In the busy world of an emergency physician (EP), many patients are cared for simultaneously and numerous decisions are made on a continuing basis. Prioritizing patients and tasks based on severity of illness necessarily means that patients with lesser illness must wait. Regardless, the EP formulates a plan of care for each patient in the emergency department (ED), integrally involving the patient in the plan. Each plan also takes into account risk management on behalf of both the patient and EP. In any discussion on risk management in the ED setting, the concept of informed consent is central to mitigating risk for the EP and patient. Assuming that the patient is competent to make autonomous health care decisions, the EP has a duty to explain the patient’s medical condition and treatment options in understandable terms. The associated risks and benefits of treatment options (including doing nothing) should also be communicated. This process allows the patient to choose a treatment option
that best fits the individual patient’s goals and values, even if this treatment option is not what the EP is recommending.

Certainly, the majority of encounters between an EP and an ED patient can be enormously satisfying for both patient and physician. Emergency medical conditions that are promptly diagnosed and treated represent the ideal in emergency care. There are times, however, that this ideal is not possible, particularly when there is disagreement between the physician and patient concerning the proposed care plan. This article focuses on the minority of times that the EP and patient do not agree about the treatment option being chosen by the patient. Attention is placed on the risk management issues relevant to the patient’s unexpected treatment choice. There can be many reasons why agreement is difficult and there can be significant risk placed on the EP depending on the specific reason for disagreement. Issues include capacity (either transient or permanent), substitute judgment for incapacitated patients, informed consent to treatment, the right to refuse care, and the decision to leave the ED against medical advice. Emphasis is placed on determining a patient’s competency or capability of making clinical decisions, with particular focus on the EP deciding that patient competency requires a formal evaluation. The EP should have a strategy for assessing clinical decision-making capability and an understanding of what circumstances should act as a trigger for considering such an assessment. Attention to documentation issues around informed consent, common barriers to consent (minors, language, substance abuse, legal directives including guardianship, living wills, advance directives, etc), refusal of care, and ED discharge against medical advice (AMA) are examined.

COMPETENCE AND MEDICAL DECISION MAKING

For the EP, determining if a patient is competent to make clinical decisions relevant to a proposed care plan can be quite complex. Competency, in the medical setting, is a distinct entity from competency in the judicial setting. In the medical arena, competency to make medical decisions is used interchangeably with the word capacity in order to steer clear of the legal connotations associated with competency. For the majority of ED patients, capacity is a nonissue. There are, however, certain patients where capacity is a potential or even likely issue. Patients with cognitive deficits such as early Alzheimer disease, after stroke, psychiatric patients (schizophrenia, bipolar disorder, or disorders associated with psychosis and altered reality testing), substance abuse (particularly withdrawal states associated with altered mentation and overdose conditions associated with depressed levels of consciousness and mentation). There are two basic premises to capacity in the medical setting. The first premise is that patients understand best what is uniquely right for them. A patient’s decision will maximize what works for their self-interest. The second premise is that the decision is autonomous.1 In a report from the President’s Commission for the Study of Ethical Problems in Medicine2 from 1982, clinical decision-making capacity included three specific elements: the patient has a set of values and goals, the patient is able to understand and communicate information, and the patient is able to reason and deliberate about the choice being made by the patient. Applebaum3 incorporates these elements in a chart on legally relevant criteria for decision-making capacity (Table 1).1

Patients with cognitive impairment increase the risk of a claim against the physician because the consent to treatment by these patients is considered invalid. A patient who is not capable of giving informed consent should not be relied on to make decisions about the care plan being considered. Under such circumstances, the physician
must seek substituted judgment. A health care proxy serves this purpose, but the majority of patients do not have a health care proxy form filled out and available for the EP to read and verify.

CAPACITY ASSESSMENT

Assessment of capacity is done simultaneously with clinical assessment in most cases. Unless a patient is obviously impaired or incapable, or presents with a preexisting condition or chief complaint suggestive of cognitive impairment, the EP proceeds with the clinical encounter as if the patient is competent. During this process it occasionally becomes apparent that a patient may lack capacity to make clinical decisions autonomously. At this point, a formal assessment of capacity should be performed. This assessment should be done with a translator, if necessary, and should include a mini-mental status examination and a neurologic examination. The mini-mental status examination correlates well with patients believed to be clinically incapable of deciding treatment options—at least in the inpatient setting. All relevant information concerning potential diagnoses and treatment options should be given in understandable language; that is, presented at the level appropriate to the given patient so information is most likely to be understood. This information must include the risks and benefits of all treatment options including the option of no treatment. The information should be presented in a neutral manner without overstating or understating actual risks and benefits. Having been given the relevant information, the patient should be asked to tell the EP what it is that is understood. The patient should be able to paraphrase the relevant information indicating understanding of the medical condition, potential treatment options, and risks and benefits of the treatment options. Any misimpressions can be corrected. The patient should also state the reasoning behind the treatment option chosen. This process now ties together the criteria necessary for determining capacity in medical decision making: appreciation of current medical condition, understanding of treatment options, and ability to communicate the decision for the patient’s treatment of choice. It is important to note that this process makes no determination on the outcome of the process. The focus is on the deliberative process necessary to make an autonomous decision. The real risk management issue for the EP centers more on the outcome of the process, particularly when a patient makes an unexpected choice that is very risky and is not the expected choice. It is generally at this point that the EP realizes that the patient may not be competent to make the treatment decision and, therefore, it is necessary to evaluate competency.

