

EMERGENCY MEDICINE REPORTS

Practical, Evidence-Based Reviews in Emergency Care

SEPTEMBER 1, 2019

VOL. 40, NO. 17

AUTHOR

Frank J. Edwards, MD, FACEP, Arnot Health Graduate Medical Education, Elmira, NY

PEER REVIEWER

Catherine A. Marco, MD, Department of Emergency Medicine, Wright State University, Boonshoft School of Medicine, Kettering, OH

STATEMENT OF FINANCIAL DISCLOSURE

To reveal any potential bias in this publication, and in accordance with Accreditation Council for Continuing Medical Education guidelines, we disclose that Dr. Farel (CME question reviewer), Dr. Schneider (editor), Dr. Stapczynski (editor), Ms. Light (nurse planner), Dr. Edwards (author), Dr. Marco (peer reviewer), Ms. Mark (executive editor), Ms. Roberts (associate editor), and Ms. Coplin (editorial group manager) report no financial relationships with companies related to the field of study covered by this CME activity.



The Capacity Conundrum in Emergency Medicine

Case Example

I came on at 7 p.m. to start my shift in a small, rural, critical access ED. The off-going doctor was turning over an intoxicated patient. The patient was seen yesterday for alcohol intoxication, observed until he sobered up, evaluated by the county crisis team, and then discharged back to the motel where he was staying. This current visit was prompted by his eviction from the motel. He had continued to drink during the day and was clinically intoxicated. When he was brought back to the ED, he was despondent and expressed that his life was not worth much to anybody. However, he had no thoughts of harming or hurting himself, nor any plans in that regard. Our treatment plan was to allow him to sober up and then reassess. The hospital security guard was stationed in visual proximity.

As the patient metabolized the alcohol during the night, he became more animated. He wanted to go outside and smoke. I had a nicotine patch placed to control those cravings. He became restless, walking about the room. I had successive doses of lorazepam given to take the edge off this restlessness.

By 4:30 a.m., he voiced that he wanted to leave. He saw no point in staying further. I went and talked with him some more. He was from out of state and had been staying in a motel by himself. He had a 20-year history of alcohol abuse with multiple stays in rehab and shelters. On direct questioning, he denied any ideas or plans to hurt or harm himself. He said that last evening he was feeling low and sorry for himself, but would never hurt or harm himself. I told him our plan was to have him stay in the ED until later in the morning when a social worker would be available to help him find shelter. He said he had his fill of shelters and was ready to walk out now. He did not have a place to go, and the small town where the hospital was located did not have any resources open for him at 5 a.m.

So, what should I do?

This issue of Emergency Medicine Reports addresses this conundrum commonly faced by emergency physicians. I hope the concepts discussed are helpful the next time you are presented with a capacity determination.

— J. Stephan Stapczynski, MD, Editor

Introduction

A patient's capacity to give informed consent or to leave the emergency department (ED) against medical advice (AMA) is a topic of great relevance to emergency clinicians. Every year, 500,000 ED patients leave AMA and have substantially higher rates of readmissions, morbidity, and mortality than those discharged.¹ Some of these individuals are intoxicated. The

EXECUTIVE SUMMARY

- Patients are presumed to be capable of making choices for themselves, unless proven otherwise; the physician is required to determine incapacity.
- Capacity is essential for valid consent for medical care and treatment.
- Capacity is NOT a test result, diagnosis, or score on an assessment tool.
- Capacity involves the process of decision making and does not depend on the specific choice that is made.
- Capacity assessment focuses on the specific abilities that a patient requires to make a decision about a specific situation.
- People who are capable can make rational decisions that are based on their values and goals, as well as on their knowledge and understanding of the issues they face. Capable people can identify and accept risks.
- Capacity is not one ability that people have or do not have. People employ different abilities to make different types of choices. Capacity is specific to the task.
- Assessment of capacity is domain-specific; six recognized domains are healthcare, nutrition, clothing, shelter, hygiene, and safety. Patients may have capacity in one domain but they may lack capacity in another.
- Assessing capacity requires considering the whole person — it is not related to an illness, a diagnosis, or a living situation. Being homeless, being a resident of a long-term care facility, or abusing drugs or alcohol does not automatically render a patient incapable of medical decision making.
- Assessment of capacity relates to two ethical principles: the need to balance autonomy (self-determination) and beneficence (protection).
- Incapacity often is reversible. Illnesses and intoxications can temporarily impair capacity. Patients can regain capacity on recovery.

question is, when does an emergency clinician have the right to abridge a patient's autonomy and prevent him or her from leaving, or to perform testing or procedures against the patient's will? The answer involves the concept of capacity. This article discusses the difference between competence and capacity and highlights the four essential elements involved in the assessment of a patient's capacity. It explores the relationship between capacity and intoxication, the medical-legal dimensions of capacity, and the question of capacity in patients with a mental illness or cognitive impairment. It reviews the role of capacity assessment tools in the ED and the issue of when it can be beneficial to call for a psychiatric consult to help determine capacity. Finally, it details a practical strategy for capacity assessment in the ED, including how to avoid common pitfalls in the documentation of patients who leave AMA.

Deciding in the ED whether a patient has capacity to give informed consent for a test or procedure or to sign out AMA can be a frustrating balancing act. Physicians are obligated ethically and legally to respect a patient's autonomy, but they also are professionally bound to act in a patient's best interests.² The stakes can be high for error in either direction.

Restraining a patient against his or her wishes may lead to claims of assault, battery, or false imprisonment. However, malpractice suits have arisen when patients in states of apparent intoxication or delirium were allowed to leave the ED and subsequently suffered harm. To give informed consent or to demand release from the ED, the patient must be able to understand and appreciate the benefits and risks of a given course of action. Fortunately, most capacity assessments are reasonably straightforward and well within the purview of emergency clinicians. Specialty consultations seldom are needed, but physicians need to know when this is the most appropriate step.^{3,4} Not infrequently, what initially appears to be a capacity conundrum can be resolved through enhanced communication and negotiation strategies.⁵

Capacity vs. Competence

Although the terms capacity and competence often are used interchangeably in the lay literature (and even the medical literature), this article will adhere to the standard terminology in which capacity is a medical term referring to an individual's ability to make an informed decision. Capacity, therefore, is a clinical judgment made by a physician.⁶

Competence, conversely, is a legal state determined by a judge. An individual is deemed competent if that person has the necessary mental soundness (i.e., capacity) to make a specific decision or to perform a certain act. Physicians cannot legally declare a patient competent or incompetent, but physicians and other healthcare providers may be asked to perform a capacity evaluation as part of a competence hearing by the court.

Capacity Dissected

Capacity can be defined as having four essential components: understanding, reasoning, appreciation, and ability to express a choice.⁶ (*See Table 1.*) The following section will review each of these fundamental elements in greater detail.

