Discharge against Medical Advice: Ethical and Legal Considerations

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Abstract

Introduction: It appears most healthcare workers do not have a proper understanding of the meaning of discharge against medical advice.

Aim of study: To discuss the ethical and legal implications of discharge against medical advice.

Method of study: Key words, Discharge against medical advice, ethical and legal consequences were search through various databases and search engine to identify scholarly articles and documents on the subject matter. The identified documents were reviewed for suitability for this review. The selected articles and documents were then extensively reviewed.

Results: The meaning of the concept of discharge against medical advice and the ethical and legal challenges associated with the concept has been extensively reviewed in this work.

Conclusion: There is a need to have a proper understanding of the entire concept of discharge against medical advice in order to avoid possible litigations.following albendazole treatment. However, the efficacy of albendazole was poor against Trichuris trichiura infection.

Key words: *Discharge against medical advice, ethical considerations, legal considerations, litigations*

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Introduction

There are often challenges when a patient decides to leave the hospital before the caregiver in charge of his care formally discharges him. Under this circumstance, there are various ways he/she may leave the hospital. At times the patient may leave the hospital premises without informing the caregiver. At other times, the patient may inform the caregiver that he is leaving the hospital but may be unwilling to engage in any other discussion with the caregiver before leaving the hospital. In some instances however, the patient informs the caregiver that he needs to leave the hospital even when the caregiver explains that the patient is not fit for discharge. The caregiver, should under this circumstance, explain the consequences of such discharge without the recommendation

of the caregiver. Ideally, the patient should be made to sign the relevant forms pertaining to discharge against medical advice. The caregiver should explain clearly to the patient the implications of his decision to leave the hospital against medical advice and the patient should demonstrate understanding of such discussion before signing the document. Where the patient is not made to understand the full implication of leaving the hospital against advice, such discharge has not complied with criteria for a proper discharge against medical advice.[1-10] To the extent of non-compliance with the criteria for a proper discharge against medical advice, the caregiver may not have a good defense in the event of a litigation relating to the discharge.[3] Most hospitals have protocols for handling cases of discharge against medical advice.[2,3,5] However, it seems attention is paid mainly to the aspect where the patient signs the forms whether indeed he/she understands the concept or implication of discharge against medical advice. A mere signature on the form without adequate explanation to the patient about the implication of discharging him/herself against medical advice is not a valid discharge against medical advice.[5,10] Patient's understanding of the entire process of discharge against medical advice is a critical requirement that may grant the caregiver a defense in the event of litigations. What then is discharge against medical advice? Discharge against medical advice is a situation when a patient/client who is receiving treatment decides to leave the facility where such care is being rendered for whatever reason but against the informed advice of the caregiver.[1-3,5,9] Several authors have reported varying rates of discharges against medical advice. Udosen *et al* reported a rate of 2.6% with a Male/Female ratio of 2:1.[2] However, the rates depend on the type of cases, location of practice and peculiarities of the patients. In Ohanaka's study, trauma accounted for the highest rates of discharges against medical advice.[7] Thus, the rate of discharge against medical advice may be as high as 20% and may equally be as low as under 1% depending on a number of factors.[5] There may be possible litigations if the process for discharge against medical advice is not properly handled.[5]

The purpose of this paper is to consider the ethical and legal aspects of discharge against medical advice and a discussion on the proper process for handling cases of discharge against medical advice. This is with a view to minimizing chances of litigations related to improper handling of discharge against medical advice.

Meaning of discharge against medical advice and other related terms Discharge against medical advice: Discharge against medical advice implies a situation where a patient who is receiving treatment in a health facility demands that he or she needs to leave the hospital even when the authorized person in charge of his or her treatment duly informs the individual that he/she is not fit to be discharged at the time he/she is requesting for discharge. For it to be a proper discharge against medical advice, the process has to satisfy certain criteria:[1-3,9,10]

1. The patient in question is on admission in a medical facility.
2. The patient is receiving adequate and standard care.
3. The patient is not fit for discharge yet

considering a number of factors.