The need to assess competency is inversely proportionate to the degree of patient agreement with medical opinion on preferred treatment option. The more a patient agrees with the expected choice of treatment option, the less the need to screen for competency is perceived by the EP. Depending on the risk of the treatment option chosen, the greater the perceived need to screen for competency. Essentially, the patient who chooses an option that carries significantly higher risk and is an unexpected treatment choice, the greater the need to explore the patient’s competency in making such a decision. There is disagreement about the relationship of a risky treatment option choice to the capability to make such a decision by the patient. Wear and Wicclair believe that the assessment of a patient’s capability to make an informed treatment decision can be decoupled from the patient’s final treatment decision. There is a theory of sliding-scale capacity that links the treatment decision rationale to the process used to reach the final treatment decision. In essence, this theory holds patients who choose a riskier treatment option to a higher standard
<table>
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<th>Criterion</th>
<th>Patient’s Task</th>
<th>Physician’s Assessment Approach</th>
<th>Questions for Clinical Assessment</th>
<th>Comments</th>
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| Communicate a choice                          | Clearly indicate preferred treatment option         | Ask patient to indicate a treatment choice | Have you decided whether to follow your doctor’s [or my] recommendation for treatment?  
Can you tell me what that decision is?  
[If no decision] What is making it hard for you to decide? | Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity |
| Understand the relevant information           | Grasp the fundamental meaning of information communicated by physician | Encourage patient to paraphrase disclosed information regarding medical condition and treatment | Please tell me in your own words what your doctor [or I] told you about:  
The problem with your health now  
The recommended treatment  
The possible benefits and risks (or discomforts) of the treatment  
Any alternative treatments and their risks and benefits  
The risk and benefits of no treatment | Information to be understood includes nature of patient’s condition, nature and purpose of proposed treatment, possible benefits and risks of that treatment, and alternative approaches (including no treatment) and their benefits and risks |
<table>
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<tr>
<th>Appreciate the situation and its consequences</th>
<th>Acknowledge medical condition and likely consequences of treatment options</th>
<th>Ask patient to describe views of medical condition, proposed treatment, and likely outcomes</th>
<th>What do you believe is wrong with your health now?</th>
<th>Do you believe that you need some kind of treatment?</th>
<th>What is treatment likely to do for you?</th>
<th>What makes you believe it will have that effect?</th>
<th>What do you believe will happen if you are not treated?</th>
<th>Why do you think your doctor has [or I have] recommended this treatment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason about treatment options</td>
<td>Engage in rational process of manipulating the relevant information</td>
<td>Ask patient to compare treatment options and consequences and to offer reasons for selection of option</td>
<td>How did you decide to accept or reject the recommended treatment?</td>
<td>What makes [chosen option] better than [alternative option]?</td>
<td>This criterion focuses on the process by which a decision is reached, not the outcome of the patient’s choice, since patients have the right to make “unreasonable” choices</td>
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*Questions are adapted from Grisso and Applebaum. Patients’ responses to these questions need not be verbal.*
of competency by requiring the patient to demonstrate greater clarity in explaining the rationale behind the choice of the higher risk treatment option. From a practical standpoint and a risk management vantage point, coupling of the decision and treatment choice is important to the EP. Capable patients may choose options that are not consistent with what the EP considers the expected treatment choice. This unexpected treatment choice may be questioned in the future, particularly if an adverse event occurs or if the treatment choice is ineffective and there is a perception that another treatment choice would have been significantly better. It is in precisely these situations that documentation of a capability assessment coupled with a documented explanation of the patient rationale for the treatment choice highlighting the understanding of the risks and benefits of such a choice becomes extremely important. A further explanation of attempts to correct any misinterpretations will also serve to demonstrate that a capable patient made an autonomous decision based on maximizing the patient’s best self-interest despite the fact that the choice was not the expected choice for the EP or, for that matter, a majority of individuals facing a similar decision.

