Online Journal of Health Ethics

Volume 4 | Issue 2 Article 3

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Recommended Citation
Lovrin, M., & Reinisch, C. (2007). The Ethical Management of a Psychiatric Patient Disposition in the Emergency Department. *Online Journal of Health Ethics, 4*(2). http://dx.doi.org/10.18785/ojhe.0402.03

The Ethical Management of a Psychiatric Patient Disposition in the Emergency Department

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Abstract

This case examines the ethical issue of the disposition of a patient who presents in the emergency room with a psychotic disorder when a nurse practitioner is given the autonomy to determine disposition of a patient and the attending physician disagrees. Therein lies the dilemma of an NP lacking emergency psychiatric admitting privileges. The NP ethically needs to continue to act as a patient advocate to ensure patient safety and best outcomes.

Keywords: Disposition, autonomy, ethical issues in emergency care, patient advocacy

Psychiatric Patient Disposition in the Emergency Department

Mr. P a 42 year-old Caucasian male was brought to the emergency department (ED) by ambulance with chief complaint "I was in the pharmacy and became paranoid and very anxious and asked the pharmacist to call 911". Mr. P had been discharged from another hospital earlier in the day following a three week hospitalization for paranoid thoughts and suicidal ideation with a plan follow up in the community by the Assertive Community Treatment (ACT) team and community services as he is homeless and has no source of informal support from family or friends.

Mr. P has had numerous hospital admissions. Prior to his most recent hospitalization, his last hospitalization occurred four months ago. At that time he was brought to the ED via ambulance after an attempted suicide. He had cut his neck, stating he heard voices telling him to hurt himself. He was discharged from the hospital with diagnosis psychotic disorder, not otherwise specified. Subsequently, he was noncompliant with the medication prescribed which included haloperidol 7.5mg twice daily, benztropine 0.5mg twice daily, and escitalopram 20mg once daily, and did not follow-up at the clinic associated with the hospital. This resulted in the three week hospitalization from which he was released this morning.

According to Mr. P. his medication regimen was not changed during the hospitalization. He was discharged this morning with a social services appointment and prescriptions to be filled at the local pharmacy.

MENTAL STATUS EXAMINATION

Mr. P. presents as a casually and appropriately dressed 42 year-old male, who appears his stated age. He is clean-shaven, soft spoken and makes infrequent eye contact. He appears

anxious and dysthymic. He exhibits mild psychomotor retardation, and has minimal word usage. His speech is coherent though simplistic. His thought processes are difficult to assess due to his limited, one-word answers, often answering "I don't know" in response to simple questions, particularly in regard to his most recent hospitalization. He has been hearing voices throughout the day and experiencing feelings of paranoia. The voices are not telling him to hurt himself or anyone else, but are whispering advice to him. He denies visual hallucinations. He has a flat affect that is congruent with his mood. He appears internally preoccupied although he denies suicidal and homicidal ideation at this time.

DIAGNOSTIC TESTS

Laboratory tests were ordered including a comprehensive metabolic panel, thyroid panel, and urine for toxicology. All results were within normal limits and the urine toxicology was negative.

CLINICAL IMPRESSION

The patient is a 42 year-old Caucasian male who had been discharged from another psychiatric facility this morning. The patient presents with symptoms consistent with a DSM-IV-TR diagnosis of Psychotic Disorder Not Otherwise Specified (NOS). Due to the patient's disorganized thinking he is unable to describe his mood state and thought processes; and thus there is inadequate information to make a specific diagnosis and he does not meet full criteria for any specific Psychotic Disorder.

The patient had a negative urine toxicology indicating that the psychotic episode is not substance induced. His lab results are all within normal limits, eliminating the possibility that this psychotic episode is related to a medical condition or response to medication.

CONSULTATION WITH ATTENDING PSYCHIATRIST

Due to the acute nature of the patient's presentation, it seemed appropriate to admit this patient to the inpatient psychiatric unit for treatment of symptoms consistent with a diagnosis of psychotic disorder. As the ED attending Nurse Practitioner, I consult the on-call Attending Psychiatrist for all admissions. The psychiatrist, who is not on site and has not seen the patient, disagreed with my plan for admission. He stated that since the patient had been discharged from another hospital just this morning, after a three week hospitalization, the patient must be stable and should be discharged to the homeless shelter.

