Against Medical Advice Discharges

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The "Things We Do for No Reason" (TWDFNR) series reviews practices which have become common parts of hospital care but which may provide little value to our patients. Practices reviewed in the TWDFNR series do not represent "black and white" conclusions or clinical practice standards, but are meant as a starting place for research and active discussions among hospitalists and patients. We invite you to be part of that discussion.

Against medical advice (AMA) discharges, which account for up to 2% of all inpatient discharges, are associated with worse health and health services outcomes and disproportionately affect vulnerable patient populations. This paper will review the background data on AMA discharges as well as the reasons physicians may choose to discharge patients AMA. From a healthcare quality perspective, the designation of a discharge as AMA is low-value care in that it is a routine hospital practice without demonstrated benefit and is not supported by a strong evidence base. We argue that designating discharges as AMA has never been shown to advance patient care and that it has the potential to harm patients by reducing access to care and promoting stigma. We believe that greater attention to both shared decision-making as well as harm reduction principles in discharge planning can serve as effective, patient-centered alternatives when patients choose not to follow a healthcare professional's recommended advice.

CASE PRESENTATION

A 54-year-old man with active intravenous (IV) drug use and hepatitis C was admitted with lower extremity cellulitis. On hospital day 2, the patient insisted that he wanted to go home. The treatment team informed the patient that an additional 2-3 days of IV antibiotics would produce a more reliable cure and reduce the risk of readmission. Should the team inform the patient that he will be discharged against medical advice (AMA) if he chooses to leave the hospital prematurely?

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BACKGROUND

In the United States, patients are discharged AMA approximately 500,000 times per year (1%-2% of all discharges).[1] These discharges represent a wide array of clinical scenarios that all culminate in the formal recognition and documentation of a competent patient's choice to decline further inpatient medical care and leave the hospital prior to a recommended clinical endpoint. Compared with standard discharges, AMA discharges are associated with an increased adjusted relative risk of 30-day mortality as high as 10% and 30-day readmission rates that are 20%-40% higher than readmission rates following standard discharges.[2] AMA discharges are more likely among patients with substance use disorders, psychiatric illness, and HIV.[3]

WHY YOU MIGHT THINK AMA DISCHARGES ARE HELPFUL

Although there are little empirical data to inform how and why physicians choose to designate a discharge as AMA when patients decline recommended care, the existing evidence suggests that fears of legal liability are strongly driving the practice.[4] Physicians may believe that they must discharge patients AMA in order to fulfill their legal and ethical responsibilities, or to demonstrate in writing the physician's concern and the significant risk of leaving.[5,6] Clinicians may have been acculturated during training to believe that an AMA discharge may also be seen as a way of formally distancing themselves from the patient's request for a nonstandard or unsafe discharge plan, thus deflecting any potential blame for worse patient outcomes.

Finally, clinicians and administrators may also believe that an AMA discharge is the appropriate designation for a hospital stay that ended because the patient chose to prematurely discontinue the treatment relationship or to decline the postdischarge placement recommendations. This reasoning may explain why the hospital penalties authorized by Medicare's Hospital Readmission Reduction Program generally exclude initial admissions ending in an AMA discharge[7] and may provide the rationale (and perhaps a financial incentive) to discharge patients AMA in order to limit CMS readmission penalties.

WHY AMA DISCHARGES ADD NO VALUE TO A PATIENT'S FULLY INFORMED DECLINATION OF CARE

The AMA discharge is a routine hospital practice without demonstrated patient benefit and which disproportionately affects vulnerable populations. There is also a growing liter-

ature that demonstrates that AMA discharges stigmatize patients, reduce their access to care, and can reduce the quality of informed consent discussions in discharge planning.[8-10] Although there are no conclusive data that AMA discharges are more likely among underrepresented racial minorities, the disproportionate burden of AMA discharges and their worse health outcomes are borne by the homeless, those with substance use disorders, and the uninsured.[3,11]

Compared to patients discharged conventionally from an emergency department, 25% of patients discharged AMA reported not wanting to return for follow-up care.[8] This reluctance to return for care is in part mediated by provider-generated stigma and blame[9,12] and may be exacerbated when patients believe that their decision to leave AMA was based upon extenuating circumstance or competing necessity (eg, limited care options for their dependents, poor quality hospital care, etc.).

To persuade patients to remain hospitalized, 85% of trainees and 67% of attending physicians in one study incorrectly informed their patients that insurance will not reimburse a hospitalization if they leave AMA.[13] Because this study demonstrated that there is no empirical evidence that payment after AMA discharges is denied by private or government payers, physicians sharing this misinformation can breed distrust and coercively undermine patients' ability to make a voluntary choice.

When clinicians assert they are bound by duty to discharge a patient AMA, they may be conflating a presumed legal obligation to formally designate the discharge as AMA in the medical record with their actual obligation to obtain the patient's informed consent for the discharge. In other words, there is no identifiable medico-legal requirement to specifically designate a discharge as AMA.