**INFORMED CONSENT**

When a patient decides to refuse care or to leave the ED AMA, it is a most unsatisfactory choice for the EP. The EP’s duty to protect a patient from harm is now cast in stark opposition to the duty to respect a patient’s autonomy. An unexpected treatment choice on the part of a patient results in the EP assessing patient competence or capability to make clinical decisions. The principle of informed consent is paramount in providing the patient the necessary information required to make an informed choice from available treatment options. In emergency medicine, informed consent is not absolute. Life-threatening situations necessitating emergency intervention to prevent death or serious bodily harm are generally accepted as exceptions to this principle under the premise that preserving life is in accord with the duty of the EP to prevent harm to a patient and that the patient would choose life as a treatment option over certain death. In a General Accounting Office report from 1993 on the type of care provided in EDs across the United States, it was estimated that 49% of all ED visits were nonurgent based on discharge diagnoses. Using discharge diagnosis is a poor proxy for determination of the urgency or emergency of ED visits as the presenting chief complaint may well represent a possible life-threatening condition or emergency medical condition that will not be discovered to be emergent or nonacute until a medical screening examination is performed.

Informed consent, like competency, is a term with legal and medical connotations. The EP has a duty to disclose the relevant clinical information to the patient so that the capable patient can understand treatment options and make an autonomous decision that maximizes the patient’s best interest. As discussed before, each patient has a unique set of values and goals by which each treatment option’s risks and benefits are heavily weighted. Whereas the EP is uniquely suited to understand the emergency treatment options and associated risks and benefits, the lack of a longstanding relationship with the patient makes it difficult for the EP to customize treatment alternatives in light of the patient’s goals and values. In terms of risk management, it is important to understand that the patient’s autonomy in determining the correct treatment option based on individual values and goals is the only control the patient has in the ED setting. The choice of setting and provider is by necessity not under patient control. Autonomy is then confined to treatment options that the patient can weigh in light of individual goals and values.
In the medical setting, informed consent has three main features: patient capacity to make the treatment decision, sufficient relative information that is understandable in terms of current condition and treatment options with corresponding risks and benefits, and the ability to voluntarily consent to the perceived treatment option that best fits the patient’s values and goals without coercion. Capacity has been discussed in detail earlier. Sufficient relative information necessary for informed consent in the legal arena has two competing standards. The first standard is from the perspective of the average qualified EP. This local professional standard requires the EP to disclose information that the average qualified physician would disclose under similar circumstances. This standard is not patient centered; therefore, the second standard requires the EP to disclose the relevant information that an average reasonable patient would require to make an informed treatment decision. This standard does not tailor the information to particular needs of a patient who does not neatly fit into the average patient category. For the practicing EP, this lack of clarity about the legal requirement of relevant information disclosure may retrospectively present risk management issues based on local legal jurisdictions and standards. The practice of the patient signing the consent to treatment form in most EDs gives blanket consent to all treatment options. To mitigate risk associated with potentially risky treatment options or procedures in the ED, it would be wise for the EP to simultaneously document the associated consent process. Voluntary consent to treatment is the third element of valid informed consent for the patient. Involuntary consent using manipulation, coercion, or duress to persuade a patient to consent to a treatment option is not morally or legally binding. Persuasion in the form of EP recommendation is permissible because it is usual and customary that the EP provides guidance concerning particular courses of action in a rational discussion.

Special Considerations

Informed consent is extremely important in emergency medicine. Under life-threatening situations, however, there is an exception to the doctrine of informed consent. The American College of Emergency Physicians publishes a code of ethics. Ladd, a philosopher, argues that the ED presents several ethical challenges to patients concerning autonomous decision making. Patients do not generally choose the hospital or the physician. Emergency medical service ambulances transport patients to the closest facility if the medics believe a life-threatening medical condition exists. The patient does not choose the EP on duty. Real choice for the ED patient lies, ironically, with the informed consent doctrine. This is ironic because the ED culture is one of saving life even if heroic measures are required. Unless a patient has a documented living will that specifically requests no heroic life support, heroic measures will be undertaken because of the underlying belief that life-sustaining treatments would be preferred by patients.

Ladd also argues that operational efficiency may come into conflict with patient autonomy. All EPs are aware of how an argument can be framed to suit a specific choice or desired option. Documentation of treatment options devoid of manipulation or coercion is important in demonstrating that the patient’s choice of treatment is autonomous and not the result of being under duress. Recognizing that a physician’s recommendation usually carries significant weight, it is reasonable for the EP or patient’s family to use this recommendation as a tool to persuade the patient as long as the patient’s ultimate decision is not made out of capitulation. The American Medical Association code of ethics states, “Patients should receive guidance from their physicians as to the optimal course of action.”
There are circumstances when an EP may want to treat a patient even though informed consent is not easily obtained. Situations involving patients (1) that are minors, (2) speak a language other than the language spoken by the EP, (3) with strong religious beliefs that do not sanction medical care or disallow certain medical practices (Jehovah’s Witness and blood transfusions, Church of Scientology and medicine in general), (4) in active substance abuse or substance withdrawal states, (5) with altered mental status, with psychiatric illness with a psychotic mental state, and (6) presenting with depressed mental status or altered mental status as a chief complaint. In all such cases, the capability to make medical decisions should be assessed. Patients found to be incapable of consenting to medical care decisions require substitute judgment.

