

Discharge Against Medical Advice: Ethical Considerations and Professional Obligations

Jeffrey T. Berger, MD

Associate Professor of Medicine, SUNY Stony Brook School of Medicine, Stony Brook, New York, and Director of Clinical Ethics, Department of Medicine, Winthrop-University Hospital, Mineola, New York.

Discharges against medical advice (AMA) account for approximately 1% of discharges for general medical patients. Patients discharged AMA have longer eventual hospital stays and worse health outcomes. These patients are also less likely to have an established relationship with a physician, tend to have poorer social supports, and are more likely to abuse alcohol and other substances. These discharges are also distressing for physicians and other health professionals. How should physicians manage their conflicted obligations to respect patients' choices and to prevent harms from befalling their patients? What are physicians' obligations to their patients who leave accepting only partial or inadequate treatment plans or no treatment at all? When should physicians question the decision-making capacity of patients who make dangerous judgments to leave the hospital? This article examines the ethical and professional implications of discharge AMA. *Journal of Hospital Medicine* 2008;3:403–408. © 2008 Society of Hospital Medicine.

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BACKGROUND

Discharges against medical advice (AMA) account for approximately 1% of discharges for general medical patients and up to 10% and 30% for patients afflicted with HIV disease and psychiatric disorders, respectively.^{1–7} Patients discharged AMA have higher rates of readmission, longer subsequent hospital stays, and worse health outcomes.^{3,5,8–11} Not unexpectedly, discharges AMA are associated with overall health costs of up to 50% greater than usual discharges.²

Patients who leave AMA are more likely to have poorer social supports, to abuse alcohol, heroin, and other substances, and often have weighty psychosocial or financial concerns.^{12–18} They are also less likely to have an established relationship with a primary care physician.¹⁹ Although studies have found that rates of discharge AMA are higher among some ethnic minorities, one recent study suggests that other patient variables, such as level of income and type of insurance, may be more closely related.^{7,20} Unfortunately, many patients who leave AMA have dual sources of distress: compelling personal concerns that fuel one's wish to leave and the illness that initially caused the patient to seek care.

Physicians are often distressed by the clinical and ethical challenges of discharges AMA. How should physicians manage their conflicted obligations to respect patients' choices and to prevent harms from befalling their patients? What are physicians' obligations to their patients who leave accepting only partial or inadequate treatment plans or no treatment at all? When should physicians call into question the decision-making capa-

city of patients' who make seemingly unwise or clearly dangerous judgments to leave the hospital? In addition to these sorts of concerns, physicians who discharge patients AMA enjoy no definitive legal protection from the consequences of their patients' choices.²¹⁻²³ In fact, good clinical judgment and careful documentation provide the best liability protection.²⁴

Clearly, discharges AMA are problematic for patients, stressful for physicians, and resource intensive for health facilities. Therefore, efforts to understand, better manage, and ultimately decrease discharges AMA will benefit all parties. Whereas the literature on discharge AMA tends to focus on psychiatric and substance abuse patients, this review examines the professional and ethical implications of discharge AMA more generally.

Does Discharge AMA Differ from Treatment Nonadherence Elsewhere in Health Care?

Patients' nonadherence to recommended treatment is often influenced by treatment side effects, costs, inconvenience, psychosocial burden, and the quality of the patient-physician relationship. Not surprisingly, these same factors are often associated with discharge AMA.²⁵⁻²⁸ In fact, nonadherence in discharge AMA and nonadherence elsewhere are fundamentally similar. Differences, where they exist, are often in the degree or imminency of health risk and in the ability of physicians to monitor the patient.

Discharges AMA tend to involve health risks that are more acute and more severe compared to general nonadherence. To illustrate, Patient A is diagnosed with the metabolic syndrome during an office visit. His physician recommends medical therapy, and the patient declines, thereby incurring a high risk of a cardiovascular event within the next 10 years. Patient B presents to the hospital with an acute coronary syndrome. He declines to remain in the hospital for an evaluation of ischemic burden despite a high risk of a myocardial infarction in the next few days. Patient A is motivated by the cost of medication and chooses to purchase his wife's medications, foregoing his own. Patient B is motivated by distress over leaving his frail wife alone at home and concerns of medical bills that he can not afford to pay. The patient in each of these cases is motivated by social and financial concerns. The consequence of each patient's choice is a higher risk of a cardio-

vascular event. A major difference is the temporal relationship between the decision to not accept treatment and the ensuing adverse event.

Of course, high-risk situations are not exclusive to the inpatient setting. For example, a patient presents to a physician's office after having experienced substernal chest pain during the previous evening. The physician recommends hospitalization but the patient declines. Conversely, a hospitalized patient may pursue discharge AMA because the patient disagrees with the physician's stipulations for safe discharge plan including assistance at home. Yet, these concerns about custodial needs, if identified by the physician in an office setting, may not necessarily compel the physician to hospitalize the patient.