Although clinicians may presume that the AMA designation provides protection from liability, the claim is not supported by the available literature.[14,15] In these studies, which reviewed relevant case law, defendants prevailed not because of the physician's AMA designation, but because the plaintiff was not able to prove negligence. The proper execution of the discharge process, not the specific designation of AMA, is what conferred liability protection.[5] Indeed, malpractice claims, which are associated with patient perceptions of feeling deserted or devalued,[16] might be more likely with AMA discharges when they result from flawed and stigmatizing communication processes.[17]

Finally, there are no clinical, regulatory, or professional standards that specify the designation of an AMA discharge. Neither the Joint Commission nor any other professional organization specify under what conditions a clinician should discharge a patient AMA, thus promoting wide variability in its use and further limiting it as a valid and reliable healthcare metric.

WHAT SHOULD PHYSICIANS DO INSTEAD: AVOID THE AMA DESIGNATION AND PROMOTE SHARED DECISION-MAKING AND HARM REDUCTION

Because all competent patients have the right to decline recommended inpatient treatment, the ethical and legal standard is that the physician obtain the patient's informed consent to leave by communicating the risks, benefits, and alternatives to leaving and fully documenting the conversation in the medical record.[2] The additional steps of formalizing the discharge as AMA and providing AMA forms for the patient to sign have never been demonstrated to improve quality (and add needless clerical work). When declining any treatment, even life-sustaining treatment, the request for a patient signature to decline such treatment has not been demonstrated to improve risk communication and is not considered a best practice for informed consent.[18] When the physician's motives for this behavior are punitive or directed primarily at reducing liability, it may distract the physician from their fiduciary duty to put patients first.

The solution to improve quality is straightforward—avoid designating discharges as AMA. Instead, clinicians should maintain a single discharge process with clear, objective documentation including providing appropriate prescriptions and follow-up appointments regardless of whether the patient's choice is consistent with a physician's recommendation. In its place, the physician should use shared decision-making (SDM) and harm reduction principles to enhance the patient's well-being within the identified constraints. SDM involves physicians and patients making healthcare decisions together by combining the patients' values and preferences for care with the physicians' expertise and knowledge of medical evidence. Harm reduction practices seek to reduce the adverse health consequences that may come from unhealthy behaviors while assuming that patients will likely continue such behaviors. Evidence-based and widely accepted examples of harm reduction strategies include nicotine replacement therapy and needle exchange programs.[19]

SDM in discharge planning provides a range of discharge and transitional care options that are within prevailing medical standards, not simply a single recommendation that prioritizes health promotion to the exclusion of other identified patient goals. Quality discharge planning should provide the "right care for the right patient at the right time"[20] that moves beyond the false choice of either remaining in the hospital under the conditions specified by the physician or leaving AMA. Although physicians are understandably concerned about patients making choices that do not prioritize their health, physicians can consider the evidence for harm reduction programs' effectiveness in improving health outcomes[21] and accommodate patients by providing harm-reducing discharge options that, while suboptimal, may not be substandard.[22]

Physicians who wish to promote stronger patient-centered discharge practices may find that avoiding or limiting AMA discharges may conflict with their institution's policy. In those cases, physicians should work closely with their leadership and legal counsel to ensure that any proposed practice changes are legally compliant but also improve SDM and reduce stigma for this population.

Although ending the clinical practice of designating discharges as AMA is unlikely to completely ameliorate the

morbidity and costs associated with patients declining episodes of inpatient care, there is reasonable face validity to conclude that replacing the AMA practice with greater attention to harm reduction and SDM can reduce some of the preventable harms like stigmatization and reduced access to care. Together, these practices demonstrate the profession's continued commitment to the public to practice patient-centered care.

RECOMMENDATIONS

- Treat all discharges similarly. Avoid designating an inpatient discharge as AMA.
- Ensure there is objective documentation of the patient's informed choice to leave the hospital.
- When patients wish to leave the hospital prior to a physician-recommended clinical endpoint, engage in SDM with a focus on providing all medically reasonable treatment options that promote harm reduction.
- If you choose to designate a discharge as AMA, approach the discharge planning process consistently and with patient-centered principles by optimizing SDM and harm reduction.

CONCLUSION

The physician informed the patient of the risks, benefits, and alternatives to leaving the hospital prior to the completion of IV antibiotics and confirmed the patient's decision-making capacity. Next, the physician elicited the patient's preferences for care and identified competing priorities. The patient wanted treatment for his cellulitis, but he was experiencing pain and opioid withdrawal. The physician then expanded the range of potential treatment options, including evaluation for medication-assisted treatment for the patient's opioid use disorder (OUD) and harm reduction measures such as safer injection practices, needle exchange, housing assistance, and overdose prevention and treatment education.[23] An alternative harm-reducing option included discharge with oral antibiotics and follow-up with his primary physician in 48-72 hours. After the patient indicated that he wanted to leave because he was not yet ready for OUD treatment, he was discharged with the standard discharge paperwork and antibiotics, and the physician documented the informed consent discussion.

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Do you think this is a low-value practice? Is this truly a "Thing We Do for No Reason?" Share what you do in your practice and join in the conversation online by retweeting it on Twitter (#TWDFNR) and liking it on Facebook. We invite you to propose ideas for other "Things We Do for No Reason" topics by emailing TWDFNR@hospitalmedicine.org.

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