**SUBSTITUTE JUDGMENT**

The duty of the EP to a patient does not change if the patient is deemed incapable of making medical decisions. The patient’s judgment is substituted by another person (usually a relative) for making medical decisions that reflect the values and goals of the patient. A power of attorney (POA) is a legal document that specifically names a responsible person, authorized by the patient and recognized by law, to make medical and legal decisions for an incapacitated patient. The POA may be separated into legal and medical documents as an individual may wish to have different people named for legal and health care decisions. An advance directive refers to specific instructions for anticipated medical conditions such as a do-not-resuscitate order or a do-not-intubate order. The environment in the ED generally requires patients to make decisions over a relatively short time. Patients that are obviously incapacitated and are being transported to the ED from a nursing home, generally have advance directives that accompany the paperwork from the nursing home. The next of kin is listed with contact information so that the EP may discuss treatment options with family, most often to confirm the patient wishes stated in the advanced directive.

Patients that experience a material change in their physical and mental condition so that they are now acutely incapable of medical decision-making present a unique challenge to the EP. The EP wishes to respect the autonomy of the patient and the patient’s right to determine treatment options in line with their values and goals, while acting in the patient’s best interest to protect the patient from harm. In situations such as this, there is an exemption to informed consent. The physician is expected to render life-sustaining treatment.

**REFUSAL OF CARE**

Competent patients can refuse care. This can be an admission, a procedure, or even a test. Because the choice may be unexpected, it is reasonable for the EP to consider competency before agreeing with a request to refuse care. As part of a good risk management strategy, it is worth examining the communication between the patient and EP. Establishing trust by introducing one’s self, sitting, listening, not interrupting, asking open-ended questions, using understandable language, and making empathetic statements helps to mitigate communication issues and minimizes or prevents conflicts.

Despite an EP’s good communication skills, a competent patient may still refuse care. Attempts to negotiate an acceptable compromise may potentially buy time for further patient reflection. Another option at the disposal of the EP is use of the family (or substitute) to help the patient fully appreciate the risks and benefits associated with treatment options. Ethics consults are another option in the general hospital setting,
but are rarely used in the ED given the time constraints for decision-making. In the inpatient setting, psychiatry consultations are more commonplace for evaluating competency, and can be used in the ED particularly for patients with mental illness or substance abuse issues. As a last resort, legal consultation with the hospital attorney may be obtained in cases of life- or limb-threatening decisions or, particularly, for decisions by caregivers or substitutes.

DISCHARGING AGAINST AMA

Discharging patients AMA is a tool employed by the EP to document a patient’s decision to leave the hospital despite the physician’s recommendation for admission for further treatment. The medical literature is sparse concerning this topic in emergency medicine. A study looking at the rate of AMA discharges from a general medicine service estimates the rate to be 1% to 2% of all discharges. Factors associated with AMA discharge include male gender, younger age, substance abuse, Medicaid, and being uninsured. In a retrospective cohort analysis of ED patients over two 6-month periods in consecutive years, a significant number of patients discharged AMA were found to have significant pathology (17.5%). The principle diagnostic diagnoses in the AMA group were cardiovascular disease, undifferentiated abdominal pain, respiratory illness, and cellulitis. In the patient group discharged AMA with cardiovascular complaints, 75% reported that their symptoms had improved or abated and the patients would not be returning for care. In a study by Pope and colleagues examining missed diagnoses of acute cardiac ischemia in the ED, it was estimated that 2.1% of patients with acute myocardial infarction were discharged and that 2.3% of patients with acute cardiac ischemia were discharged. It makes sense that some of these patients could fall into the AMA discharge category even though this was not actually looked at in the study. Patients being discharged from the hospital, AMA or in regular fashion, present a risk management issue for the EP. Documentation that a patient being discharged AMA is competent to make such a decision is helpful, but documentation of capability to make medical decisions coupled with a discussion of the risks and benefits associated with such a decision is more helpful. In a review of four medical malpractice cases brought to suit over AMA discharges, documentation of AMA discharge was helpful, but the plaintiff’s inability to prove negligence was the deciding factor.

REFERENCES