Best Practices for Two Physician Holds and Consent to Treatment: A Panel Discussion

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Panel:
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Case Presentations

My dilemma as a hospitalist

- I have patient with diminished capacity to provide informed consent for medical care or refuse medical care. My first concern is his or her safety and health.

- What are my tools in this situation?
- Is the Emergent Physician Hold appropriate?
- Once placed, how do I actually compel treatment?

Nursing concerns

- As nurses act on physician’s orders, nurses would like a review of the legality of compelling medical care… diagnostic testing, procedures, and giving medications in the setting of the emergent hold or ill patient with potentially diminished capacity

Nursing concerns continued

- Once a patient is placed on the emergent hold and is sent to the medical floor, how does that or should that limit a patient’s access to visitors or their personal belongings?
- What safety modifications are needed to a standard medical room for a suicidal patient besides a nursing 1:1?

Patient Concerns

- Many times they shout – “this is illegal” when placed on a hold…

- What is the process that occurs and should occur when we place a hold to make sure that patient rights are not being violated?
Delirium from a medical cause is a DSM-IV diagnosis

- Do we use this to place a hold on all delirious patients who try to refuse care?
- Issues
  - 1) imminent self harm or harm to others if released
  - 2) inability to care for oneself if released
  - 3) existence of an underlying mental health disorder
  - 4) this is really a dire situation (i.e. serious injury, health compromise, death)

Is there any other recourse to this hold?

- Once a hold is placed on the patient, how to we legally treat the patient if he or she does not change her mind about accepting care?

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Case 1

- Ms. Beer is found by a police officer along Highway 97. She is agitated, altered and threatens to jump in front of a semi. The police bring her to the ER. She has an alcohol level of 0.300 And is fighting nursing staff stating she wants to leave. She intermittently falls asleep and has a shallow breathing pattern and gurgling breath sounds until she coughs. Then she wakes up and the agitation begins again.

What should be done?

- 2 physician hold or emergent hold is placed by ER and psychiatrist on call. The hospitalist admits the patient to the floor. The patient sleeps for 10 hours and then wakes up with confusion, heart rate to 120, temp 100.6, sweaty. Then tries to leave... hold is in place...

In this case....

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- What is trail of documentation to use restraints even 4 points, and sedate against patient will.... A hold does not give permission to treat but the risk of seizure and even death from alcohol withdrawal may give us the imminent medical danger to do so.

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Case 2

- Mr. Tumor is brought to the ER by his wife and the paramedics. He is a 50 yr old with a brain met from lung cancer on high dose steroids and concomitant radiation treatment. Last week he presented with headache and seizure and the dx of a brain met was made. His labs and imaging show no change or sign of infection. He is on decadron 4 mg TID.
He had locked himself in his home bathroom, spent the night in there and his wife heard him yelling at his deceased parents, crying hysterically and occasionally banging his head on the door. The day before he refused to eat any food— he only drank water.

What is the next step?

Now consider the same case but change the circumstances. He has no family—he was found yesterday by his cleaning lady confused—she was concerned so she checked on him today and heard him in the bathroom crying and banging his head…. No family, no POA, no friends.

Case 3

June Encephalitis is brought by her roommate at COCC to the ER. She is a 20 yr old college student. Her friend was concerned when she found her dishelved on the couch—sweaty and incoherent instead of at her midterm. June complains of headache, covers her face with the pillow in the ER and lies on her side unmoving. ER staff begin a workup and start IVF, pain meds. June suddenly wakes up more coherent and says she is leaving. She needs to get to her classes and her midterm that night.

Work up so far

- WBC 18,000 with lymphocyte predominance
- Sodium 129
- Exam—pt refused to keep her eyes open in the bright light and winces when you feel her neck and actually complains of pain with neck ROM and knee/hip flexion.

And then…

The ER doctor comes in to explain she needs an LP to rule out lifethreatening infection. June says I feel better I will come back after my midterm in the am. She states she understands she may be sick and could even die.

But you wonder

- Did the pain medicine diminish her capacity? Is her underlying condition making her near delirious … though she seems maybe to have some capacity…
You think ….
maybe I can put her on a hold …but does this enable me to diagnose and treat her if she still refuses testing and therapy?
the clock is ticking….. For both of you….
She still wants to leave after you talk to her again…..

Panel Discussion
And questions …..
DSM-IV Criteria

- Delirium Due to Multiple Etiologies
  - Diagnosed when there is more than one etiology (e.g., both a substance and a general medical condition)

- Substance-Induced Persisting Amnestic Disorder
  - Diagnosed if the memory disturbance results from the persisting effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure)

- Personality Disorder
  - An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture.

- Dementia
  - Cognitive Disorder NOS
  - Mental Disorder NOS Due to General Medical Condition
  - Catatonic Disorder Due to General Medical Condition
  - Personality Change Due to General Medical Condition
  - Mental Disorder NOS
IN THE CIRCUIT COURT OF THE
STATE OF OREGON
FOR ________________________ COUNTY

In the Matter of )
) NOTICE OF MENTAL ILLNESS
) ) EMERGENCY HOSPITALIZATION
) ) BY A PHYSICIAN
) alleged to be a mentally ill person )

TO THE JUDGE OF THE ABOVE COURT:
You are hereby notified that at ______ m. on the ______ day of ________________, 20____, the undersigned, a physician licensed to practice medicine by the Oregon Board of Medical Examiners, after completing a face to face examination of the above-named person and in consultation with:

______________________________________________, ( ) a similarly qualified physician or ( ) a qualified mental health professional, neither of whom are related by blood or marriage to the above-named person, admitted or caused to be retained in:

______________________________________________, a hospital approved by the Addiction and Mental Health Division of the Oregon Health Authority where the undersigned has admitting privileges.

The condition of the above-named person, as set forth in writing below, caused the undersigned to believe that the above-named person is dangerous to self or others because the person exhibits the following:
(Briefly describe specific examples of thoughts, plans, means, actions, history of dangerousness, or other indicators that support the physician’s belief the person is imminently dangerous.) ________________________________

______________________________________________________________________________

______________________________________________________________________________

In addition, the undersigned believes that the above-named person is in need of emergency care or treatment for mental illness because the person exhibits the following: (Briefly describe specific indicators that support the physician's belief the person has a mental disorder: ________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

___________________________________________ M.D. ________________________________ (Signature) (Print Name)

Original: Circuit Court
Copy: CMHP Director
Copy: Medical Record

Revised: 7/10/12