Outpatient ‘No Shows’: Must I follow up?

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Introduction:

Every now and then a sensational story hits the news about some person with mental illness who has done something terrible and violent. This is understandably followed by attempts to sort out “what went wrong”, with much attendant finger pointing aimed at “the mental health system” and doctors, and a subsequent scramble through the morass of inquests and legislation.

As psychiatrists, we feel the public response is sometimes distorted by false assumptions about preventability. Maybe nothing “went wrong” clinically or systemically. Maybe some poor soul’s brain disease just got worse. Or maybe a competent adult simply decided to do something bad that produced horrible consequences. The armchair quarterbacks blessed with hindsight may miss the fact that most of the time skilled psychiatrists are very good at identifying and managing illness related risk and crises, and will intervene if possible.

A Case in Point:

Medical Post headline: “Lost to follow-up: If a psychiatric patient is a no show, what’s your duty?”

The article tells the story of a 46 year old woman with schizophrenia who became ill and missed her appointments with her psychiatrist. “He never called to find out how she was doing”, it says. The patient felt he “should have followed up on her”, but acknowledges that “she doesn’t think it would have made a difference to her outcome”.

The news report then goes on to discuss a high profile and tragic case of a man who was found NCR (‘not criminally responsible due to mental illness’) for the killing of his wife and children. He had been seeing his family doctor monthly for monitoring but missed appointments before the murders and his family doctor did not try to track him down when he didn’t show up.

The key questions posed by the article are, “Is it a physician’s responsibility to follow-up on all mentally ill patients who don’t show up for appointments? And should the doctor be held liable if something bad happens as a result?”

Responsible Physicians vs Physicians held Responsible:

The no-show rates for outpatient psychiatry services are reported across a wide range of anywhere from 12 to 60% (Eytan A et al.). Given that persons living with psychiatric illness commonly do not attend all outpatient appointments, is it a doctor’s duty to always follow-up? As we discuss below, it seems apparent to us that “always” is neither practical, nor clinically, nor ethically, necessary.

No one disputes we have to take care of people whose judgment is so impaired they can’t take care of themselves. Most people who are clearly in this domain are already followed by specialty services (e.g. ACT Teams) or subject to restrictions (e.g. forensic/judicial order) that ensure follow-up regardless of patient cooperation or insight.

But what about the huge majority of patients who are capable of consenting to (or refusing) treatment and who are followed in typical non-restrictive outpatient settings (hospital clinic, private office)?

We state the obvious when we say that these patients can experience complex illness trajectories that are sometimes punctuated by rapid and unpredictable deterioration that calls forth a duty of protective action. “Unpredictable” being the key word here. Statistically, however, only 5-10% of violence in a community can be attributed to those with mental illness (Walsh et al.; Fazel & Grann). And while figures vary, and definitions of what constitutes violence (vs aggression) vary, we interpret the literature as conservatively supporting a position that over 70% of persons living with mental illness will likely never be violent (Appelbaum et al.). In fact, community mental health agencies often highlight in their public education campaigns that persons living with mental illness are far more likely to be victims of violence than to be responsible for violence.

So with the odds in favour of the majority of outpatients never hurting anyone, we can reasonably defend a position of selective triage. That is to say, we need to sort out who is most likely to harm others. We know that acute psychotic symptoms, substance abuse, personality disorder, or a history of violence increases the likelihood of violence and we must of necessity be vigilant in...
response (Walsh et al.). However, we must not mistake or presume a conceptual understanding or relational/associative (rather than causal) model to entail unfailing predictive utility from the general to the particular. The public myth of behavioral predictability is simply not how brain disease plays out in the real or clinical worlds.

Please note, we are not saying that most people are ignorant of how volatile and unpredictable some persons living with mental illness can be. We are saying that psychiatrists seem to get blamed in hindsight by victims, patients’ families, other caregivers, and in the court of public opinion, for not predicting what is inherently unpredictable.

We know past violence is a good predictor of future violence, but of course at some point in time a first violent act is just that, a first (and thus unpredictable). Under this cloud of uncertainty, we come full circle back to the challenge of pragmatic and fiducial action in a clinical slice where the burden of follow-up should perhaps most often rest with the capable patient and not the physicians at all.

Responsible Patients:

Why is it not always (or even most of the time) a competent patient’s responsibility to rebook a missed appointment? Furthermore, why do we seem to avoid talking about the responsibility of the competent patient, or their autonomy, in deciding to harm self or others? The very existence of mental illness in the background often seems to grant individuals a pass on personal responsibility even when the illness is neither active nor of a type or kind that would affect personal responsibility. (We have seen individuals not charged for crimes because the police were not worth pursuing when the person is “crazy” even when, even when, from a clinician’s perspective, mental illness is irrelevant in the particular circumstances.)

Some Reasons for Why Patients do not Show up:

Resistance

There can be many reasons why patients do not show up including that they have to wait a long time, they don’t care, they were pressured by others to make the appointment, they disagree with the referral, they feel better, they don’t believe it will help, or they feel ashamed seeking help.

