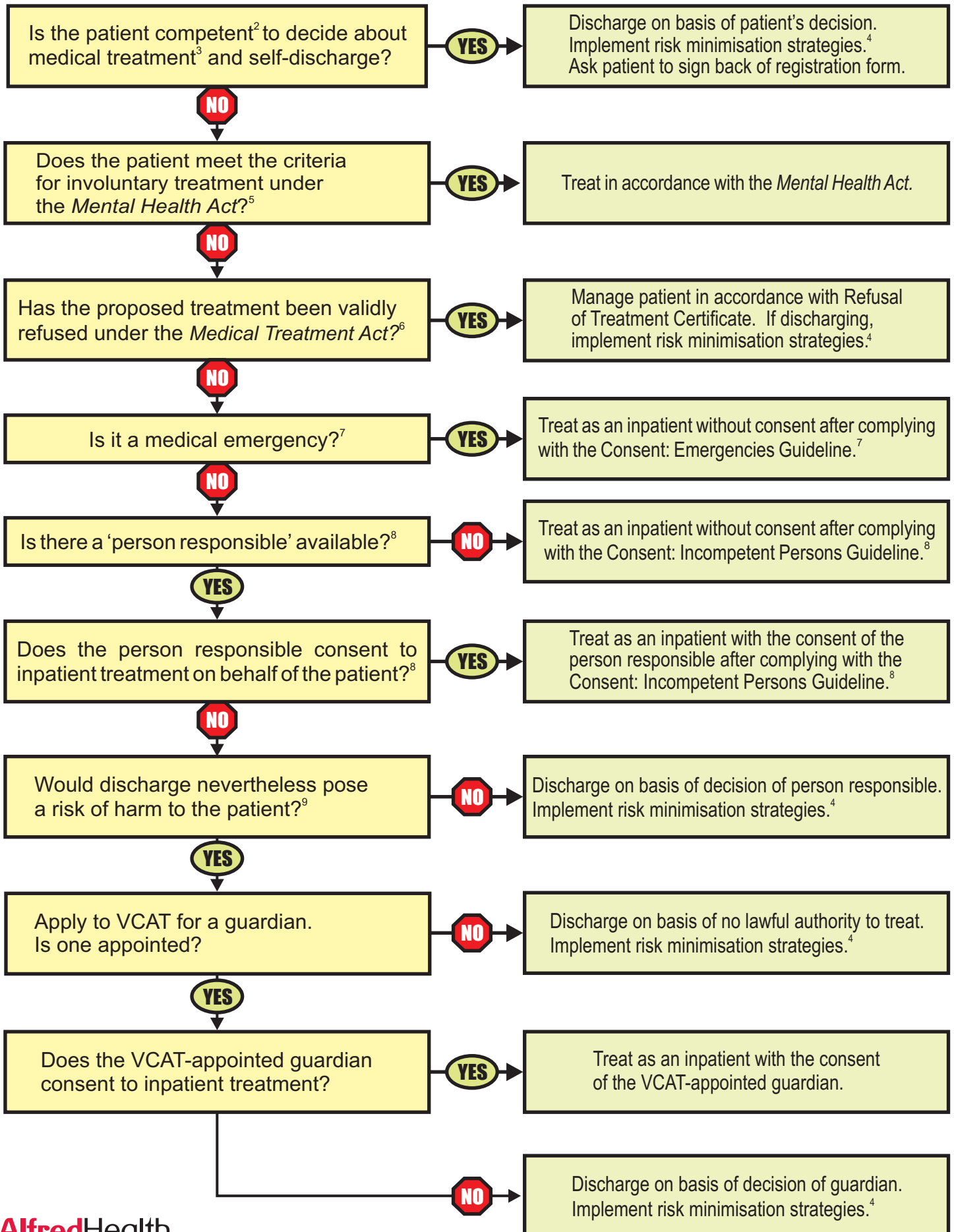


DISCHARGE AGAINST MEDICAL ADVICE FLOWCHART

Competent adult patients have the right to refuse medical treatment and to self-discharge. However if an incompetent adult inpatient wishes to self-discharge against medical advice despite all reasonable attempts at education and persuasion, the patient's doctor faces a legal dilemma¹ and should either treat or discharge the patient in accordance with this flowchart (turn page for explanatory notes).