4. The patient is fully aware of his health status, the various management options and that he receiving adequate and standard care for his condition in a conducive environment.
5. The patient is aware of the implications of and consequences of not receiving the standard care for his condition.
6. The patient make a written request to be discharged against the advice of the person in charge of his care or his authorized representative even after he has been duly informed of the implications and consequences (including death) of discharge against medical advice.
7. The patient demonstrates a full understanding of the discussion and yet insists that he should be discharged against the advice of the care givers.
8. Lastly, the patient or the authorized representative signs the relevant informed documents and leaves the facility.

The patient may or may not give reasons for his decision.

Definition of terms

For a proper and a comprehensive discuss of the subject, it is important at this early stage to define some terms that are closely related to DAMA, but are readily distinguishable.[4-6] These are:

- **Leaving before examination**: A situation where a patient who has already registered to obtain care in a medical facility leaves the facility (usually without informing the physician) before he is examined with a view to commencing treatment usually at the accident and emergency unit. It is important that the attending healthcare worker notes when the patient was last seen at the facility and attempts made to locate him/her. The documented information may become relevant particularly if the patient in question suffers harm after leaving the health facility or becomes involved in a criminal matter or is found dead soon after s/he left the health facility.
- **Escape:** A situation where a patient/client runs away from a health facility against some form of physical restraints. Most patients in this category have some form of mental impairment while others may attempt to escape because they owe bills in the hospital. If the patient must be pursued and brought back to the hospital by the security personnel, this must be done with reasonable force. In addition, the action of the patient must be immediately documented in his case file and reported to the relevant authorities (including the police) making specific mention of the time and mode of escape.
- **Elopement and absconding:** Elopement and absconding are sometimes used interchangeably by some authorities while others think there is a difference in the terms. Basically, "Absconded" means that the patient has left the hospital without permission or information and is not traceable within the hospital premises. This is a very serious situation and calls for immediate information to the police and the relatives. It is found mainly in psychiatric wards even though it may also happen in other wards. For the authors

that distinguish the terms, it is elopement where there was really no reason why the patient should leave the hospital and is absconding when there may be an identifiable reason or when it occurs in a psychiatric ward.[3-6] An identifiable reason in this sense may be that the patient owes hospital bills. The patient may also owe other patients on the ward or cases of theft are being investigated on the ward. Such patients may patients may abscond from the ward so they are not made to pay for what they owe or in order not to be caught with stolen items on the ward. It is also a common finding amongst psychiatric patients. Thus, there seems to be a subtle difference between elopement and absconding. It should be clearly documented when last the patient was seen on the ward while making the report to the police and other relevant persons.

In any form of this situation of leaving hospital without authorization, it is important to inform the security agents because of possibility of theft, protection against malpractice suit, and such persons being investigated for criminal charges or harm/death results.

Why do patients discharge against medical advice?

Several reasons have been adduced by various authors why patients discharge against medical advice.[7-14] Some reasons commonly advanced are family challenges/emergencies, personal obligations, feeling bored, feeling well enough to leave, patients expected a shorter stay, patients are not improving and not receiving adequate nursing/medical care, preference for another hospital, beliefs that the condition was terminal, dislike of the hospital environment and not wanting to be used for learning/teaching purposes or for financial difficulties. Psychiatric, emergency and paediatric cases seem to have higher incidences of discharges against medical advice. [10,11,13,]

There have been instances where a doctor in a government hospital tells a patient to ask for discharge against medical advice so that such a patient can be cared for in the doctor's private clinic.[15] This action is considered gross misconduct in a professional respect.[16] Some studies have also implicated some nurses particularly in paediatric wards encouraging mothers to discharge their children against medical advice hiding under the guise of reducing work load on the ward.[17]

However, with a proper analysis of reasons adduced for discharges against medical advice, is been found that lack of adequate communication between caregivers and the patients seems to be the major underlying factor in most cases. [9,12]