Another difference between discharge AMA and general nonadherence is that adherence is more readily and closely measured in the inpatient setting. Hospital-based occurrences of nonadherence are immediately identified and addressed. To contrast, in the outpatient setting, adherence is far poorer with a 20% nonadherence rate considered to be "good compliance".²⁹⁻³¹ Regardless of the setting for nonadherence, the variance between recommended and accepted treatments often stems from the fact that patients tend to make decisions based on values and broader interests whereas physicians tend to emphasize more circumscribed medical goals.^{32,33}

Informed and Voluntary Refusal of Treatment

A patient's intention to leave AMA may trigger physicians and other hospital staff to question the patient's decision-making capacity.³⁴ One's capacity to make decisions is specific to the decision at hand. For example, a patient with early dementia and an infected arterial insufficiency ulcer may not be able to fully appreciate all the consequences of premature discharge on her health, but may be able to reliably indicate her preferred health agent.

Clinicians commonly make implicit capacity determinations, and do so each time a patient's general consent for treatment is accepted. These assessments tend to be made more explicitly when the patient's decision appears to be grossly contrary to his or her welfare. Capacity to make decisions includes the ability to understand information germane to the decision, to deliberate, and to appreciate the consequences of choices.³⁵ As with consent to treatment, a physician who

accepts a patient's refusal for treatment has determined that the patient has adequate decision-making capacity. However, physicians do not regularly document assessments of capacity in discharge AMA.³⁶⁻³⁸

Writers on the subject suggest that patients who refuse low-risk but high-benefit treatments should be held to a higher standard of capacity.²² This notion could expose patients to incapacity determinations based on a physician's subjective assessment of net benefit or net harm. Rather, I contend that the standard itself should not vary. It should always require that the patient's level of cognitive function, insight, and deliberative abilities be appropriate to the decision at hand and sufficient for the patient to render an autonomous decision. The relative benefit of a treatment, in and of itself, is not relevant to the level of capacity required. Rather, net benefit is relevant to physicians' obligations to *more carefully verify* patients' understanding of the pertinent information and their perceptions of the consequences of their choices when declining high benefit/low harm treatments.

A capacitated patient's decision to leave AMA, however well informed, may nevertheless not be entirely voluntary. Voluntary decisions are those that are made with substantially free choice.³⁹ Various controlling influences may impact a patient's decision to leave AMA, including social or emotional challenges such as a desperate concern about losing employment.^{9,13-15} Health professionals may view a patient's action under some controlling influences as meritorious, for example, leaving AMA to fulfill one's obligation to care for a demented spouse, whereas professionals may view acting on other controlling influences as contemptible, such as a leaving to satisfy a drug addiction. Physicians should view controlling influences, regardless of its moral valence, as affecting the voluntariness of a patient's decision. Moreover, physicians are positioned, through either support or coercion, to influence the degree to which a patient's decision about treatment is voluntary. To illustrate, physicians who support their substance abuse patients by providing adequate treatment of their withdrawal symptoms see lower rates of discharge AMA among these addicted patients.^{3,5,7} Regarding coercion, physicians of hospitalized patients may state their refusal to prescribe a beneficial but inferior outpatient treatment in order to compel their patients to accept standard inpatient treatment.

Physicians' Obligations in Discharge AMA

Broadly stated, physicians' obligations are to promote their patients' welfare and to respect their autonomy which is understood as serving the patient's self-defined best interests including maintaining dignity.⁴⁰ When discharging a patient AMA, physicians are sometimes limited in the ways in which they can fulfill these obligations. Physicians should attempt to promote informed decision-making by discussing the likely harms of premature discharge, the likely harms and benefits of inpatient treatment, and alternatives to inpatient treatment, including medically inferior options where these exist.

Within this obligation to promote patients' welfare, physicians should render only objective and conservative assessments of harm and benefit. These assessments may directly reflect well-established medical evidence (eg, use of statins in acute coronary syndromes), but may also be partly or even wholly dependent on clinical judgment (eg, interpreting and applying criteria for inpatient versus outpatient treatment of pneumonia). The process though which these clinical judgments are made is critical because it forms the basis of the medical advice that defines whether a patient's discharge is routine or AMA. Physicians, in addition to their obligation to objectively assess options for treatment, should be mindful of their fiduciary responsibilities in their position to influence patients' choices by the content, emphasis, and manner with which they communicate treatment options.⁴¹⁻⁴⁴

In addition to supporting patient autonomy through information and education, physicians can promote authenticity of choice by identifying patients' compelling reasons to leave AMA. Does the patient have a demented spouse alone at home? Does the patient have a cultural or religious requirement that they perceive cannot be met while hospitalized? Is the patient concerned about loss of employment? Does the patient have an important family obligation (eg, wedding, funeral) to fulfill? Ways in which these concerns can be mitigated should be explored, often through a multidisciplinary approach that may include social work and pastoral care.⁴⁵

What are physicians' obligations to patients who are willing to accept only partial or inadequate treatment plans upon discharge AMA? Should physicians be complicit in treatments that are substandard, such as the writing of a prescrip-

tion for an oral antibiotic for a patient whose clinical condition meets criteria for inpatient treatment of pneumonia? Should physicians be complicit in treatments that are somewhat effective, but clearly inadequate and potentially dangerous? An example of this is the providing of a prescription for an oral anti-arrhythmic medication for a patient diagnosed in the emergency department (ED) with syncope from a tachyarrhythmia.