Understanding

The individual must be able to comprehend the medical information being discussed, including the risks and benefits of refusing the recommended option. There should be no language barrier or physical issue, such as hearing impairment, to hinder the patient's understanding. Furthermore, the patient must be given the information unencumbered by excessive jargon, and the level of diction must be appropriate to the

Table 1. Elements of an Emergency Department Capacity Evaluation

Element	Details
Understanding	The patient has the ability to comprehend the medical information being discussed, including the risks and benefits of refusing the recommended option.
Appreciation	The individual not only comprehends the details but appreciates how these factors might affect him or her personally.
Reasoning	There should be some evidence of a <i>reasoning</i> process behind the patient's decision.
Ability to communicate a choice	Is the patient's decision vacillating or remaining reasonably consistent over time?

person's age and degree of education.

After providing the patient with the necessary information in the appropriate manner, the physician then can assess for the patient's understanding by having the individual repeat the information in his or her own words. If patients simply dictate back to the physician what the physician said (or worse, read the information written on a consent form), the physician must question whether true understanding exists. One is more likely to believe that the patient has comprehended the nature of the situation when the patient relates it back in his or her own words.

Appreciation

Appreciation goes beyond understanding. It is the next step toward having capacity. This element means that the individual not only comprehends the details, but appreciates how these factors might affect them personally. One example is the floridly manic college professor who can articulate in accurate, rapid-fire detail the nature of bipolar disorder, including its treatment modalities, sequelae, and risks (along with Freud's opinions on the matter), but who has little insight and does not appreciate that any of this applies to him or her at that moment.⁷

Reasoning

The next element is reasoning. When a patient is able to express a

genuine understanding of the basics of his or her medical condition, and when the person is able to appreciate how the risks of refusing the recommended treatment would personally affect him or her, if the patient still refuses the treatment, there should be some evidence of a reasoning process behind the decision. For example, "I know that my chest pain could be an early heart attack," the patient says, "and that I could die if it gets worse. But I've had this pain lots of times before, and my heart has always checked out fine. Even though you say my EKG looks a little different, I feel great now. My doctor said that he will see me tomorrow, and I don't live far away. I just came in to placate my significant other." There is a rationality and reasonableness to this patient's cognitive process. Even if one does not agree with the conclusion, this person has thought it through. The patient's reasoning behind a refusal only has to be rational within his or her own belief system. A classic example is refusal of life-saving blood transfusions among Jehovah's Witnesses.

Ability to Communicate a Choice

This is the subtlest of the four elements. Some patients will vacillate between acceptance and rejection of the clinician's recommendations and ultimately may seem unable to make a final decision. Many emergency physicians have encountered patients in the

ED who initially agree to admission and then change their minds. The nurse comes over and says the patient wants to leave, then after much counseling and family input, the patient agrees to stay. Half an hour later, the nurse comes over again and hands the ED physician the AMA paperwork the patient is now requesting. Such inability to make a choice could be related simply to the inherent difficulties of coming to grips with a difficult set of options, or it could suggest that the patient has neuropsychiatric issues depriving him or her of sufficient capacity to responsibly make a life-altering decision.³ Therefore, refusal to make a firm choice does not necessarily indicate impaired capacity and must be analyzed on a patient-by-patient basis.⁴

Capacity Is a Sliding Scale

A modifying element in judging a given patient's capacity involves the seriousness of the treatment being refused.⁴ What are the stakes if the patient refuses treatment? For example, in one study researchers found that among patients with a myocardial infarction who left against medical advice, the mortality rate was more than 50% higher than among those with standard discharges.⁸ Therefore, a pale, diaphoretic patient who seems somewhat confused and who is demanding to leave AMA despite unequivocal evidence of an acute anterior ST-elevation myocardial infarction (STEMI) would warrant a more rigorous evaluation of capacity than the patient in the next room who refuses repair of a minor laceration.

This sliding-scale approach to capacity was supported by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.⁹ If a patient with a high-risk condition desires to leave AMA, it would be ethically incumbent on healthcare providers to make every effort to ensure that the patient understands the situation, appreciates the risks to his or her personal safety, has some rationale for the decision, and is expressing a clear choice that does not

Table 2. Factors Affecting Capacity

Factor	Description
Intoxication	<ul style="list-style-type: none"> Alcohol is the most common agent involved in impairment of capacity, but other substances with sedating, hallucinogenic, or psychoactive properties also may transiently impair capacity. The presence of varying degrees of intoxication raises the likelihood of capacity impairment but does not automatically prevent the patient from having capacity to make specific decisions. Patients must be evaluated on a case-by-case basis.
Psychiatric disorders	<ul style="list-style-type: none"> Schizophrenia is associated with greatest likelihood of impaired capacity, followed by others, including bipolar disorder, major depression, and anxiety disorder. Many patients with underlying psychiatric disorders still may have decision-making capacity. Poor insight is the strongest predictor of a potential lack of capacity. Psychiatrist evaluation for capacity may be useful in ambiguous cases.
Cognitive disorders, such as dementia, delirium, autism spectrum disorder, advanced parkinsonism, and others	<ul style="list-style-type: none"> These disorders may or may not cause impaired capacity. These disorders may impair capacity for some decisions only. Psychiatrist evaluation for capacity may be useful in ambiguous cases. Transient conditions, such as high fever, hypoglycemia, electrolyte disorders, and dehydration, transiently impair cognitive ability.
Communication issues	<ul style="list-style-type: none"> Any barrier to understanding or expression (language barrier, deafness, aphasia) can hinder the ability to render impairment of capacity decisions and must be overcome as needed.
Miscellaneous	<ul style="list-style-type: none"> Severe pain, stressful situations, and fatigue may impair capacity.

waver. If those conditions are met and the patient appears to have capacity but still refuses treatment, other strategies (discussed in the section on ED Approach) can be attempted before allowing the patient to leave the ED.¹⁰

Intoxication, Capacity, and Legal Liability

Impaired capacity often is a transient phenomenon in a dynamic continuum.^{1,11} Intoxication is the most common example of temporary capacity impairment, but many other conditions, such as hypoglycemia, hypoxia, hypotension, hypothermia, electrolyte abnormality, postictal states, fever, encephalitis, dehydration, severe pain, and other stressors, can transiently impair an individual's capacity to give informed consent or refuse treatment or admission. (See Table 2.) Alcohol intoxication, along with being strongly associated with trauma in general, has been shown to correlate with injured patients leaving AMA. In one recent study, approximately 40% of patients

with trauma who left AMA had consumed alcohol acutely, compared to 16.6% of those who were discharged and 15.5% who were transferred or admitted.¹² The use of illicit substances, which also may impair capacity transiently, has been shown to correlate with higher rates of patients leaving against physician advice.¹³

There is no specific level of blood alcohol at which individuals uniformly develop capacity impairment, and the presence of intoxication alone does not necessarily beget impaired capacity.¹⁴ The degree of intoxication and the seriousness of the condition must be weighed; the sliding-scale principle applies. An intoxicated individual who refuses care for a relatively superficial laceration, for example, is far different from a patient with a potential traumatic intracranial bleed after a fall or a bar fight.