Being the individual who evaluated this patient, I described the patient's current mental status, detailing hallucinatory content, paranoid ideation and acute anxiety state. I explained to the psychiatrist that because the patient was not forthcoming in his responses, and was guarded, anxious, paranoid and fearful; I felt that his safety was of concern. The attending psychiatrist did not agree that the patient should be admitted and again repeated that the other hospital would not have discharged the patient unless he was stable, and must therefore be stable.

ETHICAL DILEMMA

The ethical dilemma concerns the patient's disposition based upon the clinical assessment done in the ED, and the refusal of the covering psychiatrist to admit the patient. A clinical quandary is created when a psychiatric nurse practitioner has the authority and autonomy to perform a psychiatric assessment and determine the patient's disposition, but the decision is challenged by a physician who is not onsite, yet has the authority to decide whether the patient is admitted.

LITERATURE

NPs are assuming more independent roles. Core competencies, for Nurse Practitioners include Independent Practice, stating: that the NP practices independently by assessing, diagnosing, treating and managing undifferentiated patients, and assumes full accountability for actions as licensed independent practitioners. There is little evidence in the literature available on patient disposition when nurse practitioners and attending physicians disagree with regard to what is in the patient's best interest.

The Code of Ethics for Emergency Physicians, (American College for Emergency Physicians (ACEP), 1997) can used as a guide to determine treatment and appropriate patient disposition. It is expected that NP's will follow the same ethical guidelines as ED physicians.

PRINCIPLES OF ETHICS FOR EMERGENCY PHYSICIANS

Emergency physicians assume more specific ethical obligations that arise out of the special features of emergency practice. The clinician-patient relationship is the defining element that categorizes the emergency physician's ethical responsibilities. The emergency physician-patient relationship is usually episodic and dictated by the patient's urgent need for care. The patient's willingness to seek emergency care and to trust the clinician is based on institutional and professional assurances rather than on an established personal relationship. The emergency physician's ethical duties in these relationships may be categorized into those dealing with beneficence, autonomy, fairness and nonmaleficence. (Approved by the ACEP Board of Directors June 1997. Reaffirmed October 2001 by ACEP Board of Directors)

Beneficence

Physicians serve the best interest of their patients by treating or preventing disease or injury and by informing patients about their conditions. Emergency physicians respond quickly to acute illnesses and injuries to prevent or minimize pain and suffering, loss of function, and loss of life. (Approved by the ACEP Board of Directors June 1997. Reaffirmed October 2001 by ACEP Board of Director) In this case, there is an apparent need to balance the benefits of hospitalization for an unstable psychiatric patient against the risks of discharging him to a homeless shelter or holding him in an ED overnight. If the goal, according to the Code, is to minimize suffering, it is believed that this patient would be best served on an inpatient psychiatric unit.

Respect for patient autonomy

Adult patients with decision-making capacity have a right to and physicians the concomitant duty to respect, their preferences regarding their own health care. This right is grounded in the legal doctrine of informed consent. According to this doctrine, patients with decision-making capacity must give their voluntary consent to treatment after receiving appropriate and relevant information about the nature of the affliction and expected consequences of recommended treatment and treatment alternatives.

To act autonomously, patients must receive accurate information on which to base their decisions. Emergency physicians should relay sufficient information to patients for them to make an informed choice among various diagnostic and treatment options. In this case study, the patient requested inpatient hospitalization, expressing fear that he was not stable and believed he

needed help. Since a bed was available for him, it seemed apparent that an admission was in order.

Fairness

Emergency physicians should act fairly toward all persons who rely on the ED for unscheduled episodic care. They should respect and seek to understand people from many cultures and from diverse socioeconomic groups. No patient should ever be abused, demeaned, or given substandard care. (Approved by the ACEP Board of Directors June 1997. Reaffirmed October 2001 by ACEP Board of Directors)

The question arose for this practitioner as to whether discharging the patient who voluntarily came to the ED was substandard care.

Nonmaleficence

Nonmaleficence, or not harming patients, is a key to maintaining the emergency physician's integrity and the patient's trust. Emergency physicians must never endanger patient safety or subject their patients to excessive harms or risks. (Approved by the ACEP Board of Directors June 1997. Reaffirmed October 2001 by ACEP Board of Directors)

For this patient, who was already unstable and frightened by his own internal preoccupation and paranoid feelings, it would seem that discharging him to a homeless shelter could cause harm, thus increasing his paranoia and anxiety.

