

Navigating the challenges of patients with substance use disorders who leave AMA

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Working closely with individuals with substance use disorders (SUDs), we've observed a worrisome trend of patients leaving the hospital against medical advice (AMA). This issue is not only prevalent in psychiatric settings, but also in emergency departments, medical and surgical floors, and even intensive care units.¹

Compared to individuals without such disorders, individuals with SUDs—particularly those with opioid use disorders—are up to 3 times more likely to leave the hospital AMA.^{1,2} Leaving AMA can lead to multiple complications, including an increased risk of readmission, suboptimal treatment outcomes, and an increased use of health care resources.¹⁻³

It is critical to understand why patients elect to leave a hospital AMA. In a qualitative study, Simon et al¹ found that individuals with SUDs often leave AMA due to uncontrolled withdrawal symptoms and pain, perceived stigma and discrimination, and dissatisfaction with care. Predictors of patients leaving the hospital AMA include the severity of their drug dependence and previous negative treatment experiences.⁴ A systematic review found housing instability and a lack of social support influence an individual's decision to leave AMA.⁵

Recommendations for managing patients who leave AMA

Enhancing your understanding of withdrawal symptoms may allow you to offer patients more effective symptom control, possibly with methadone or buprenorphine.² Injectable opioid agonist treatment may also help to retain a patient in care. In a case report, a 47-year-old man with a severe opioid use disorder who had left the hospital AMA due to uncontrolled opioid withdrawal was readmitted, treated with IV hydromorphone, and enrolled in ongoing community injectable opioid agonist treatment.⁶

Clinicians must address the stigma and discrimination patients with SUDs often face in health care institutions. Additional training for clinicians to improve their understanding of these disorders and foster a more compassionate and nonjudgmental approach to care may be beneficial.

Like most medicolegal conflicts, leaving AMA is often a clinical and interpersonal problem disguised as a legal one. When assessing these patients' decision-making capacity, we often find they are angry and dissatisfied with the care they have (or have not) received. The most useful intervention may be to restore communication between the patient and their treatment team.

Even after a patient leaves AMA, the treatment team may experience countertransference issues, such as heightened emotional reactions or biases, that could compromise their clinical judgment. Addressing these dynamics may require team debriefings, supervision, or further training in managing

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Clinical Point

Patients with SUDs often leave AMA due to withdrawal symptoms, stigma/discrimination, and dissatisfaction with care

transference and countertransference, particularly since patients who leave AMA may return for subsequent care.⁷

Integrated care models, which feature close collaboration between clinicians from different specialties, can help ensure that a patient's diverse health needs are met and reduce the likelihood of them leaving AMA. Integrated care models may be particularly effective for patients with co-occurring conditions such as HIV and SUDs.⁸

Implementing these recommendations can be challenging. Barriers to addressing AMA departures span several domains, including patient-specific barriers (eg, stigma and discrimination), clinical barriers (eg, lack of resources and training for clinicians), institutional hurdles (eg, systemic inefficiencies), and broader social barriers (eg, housing instability and inadequate social support). Overcoming these barriers requires a multifaceted approach involving clinicians, policymakers, and the

community that considers medical, psychological, and social factors.

References

1. Simon R, Snow R, Wakeman S. Understanding why patients with substance use disorders leave the hospital against medical advice: a qualitative study. *Subst Abus.* 2020;41(4):519-525.
2. Kenne DR, Boros AP, Fischbein RL. Characteristics of opiate users leaving detoxification treatment against medical advice. *J Addict Dis.* 2010;29(3):383-394.
3. Mahajan RK, Gautam PL, Paul G, et al. Retrospective evaluation of patients leaving against medical advice in a tertiary care teaching hospital. *Indian J Crit Care Med.* 2019;23(3):139-142.
4. Armenian SH, Chutuape MA, Stitzer ML. Predictors of discharges against medical advice from a short-term hospital detoxification unit. *Drug Alcohol Depend.* 1999;56(1):1-8.
5. Ti L, Ti L. Leaving the hospital against medical advice among people who use illicit drugs: a systematic review. *Am J Public Health.* 2015;105(12):e53-e59.
6. McAdam M, Brar R, Young S. Initiation of injectable opioid agonist treatment in hospital: a case report. *Drug Alcohol Rev.* 2020;39(2):138-141.
7. Schouten R, Weintraub BR. Legal aspects of consultation. In: Stern TA, Freudenreich O, Smith FA, et al, eds. *Massachusetts General Hospital Handbook of General Hospital Psychiatry.* 7th ed. Elsevier; 2018:578-579.
8. Vallecillo G, Robles MJ, Fonseca F, et al. Integrated care on leaving hospital against medical advice among HIV-infected people with substance use disorders. *AIDS Res Hum Retroviruses.* 2018;34(12):1044-1049.