

AMA 302 Restraint Lecture Notes

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- ❖ Thank audience for attending – and staying awake
- ❖ Keep on emergency physician hat, add hospital admin and hospital or malpractice lawyer hats too
- ❖ Objectives:
 - Describe the following:
 - ◆ constitutional law
 - ◆ legislative law
 - ◆ regulatory law
 - ◆ common (case) law
 - List two guiding principles for informed refusal.
 - List four tests a patient must pass to meet the requirements to sign AMA with adequate informed consent.
 - Outline the essential provisions of the PA Mental Health Code provisions about involuntary psychiatric commitment (“302”).
 - Describe the legal concept of medical restraint and the essential elements required for lawful medical restraint.
- Rules of the game: I present seven cases where there are questions about AMA and patient restraint. After each case, you decide what you would do.

Then we go through some background and principles. Then we discuss the cases.

- ❖ **Cases Intro: play recording of screaming patient (second from last)**
 - It's Monday overnight. You can tell it's going to be bad. There are several screamers, but let's consider this one first.
 - 1. A severely demented 71 year old female nursing home resident, no real PMH, on Colace and Senna and something for osteoporosis, with apparent hip pain after a fall. Doesn't look too bad, maybe a bit of an impacted fracture though. This patient gets out of bed and starts crawling towards the door.
 - 2. It's 2:30 AM. A 31 year old male is "found down" outside a bar, smelling strongly of alcohol, with a large scalp laceration, confused, and with slurred speech. He is brought in by 6 police officers, combative, and immediately placed in leather restraints. The patient says "You can't do this to me! I'll sue your ass for kidnapping! I wanna call my lawyer!"
 - 3. A few minutes later, a quietly tearful 21 year old female college student with no PMH is brought in by her

friends because she told them she wants to overdose on pills. VS normal, physical exam normal.

- Answers are easy so far, right?
- 4. A 41 year old man presents with 30' of severe substernal chest pressure, diaphoretic and tachycardic. VS normal, He insists it's just from a hot sausage he had at PNC park, and asks for antacid. The nurses have him on the monitor, and on the monitor you see ST elevation—then a sudden run of V Tach—and then the ST segments normalize. The patient says “I'm all better now, I'm ready to go. I'll sign whatever you want.” You persuade him to stay at least for a 12-lead, which you get, and is normal. He insists on signing AMA. What do you do? (While getting ready to sign AMA, he becomes diaphoretic again, and then has a sudden ventricular fibrillation arrest as Chris Conti is walking it to relieve me “That man's in v fib! Shock him!” “Yes, Chris, we're already working on it, go see a patient or something.” A single shock brings him out, and then he says “can I go home now?”)
- 5. 66 year old man brought by very concerned and anxious family; very poor historian, only complaint is “I'm sick.” Does say something about vomiting

blood a few days ago. Exam shows not orthostatic, some epigastric tenderness, heme (-) rectal, disoriented to place and date, otherwise normal. Per family and old records, had been admitted a couple of days ago, with alcohol intoxication, pancreatitis, and upper GI bleed, treated with big doses of Ativan; was going to be transferred to alcohol detox unit in 3 days. Had signed "AMA" from the floor 3 hours ago, and family found him lying in a snowdrift a block from the hospital. Patient refuses to stay in the hospital. Family willing to sign a 302 (involuntary psychiatric commitment).

- 6. Same shift, family also brought in a 55 year old woman, against her will, who also had just signed out AMA from the floor and found by the family in a bar drinking. She was alert, able to give a detailed and excellent history (with a few jokes thrown in) with no pertinent PMH, smiling, cooperative, not intoxicated, and ready to sign out again AMA. Family says 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 you go back to her, she is still alert, smiling, and a good historian, but with a **completely** different history. She remembered nothing about

her previous history, of having liver failure, or hepatorenal syndrome.

- 7. At about the same time, a very reasonable 32 year old professional woman you'd been seeing for fever, headache and stiff neck, after receiving Compazine for her nausea, but before her LP, becomes very irritable and demands to sign AMA – but is unable to describe why she wants to leave or what she plans to do once she leaves.

❖ **Morals, Ethics, and Law**

- Moral:
- Ethical:
- Legal: Certain moral dilemmas have occurred before, often many times. Courts and legislators have looked carefully at many of these recurring cases, and established legal principles or laws which, in a real sense, guide us in what is right to do.

❖ **Types of Law (show diagram)**

- Constitutional Law
- Legislative (Statutory) Law: “Codes”
- Regulatory Law:
- Common (Case) Law: decided by that appellate court, sets precedent.
- The US is a federation of states, each with their own laws.
- Who has primary jurisdiction over medical law? Federal, State, local?

