

Discharge Against Medical Advice: Approaching a Frustratingly Common Situation

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Patients are often discharged against medical advice (AMA) when they intend on leaving despite the need for continuing hospitalization. These situations are often clinically and ethically challenging for hospital-based physicians, who seek to maintain patient autonomy while providing optimal care. This case report highlights the ethical considerations when dealing with a patient who desires to leave AMA, and outlines a pragmatic approach to reconcile these opposing ethical imperatives.

INTRODUCTION

Medical treatment of non-adherent patients is a frustratingly common situation for many hospital-based physicians. This is particularly true when the patient desires to leave the hospital despite inadequate or incomplete treatment. Such circumstances raise clinical and ethical dilemmas that pit the desire to maintain patient autonomy against the desire to provide proper treatment.¹ To reconcile these diametrically opposed ethical imperatives, many hospitals provide the option for patients to leave 'against medical advice.' But even in these circumstances, the physician must carefully consider the risks and benefits of premature discharge. This case seeks to highlight the thought processes underlying this common clinical dilemma.

CASE PRESENTATION

A 52-year-old male with acquired immune deficiency syndrome (AIDS) presented with two days of severe abdominal pain and multiple episodes of bright red blood per rectum. He was first diagnosed with HIV over 10 years ago and has been noncompliant with his

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antiretroviral regimen. His last CD4 count, taken eighteen months prior to presentation, was 68. He denies alcohol use, tobacco use, and intravenous drug abuse. On presentation, the patient was tachycardic (T: 99.1, BP (standing): 103/81, BP (supine): 118/87, PR: 119, RR: 18, SatO₂: 98% on RA). Physical examination revealed dry mucous membranes, pallid conjunctivae, a soft belly with moderate tenderness in the left lower quadrant, active bowel sounds in all four quadrants, and blood in the vault of the rectum. Complete blood count showed anemia (Hemoglobin: 9.8) without leukocytosis or thrombocytopenia. Serum chemistries, INR and PTT were within normal limits. CT Scan of the abdomen/pelvis showed nonspecific diffuse colonic wall thickening. The patient was volume resuscitated and pantoprazole drip was started. The patient was made NPO in preparation for upper and lower endoscopy within 12 hours.

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Within three hours of admission, the patient demanded to leave. He stated that he was hungry and no longer wanted to be in the hospital. The physician was called to the bedside. The patient was found to be alert, oriented to person, place, and time, and attentive enough to spell the word 'world' backwards. After some deliberation, the physician gave instructions that he could be given a clear liquid diet, yet the patient insisted on leaving. When the patient was asked what would happen if he left the hospital, the patient said, "I don't care what happens. It's not going to bleed again and I want to go home!" Even after explaining the high risk of leaving the hospital without evaluation, the patient insisted on leaving 'against medical advice.' Given the imminently life-threatening situation, the patient's impaired decision-making capacities, and the inability to find any relative or friend to act as a surrogate, the patient was involuntarily hospitalized overnight. He was offered some of his favorite foods, and reluctantly agreed to stay overnight. The following morning, colonoscopy showed multiple nonbleeding diverticuli. He was promptly discharged with bleeding due to diverticulosis, and was instructed to follow up with the gastroenterology clinic.

DISCUSSION

In the vast majority of cases, patients are discharged in a timely manner, with agreement between physicians and patients over when it is best to transition to outpatient management. However, in approximately 2% of cases, there is significant discord, leading to a discharge 'against medical advice' (AMA). Over the past decade, there has been a significant increase in the number of discharges against medical advice, with the Agency for Healthcare Research and Quality (AHRQ) estimating a 39% rise.²

AMA discharges are particularly commonplace in urban hospitals and in community hospitals, where rates can approach as high as 6%. Patients with HIV/AIDS are more likely to leave against medical advice, and rates have been reported as high as 13%.² Other risk factors for leaving against medical advice include male sex, lack of health insurance, lack

of a primary care physician, admission through the emergency department, and history of prior AMA discharge. Concomitant substance abuse and alcohol abuse problems are also strongly associated risk factors, leading to an 11-fold increase in likelihood for leaving against medical advice.²

These discharges bear an inordinate toll in health care costs and mortality. Studies have consistently shown that patients are 25% more likely to be readmitted within 15 days and have a 30-day, all-cause mortality rate twice as high as those whose discharges were planned.^{3,4} Cumulative hospital stays are on average longer, and the disruptions in patient management between the inpatient and outpatient settings increase the possibility of medical errors.

For these reasons, the physician should avoid taking a cavalier approach to discharging a patient against medical advice, and instead should see if there is a mutual solution that can avoid premature discharge. Towards that end, it is critical for the physician to talk to the patient directly and negotiate to make the patient's hospital stay a more tolerable option. Determining the cause of the patient's dissatisfaction is a suitable starting point. Indeed, when pressed, patients cite a variety of reasons for wanting to leave, including personal or financial obligations, family emergencies, feeling well enough to leave, or dissatisfaction with their treatment.⁵ Engaging nurses, support staff, family members and friends may help to alleviate these concerns and help in the formulation of an agreeable solution.