It would be the rare emergency medicine clinician who never listened to a belligerent and verbally abusive intoxicated individual shout: "You can't keep me here against my will!

You're going to hear from my lawyer!" Although the path of least resistance may be to let such a patient simply leave, the argument for restraining an intoxicated patient for whom there are doubts about capacity is very strong and based upon physicians' ethical duty to protect that individual's well-being.¹⁵

Indeed, patients can sue providers for assault and battery or false imprisonment, but such cases are rare. In such suits, judges and juries appear inclined to side with physicians who act in good faith to protect patients who have an intoxication-related impairment of capacity. Common wisdom holds that it would be far more comfortable to defend oneself against a suit for assault and battery or false imprisonment than against a suit for negligently allowing an intoxicated patient to leave AMA.^{1,16}

However, one recent malpractice case in New York State upheld the right of an intoxicated patient to leave the ED AMA. In *Kowalski v. St. Francis Hospital*, a patient suffered

an injury after leaving the ED while highly intoxicated (blood alcohol level: 0.369).¹⁷ In this situation, the individual absconded from the ED after evaluation while he was awaiting transportation to a detoxification facility. Shortly afterward, he was struck by a car. He subsequently brought a negligence suit against the hospital and the emergency physician because he had not been prevented from leaving. In this case, the New York Court of Appeals ruled in favor of the physician. There were mitigating factors in this case because the patient had presented voluntarily and initially was cooperative with the disposition plan, which suggests that this verdict does not lessen physicians' duty to appropriately restrain an individual who is so intoxicated as to lack capacity.¹ A number of cases (including one brought before the Supreme Court) have established the principle that physicians have a duty to involuntarily hold a patient who is unable to give informed consent because of a lack of capacity in general.¹⁸

A corollary to this principle is that when restraining patients against their will becomes necessary, physicians have a duty to protect them from harm caused by the method of restraint. Negligence suits have been brought successfully against emergency clinicians whose patients died of asphyxiation after being physically restrained, with and without chemical restraint.^{18,19,20}

Capacity and Mental Illness

There is a higher likelihood of impaired decision making among patients with schizophrenia, bipolar disorder, major depressive disorders, anxiety disorder, and other psychiatric conditions. However, as with intoxication, the presence of a mental illness does not automatically mean the patient lacks capacity. For example, it has been reported that about half of patients hospitalized with schizophrenia retain the ability to give informed consent, and those admitted for depression have about half the rate of capacity impairment as those with schizophrenia.²¹ Another

study reports that patients with bipolar disorder have degrees of capacity impairment comparable to those with schizophrenia.²² The psychiatric feature that appears to predict a lack of capacity most strongly is diminished insight.^{3,23}

The interplay between psychiatric disorders and decision-making capacity in the ED usually manifests in one of two general scenarios. In the first category are patients brought in for suicide evaluations or with an exacerbation of psychotic symptoms. With uncommon exceptions, these patients will not be considered safe for discharge prior to psychiatric consultation, during which the psychiatric provider will assist the emergency clinician in determining whether the patient has capacity to refuse treatment. The second category includes individuals with underlying mental disorders brought to the ED because of an acute medical condition but who refuse care and may or may not lack capacity. If the emergency physician is uncertain about the degree to which the psychiatric condition is affecting the patient's capacity, requesting a formal capacity evaluation by a psychiatrist can be very useful in this circumstance.²⁴

Capacity and Cognitive Disorders

A wide variety of neurocognitive disorders, including dementia, delirium, and autism spectrum disorders, are associated with higher degrees of capacity impairment than either psychotic or mood disorders.²⁵ Cognitive disorders have been observed to generate decision-making capacity impairment more frequently in males.²⁶ Aging is the most common risk factor for cognitive disorders in general,²⁷ with dementia the most common manifestation seen in the ED.

As holds true for intoxication and psychiatric disorders, patients with a cognitive disorder, such as dementia, may retain capacity despite their impairment in other domains.¹¹ This determination can be very difficult to make in patients with milder states of dementia, and physicians evaluating

such patients for capacity commonly disagree.²⁷ In terms of routine screening for impaired capacity in the elderly population, physician evaluations have been shown to be poorly sensitive, although they are somewhat more specific.²⁸

Impaired capacity is uncommon in healthy elderly people in general, but it increases in those who are ill. In one systematic review, investigators found a 2.8% rate of capacity impairment among a control group of healthy elderly individuals, compared to a rate of 26% among hospitalized elderly patients.²⁸ In another study, researchers found that 25% of cancer patients older than 65 years of age exhibited some degree of decision-making impairment.²⁹

In a different study, investigators noted that when emergency clinicians are faced with life-or-death resuscitation decisions involving elderly patients in the ED, value-of-remaining life considerations may introduce bias into their decisions related to an individual's actual decision-making capacity.³⁰

The increasing prevalence of impaired capacity in older patients combined with difficulties in relying solely on clinical judgment has led to great interest in the use of capacity assessment tools. The following section will discuss capacity assessment tools in greater detail.

Capacity Scales

Several capacity assessment scales have been well studied and are used widely, but their value in the ED is limited by time constraints and the lack of training in their use and interpretation. Even in the inpatient setting, the application of assessment scales appears to be variable.³¹ Although capacity scales generally are not in the ED's bailiwick, emergency medicine clinicians should be familiar with them. The scales include the Mini-Mental State Exam (MMSE), the Montreal Cognitive Assessment tool, the Hopkins Competency Assessment Test, the MacArthur Competence Assessment Tool for Treatment, and others. (See *Table 3*.) Unfortunately, there are

Table 3. Capacity Assessment Tools

Name	Characteristics
Aid to Capacity Evaluation (ACE)	Decision-specific questions across seven domains
Capacity Assessment Tool (CAT)	Loosely structured interview across six domains
Competency Interview Schedule (CIS)	Structured interview regarding 15 items
Composite Screening Examination (Mini-Cog)	Cognitive questions in three domains
Hopkins Competency Assessment Test (HCAT)	Six questions pertaining to an essay
MacArthur Competence Assessment Tool for Treatment (MacCAT-T)	Loosely structured interview
Mini-Mental State Examination (MMSE)	Cognitive questions in five domains
Montreal Cognitive Assessment (MoCA)	Cognitive questions in nine domains
Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory (SICIATRI)	Structured interview regarding 12 items

no standardized guidelines for the application of certain tests in specific situations.^{3,32} Clinicians should be aware that the MMSE is not a test for competency per se, but rather a test of cognitive function in general. It assesses orientation, attention, memory, language, and visual-spatial abilities, and it is widely used among older patients. Scores range from 0 to 30, with higher scores indicating greater function. Lower scores (< 19) tend to correlate with a lack of capacity and higher scores (> 25) with intact capacity, but there are no cut-offs that are both highly sensitive and specific.^{3,28,33}

