LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. Such consultations require the integration of medical and psychiatric knowledge. During their twice-weekly rounds, Dr Stern and other members of the Psychiatric Consultation Service discuss the diagnosis and management of conditions confronted. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Staying Against Advice: Refusal to Leave the Hospital

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Have you ever wondered what to do when a patient of yours refuses to leave the hospital? Have you ever wondered what drives someone to insist on staying when you believe there is no reason to stay? If you have, then the following questions and answers should serve to highlight the issues involved and serve as a stimulus to enhance your management of patients who attempt to stay in the hospital against your advice.

While nearly all physicians are familiar with patients who request to leave against medical advice, physicians are challenged even more by those who insist on staying against advice. In this article, we present a clinical vignette and formulate a differential diagnosis for patients who attempt to stay against advice, discuss their motives for doing so, and provide a plan for their effective management.

CASE VIGNETTE

Mr A, a 52-year-old man with a psychiatric history notable for major depression, alcohol abuse, and chronic suicidal statements, as well as a medical history replete with atrial fibrillation, hyperthyroidism, and numerous recent emergency department visits for chest pain, arrived at our hospital with recurrent chest pain. Although his cardiovascular workup on prior admissions was unremarkable for ischemia, he was admitted to the medical service.

Once again, acute cardiac problems were ruled out. After being told of his imminent discharge, Mr A reported that he planned to "stick a gun in my mouth and pull the trigger." This prompted a call for psychiatric consultation. He was transferred to the inpatient psychiatry unit of our hospital on the basis of this threat where his safety could be assured, diagnostic clarification could be achieved, medications could be adjusted, and a safe discharge planned.

On arrival to the inpatient unit on a Friday night, Mr A appeared neither depressed nor dysphoric; he joked with staff and socialized with other patients. Nevertheless, he continued to endorse thoughts of suicide with a plan to shoot himself. When asked about access to weapons, he reported, "I'm a small arms expert and know people who have them. I can get a gun easily." Over the weekend, he made little effort to participate in group discussions, was often seen joking with staff and other patients, pretended to be asleep during morning rounds, and became agitated when the topic of discharge was broached. He was caught trying to light a cigarette (our facility is smoke free) using an electrical outlet and wires from a hand-held radio that he had smuggled onto the unit and later dismantled.

On Monday, the treatment team decided that he should be discharged with outpatient follow-up. Early that morning, members of the treatment team met to formulate a plan in anticipation of his resistance to leave the hospital. Mr A was interviewed with security at hand. When the team discussed discharge with Mr A, he became agitated, stood up, and threatened the attending psychiatrist. Security entered the room and escorted him out of the facility at noon.

Three hours later, Mr A returned to our hospital's emergency department complaining of chest pain, noting that he had forgotten to mention it earlier in

CLINICAL POINTS

- Patients who stay against medical advice are challenging and often frustrate general hospital staff.
- While the reasons people refuse to leave are limitless and sometimes difficult to ascertain, determining the motive is an important first step to managing these patients.
- Clinicians should be swift to discharge the patient as soon as he/she is medically cleared. The discharge plan should be coordinated with the nursing staff and hospital security staff, who should be present when the discharge plan is explained to the patient. The clinician should speak in measured tones and avoid negotiating with the patient.

the day. He was again admitted to the medical service. Mr A denied feeling suicidal while in the emergency department or during his stay in the hospital later that night. He claimed that he only became suicidal when he was told that he would be discharged. When Mr A was told again that he was to be discharged, he told the physicians that he was depressed and that he needed help. The team reminded him that he had a referral to an outpatient psychiatry program, but he did not want to leave "given a lack of transportation." Mr A then threatened the doctors, claiming he would involve the American Medical Association; he asked for all of their names to prepare for the complaint. He then ripped out his intravenous line; this caused obvious bleeding, as he was anticoagulated with warfarin. Mr A then demanded narcotics. Security was called, and they again escorted him out of the hospital.

WHY MIGHT A PATIENT STAY AGAINST ADVICE?

The reasons why a patient might want to stay in the hospital against advice are nearly limitless. Some patients desire to stay in the hospital to achieve primary gain (involving a desire to play the sick role in the hospital); others attempt to stay to obtain secondary gain (eg, shelter, meals, attention, financial benefits, or avoidance of legal problems). Such patients are most likely to attempt to stay against advice during periods of personal turmoil (eg, psychosocial stress, homelessness, and a lack of access to pain medications). There also is a seasonal relationship with staying against advice among malingerers, as more individuals seek food and shelter in northern states during the winter months. Others are afraid to leave the hospital (eg, in the hospital they feel safe and outside of the hospital they become overwhelmed and incapable of functioning). Still others disagree with the opinions of the medical team and attempt to stay until a better solution to their problems can be identified and applied.