Unfortunately, in many cases the patient may continue to insist on leaving against medical advice. Numerous legal cases have established that leaving AMA does not absolve a physician of his medical responsibilities. Most notably, in the New York Supreme Court case of *Dedely v Kings Highway Hospital Center*, it was determined that the forms transferring 'all responsibilities and risks' to the patient are contrary to public policy and are thus legally inadmissible.^{5,6} Therefore, in the evaluation of a patient who desires to leave AMA, the physician should not assess whether a patient can sign a document but

rather whether a patient can reasonably make an informed decision.⁷⁻⁹ In most cases, a bedside evaluation is sufficient to determine decision-making capacity, though a psychiatry consult may be needed in more complicated cases involving mental illness.

Determination of decision-making capacity is considered a difficult task for many, but taking a systematic approach may reduce the complexity and ambiguity of the process. Some of the questions that ought to be asked include: (1) Does the patient understand and appreciate the admission diagnosis, its prognosis, and the likelihood of risks and benefits of leaving the hospital? (2) Is the patient aware of the alternatives to treatment in the hospital and the risks and benefits associated with them? (3) Can the patient make and communicate a choice? (4) Can the patient articulate a reason for the refusal that is consistent with his or her values?^{1,10,11}

Throughout this entire process, the physician must be attuned to the patient's level of health literacy. The physician should explain in simple terms the reasons why continued hospitalization is necessary, and should ensure the patient has a reasonable understanding of the consequences of premature discharge. Some experts have advocated for a 'sliding scale' approach to determining the capacity for informed decision-making, depending on the gravity of the situation.¹² In cases of imminent life-threatening illnesses, the standard to determine decisional capacity should be higher than in cases where premature discharge may not compromise the patient's health significantly.

Ultimately, the aim of all these measures is to reconcile the ethical principles of preserving patient autonomy and acting beneficently. However, there are cases in which the principle of patient autonomy is superseded, such as when a patient without decision-making capacity insists on leaving despite posing a significant risk to himself or to others. In such a situation, if no surrogate can be found, the physician may hospitalize the patient against his will. At the same time, if a patient has decision-making capacity, there is no degree of risk that crosses the threshold for involuntary hospitalization.^{12,13} Laws regarding

involuntary hospitalization vary by state, but consultation with an ethicist or psychiatrist can help to bring clarity to the situation.

For patients who insist on leaving and have decisional capacity, measures should be taken to mitigate the harm of premature discharge. The patient should be counseled extensively on self-care for their condition, appropriate prescriptions provided, and encouraged to return for further care if they reconsider their decision. The primary care physician ought to be notified of the patient's impending discharge to ensure outpatient follow-up. If the patient has a high risk of serious health consequences and lacks a primary care physician, the hospital physician may decide to follow up personally.²

The role of proper documentation of a discharge against medical advice cannot be understated. Several cases have been brought to trial over whether allowing a patient to leave against medical advice constitutes medical malpractice. In these cases, proper documentation has enabled physicians to fend off accusations that they had relinquished their responsibilities.¹⁴ Therefore, the circumstances behind the discharge against medical advice should be comprehensively documented.

The specific date and time, stated reasons for leaving, medical condition and stability, decision-making capacity, steps taken to prevent discharge against medical advice, and plans for follow-up should be addressed. With regards to decision-making capacity, providers ought to record mental status and ability to comprehend disclosed information, as well as insight into his disease process and the consequences of deferring medical interventions. Lastly, signatures of both the patient and the physician should be obtained to affirm mutual understanding of the situation.

CONCLUSION

AMA discharge is a viable option for patients who refuse to stay in the hospital despite the need for continuing inpatient treatment. However, the physician must be cautious in discharging a patient against medical advice, since it does not ethically or legally absolve

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TAKE HOME POINTS

- Patients have the right to refuse medical treatment and may leave against medical advice if they do not want to continue being hospitalized.
- Because 30-day mortality and readmission rates are substantially higher in patients who leave AMA, efforts should be taken by providers to prevent discharge AMA.
- Providers should assess the patient's reasons for wanting to leave AMA, and attempt to make their hospitalization more tolerable.
- Prior to discharge AMA, patients should be assessed for decision-making capacity, including insight into their medical condition and consequences of leaving AMA.
- The circumstances of the discharge AMA must be documented comprehensively. Providers should comment on the stability of the patient's condition, reasons for leaving, decision-making capacity, steps taken to prevent discharge, and plans to mitigate harm such as arranging follow up and providing instructions on how and when to seek medical attention.

one from his responsibilities as a health care provider.¹⁵⁻¹⁷ Thus, a systemic approach that emphasizes pragmatic compromise between maintaining patient autonomy and upholding beneficence should be taken.^{10,18} Regardless of the eventual outcome, thorough documentation should be provided in order to justify the decision.

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