

Emergency Medicine Grand Rounds

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Against Medical Advice, 302s and Medical Restraint

A man is brought to the ED by police and medics. He admits to drinking, smells strongly of alcohol, is fighting and screaming “You can’t hold me! I’ll sue you all!” A few minutes later, a quietly tearful college student is brought in by her friends because she told them she wants to overdose on pills. At about the same time, a very reasonable young 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.

Should you to restrain any or all of these patients? If you order Security to restrain them, will you be sued? Will you face criminal charges?

Objectives

1. Describe the following:
 - constitutional law
 - legislative law
 - regulatory law
 - common (case) law
2. List two guiding principles for informed refusal.
3. List four tests a patient must pass to meet the requirements to sign AMA with adequate informed consent.
4. Outline the essential provisions of the PA Mental Health Code provisions about involuntary psychiatric commitment (“302”).
5. Describe the legal concept of medical restraint and the essential elements required for lawful medical restraint.

Morals, Ethics, and Law

- **MORAL:** We all have a sense of what is right and what is wrong, and though most of us will agree on what’s moral and what’s not, it’s an individual decision.
- **ETHICAL:** Groups of people, such as ACEP or the AMA, establish guidelines to what most believe are moral, and these are called ethics.
- **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

- **CONSTITUTIONAL LAW:** In the US, the supreme law is the constitution; any Federal, State, or local law that conflicts with the Constitution is invalid.
- **LEGISLATIVE (STATUTORY) LAW:** The national legislature (Senate and House of Representatives) may pass laws (statutes) that apply to everyone in the US.
- **REGULATORY LAW:** Laws often specify

what the government is to do, but not precisely how to do it. Government agencies are often tasked with making up regulations as to how a law is to be interpreted. An example is the regulations that CMS (the Centers for Medicare and Medicaid Services) have established for enforcing EMTALA (the Emergency Medical Treatment and Active Labor Act).

- **COMMON (CASE) LAW:** Over the years courts have heard enough similar cases, and come to similar enough decisions, that certain legal principles have emerged, separate from legislative law. When a case is first decided by a court, it doesn’t make it into the law books. Only when a case is *appealed* to an court, and decided by that *appellate* court, does a decision set precedent. Years (and centuries, and millennia) of decisions have resulted in certain principles that, though not found in law or regulation, are still the law of the land. Principles of informed consent are found in case law (common law).

The US is a federation of states, each with their own laws. The practice of medicine, for example, is regulated by state, not Federal law, and each state has a different mental health law. When they conflict, Federal (national) laws trump state laws. The PA Mental Health Code provides for psych patients with Medicaid or no insurance to be transported to specific hospitals that get money from the state to care for indigent or Medicaid patients; but this is illegal by the Federal EMTALA (Emergency Medical Treatment and Active Labor Act).





The Federal government, however, encroaches on the states by the power of the purse. Hospitals must meet Medicare regulations on restraints if they want to continue getting paid by Medicare.

So we have Federal constitutional, legislative, and regulatory law with cracks stuffed with bits of common (case) law –

and a similar complex of law for each state. That’s why we have so many lawyers.

Law and Restraint

Compliance with restraint rules is a big issue, what with state health department surveys and JCAHO¹ visits, which may focus on Medicare regulations, such as for a physician to see a patient in restraints within an hour, and that restraint orders only last for 4 hours. But for the emergency physician, it’s more complex.

It’s obvious that you need to restrain drunks, so they don’t go walk in front of a bus, or drive over a two-year-old. But if you look at the Pennsylvania involuntary psychiatric commitment law (section 302 of the Mental Health Code, so we talk about “302ing” a patient), it specifically states that alcohol is excluded. A family can’t 302 an alcoholic relative who is gradually “drinking himself to death” unless the person is suicidal. So no 302 for drunks, but:

Medical Restraint

The courts generally give physicians wide latitude in restraining patients. The general principle is simple: if you think restraints are needed to restrain a patient to protect against harm, and you have doubts about the capacity of the patient to make an informed decision to refuse treatment, restrain the patient in the least-restrictive manner you can. A sage MD/JD once said “Treat the patient the same way you would treat your mother – with concern for her Constitutional right to make her own decisions, even if it kills her, but when her decision-making is impaired, you make decisions for her.”

Competence and Capacity to Consent

Unless a court has declared a person incompetent and assigned a *power-of-attorney* for making medical decisions, an individual is assumed to be *competent* to make medical decisions. But an ordinarily-competent individual may have impaired

decision-making, whether from alcohol or other intoxication, side effects of medications, illness or injury. Sometimes patients are so impaired (e.g., unconscious) that one assumes *implied consent*. In cases not so severe, the courts expect physicians to be able to judge *capacity* to provide informed consent.

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. In the words of Mark Plaster, M.D., J.D.: *The test is the same whether the patient is a Jehovah’s Witness who refuses life-saving blood or the fearful elderly person who refuses life-sustaining protective measures.*

There are two principles to employ, and four tests to use, when deciding capacity for informed refusal of care.

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.

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 four tests for capacity are:

1. Does the patient understand the relevant information? *Ask the patient to paraphrase what you told him or her is better than asking him to simply regurgitate information. If patients are disoriented, they probably can’t appreciate the personal danger.*

2. Does the patient have the ability to process the information? *Ask the patient about hypothetical situations based on what a rational person would do. A patient with normal capacity, but differing values, can still demonstrate that understanding.*

3. Does the patient have the ability to make a choice? *Differing responses within a short period suggest the patient’s capacity to organize thoughts and choose a course of action is impaired.*

4. Can the patient put all of these together to appreciate the situation and its consequences? The patient should appreciate the seriousness of the likely outcome of his or her plan of action.

Here is a suggested charting template: I have provided information to the patient regarding his or her condition: [$< >$], the treatment or additional diagnostic tests required: [$< >$], and the risks and benefits of treatment or additional diagnostic tests as well as the lack thereof: [$< >$], and potential treatment plans: [$< >$]. I have confirmed that the patient understands his or her condition: [$< >$] and understands the risks of going against medical advice: [$< >$]. The patient has the ability to use the information I have provided him or her to come to a reasoned decision. According to the information available to me the patient’s decision is in keeping with the patient’s enduring goals, wishes, values and willingness to assume these risks. I have considered the risks to the patient of his refusal and believe that the patient’s capacity to make decisions is adequate to assume this risk.

1. The Joint Commission on Accreditation of Healthcare Organizations now goes by the more trendy “Joint Commission.”