Interplay between doctrine of informed consent/refusal and discharge against medical advice: ethical considerations

Informed consent (or informed refusal) is one of the very core values in medical ethics and occasionally poses a challenge for the healthcare provider where the exercise of such rights by the patient is deemed by the caregiver to portend danger for the patient. Thus, in some instances, the principle of beneficence may be pitched against patient's right to either accept or refuse treatment but patients' wish should prevail while considering the

Table 1: Summary of studies on the efficacy of anthelminthic drugs against soil-transmitted helminth infections in school children in sub-Saharan Africa

Country	Type of Study	Drug used	Hookworm			A. lumbricoides			T. trichiura			Post-treatment assessment	Reference
			P/P (%)	CR (%)	ERR (%)	P/P (%)	CR (%)	ERR (%)	P/P (%)	CR (%)	ERR (%)		
Ethiopia	CI	ALB	NA	84.2	95.0	NA	83.9	96.3	NA	NA	NA	NA	Adugna et al., 2007
		MEB	NA	83.5	94.2	NA	90.6	96.7	NA	NA	NA	NA	
Ethiopia	RCT	MEB	NA	NA	NA	NA	NA	NA	NA	89.8	99.1	NA	Legesse et al., 2004
		ALB	NA	NA	NA	NA	NA	NA	NA	17.1	69.8	NA	
South Africa	CI	ALB	3.1/0.0	100	NA	29.5/4.7	84.1	NA	51.9/38.0	26.8	NA	16 weeks	Jinabhai et al., 2001
South Africa	CI	ALB	59.4/0.0	100	NA	58.9/17.4	68.9	NA	83.6/61.5	26.4	NA	12 months	Taylor et al., 2001
South Africa	CI	ALB	NA	NA	NA	NA	NA	NA	NA	23.0	96.8	NA	Adams et al., 2004
South Africa	CI	ALB	82.9/17.6	78.8	93.2	22.0/0.8	96.4	97.7	59.8/52.2	12.7	24.8	3 weeks	Saathoff et al.2004
Tanzania	RCT	MEB	NA	NA	68.0	NA	>96.0	>95.0	NA	23.3	>80.0	4 weeks	Albonico et al., 2002
		PY-OX	NA	NA	67.0	NA	>96.0	>95.0	NA	35.1	>80.0	4 weeks	
Tanzania	CI	ALB	61.0/11.0	82.0	97.6	NA	NA	NA	NA	NA	NA	6 weeks	Guyatt et al., 2001
Tanzania	CI	ALB	45.6/11.9	73.9	NA	0.9/0.7	22.2	NA	4.8/0.7	85.4	NA	8 months	Massa et al.,2009
Tanzania	RCT	MEB+LEV	94.0/71.8	26.1	88.7	62.0/1.4	98.5	99.1	93.1/74.5	22.9	85.0	3 weeks	Albonico et al., 2003
		LEV	96.2/87.6	11.9	61.3	59.5/5.7	91.2	98.5	93.8/90.0	9.6	41.5	3 weeks	
		MEB	94.9/91.5	7.6	52.1	59.7/3.0	96.5	99.0	90.7/75.0	22.9	81.0	3 weeks	
Uganda	CI	ALB	50.9/10.7	79.0	92.9	2.8/0.6	78.6	NA	2.2/1.6	27.3	NA	2 years	Kabateriene et al,2007
Kenya	CI	MEB	NA	50.0	66.3	NA	79.6	NA	60.6	NA	NA	6 months	Muchiri et al., 2001
		ALB	NA	92.4	96.7	NA	83.5	NA	67.8	NA	NA	6months	
Kenya	CI	ALB	16.7/ 0.2	98.8	NA	1.6/0.0	100	NA	0.8/0.6	25.0	NA	8 weeks	Kihara et al., 2007