WHICH DIAGNOSES SHOULD BE CONSIDERED FOR A PATIENT WHO WISHES TO STAY AGAINST ADVICE?

The differential diagnosis for patients who wish to stay against advice involves diagnoses on Axis I through IV.[1] Axis I disorders include major psychiatric illnesses, Axis II involves personality disorders, and Axis III includes physical and general medical conditions, while Axis IV involves psychosocial stressors (eg, homelessness, financial troubles, and social isolation). In addition, malingering should be considered. Table 1 provides a list of selected conditions (categorized according to Axis I-IV) associated with attempts to stay against advice.

HOW ARE PATIENTS WHO WISH TO STAY AGAINST ADVICE ASSESSED?

The assessment of patients who attempt to stay against advice often starts with a determination of their conscious and unconscious motivations. If a patient is seeking to stay against advice in order to obtain clear-cut secondary gain, then malingering should be diagnosed; however, if the patient is instead interested in being a patient, factitious illness is the proper diagnosis.

When the motivation to stay against advice is unconscious, then the differential diagnosis often involves somatoform and anxiety disorders (eg, somatization disorder and conversion disorder).

HOW COMMON IS MALINGERING IN THE GENERAL HOSPITAL?

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (*DSM-IV-TR*)[1] defines malingering as the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives (eg, avoiding military duty or work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs). Malingering is categorized with a "V" code by the *DSM-IV-TR*, which means it is not a mental illness per se, but an associated condition that requires consideration.[1]

Table 1. Selected Disorders Associated With Staying in the Hospital Against Medical Advice[a]

Axis I
Delusional disorder
Psychotic depression
Somatization disorder
Conversion disorder
Pain disorder
Hypochondriasis
Body dysmorphic disorder
Factitious illness
Substance abuse/dependence
Axis II
Conduct disorder
Antisocial personality disorder
Borderline personality disorder
Histrionic personality disorder
Narcissistic personality disorder
Dependent personality disorder
Axis III
Chronic pain
Delirium
Dementia
Axis IV
Homelessness
Financial challenges
Social isolation
Other conditions
Malingering

[a]Based on American Psychiatric Association.[1]

A thorough search of the medical literature reveals that while malingering in the psychiatric population has been well studied, the prevalence of malingering in the general hospital is less well known. Nonetheless, it is reasonable to assume that nearly all physicians who work in general hospitals will be confronted by patients who attempt to malinger (and to derive secondary gain). Anytime there are incentives for the patient to stay and report symptoms that do not match physical findings, a physician should keep malingering in the differential.

The desire for drugs is a powerful siren for the addicted patient. This will often be obvious to clinicians, as such patients will ask for more pain medication than will other patients or will attempt to garner stronger than indicated opioids from the physician. Regardless of age, patients who complain of "10 out of 10 pain" from a variety of sources (despite adequate function) often attempt to convince physicians of their need for ongoing and more intensive treatment. Commonly feigned medical conditions that are often difficult to prove include mild head trauma and toxic exposures.[2]

HOW CAN YOU TELL IF SOMEONE IS MALINGERING?

When the patient who attempts to stay against advice feigns thoughts of, or plans for, suicide, it is difficult to create an action plan. Malingering should be suspected when a patient presents (1) in a medical-legal context (eg, when referred to a physician by an attorney for examination), (2) with discrepancies between the person's claimed stress or disability level and objective findings, (3) with refusals to cooperate, and (4) with an antisocial personality disorder.[1]

Perhaps the most obvious red flags are a history of multiple hospitalizations that are clustered together and refusals to allow the medical team to obtain collateral information. Physicians can run criminal offender record information checks on any patient that they suspect of malingering. This can usually be managed by hospital security; such an inquiry often provides information within 24 hours on the patient's legal history. Another option is to ask the patient to speak with his/her outpatient primary care provider, which nearly always provides important collateral regarding the patient's background.

Patients who are malingering often feign psychotic symptoms including auditory hallucinations.[3] A clinician should ask questions to discern whether a patient is truly psychotic, including (1) Tell me exactly what the voices say? (2) Are the voices continuous or do they come and go? (3) Do you always feel compelled to carry out the instructions of the voices? and (4) Are the voices heard in 1 or both ears? These questions are designed to make the patient provide more specific details about the nature of the hallucinations and might expose a malingerer.[3] Any patient who claims that he or she always obeys command hallucinations likely is feigning illness. Real hallucinations are rarely continuous. Patients with true auditory hallucinations hear the voices in both ears.[3]

WHY DO PATIENTS WITH FACTITIOUS ILLNESS STRIVE TO BE PATIENTS?