1. Doctor's legal dilemma

If an incompetent adult patient wants to self-discharge against medical advice, the patient's treating doctor faces a legal dilemma. If the doctor detains or treats the patient without lawful authority, the doctor commits a crime and also risks being sued for false imprisonment and battery. If the doctor discharges the patient and the patient suffers harm as a result, the doctor risks being sued for failure to take reasonable care.

2. Competence

(a) Why should a doctor assess competence?

There are cases of people successfully suing after not having their competence properly assessed. If a competent patient refuses treatment, a doctor must not detain or treat the patient and must allow the person to self-discharge (unless there is some other lawful authority for detaining or treating the person). If an incompetent patient refuses treatment, a doctor must not rely on the refusal and must still consider whether there is some lawful authority for treating the patient.

(b) What is the test for competence to consent to medical treatment?

Every adult is presumed to be competent, including those with a disability or mental illness. However, a patient is not competent to consent to medical treatment if he or she is incapable of:

- understanding the general nature and effect of the proposed procedure or treatment; or
- indicating whether or not he or she consents or does not consent to the carrying out of the proposed procedure or treatment.

(c) What should a doctor consider when assessing competence?

A doctor assessing a patient's competence should:

- start with the common law position that every adult is presumed to be competent, and only consider the patient to be incompetent if the doctor can reasonably justify it based on the test for competence.
- make a decision about whether or not each patient is competent. Before deciding, it may be useful to consult with others (e.g. nursing, allied health or neuropsychology staff), particularly if the doctor suspects that the patient may have cognitive deficits as a result of traumatic injury or other cause.
- assess each patient individually – do not assume that a patient lacks competence just because he or she has a particular condition or because of the way the patient looks, communicates or behaves.
- avoid blanket labelling of a person as incompetent, because a patient may be competent at some times and not competent at other times.
- assess whether the patient is competent to make the particular decision – a patient may be competent to decide about some things (e.g. to agree to a physical examination), but not competent to decide about other things (e.g. whether to refuse life-sustaining treatment).
- assess the patient's decision-making ability, not the decision itself. A patient is not incompetent merely because he or she makes a decision you think is unwise, reckless or wrong. A patient has the right to make a 'bad' decision.
- contact CL psychiatry if the doctor is unsure of the cause of apparent mental disturbance, or if the patient has a history of mental illness.
- be aware that there are various reasons why a patient may be incompetent e.g. due to intellectual disability, head injury, mental illness, dementia, delirium, being in a state of depression, grief, pain, shock, fatigue, panic or fear, or being influenced by medication, alcohol or drugs.
- document the decision regarding competence, together with the reasons, on the patient's medical file.

3. Treatment

A doctor should only treat a patient if the patient consents or the treatment is otherwise lawfully authorised. Similarly, a doctor who considers that a patient should remain in hospital for observation should obtain patient consent or otherwise ensure that there is lawful authority to keep the patient in hospital.

4. Risk minimisation strategies

The following strategies are recommended, if necessary, to minimise the risk of harm after discharge:

- give adequate information to patient/relatives/carers;
- ensure home environment is safe;
- ensure time off work/driving/studying;
- limit access to vehicles/machinery; and
- arrange appropriate follow up care.

5. Involuntary treatment under the *Mental Health Act 1986*

The criteria for involuntary treatment for a mental illness are set out in section 8 of the *Mental Health Act 1986*.

6. Refusal of treatment

Refer to the Refusal and Non-Initiation of Treatment Guideline on the Alfred Health intranet.

7. Emergency treatment

Refer to the Consent: Emergencies Guideline on the Alfred Health intranet.

8. Person responsible

Refer to the Consent: Incompetent Persons Guideline on the Alfred Health intranet for the definition of 'person responsible', what the person responsible can consent to and for situations where there is no person responsible.

9. Risk of harm

Factors increasing risk of harm to the patient or others include the degree of cognitive, emotional or behavioural disturbance, the degree of care required, the presence of drug or alcohol issues, the lack of an appropriate home environment, the lack of appropriate supervision or support available at home, poor insight (or suspected 'lip service') regarding recommendations for return to driving, work, study or parenting and pre-existing aggressive tendencies that may be exacerbated by the injury.