CI=Chemotherapeutic intervention; RCT=Randomized controlled trial; MEB=Mebendazole; ALB=Albendazole; LEV=Levamisole; PY-OX=Pyrantel oxantel; P/P= Pre/post treatment prevalence; CR= Cure rate; ERR= Egg reduction rate; NA= not accessible/not determined

exceptions.[18-27] The potency of the doctrine of informed consent or informed refusal was succinctly captured in the words of Lord Justice Cardozo in 1914 in the case Schoendorff v Society of New York Hospital when he said "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault...."[22] The doctrine of informed consent/refusal was similarly strengthened by the United States Supreme Court in Cruzan decision and recently by the Nigerian Supreme Court in the case of Nigeria medical and dental practitioners' disciplinary tribunal v Okonkwo.[26,27] This principle of informed consent/refusal derives its breath of life from the principle of patient's autonomy. [22]

Discharge against medical advice: a process and not a mere signature

The physician ought to know that discharge against medical advice is a process and not a mere signature. The literature is replete with cases where caregivers were found liable because the process of discharge against medical advice was not properly handled.[28-35] As with informed consent, informed refusal of care is a process, not merely a signature on a "DAMA" form but a process[28,29] Consequently, for it to be a proper withdrawal of consent, the following conditions should be satisfied: (1) the patient's withdrawal of consent is fully informed with respect to risks and alternatives; (2) the patient possesses the mental competency to make a reasoned decision on the basis of adequate information; and (3) the patient does not meet the state standard for involuntary psychiatric hospitalization or any other form of involuntary admission. The medical doctors should recognize that forms signed by a patient who is leaving against medical advice that purports to exonerate the hospital and its staff in the event of an untoward consequence are meaningless, worthless and against public policy and have no legal protective value neither can it be a royal road to legal immunity once the due process of discharge against medical advice has been jettisoned.[28-30] In Battenfeld v. Gregory, the jury returned a verdict for the plaintiff and found that the failure to explain the risks of leaving against medical advice was not excused by the patient's execution of an AMA form.[30] In Canterbury v. Spence, the court held "ideally, a healthcare provider should disclose the benefits, risks and side effects of the treatment in addition to the alternatives to the treatment and the consequences of no treatment".[33,36]

While the documentation may be done in the body of the case file, Henson et al found that when healthcare providers used detailed against medical advice forms, physician documentation improved.[31] The documentation should include the following:

Ascertain decision making capacity: The physician must be certain that the patient seeking discharge against medical advice has appropriate decisional capacity. Who is the competent adult? The answer is not clear cut but demands a lot of reasonableness on the part of the physician. The services of a mental physician maybe required when there is doubt about decisional capacity of patients. In emergency situations, physicians must promptly assess whether a patient is capable of making a decision.[21,28,29,38,39]

Assess patient's values/applications for the situation at hand: The physician should assess and document the patient's values/applications for the situation at hand.

Address patient's concerns: Reasonable attempt must be made to address patient's concern and reasons for wanting to leave. Studies have shown that if there is a deep concern to determine why the patient plans to leave against medical advice, most patients would open up to verbalize their concerns. With adequate discussion and empathy on the part of the care givers, most patients would reverse their decision to discharge against medical advice.[5,6,12,37-39] This duty on the part of the care givers borders more on ethical considerations and demonstrates conscientious application of the Hippocratic Oath.

Inform patients of risks DAMA: The patient should be properly informed about the risk of discharge against medical advice even the risk of possible death depending on the severity of the ailment.[28,29,32-34,38]

Inform other parties when appropriate: In some cases, it may be pertinent to inform family members or the next of kin, hospital management and the police about the patient's decision to discharge against medical advice but consider the appropriateness of doing so.

Consider alternative treatments and compromises: When a patient has declined a particular form of treatment, the physician should be willing to consider alternatives and compromises.[20] For example, if an orthopaedic surgeon offers open reduction and internal fixation for a tibia fracture and the patient declines this method of treatment, the surgeon may consider use of plaster of paris or any other method of closed reduction and immobilization after explaining the implications to the patient.