With factitious illness, the patient is aware of his/her behavior, but the secondary gain that is garnered from the behavior (as in malingering) is absent. The external benefits to the patient and the physician are far from obvious. Usually, the patient is trying to attract attention by occupying the sick role. Motives for this behavior include trying to satisfy a childhood relationship with a caretaker; frequently, such patients have had an illness as a child during which they received sympathy or avoided responsibilities. Unlike those who malinger, patients with factitious disorder shun evaluations by a psychiatrist and are more likely to sign out against medical advice than to stay against advice.

WHY DO SOME PATIENTS CONTINUE TO BELIEVE THAT THEY HAVE A PROBLEM THAT WARRANTS ONGOING HOSPITAL CARE AND TREATMENT?

Some patients with somatoform disorders (eg, those with somatization disorder) have a bevy of physical complaints that began before the age of 30 years that

have led to repeated diagnostic testing and treatment trials, as well as to impaired function. They experience multiple symptoms that are seemingly unrelated: 4 pain symptoms, 2 gastrointestinal symptoms, and 1 sexual and 1 pseudoneurologic symptom. Others with conversion disorder predominantly manifest neurologic symptoms. Typically, they develop a loss of motor or sensory function under stress. Their symptoms are not intentionally produced.

Cognitive-behavioral therapy and antidepressants may be effective in the long run,[4] but in the acute hospital setting, the physician should instead attempt to establish a therapeutic alliance with the patient. It is important to acknowledge his/her suffering, despite normal diagnostic testing. Symptom management should be the focus of care, rather than additional testing or prescribing medications.

WHAT ELSE CAN BE RESPONSIBLE FOR STAYING AGAINST ADVICE?

A patient's impaired understanding of his/her condition and the explanations and plans of the providers, as well as dysregulated emotions, may also lead to a desire to stay against advice. For example, an elderly inpatient may have depression with psychotic features[5] involving a somatic delusion. Such a patient may not be satisfied by the existing medical evidence and will insist on being worked up repeatedly for the same complaint. Unfortunately, this condition often goes unrecognized. One recent study suggested that psychotic depression was misdiagnosed in more than a quarter of cases.[6] Electroconvulsive therapy is an important therapeutic tool for this condition. Some elderly patients are also the targets of abuse or neglect (unbeknownst to their providers); this can also lead to a desire to remain in the hospital.

Others have personality disorders (eg, borderline, narcissistic, or dependent) and pose a management challenge for staff. By definition, these individuals display longstanding, fixed patterns of maladaptive behavior that are usually manifest by impaired relationships and function.

For those with a borderline personality, their basic issue is a lack of trust in others. In light of this, they often fear abandonment and yearn to be cared for. They become enraged when that nurturance is absent. In the general hospital, such patients often become quite distressed when the subject of hospital discharge is broached. Narcissists often feel entitled to stay in the hospital.

The care of personality-disordered patients can be complicated; they are often considered hateful by staff. Groves[7] coined the term *hateful patient* in 1978 and categorized the hateful patients into 4 categories (1) dependent clingers (eg, borderline or dependent personality disorders), (2) entitled demanders (eg, narcissists), (3) manipulative help-rejecters, and (4) self-destructive deniers. Manipulative help-rejecters continue to seek medical workups despite normal findings and repeated reassurances by physicians. They believe that nothing will cure them, but they nonetheless continue to seek medical attention.[7]

WHAT EMOTIONS ARE EVOKED BY A PERSON WHO ATTEMPTS TO STAY AGAINST ADVICE?

Patients who attempt to stay against advice generate turmoil throughout the hospital; as a result, physicians should be mindful of their own emotions when confronted by these patients. Their general disappointment in the idealized doctor-patient relationship can lead to frustration, fear, rage, and malice toward patients. The negative emotions evoked usually are followed by guilt and shame, as providers know they have been taught to treat all patients with compassion and empathy. But health care providers cannot escape from being human; these emotions and thoughts are normal reactions and should be acknowledged and processed. Patients who desire to stay against advice are often difficult to empathize with. By being more aware of the negative feelings that these patients create, physicians can adjust their responses toward them; this can lead to more positive outcomes. An important management strategy is to have team meetings to avoid intense conflicts among the staff. This is especially true in the general medical setting wherein there are many participants in the patient's care.

WHAT STRATEGIES EXIST FOR PHYSICIANS?