In one study, researchers reported that the Aid to Capacity Evaluation (ACE) tool, a Canadian-devised assessment scale, is the best single device regarding the assessment of a patient's capacity to consent.²⁸ It directly assesses a patient's understanding of the medical condition, the proposed treatment, and the alternatives. It also assesses whether the individual understands that he or she has the option to refuse and can appreciate the consequences of refusing or accepting. Furthermore,

it assesses whether the person's decision is affected by depression or psychosis.³⁴

The MacArthur Competence Assessment Tool for Treatment is favored by some authors, and it still appears to be the most commonly used device to evaluate decision-making capacity. It has been validated repeatedly, has relatively high inter-rater agreement, and can be tailored to specific interventions. However, it requires special training to administer.^{3,7,6}

Capacity Consultations

A survey of psychiatrists, geriatricians, and psychologists reported that the most common misunderstanding they encounter among physicians who refer patients for capacity evaluations lies in the referring physician believing that if a patient lacks capacity regarding one medical intervention, he or she lacks capacity for all interventions.^{6,35} When physicians call for a capacity consult, the question to be addressed should be as specific as possible. For example, the emergency physician should ask the consultant whether the patient has capacity to refuse admission for an

acute coronary syndrome, not whether the patient lacks decision-making ability in general. However, most capacity decisions in the ED can be made by the emergency clinician who is seeing the patient. Most often, capacity consultations in the ED will be required when a patient is refusing treatment in especially complicated or ambiguous situations or when the patient has an underlying mental illness.³

Surrogate Decision Makers

When a patient has been determined to lack capacity, the responsibility for decision making with regard to treatment passes to that patient's legally designated surrogate decision maker, if one is available. Surrogate decision makers are individuals who have been formally designated by the patient to act on their behalf in accordance with the patient's wishes in the event of impaired capacity. The legal document that designates a surrogate decision maker is known as a "healthcare proxy," a "healthcare surrogate," or a "medical power of attorney." A healthcare proxy is not the same as an advance directive (also known as a living will), which expresses the patient's wishes regarding healthcare interventions in the event of impaired capacity. Although they vary in format from state to state, advance directives and living wills generally have legal standing once a patient has been medically determined to have impaired decision-making capacity. Advance directives can be extremely helpful in assisting family members and physicians to decide upon an appropriate course of action in the event there is no healthcare proxy.⁴

Most states accept the terms of a healthcare proxy or advance directives from the patient's home state. Certain states have developed hybrid documents that combine healthcare proxies with living wills and advance directives. In the absence of a healthcare proxy, there is a general hierarchy that indicates who would be most able to make decisions on behalf of an incapacitated patient (*see Table 4*), although this varies to some extent by state. As of 2017, 41 jurisdictions

Table 4. Hierarchy of Surrogate Decision Makers*

1. The patient's guardian
2. The patient's spouse or domestic partner
3. Any adult child of the patient
4. Either parent of the patient**
5. Any adult sibling of the patient**
6. Any adult grandchild of the patient, or an adult relative who has exhibited special care and concern, who has maintained close contact, and who is familiar with the patient's activities, health, and religious or moral beliefs
7. A close friend of the patient
8. The patient's guardian of the estate

* Varies by state; 35 states have statutes that establish surrogate hierarchy

** Adulthood usually defined as 18 years of age or older

Table 5. Necessary Documentation Steps for Patients Leaving Against Medical Advice

- Summarize patient presentation and emergency department evaluation.
- Describe the emergency department capacity assessment.
- List proposed treatment and risks of refusing.
- List alternatives discussed.
- Indicate that the patient understands risks.
- State follow-up care instructions.
- State that the patient is free to return at any time.
- Identify witnesses present.

out of 51 (states plus the District of Columbia) have statutes that allow for the appointment of a default surrogate for medical decisions in the absence of a previously designated medical power of attorney.³⁶ Thirty-five of the jurisdictions indicate a hierarchy for decision making in descending order of preference.

In such circumstances, it may become necessary to obtain a court-appointed surrogate. Nevertheless, family input may be of great assistance in making the right decision on behalf of a patient without a healthcare proxy in place, just as family input can be of tremendous value in the initial assessment for capacity in the ED.¹

Documentation and AMA Forms

When patients leave against advice from either the ED or an inpatient service, they have a substantially higher likelihood of morbidity, readmission, and mortality.^{37,38} Good documentation of the initial encounter with the patient is essential. Ideally,

this documentation should include the following:

- an adequate description of the patient's presentation and ED evaluation;
- the emergency physician's assessment of capacity;
- information regarding the proposed treatment, the risks of refusing, and that any alternatives offered were discussed;
- an indication that the patient understood and made a decision of his or her own free will;
- documentation that adequate discharge and follow-up care instructions were given;
- documentation mentioning that the patient is free to return at any time; and
- notation of the presence of witnesses, such as family members. (*See Table 5.*)

In one study, researchers reviewed the records of 418 patients who left AMA and discovered that only 22% of the charts contained a discussion of the patient's capacity.³⁹ In another

study, investigators assessed the value of educating ED providers regarding AMA documentation through the use of a checklist. The checklist contained these reminders: capacity, explanation of diagnosis, reasons for leaving AMA, explanation of treatment, risks of no treatment, what to look out for, when to return, family involvement, alternative treatment, follow-up plans, and documentation that the patient understood. After implementing the checklist, the quality of documentation dramatically improved, with the rate of charts judged "poor" decreasing from 59% to 2%.⁴⁰

The value of AMA forms is a subject open for discussion.¹ AMA forms provide additional evidence of the physician's attempts to convince the patient to stay, but they do not confer legal protection from malpractice actions. There are several pitfalls to AMA forms. The design of the AMA forms at some hospitals may lack essential items. Simply filling it out can give the provider a false sense of security that he or she has taken all the necessary steps. Filling out an AMA form does not obviate the need to document all the factors listed earlier in the patient's chart, which renders the form redundant. Some AMA forms state that the patient waives his or her right to litigate for damages that might occur due to the refusal of care, which is not legally valid and may contravene public policy.¹ Furthermore, many clinicians find that introducing the AMA form into the encounter kindles a degree of defensiveness and antagonism that can hinder communication with the patient.^{1,41}

A reasonable strategy is to use the AMA form on a case-by-case basis when it seems appropriate and to recognize that the AMA form by itself is neither protective nor adequate in terms of documentation.