- Power of the Purse: hospitals have to follow Federal regs to get Medicare \$ (e.g., restraint regs, enforced by State and JCAHO)
- ❖ Three Types of Restraint (discuss)
- ❖ PA State Mental Health Code (State LAW) and subsidiary regulations: highlights
 - only for psych, no alcohol or drug:
"Persons who are mentally retarded, senile, alcoholic, or drug dependent shall receive mental health treatment only if they are also diagnosed as mentally ill, but these conditions of themselves shall not be deemed to constitute mental illness:"
 - section 302: involuntary commitment
 - "A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself. ... For the purposes of this subsection, a clear and present danger may be demonstrated by the proof that the person has made threats to commit suicide and has committed acts which

are in furtherance or the threat to commit suicide” or, mutilated self, or unable to care for self (used for dementia)

- petitioner: has to agree to show up at magistrate hearing in 3 days
- approved (or rarely denied) by County Representative: can also order police to drag the person to hospital
- approval by doc (can deny)
- 2-physician: physician petitioner AND examiner, doesn't require County approval.
- have to use “least restrictive method”: if patient signs 201 (voluntary: can be restrained/kept locked up for up to 3 days), 302 neither needed nor appropriate.

❖ **Competence vs Capacity: Medical Restraint**

- Ordering of restraints: big JCAHO and hospital administrator emphasis, as bad things happen to people in restraints. “Four-hour” rule: have to see patient face to face within 4 hours (less for kids): but as physician, you have bigger legal concerns about restraints.
- Common Law
- “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.”

➤ **Informed Consent**

➤ “If 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.” – Mark Plaster, MD, JD, FACEP.

➤ Can call magistrate if prolonged

❖ **Two Principles:**

- First: when in doubt, do what's best for the patient. This may mean restraining until it is clear the patient can make an informed decision. "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]
- Second: the needed level of capacity varies with the seriousness of the decision. A drunk refusing to have a minor laceration sewed should have his wishes honored. But a patient with DTs and Valium on board shouldn't walk into a winter night in a hospital gown.
- ❖ **The legal capacity to consent or refuse consent can be reasonably determined by a four-prong test:**
 - 1. Does the patient understand the relevant information?
 - Have patients paraphrase (not just regurgitate) what you told them
 - Hard to say that a disoriented patient can understand.
 - 2. Does the patient have the ability to manipulate the information?
 - 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
- 3. Does the patient have the ability to make and communicate a choice?
 - Can the patient 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.
 - "Patients who repeatedly change their minds should be protected until their decision-making process is stabilized." –Mark Plaster, M.D., FACEP
- 4. And finally, can the patient put all of these together to appreciate the situation and its consequences?
 - Can the patient appreciate the likely outcome of his action?
 - Can the patient give reasonable reasons for his choices? (N.B.: this is where patient's values can legitimately make patient come to a decision opposite to what most people would decide) "Physicians may neither impose their values on their patients nor substitute their level of risk aversion for that of their patients." -

Matthies v Mastro Monaco. 160 NG 26,
733 A2d 456 (1999)

- ❖ Special Cases:
 - Pediatrics: complex. See 302-text.pdf online.
 - POA: Power of attorney
 - must be competent to set up POA
 - (court may appoint POA if you're incompetent)
 - may be temporary (e.g., you're going on an expedition to the Amazon)
 - may be for financial, medical, or everything
 - may be durable ("permanent") – takes effect if doctor certifies that you're incapacitated
 - finding of incompetence to make medical decisions results automatically in a medical POA
 -
- ❖ Risk Management/Documentation: AMA needs the following documented on the chart:
 - **Told of**
 - Medical opinion
 - Risks/potential outcomes
 - Alternatives
 - **Capacity** to make decisions
 - Understands
 - Can manipulate the info

- Can make and communicate a stable choice
- Appreciates the situation and consequences
- **Involved** family or friends if done
- ❖ **Review cases**
 - 1. 71 year old severely demented female nursing home resident with hip injury crawling towards the door.
 - 2. 31 year old male “found down” with large scalp laceration, confused, slurred speech, combative.
 - 3. 21 year old suicidal college student.
 - 4. 41 year old man with chest pain from hot sausage.
 - 5. 78 year old man found confused in snowdrift by family.
 - 6. 55 year old woman with hepatorenal syndrome and Korsakoff's syndrome.
 - 7. 32 year old woman with fever and stiff neck who got Compazine and wants to leave but can't decide what to do.
- ❖ **Review objectives**
 - Describe the following:
 - ◆ constitutional law
 - ◆ legislative law
 - ◆ regulatory law
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- List two guiding principles for informed refusal.
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- ❖ **And, Later That Night...**
- Two of these cases occurred during an overnight shift, within 2 hours of each other.
 - An hour later, medicine resident from the floor, a friend of yours, calls and asks for advice. He has a patient who wants to sign out AMA but he’s not sure whether he should let him sign out or not. “What’s the patient’s problem?” “DTs” “Is the patient hallucinating?” “Yes.”
 - How do you tell him the right thing to do without cursing?
- ❖ **The End**