When a patient decides to stay against advice, the physician should (1) determine what the patient's gain is, (2) attempt to help the patient gain greater insight into his/her behaviors and motivations, and (3) provide alternatives to the hospital that may satisfy the patient's needs. Determining the patient's gain is complicated. If the patient is consciously seeking secondary gain, the patient may not want to reveal his/her true intentions to the team. On the other hand, if the patient's drive is unconscious, then the patient will often have little insight into his/her behavior. The physician who identifies a desire to stay against advice should spend more time with the patient in an attempt to gather more information and to search for inconsistencies in the patient's story or symptoms. If the physician can determine the gain, then he/she will have valuable information that can be used to improve management. Physicians should attempt to discuss the gain with the patient in a nonjudgmental manner with the focus placed on alternative ways to meet his/her needs.

HOW CAN A SMOOTH DISCHARGE BE FACILITATED?

Regardless of the cause, a patient who insists on staying against advice typically causes distress within the medical team. The natural inclination is for the staff to extrude the patient and remove him/her from their service as soon as possible. Often, these experienced patients are difficult to discharge. It may be best to discharge the patient early in the morning. The longer these patients stay in the hospital, the more likely they will become entrenched and thereby obtain the secondary gain that they are seeking. Formulating a plan for discharge of the malingering patient (with staff, nurses, and security) is comprised of 3 phases: planning, the encounter, and follow-up. In the planning stage, physicians should meet with staff members (from different disciplines) to formulate a safe discharge plan. The most important component is effective communication among team members. The legal department and risk management team of the general hospital can be a valuable resource and should be contacted before meeting with the patient.

Organization is critical so that the patient leaves the premises with his/her belongings. It is paramount to discuss safety for staff and the patient. The patient should not be told until the encounter phase (ie, the last possible moment) about the plan. All of the patient's possessions should be gathered and a point person designated to carry the possessions off the floor with the patient. It is not unusual for patients to pretend that they left something in their room. Staff could also consider premedicating (with a benzodiazepine) the patient who is likely to become anxious and agitated. Before the conversation, hospital security should be called and be in attendance. Often, just having the patient aware of security's presence facilitates a smooth encounter.

The encounter phase is typically challenging, as the physician knows that he/she will have a difficult conversation, replete with anxiety, disappointment, and frustration. The doctor should attempt to speak in measured tones; negotiations with the patient should be kept to a minimum. At the outset, the physician should acknowledge, using an empathic tone, what the patient is doing. For example, a physician could say, "We know that this is how you react when you encounter stress; however, we can neither condone nor permit you to stay in the hospital, as it is not medically indicated." If the patient becomes agitated and threatens staff when discharge is discussed, then it is time to shift to a firmer and more forceful approach. This is also the appropriate time for security to intervene. Then, the patient should listen to what is about to occur and learn how he/she will be discharged.

The discharge process does not end when the patient leaves the hospital. In the follow-up phase, the encounter should be documented. If the patient feigns being suicidal, this should be documented. The physician should call the emergency department and inform staff that the patient was discharged and that it is possible that he/she could return imminently. During this time, the primary care physician can play a valuable role by providing collateral and further evidence, which can guide future care. Primary care coordination can help put a stop to the "revolving door" phenomenon. A plan should be crafted with the emergency department so that the patient is not readmitted to the medical service.

After discharge, a short debriefing meeting should take place to discuss the strengths and weaknesses of the discharge process to guide future encounters. This likely will remain a complex issue, as by law emergency departments cannot turn patients away, especially those who are complaining of chest pain, even if it is for the 100th time. However, hospitals can be better prepared for return visits by certain patients and triage them appropriately, possibly directly to psychiatry, avoiding admission to the medicine floors, and attempting to set firm limits when they are in the emergency department. Other solutions also include referring some frequent patients to mental health programs or primary care doctors for future outpatient follow-up care.

CONCLUSION

Physicians in the general hospital have almost always encountered patients who attempt to stay against advice. These patients bring with them a unique challenge, stir emotions of providers, and can cause chaos in the hospital. While these patients are difficult to manage, certain strategies can de-escalate a highly charged atmosphere.

EPILOGUE: FOLLOW-UP OF MR A

As presented in our case vignette, Mr A sought shelter, companionship, and pain medications through the hospital. As we gathered more collateral information, the treatment team learned that Mr A was homeless and intermittently living with friends and relatives. In the hospital, he was getting 3 meals a day, significant amounts of attention from staff and other patients, and pain medications. We employed many of the strategies discussed in this article when discharging the patient. The staff was organized and collaborated to discharge Mr A early in the morning. His personal belongings were gathered and placed in a spot near the exit from the floor. We called security before entering Mr A's room, and when he became upset at discharge, they were able to intervene quickly and de-escalate the situation. Mr A left the hospital without requiring physical restraints or engaging in a violent encounter. Mr A will likely visit our institution and other general hospitals in the future, as will others who wish to stay against advice.

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