ED Approach

The American College of Emergency Physicians Code of Ethics states that emergency physicians shall respect the rights of patients, strive to protect the interests of those with impaired decision-making capacity,

and obtain informed consent whenever possible, unless circumstances dictate otherwise.¹⁶ When the patient's capacity to give informed consent is impaired for whatever reason and a surrogate decision maker is not present, the need for informed consent is waived and physicians are ethically and professionally justified in performing the interventions that a "reasonable" person would have agreed were appropriate.¹

Emergency physicians can make most decisions regarding the presence or absence of decision-making capacity, but capacity is not always easy to determine with certainty. When an intoxicated or agitated patient demands to leave the ED, raising legitimate concerns that this might present a risk to the patient or to others, providers should err on the side of keeping that individual in the ED by whatever means necessary.⁴² However, the use of physical and chemical restraints is not without risk and must be undertaken judiciously and with all due caution. The safety of all parties is the highest priority, and restrained patients require close observation.

Evaluate capacity using the four elements discussed in detail earlier, answering these questions:

- Can the patient understand the information?
- Does the patient appreciate how the risks being described would affect him or her personally?
- Is there evidence that the patient is applying a process of reasoning to the decision?
- Does the patient have the ability to express a reasonably consistent choice?

Good communication with the patient will resolve many dilemmas in which the individual balks at following provider recommendations. Enlisting the patient's family or the patient's primary physician in the decision-making process can be very helpful.¹ Listening carefully to the patient's reasons for refusing admission can be revealing as well. Often, a refusal to be admitted is related to such factors as concern about leaving a pet or a family member at home alone, leaving the house unlocked, or missing

a grandchild's birthday. Negotiating ways to address concerns such as these often will resolve the capacity dilemma.

Providers can foster trust by making small gestures, such as offering a meal or a warm blanket, and simply giving patients time to make a decision and ensuring that pain has been controlled adequately. A display of empathy is always more helpful than frustration. Overt manipulation or coercion is neither ethically justifiable nor helpful in most instances. Telling the patient that insurance will not cover the visit if the patient signs out AMA is telling him or her an untruth. This urban legend has been studied in a large series of patients who signed out AMA, and there were no instances of bills being denied by a carrier because the patient left AMA.⁴³

Some patients ultimately judged to have capacity will refuse treatment and leave against advice. The physician's duty is to make sure that the cause was not a communication failure. Another concern is whether physicians should or should not offer partial treatment to a patient who signs out AMA. The concern arises out of a sense that extending liability to a patient who is not following physician recommendations. However, in practice, offering appropriate treatment (an antibiotic for a urinary tract infection, for example) to a patient leaving AMA is more likely to indicate that the physician is concerned for the patient's welfare and did everything in his or her power to protect the patient's well-being.^{1,44}

Summary

Most capacity assessments in the ED can be made appropriately by the emergency medicine clinician and do not require consultation from psychiatrists, psychologists, or geriatricians. For a patient to have capacity, the person must be able to understand the situations with its risks and benefits, appreciate how these risks and benefits apply personally to the individual, have some reason behind the decision, and be able to express a clear choice. Patients with cognitive impairment, such as dementia, intoxication, or a

psychiatric disorder, are more likely to have a capacity impairment but also may possess capacity.

Capacity assessments should be situation-specific. The threshold for judging a patient to have a lack of capacity is lower when the risk of a given situation is greater. Capacity consultations (with the possible application of capacity scales) can be useful in certain patients with underlying psychiatric disorders or mild cognitive disorders. When patients have capacity and are allowed to sign out AMA, they have a greater risk of morbidity and mortality. Careful documentation is necessary. Good communication, empathy, negotiation, and enlisting family members often resolves many capacity dilemmas in the ED. In the case of intoxicated individuals who obviously lack capacity and are demanding to leave, the duty to protect the patient supersedes other considerations.

References

1. Marco CA, Brenner JM, Kraus CK, et al; ACEP Ethics Committee. Refusal of emergency medical treatment: Case studies and ethical foundations. *Ann Emerg Med* 2017;70:696-703.
2. Grisso T, Appelbaum PS. *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*. New York, NY: Oxford University Press; 1998.
3. Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. *N Engl J Med* 2007;357:1834-1840.
4. Simon JR. Refusal of care: The physician-patient relationship and decision-making capacity. *Ann Emerg Med* 2007;50:456-461.
5. Buchanan AE, Brock DW. *Deciding for Others: The Ethics of Surrogate Decision Making*. Cambridge, UK: Cambridge University Press; 1989.
6. Sorrentino R. Performing capacity evaluations: What's expected from your consult. *Current Psychiatry* 2014;13: 41-44.
7. Palmer BW, Harmell AL. Assessment of healthcare decision-making capacity. *Arch Clin Neuropsych* 2016;31:530-540.
8. Fiscella K, Meldrum S, Barnett S. Hospital discharge against advice after myocardial infarction: Deaths and