In considering these scenarios, physicians may need to focus primarily on their ethical obligations to not cause harms, because discharge AMA limits physicians' ability to actively promote patients' health.⁴⁶ To illustrate, Patient C, a frequent abuser of alcohol, presents to the ED and is diagnosed with a pulmonary embolus. She wants only analgesic medication for her chest pain and states that she plans no outpatient follow up. What options should the ED physician consider? The physician should not discharge the patient with a prescription for warfarin, the use of which requires close and careful monitoring especially in the setting of alcohol consumption, because this treatment, along with this patient's social practices and disinclination for follow up, introduces risks similar in seriousness to her medical condition.⁴⁷ Should the ED physician give her an injection of low molecular weight heparin before the patient exits? Although a single injection of heparin is not likely to meaningfully affect her disease course, there is little direct harm in providing it. However, one must also consider possible indirect harms. For example, the offer of heparin may harm Patient C if she construes it as a bona fide treatment alternative, thereby influencing her decision to leave AMA. In another scenario, Patient D presents to the ED with an upper gastrointestinal hemorrhage and orthostatic hypotension that responds quickly to intravenous fluids. The patient unconditionally refuses to undergo an endoscopy or to accept admission into the hospital. Should the ED physician administer a dose of intravenous proton pump inhibitor (PPI), and write a prescription for high-dose oral PPI? Because the harms of PPIs are low and it may prevent rebleeding, providing such care does not violate the obligation to not cause disproportionate harms, and attends to the obligation to promote the patient's health. To summarize, physicians' obligations to provide treatment upon discharge AMA is determined by a complex evaluation of the likelihood and magni-

TABLE 1
Obligations to Provide Treatment Upon Discharge AMA

Disease Risk	Treatment Efficacy	Treatment Risk	Ethical Obligation
High	High	Low	Clear obligation to treat
High	Low	Low	Weak obligation to treat
Low	High	Low	Weak obligation to treat
High	High	High	No clear obligation to treat
High	Low	High	No clear obligation to treat
Low	High	High	No clear obligation to treat
Low	Low	Low	No clear obligation to treat
Low	Low	High	Clear obligation not to treat

tude of each the harms and benefits associated with the outpatient treatment and the disease-associated risks of morbidity and mortality. This assessment is outlined in Table 1.

Do physicians have obligations for facilitating after-care when discharging a patient AMA? The policy of some hospitals is that there are no such obligations.⁴⁸ Arguably, providing resources for after-care to these patients may benefit these patients with no additional medical risk, with the caveat that offering after-care does not influence the patient's decision to leave AMA. Therefore, physicians are ethically obligated to offer this care. In fact, this is the practice of many physicians and consistent with a number of authorities in medicine and ethics.^{24,36,49,50} There is little evidence to support the concern that providing patients with after-care resources exposes physicians or institutions to greater legal liability. In fact the opposite may be true.⁵¹ For patients who habitually leave AMA and who repeatedly have not sought recommended after-care, it should not be ethically obligatory for hospital staff to expend efforts to secure after-care.

A corollary to physicians' obligations is the obligations of patients as users of health resources. There is an enormous literature on patients' rights, yet a relative dearth of discourse, let alone consensus, on patients' duties and responsibilities.^{52,53} At a minimum, patients are obligated to honor commitments and to disclose relevant information in the interest of their personal health.⁵⁴ Do patients discharged AMA have moral obligations to their fellow patients or to society in terms of responsible use of often costly and sometimes limited health resources? If so, what do these obligations require and which patients should be so obligated? These are impor-

TABLE 2
Clinicians' Discharge AMA Response List

1. Capacity	Assess patient's factual understanding, reasoning, and insight into consequences of decision
2. Voluntariness	Assess for controlling influences; physical, social, emotional, psychiatric, cultural
3. Mitigation	Multidisciplinary efforts to mitigate controlling influences
4. Treatment alternatives	Assess for medically appropriate outpatient treatment alternatives. (See table 1)
5. Aftercare	Encourage and facilitate after care

tant questions to consider, yet are beyond the scope of this discussion.

SUMMARY AND CONCLUSIONS

Clinicians caring for patients who seek discharge AMA are often faced with emotionally charged and time-pressured treatment situations. These clinicians must weigh multiple considerations for the benefit of their patients, and maintain professional standards of clinical care. Clinicians presented with these situations should (1) evaluate patients' decision-making capacity, (2) assess the degree to which their choices are influenced by controlling external influences and mitigate these factors where possible, and (3) encourage and facilitate after-care (Table 2).

Although discharge AMA accounts for only a small percentage of hospital discharges, its medical, emotional, and resource utilization consequences for patients as well as for physicians and hospitals is disproportionate. The clinical impacts of discharge AMA should be further investigated and specific strategies and interventions to mitigate its health effects should be validated.

Address for correspondence and reprint requests: Dr. Jeffrey Berger, 222 Station Plaza North, Suite 518, Mineola, NY 11501; Fax: 516-663-4644; E-mail: jberger@winthrop.org

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