Forgotten

In one study, “the most common stated reason for missing an appointment was patient error, such as forgetting, oversleeping, or getting the date wrong.” (Sparr L, Moffitt M).

Transportation Barriers

Transportation costs and difficulties can also be a significant problem. (Carrion, PG)

Clear Needs

Some authors identified that “those with the most clearly defined problem. (Carrion, PG)

Demographics

“Patients who were younger, had a history of missed appointments, were scheduled to see a resident physician, had a routine appointment and lived a distance from the hospital, were at greater risk of missing their appointment.” (Campbell B, Staley D, Matas M)

“The no-shows were more likely to have had frequent changes of occupation or belong to families where this was the case with the head of the household, a history of court conviction, and a history of previous psychiatric treatment. They were less likely than controls to have improved since referral to the clinic and less likely to have received a diagnosis of depressive psychosis, depressed type. . . There appears to be some self-selection, the most treatable patients keeping their appointments” (Whitney R)

Timing

People are more likely to miss appointments scheduled on Mondays (Flynn, A., Ges, Fauhy, M., Ferters, F., Bertyc, G.) and are more likely to attend appointments on Fridays and in winter months. (Mitchell AJ; Selmes T)

Service Populations

Attendance is better “in geriatric psychiatry and highest for patients with the most defined problem.” (Mitchell AJ; Selmes T)

Substance Use

Not surprising “a high nonattendance rate was found among persons with drug and alcohol difficulties.” (Mitchell AJ; Selmes T)

Referral Source

One study reported that no shows are “significantly more likely to be single, diagnosed personality disorder or substance abuse, and referred from the Emergency Department…” Further analysis of emergency referrals, the single most significant predictor, indicated that patients from this referral source were more likely to be male, unmarried, unemployed or on welfare, and diagnosed personality disorder or substance abuse than referrals from general practice and internal sources.” (Mata MStaley D, Griffin W)

Diagnostic Categories

When considering diagnostic categories, among those “with diagnosis of schizophrenia, schizoaffective disorder, and delusional disorder . . . patients who missed 20% or more of their appointments were significantly younger, were more likely to abuse drugs and alcohol, and manifest lower levels of community functioning” (Coosind S, Staley D, Cortens R, Desrochers R, McAnders S)

“Patients with PTSD and/or substance abuse were significantly more likely than others to miss appointments, and those with major depression were somewhat less likely to do so.” (Sparr L, Moffitt M)

Do Patients Rebook Missed Appointments?

Most often “(Sparr L, Moffitt M). If someone values the appointment, it seems reasonable to assume that the likelihood of comonitant motivation to reschedule.

Standards for Follow-up:

The articles referenced above highlight the diversity of reasons for missing appointments. They also illustrate the complex challenge of developing universal follow up practices or policies for ‘no shows’.

In one survey, with 356 physicians responding, “psychiatrists tended to be initially less active in pursuing patients than were nonphysician therapists and internists. A number of clinical variables were associated with clinicians’ responses including the perception of a bad outcome, hospital site, support staff availability, and billing practices…” The results suggest that clinicians’ responses to missed appointments are determined by a mix of situational factors, rather than adherence to a readily definable “standard of care.” (Smoller J, McLean R)

While caregivers have disparate views, professional bodies appear silent on what amounts to a matter of ‘point in time’, situation specific, clinical judgment. What is clearer and easier to do is finger pointing after a catastrophic event. Forensic or retrospective adverse event analyses may highlight or mandate practice changes, but we are unaware of any that necessitate universal follow up ‘no shows’.

In Outpatient Psychiatry, What Counts as Adequate ‘Follow-up’?

Answer: A phone call to the patient that is answered.

Our comment: This is not necessarily adequate. Suicidal or homicidal patients asking the patient to call back and let the doctor know he/she is alright? (Unfortunately, this is as likely to be ignored as the initial appointment was.)

How about a phone call to a family member (if you have permission)? This might worry family members unnecessarily and anger the patient.

If the patient has a community case worker, then how about a phone call to the caseworker (e.g., ACT, Community Mental Health Association?) Is this simply offloading responsibility to someone else? How do you provide risk information if the person was fine the last time seen?

Perhaps a phone call to the police asking them just to check in on a particular patient? Realistically, police usually do not act without specific and imminent risk data, or without a commissural document in hand. Given the volume of ‘no shows’, this is also a highly impractical use of a precious resource.

In fact, all of the above may happen, but there are many other elements of the patient, psychiatrist relationship that may colour the selection and persistence of follow up attempt(s).
The Relationship is Critical:

1. I do a risk assessment with every patient I see, every time I see him or her, and I gear my responses to a subsequent ‘no shows’ accordingly. Unless I have new information between visits (e.g., a call from a family member, a note left in my mailbox at work, a phone/page message), then my assumption about a patient’s present status on the ‘no show’ day is based on the last contact (which might be over a month ago) and the richer context of their safety and known clinical history. Clinical judgment is imperfect but it is what we must rely upon.