- readmissions. *Am J Med* 2007;120:1047-1053.
9. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Making health care decisions: A report on the ethical and legal implications of informed consent in the patient-practitioner relationship. Vol. 1. Washington, DC: Government Printing Office, 1982.
 10. Larkin GL, Marco CA, Abbott JT. Emergency determination of decision-making capacity (DMC): Balancing autonomy and beneficence in the emergency department. *Acad Emerg Med* 2001;8:282-284.
 11. Ganzini L, Volicer L, Nelson WA, et al. Ten myths about decision-making capacity. *J Am Med Dir Assoc* 2005;6:S100-S104.
 12. Jeong J, Song KJ, Kim YJ, et al. The association between acute alcohol consumption and discharge against medical advice of injured patients in the ED. *Am J Emerg Med* 2016;34:464-468.
 13. Ti L, Ti L. Leaving the hospital against medical advice among people who use illicit drugs: A systematic review. *Am J Public Health* 2015;105:e53-e59.
 14. 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.
 15. Raines RT. Evaluating the inebriated: An analysis of the HIPAA privacy rule and its implications for intoxicated patients in hospital emergency departments. *University of Dayton Law Rev* 2016;40:479-498.
 16. [No authors listed]. Code of Ethics for Emergency Physicians. *Ann Emerg Med* 2017;70:e7-e15.
 17. *Kowalski v. St. Francis Hospital and Health Centers*, 2013 N.Y. LEXIS 1677 (N.Y. Ct. App. June 26, 2013), 2013 WL 3197637, 2013 N.Y. Slip Op. 05437 (2d Dept. July 24, 2013).
 18. Thomas J, Moore G. Medical-legal issues in the agitated patient: Cases and caveats. *West J Emerg Med* 2013;14:559-565.
 19. *Estate of Doe v. ABC Ambulance*. Medical Malpractice: Verdicts, Settlements, and Experts 1999;15:15.
 20. *Larry Gazda and the Estate of Wendy Gazda v. Kino Community Hospital* Case No. C20041725 Pima County Superior Court, Arizona. 3/31/2004.
 21. Palmer BW, Dunn LB, Depp CA, et al. Decisional capacity to consent to research among patients with bipolar disorder: Comparison with schizophrenia patients and healthy subjects. *J Clin Psychiatry* 2007;68:689-696.
 22. Vollmann J, Bauer A, Danker-Hopfe H, Helmchen Hl. Competence of mentally ill patients: A comparative empirical study. *Psychol Med* 2003;33:1463-1471.
 23. Wang SB, Wang YY, Ungvari GS, et al. The MacArthur Competence Assessment Tools for assessing decision-making capacity in schizophrenia: A meta-analysis. *Schizophr Res* 2017;183:56-63.
 24. Ackerman S, Watkins MW, Kostial AF, Rabinowitz T. Urgent assessment of decision-making capacity in a patient with schizophrenia and an evolving myocardial infarction who is refusing care. *Psychosomatics* 2015;56:89-93.
 25. Boettger S, Bergman M, Jenewein J, Boettger S. The assessment of decisional capacity: Gender differences, corresponding medical and psychiatric illness, and their impact on decisional capacity. *Int J Ment Health* 2015;44:159.
 26. Boettger S, Bergman M, Jenewein J, Boettger S. Assessment of decisional capacity: Prevalence of medical illness and psychiatric comorbidities. *Palliat Support Care* 2015;13:1275-1281.
 27. Moyer J, Marson DC. Assessment of decision-making capacity in older adults: An emerging area of practice and research. *J Gerontol B Psychol Sci Soc Sci* 2007;62:P3-P11.
 28. Sessums LL, Zembrzuska H, Jackson JL. Does this patient have medical decision-making capacity? *JAMA* 2011;306:420-427.
 29. Sugano K, Okuyama T, Iida S, et al. Medical decision-making incapacity among newly diagnosed older patients with hematological malignancy receiving first line chemotherapy: A cross-sectional study of patients and physicians. *PLoS One* 2015;10:e0136163.
 30. Frassier T, Valour E, Colin C, Danet F. Who am I to decide whether this person is to die today? Physicians' life-or-death decisions for elderly critically ill patients at the emergency department-ICU interface: A qualitative study. *Ann Emerg Med* 2016;68:28-39.
 31. Lamont S, Stewart C, Chiarella M. Documentation of capacity assessment and subsequent consent in patients identified with delirium. *J Bioeth Inq* 2016;13:547-555.
 32. Lamont S, Jeon YH, Chiarella M. Assessing patient capacity to consent to treatment: An integrative review of instruments and tools. *J Clin Nurs* 2013;22:2387-2403.
 33. Kahn DR, Bourgeois JA, Klein SC, Iosif AM. A prospective observational study of decisional capacity determinations in an academic medical center. *Int J Psychiatry Med* 2009;39:405-415.
 34. Joint Centre for Bioethics. Aid To Capacity Evaluation (ACE). Available at: <http://www.jcb.utoronto.ca/tools/documents/ace.pdf>. Accessed July 20, 2019.
 35. Ganzini L, Volicer L, Nelson W, Derse A. Pitfalls in assessment of decision-making capacity. *Psychosomatics* 2003;44:237-243.

Assess • Manage • Reduce Healthcare RISK

Listen to our free podcast!

Episode 13: More Education, Better Provider Training
Needed in Fight Against Stroke

www.reliasmedia.com/podcasts



36. DeMartino ED, Dudzinski DM, Doyle CK, et al. Who decides when a patient can't? Statutes on alternative decision makers. *N Engl J Med* 2017;376:1478-1482.

37. Southern WN, Nahvi S, Arnsten JH. Increased risk of mortality and readmission among patients discharged against medical advice. *Am J Med* 2012;125:594-602.

38. Yong TY, Fok JS, Hakendorf P, et al. Characteristics and outcomes of discharges against medical advice among hospitalized patients. *Intern Med J* 2013;43:798-802.

39. Schaefer MR, Monico EP. Documentation proficiency of patients who leave the emergency department against medical advice. *Conn Med* 2013;77:461-466.

40. Juan SJ, Lim GH, Lim BL. Audit of documentation proficiency of emergency department patients who are discharged against medical advice before and after implementation of a checklist. *J Hosp Admin* 2016;5:28-33.

41. Alfandre D, Schumann JH. What is wrong with discharges against medical advice (and how to fix them). *JAMA* 2013;310:2393-2394.

42. Goldfrank LR, Wittman I. Capacity? Informed consent; informed discharge? Uncertainty! *Ann Emerg Med* 2017;70:704-706.

43. Schaefer GR, Matus H, Schumann JH, et al. Financial responsibility of hospitalized patients who left against medical advice: Medical urban legend? *J Gen Intern Med* 2012;27:825-830.

44. Marco CA, Derse AR. Refusal of life-saving therapy. In: Jesus J, Rosen P, Adams J, et al, eds. *Ethical Problems in Emergency Medicine: A Discussion-Based Review*. Wiley-Blackwell; 2012:89-97.

CME/CE Questions

1. Which of the following statements is true?
 - a. A patient experiencing an acute psychotic break may still have capacity.
 - b. The Mini-Mental State Exam accurately predicts incapacity.
 - c. Blood alcohol levels greater than 0.250 are considered incapacitating.
 - d. Approximately 65% of healthy patients older than 90 years of age lack capacity.

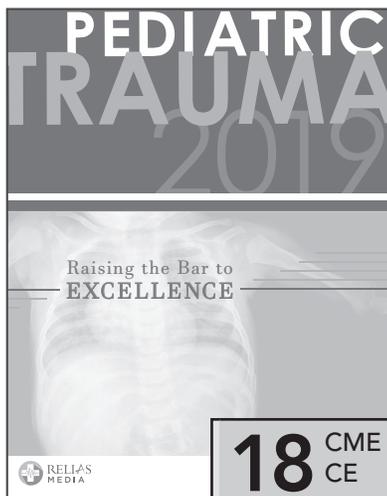
CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the references for further research.
2. Log onto ReliasMedia.com and click on My Account. *First-time users must register on the site.*
3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%. Tests are taken with each issue.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

Small Patients. Large Challenges.

Make sure you're prepared.



Complete with peer-reviewed, evidence-based articles, make ***Pediatric Trauma 2019: Raising the Bar to Excellence*** your go-to resource for learning how to recognize and manage pediatric injuries in a timely manner to decrease risk, quickly stabilize patients, and improve outcomes.

GET THE LATEST ON RESEARCH
AND BEST PRACTICES

Visit ReliasMedia.com/Books

To learn more call **1-800-688-2421**.

