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LETTER TO THE EDITOR

In Response to "Discharge Against Medical Advice: How Often Do We Intervene?"

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We believe medications can safely be prescribed to most patients who leave against medical advice (AMA), and that follow-up should be offered to most if not all such patients. Why should we do this? Consider a wheezing asthma patient who leaves AMA. She or he is probably more likely to return to the emergency department (somewhere) or be readmitted (somewhere) and cost more money (to the system) than if given an inhaler and steroid taper.

Dr. Querques et al. suggest that doctors should potentially not prescribe and should not offer follow-up to certain patients who want to leave AMA, particularly those who show disinterest in heeding the doctor's advice and have already demonstrated a lack of adherence. How should doctors make those judgments? Patients leave AMA for a variety of reasons: for example to avoid cost, because they feel better, or poor communication. Certainly, not all patients who want to leave AMA are categorically nonadherent. Conversely, up to 50% of all continuity patients are not fully adherent to the lifestyle changes and medications their physicians prescribe,[1] yet they would rarely if ever threaten AMA. Is withholding treatments that are likely to be effective and have minimal risk worth the potential benefit of increasing a patient's priority on their own healthcare? As emphasized by Berger (2008),[2] interventions with low risk and high potential for efficacy (assistance with establishing a follow-up) should be pursued, and those with potential risks (starting new long-term medications) should be avoided. At minimum, considering these options is an ethical requirement in the care of patients. We maintain that this reasoning should be explained and documented, which often is not being done in healthcare today.

How many AMAs are avoided by truly collaborative relationships with patients (nonevents), and how many are fueled by a more paternalistic relationship? For example, if a patient truly has a sick family member or child to take care of or has financial problems or no insurance, then it seems reasonable, perhaps even responsible, to leave the hospital even if maximal benefits of care have not been reached. In a collaborative relationship, providers may then tailor treatment to the patient's circumstances, even if this means the patient is not getting the best possible care.

References

1. Brown MT, Bussell JK. Medication adherence: WHO cares? *Mayo Clin Proc*. 2011;86(4):304–314.
2. Berger JT. Discharge against medical advice: ethical considerations and professional obligations. *J Hosp Med*. 2008;3(5):403–408.

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