Relationships with other physicians

Emergency physicians, keeping patient benefit as a primary goal, must participate with other physicians in the provision of health care. Channels of communication between health care providers must remain open to optimize patient outcomes. However, communication may be interrupted when a sick patient requires immediate and definitive intervention before discussion with other physicians can take place. When possible, emergency physicians should cooperate with the primary physician to provide continuity of care that satisfies the needs of the patient, and minimizes burdens to other providers. Although the patient's primary physician has a moral, legal, and often financial interest in coordination of care, patient benefit must remain paramount. Concerns regarding the extent of primary care rendered and referral required should be discussed with the primary physician whenever possible.

Physicians who provide on-call services to ED patients usually are fulfilling an obligation of medical staff membership; they may also be financially supported for these services. On-call physicians, like the emergency physicians, are morally obligated to provide appropriate medical care. In turn, the emergency physician should strive to treat consultants fairly, and to make efficient care possible. Consultant choice may be guided by the preferences of both the primary care physician and the patient or by a rotation system of some sort. The hospital and its medical staff are obligated morally and legally to provide appropriate and timely "back-up" care for patients who present to the ED requiring such care. If a designated consultant refuses to evaluate a patient in the ED, the emergency physician may have to call another consultant, discuss the situation with the hospital administrator, or transfer the patient to another facility that has the resources available to care for the patient.

The ED Code specifically speaks to the principles for direct patient care. Several principles specifically apply to this case.

1. Professional responsibility to embrace patient welfare: Mr. P. was not psychiatrically stable enough to be discharged to a homeless shelter the evening he was admitted to the ED. His unstable mental status warrants an inpatient admission, yet because of the disagreement in disposition plan will remain in the ED overnight and not be admitted to an inpatient floor.

2. Respect the rights and strive to protect the best interests of their patients, particularly the most vulnerable and those unable to make treatment choices due to diminished decision-making capacity: Patients who suffer from mental illness, like Mr. P. are considered a vulnerable population. Although the patient is unable to provide an accurate psychiatric history, he is forthcoming in describing his fear and paranoia after he had been discharged from the hospital this morning. The ethical issue raised here was whether it was the best treatment choice hold Mr. P. in the ED and not to admit him to an inpatient unit.

3. Work cooperatively with others who care for, and about, emergency patients: The on-call psychiatrist, who was not on-site at the time of Mr. P.'s arrival to the ED, decided the patient's disposition, without knowing the patient, without seeing the patient, and disregarded my treatment recommendation for this patient. There was a lack of cooperation on his part to see what the best disposition plan for this patient might be.

It raises the question, when an attending NP and an on-call Physician disagree on disposition, how we can work cooperatively to resolve the difference. It would seem that inviting the

opinion of the Unit Chief for the inpatient unit or the Director of Behavioral Services may be helpful in providing the final say.

4. Support societal efforts to improve public health and safety, reduce the effects of injury and illness, and secure access to emergency and other basic health care for all: It could be argued that by holding a psychiatric patient in a busy ED throughout the night when a bed is available might jeopardize the patient's already precarious mental health status.

RESOLUTION OF THE CASE

Acting on the patient's behalf, I informed the psychiatrist that I would write holding orders for the patient to remain in the hospital ED overnight, with the intention that he would be reevaluated in the morning by the ED Attending Psychiatrist when he arrived. I informed the on-call psychiatrist that I would not write discharge orders for the patient, due to the instability of the patient's condition to be discharged to a homeless shelter. The covering psychiatrist did not disagree with this plan.

As a patient advocate, I explained that since a bed was available on the general psychiatric unit, the patient would be better served if he was admitted rather than spending the night on a stretcher in the busy medical ED. The psychiatrist again refused to give admitting orders to the RN for this patient.

FUTURE PRACTICE IMPLICATIONS

ED's need to explore further use of day of observation admissions, clinical decision making units, and better conflict resolution between attending providers to improve patient flow, improve patient comfort and decrease overcrowding. This would assist in avoiding future

patient's that are boarding simply because two attending providers have a difference of management opinion. In this scenario the result was that the patient was placed in a holding pattern and remained in the emergency room throughout the night.

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