2. Which of the following is true regarding capacity and competence?
 - a. The terms are indistinguishable.
 - b. Capacity is a medical judgment.
 - c. Medical input is never needed to declare competency.
 - d. Judges ultimately determine capacity.
3. Which is the most accurate statement?
 - a. Capacity is an all-or-none characteristic.
 - b. Capacity is situation-specific.
 - c. Capacity assessment requires psychiatry input.
 - d. Capacity is never transient.
4. The characteristic that most strongly predicts a lack of capacity in a patient with a psychotic disorder is:
 - a. auditory hallucinations.
 - b. dishevelment.
 - c. ideas of reference.
 - d. a lack of insight.
5. Which of the following statements is most true regarding Against Medical Advice forms?
 - a. They provide adequate legal protection against potential liability actions.
 - b. They provide additional evidence of the physician's attempts to convince the patient to stay.
 - c. They cover the need for additional documentation in the medical record.
 - d. They waive the right of the patient to litigate for damages.
6. Which of the following is the best example of a situation in which a consultation from psychiatry is appropriate to evaluate for capacity to refuse treatment?
 - a. A middle-aged male with a history of schizophrenia who is refusing admission despite clear evidence of an acute coronary event
 - b. An intoxicated male belligerently demanding to leave the ED
 - c. An elderly female with sepsis who is hypotensive but refuses admission
 - d. A healthy mechanic with a minor laceration who does not want sutures placed because of the expense

EMERGENCY MEDICINE REPORTS

CME/CE Objectives

Upon completion of this educational activity, participants should be able to:

- recognize specific conditions in patients presenting to the emergency department;
 - apply state-of-the-art diagnostic and therapeutic techniques to patients with the particular medical problems discussed in the publication;
 - discuss the differential diagnosis of the particular medical problems discussed in the publication;
 - explain both the likely and rare complications that may be associated with the particular medical problems discussed in the publication.
7. Which of the following statements is true regarding impaired capacity due to alcohol?
 - a. A patient who is clinically intoxicated does not have capacity.
 - b. A patient with an ethanol level above the state legal limit does not have capacity.
 - c. Capacity is a sliding scale with intoxicated patients, and it depends on the circumstances and potential severity of the situation.
 - d. An ethanol level is required to determine capacity in a patient who has ingested alcohol.

The Latest and Greatest Is Here!



EMERGENCY
Medicine Reports'

**LLSA EXAM
Study Guide
2020**

- Editor-provided study points
- Full text for all articles on the LLSA reading list
- Authoritative and trusted source—tens of thousands sold

38 CME
Credits

ReliasMedia.com/LLSA2020

Interested in reprints or posting an article to your company's site? There are numerous opportunities for you to leverage editorial recognition for the benefit of your brand.
Call us: (800) 688-2421
Email us: reprints@reliamedia.com

Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliamedia.com or (866) 213-0844.

To reproduce any part of Relias Media newsletters for educational purposes, please contact The Copyright Clearance Center for permission:

Email: info@copyright.com
Website: www.copyright.com
Phone: (978) 750-8400

EDITORS

Sandra M. Schneider, MD
Adjunct Professor of Emergency
Medicine
University of Pittsburgh
Pittsburgh, PA

J. Stephan Stapczynski, MD
Clinical Professor of Emergency Medicine
Scholarly Projects Advisor
University of Arizona College of Medicine
- Phoenix
Emergency Department, Maricopa
Integrated Health System

NURSE PLANNER

**Andrea Light, MS, BSN, RN, EMT,
TCRN, CEN**
Trauma Program Manager
Mt. Carmel East
Columbus, Ohio

EDITORIAL BOARD

**Paul S. Auerbach, MD, MS, FACEP,
FAWM**
Redlich Family Professor
Department of Emergency Medicine
Stanford University School of Medicine
Stanford, California

William J. Brady, MD, FACEP, FAAEM
Professor of Emergency Medicine and
Medicine, Medical Director, Emergency
Preparedness and Response, University
of Virginia Operational Medical
Director, Albemarle County Fire Rescue,
Charlottesville, Virginia; Chief Medical
Officer and Medical Director, Allianz
Global Assistance

Michael L. Coates, MD, MS
Professor Emeritus
Department of Family and Community
Medicine
Wake Forest University School
of Medicine
Winston-Salem, North Carolina

Alasdair K.T. Conn, MD
Chief of Emergency Services
Massachusetts General Hospital
Boston, Massachusetts

Charles L. Emerman, MD
Chairman
Department of Emergency Medicine
MetroHealth Medical Center
Cleveland Clinic Foundation
Cleveland, Ohio

Chad Kessler, MD, MHPE
National Director of Emergency
Medicine, VHA
Professor, Medicine
Duke University School of Medicine
Durham, North Carolina

Kurt Kleinschmidt, MD, FACEP, FACMT
Professor of Surgery/Emergency
Medicine
Director, Section of Toxicology
The University of Texas Southwestern
Medical Center and Parkland Hospital
Dallas, Texas

Frank LoVecchio, DO, FACEP
Vice-Chair for Research
Medical Director, Samaritan Regional
Poison Control Center
Emergency Medicine Department
Maricopa Medical Center
Phoenix, Arizona

Larry B. Mellick, MD, MS, FAAP, FACEP
Vice Chairman for Academic Affairs
Interim Section Chief of Pediatric
Emergency Medicine
Assistant Residency Director
Professor of Emergency Medicine
University of South Alabama
Mobile, Alabama

**Paul E. Pepe, MD, MPH, FACEP, FCCM,
MACP**
Professor of Medicine, Surgery,
Pediatrics, Public Health and Chair,
Emergency Medicine
The University of Texas Southwestern
Medical Center and Parkland Hospital
Dallas, Texas

Charles V. Pollack, MA, MD, FACEP
Chairman, Department of Emergency
Medicine, Pennsylvania Hospital
Associate Professor of Emergency
Medicine
University of Pennsylvania School of
Medicine
Philadelphia, Pennsylvania

Robert Powers, MD, MPH
Professor of Medicine and Emergency
Medicine
University of Virginia
School of Medicine
Charlottesville, Virginia

**David J. Robinson, MD, MS, MMM,
FACEP**
Professor and Vice-Chairman of
Emergency Medicine
University of Texas Medical School at
Houston
Chief of Emergency Services, LBJ General
Hospital, Harris Health System
Houston, Texas

Barry H. Rumack, MD
Professor Emeritus of Pediatrics and
Emergency Medicine
University of Colorado School of Medicine
Director Emeritus
Rocky Mountain Poison and Drug Center
Denver, Colorado

David Sklar, MD, FACEP
Professor of Emergency Medicine
Associate Dean, Graduate Medical
Education
University of New Mexico School of
Medicine
Albuquerque, New Mexico

Gregory A. Volturo, MD, FACEP
Chairman, Department of Emergency
Medicine
Professor of Emergency Medicine and
Medicine
University of Massachusetts Medical
School
Worcester, Massachusetts

Steven M. Winograd, MD, FACEP
Attending Physician
Mt. Sinai Queens Hospital Center
Assistant Clinical Professor of Emergency
Medicine, Mt. Sinai Medical School,
Jamaica Queens, New York

Allan B. Wolfson, MD, FACEP, FACP
Program Director,
Affiliated Residency in Emergency
Medicine
Professor of Emergency Medicine
University of Pittsburgh
Pittsburgh, Pennsylvania

CME Question Reviewer

Roger Farel, MD
Retired
Newport Beach, CA

© 2019 Relias LLC. All rights reserved.

