluate this activity.
_____
_____

☐ ***Yes, I am interested in receiving more information on this topic and future CME activities from Lippincott CME Institute. I am willing to help evaluate the outcomes of this activity. (Please place a check mark in the box.)***

Name _____

Street Address _____

_____

_____

City _____ **State** _____ **ZIP Code** _____

Telephone _____ **E-mail** _____