2. The better and longer I know someone, then true, the better able I am to make a judgment call about necessary vs optional follow-up (but still false, the notion that relationship knowledge is always adequately predictive). My knowledge of previous suicide attempts or suicidal thinking, a prior history of violence, my awareness of patterns of medication non-compliance, knowledge about a particular individual’s rate of decompensation, my awareness of high risk periods (e.g., post inpatient discharge, anniversary of loss, etc.) or a history of high risk behaviours – all are important data when known or reasonably knowable.

3. Chronically suicidal patients (e.g., with Borderline Personality Disorder illness) who are testing their therapists out of fear of abandonment for example, are a special challenge because of the need of maintaining clear therapeutic boundaries. It is very hard for non-clinicians who are unfamiliar with ‘affect dysregulation’ (the person’s mood system not working properly) and leading to extreme and nonsensical emotional reactions) to understand or accept that calling a ‘no show’ patient in this diagnostic category may at times be more distressing and threatening and that simply holding to the previously stated expectation that they will attend their (next) scheduled appointment and follow a prearranged safety/crisis plan.

It is common to develop a specific safety plan in high risk patients that can kick in independently of the psychiatrist (e.g., the patient calls a crisis counseling service or a family caseworker). It is very hard for non-clinicians who are unfamiliar with ‘affect dysregulation’ (the person’s mood system not working properly) and leading to extreme and nonsensical emotional reactions) to understand or accept that calling a ‘no show’ patient in this diagnostic category may at times be more distressing and threatening and that simply holding to the previously stated expectation that they will attend their (next) scheduled appointment and follow a prearranged safety/crisis plan.

4. Some outpatient treatment services have a written service agreement up front that stipulates not that you will be called if you don’t show up for an appointment, but rather that you may be billed for a missed appointment, or that you will be discharged after missing a certain number of appointments (e.g., three in a row). Inherent in this approach is a presumption of capacity and the fostering of a sense of personal responsibility.

Shared Responsibility: The Practical Role of Community Supports

If someone suddenly becomes mentally ill enough to attend an appointment, then there is a necessary reliance on family, friends, or community caseworkers to intervene through the means available to them (e.g., asking a Justice of the Peace for a Certificate of Compellability). The greatest ongoing burden of oversight actually falls to the patient’s natural envelope of support.

What about other Mental Health Care Providers?

The above discussion is from an outpatient psychiatrist’s perspective. The “system” however, is more complex and nuanced. Different types of caregivers in different types of settings have different duties of responsibility.

We believe that the following have no general obligation to follow-up on ‘no show’ psychotic patients (i.e., low-medium risk) without specific new knowledge of imminent heightened risk or vulnerability since the patient was last seen:

a) Family doctors and Nurse Practitioners.

b) Family Health Teams (even with a mental health counsellor as a team member).

c) Private practice psychiatrists.

d) Hospital outpatient psychiatrists working without a shared care team.

We believe the following have a lower response threshold for following up with medium and high risk ‘no show’ patients precisely because their service models are designed to entail such added responsibility of monitoring. Indeed, it is commonly because patients who are in a sustained heightened state of vulnerability since the patient was last seen:

a) Outpatient psychiatrists with a team that includes community caseworkers.

b) Community mental health services with community health workers.

c) Assertive Community Treatment Teams.

d) Hospital or agency based community crisis intervention teams.

Of note, Community Treatment Orders (partial outpatient committal orders) have seemingly demonstrated that when patients are fully engaged, feel cared for, do better and perhaps comply, going down following a ‘no show’ may bear intangible fruit in the long run. However, the CTO represents an advance directive or legislative mandate, and therefore means that the patient’s psychiatrist has already been identified as high risk.

Conclusion:

We don’t hold mechanics responsible for a brake failure when they haven’t inspected the car recently. Taking the analogy further, brakes can even fail immediately following a competent inspection, because in the real world sometimes things just do break down suddenly. Yet in some cases it is overwhelmingly with an entry as variable and complex as a person living with psychiatric illness, family members and patients sometimes believe that doctors should have seen it coming in their infallible crystal ball. But this is just not realistic.

At the end of each day, we psychiatrists must live with the burden of uncertainty that pervades even the best and most experienced clinical judgment. The emotional and moral fallout when things go terribly wrong usually does not mean a clinical mistake was made (i.e., the illness is complicated, unpredictable, unpredictable that sometimes patients hide their real intentions from everyone).

There are many reasons that a patient may not show up to an appointment and most of these reasons are life and circumstance related and they are not related to the patient being in a state of increased risk of harm to self or others.

All caregivers have an obligation to follow-up on high risk patients who are missed and perhaps should, means someone should be held liable for what cannot be known in advance, or for what could not have reasonably been anticipated in the particular patient at that point in time. The public seems to undervalue a clinician’s craft knowledge before a catastrophe occurs and then overvalue it in hindsight.

Endnotes:

1. Medical Post, Nov. 18, 2008; The Rogers Newspaper for Canada’s Doctors.

References:


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1. Medical Post, Nov. 18, 2008; The Rogers Newspaper for Canada’s Doctors.

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