EMERGENCY MEDICINE REPORTS™

(ISSN 0746-2506) is published semimonthly
by Relias LLC, 1010 Sync St., Ste. 100,
Morrisville, NC 27560-5468. Periodicals
postage paid at Morrisville, NC, and
additional mailing offices. POSTMASTER:
Send address changes to *Emergency
Medicine Reports*, Relias LLC, 1010 Sync St.,
Ste. 100, Morrisville, NC 27560-5468.

Executive Editor: Shelly Morrow Mark

Associate Editor: Journey Roberts

Editorial Group Manager:
Leslie Coplin

Accreditations Manager:
Amy M. Johnson, MSN, RN, CPN

GST Registration No.: R128870672

© 2019 Relias LLC. All rights reserved. Reproduction,
distribution, or translation without express written
permission is strictly prohibited.

Back issues: \$30. Missing issues will be fulfilled
by customer service free of charge when contacted
within one month of the missing issue's date.

SUBSCRIBER INFORMATION

CUSTOMER SERVICE: (800) 688-2421

Customer Service Email Address:
customerservice@reliasmmedia.com

Editorial Email Address:
mmark@relias.com

Online: ReliasMedia.com

MULTIPLE COPIES:

Discounts are available for group subscriptions,
multiple copies, site-licenses, or electronic
distribution. For pricing information, please
contact our Group Account Managers at
groups@reliasmmedia.com or (866) 213-0844.

ACCREDITATION

Relias LLC is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Relias LLC designates this enduring material for a maximum of 3 *AMA PRA Category 1 Credits™*. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for a maximum of 3 hour(s) of ACEP Category I credit.

This Enduring Material activity, *Emergency Medicine Reports*, has been reviewed and is acceptable for credit by the American Academy of Family Physicians. Term of approval begins 01/01/2019. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Approved for 3 AAFP Prescribed credits.

The American Osteopathic Association has approved this continuing education activity for up to 2.5 AOA Category 2-B credits.

Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [3] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This is an educational publication designed to present scientific information and opinion to health professionals, to stimulate thought, and further investigation. It does not provide advice regarding medical diagnosis or treatment for any individual case. It is not intended for use by the layman. Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

This CME/CE activity is intended for emergency and family physicians and nurses. It is in effect for 36 months from the date of the publication.



RELIAS
MEDIA

EMERGENCY MEDICINE **REPORTS**

The Capacity Conundrum in Emergency Medicine

Elements of an Emergency Department Capacity Evaluation

Element	Details
Understanding	The patient has the ability to comprehend the medical information being discussed, including the risks and benefits of refusing the recommended option.
Appreciation	The individual not only comprehends the details but appreciates how these factors might affect him or her personally.
Reasoning	There should be some evidence of a <i>reasoning</i> process behind the patient's decision.
Ability to communicate a choice	Is the patient's decision vacillating or remaining reasonably consistent over time?

Factors Affecting Capacity

Factor	Description
Intoxication	<ul style="list-style-type: none"> Alcohol is the most common agent involved in impairment of capacity, but other substances with sedating, hallucinogenic, or psychoactive properties also may transiently impair capacity. The presence of varying degrees of intoxication raises the likelihood of capacity impairment but does not automatically prevent the patient from having capacity to make specific decisions. Patients must be evaluated on a case-by-case basis.
Psychiatric disorders	<ul style="list-style-type: none"> Schizophrenia is associated with greatest likelihood of impaired capacity, followed by others, including bipolar disorder, major depression, and anxiety disorder. Many patients with underlying psychiatric disorders still may have decision-making capacity. Poor insight is the strongest predictor of a potential lack of capacity. Psychiatrist evaluation for capacity may be useful in ambiguous cases.
Cognitive disorders, such as dementia, delirium, autism spectrum disorder, advanced parkinsonism, and others	<ul style="list-style-type: none"> These disorders may or may not cause impaired capacity. These disorders may impair capacity for some decisions only. Psychiatrist evaluation for capacity may be useful in ambiguous cases. Transient conditions, such as high fever, hypoglycemia, electrolyte disorders, and dehydration, transiently impair cognitive ability.
Communication issues	<ul style="list-style-type: none"> Any barrier to understanding or expression (language barrier, deafness, aphasia) can hinder the ability to render impairment of capacity decisions and must be overcome as needed.
Miscellaneous	<ul style="list-style-type: none"> Severe pain, stressful situations, and fatigue may impair capacity.

Capacity Assessment Tools

Name	Characteristics
Aid to Capacity Evaluation (ACE)	Decision-specific questions across seven domains
Capacity Assessment Tool (CAT)	Loosely structured interview across six domains
Competency Interview Schedule (CIS)	Structured interview regarding 15 items
Composite Screening Examination (Mini-Cog)	Cognitive questions in three domains
Hopkins Competency Assessment Test (HCAT)	Six questions pertaining to an essay
MacArthur Competence Assessment Tool for Treatment (MacCAT-T)	Loosely structured interview
Mini-Mental State Examination (MMSE)	Cognitive questions in five domains
Montreal Cognitive Assessment (MoCA)	Cognitive questions in nine domains
Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory (SICIATRI)	Structured interview regarding 12 items

Hierarchy of Surrogate Decision Makers*

1. The patient's guardian
2. The patient's spouse or domestic partner
3. Any adult child of the patient
4. Either parent of the patient**
5. Any adult sibling of the patient**
6. Any adult grandchild of the patient, or an adult relative who has exhibited special care and concern, who has maintained close contact, and who is familiar with the patient's activities, health, and religious or moral beliefs
7. A close friend of the patient
8. The patient's guardian of the estate

*Varies by state; 35 states have statutes that establish surrogate hierarchy
** Adulthood usually defined as 18 years of age or older

Necessary Documentation Steps for Patients Leaving Against Medical Advice

- Summarize patient presentation and emergency department evaluation.
- Describe the emergency department capacity assessment.
- List proposed treatment and risks of refusing.
- List alternatives discussed.
- Indicate that the patient understands risks.
- State follow-up care instructions.
- State that the patient is free to return at any time.
- Identify witnesses present.