Provide appropriate care within the scope of what the patient accepted: This sounds controversial but this should be the practice. A patient that has an open fracture may refuse open reduction and internal fixation. But this patient has not said his wounds should not be dressed. The patient has not declined relief of pain. And the patient has not said he does not want tetanus prophylaxis. The physician should be able to draw that reasonable line no matter how thin it seems, to know exactly what the patient refuses or accepts.

Avoid punitive statements and scare tactics: While it is acceptable to explain consequences of discharge against medical advice to the patient, it is totally unacceptable and in fact reprehensible for a physician or any care giver for that matter to use punitive statements and scare tactics. If this is done, it can grant a ground for litigation.[2,28,29,38]

Inform patient that he can always come back: An erroneous practice in most healthcare facilities is the belief that once a patient has discharged against medical advice then such patient cannot come back to the same health facility. The patient who has so discharged himself against medical advice has the right to come back to the same facility at any time. [28,29,38] And this position is also clearly described in the code of conduct for physicians in Nigeria.[40] Accepting such patient back to continue care should be without prejudice to the initial activities that led to the request by the patient for discharge against medical advice. It should be noted also that informed consent and informed refusal are both

dynamic and ambulatory.

Document informed refusal discussion/outcome: The hallmark of the process of handling cases of discharge against medical advice is to have appropriate and detailed documentations of all the discussions regarding informed refusal of treatment and the outcome of such discussion. The documentation must not be nebulous or ambiguous.[5,28,29,31,38]

Consider telephone follow up: For very critical cases, physicians are enjoined to have a telephone follow up to ascertain the state of health of the patient after he had discharged against medical advice from the facility particularly if that patient had indicated that he was going to another facility to continue care.[41]

Various forms of documentations and forms for discharge against medical advice have been designed.[42]

A typical documentation which summarizes the DAMA process above and which should be signed by the physician should take this format:

I have examined _____ and I judge that he has appropriate decisional capacity. I have informed him of the risks of refusing medical care, including potential risks of _____. He understands these risks and voluntarily chooses to refuse medical care at this time. I have offered alternatives including _____. He chooses to _____. I invited him to return at any time for further treatment.

A form to be signed by the patient, the doctor and a witness may be designed with the following format:

This document is to certify that I am leaving this hospital or health care center upon my own free will. In doing so I hereby release this hospital or health care center and the attending physician from any and all claims that I may hereafter make. I understand that further care has been recommended and that my condition may worsen or lead to other problems, causing me further bodily injury, illness, or even death if care is not rendered. I further certify that the medical staff has fully explained to me the risk that I am taking in leaving against medical advice.

Additional notes:

Risks of refusal of medical care:

We invite you to return for medical care at any time, should you decide to consent to treatment.

Signed:_____

Date_____

Witnessed:_____

In the accident and emergency room, the following format may be used:

I acknowledge that my medical condition has been evaluated and fully explained to me to my satisfaction by the Emergency Department physician or other qualified person and/or my attending physician. The discussion included a full explanation of medical benefits to be anticipated from further examination and/or treatment and the potential risk to my medical condition resulting from refusal of further medical examination and/or treatment, including _____. Nevertheless, I hereby refuse to consent to further examination, or treatment of my medical condition.

I hereby release ___(institution) and my physicians from ALL liability and will protect them from all claims made by anyone that may relate to my refusal of medical examination and/or treatment. I understand that I am

encouraged to return for further treatment if I choose to. _ _____

Signature of patient or legally responsible individual signing on patient's behalf Witness

_____ _____

Relationship to patient Date and time[42]

Cases involving incompetent adults and minors: If the adult is incompetent, then a guardian or next of kin can take decisions that will be in the best interest of the patient. Where such decisions are not in the best interests of the patient, then peculiar challenges will need to be handled. For example, if a patient, who was involved in a road traffic accident, became unconscious and has a fracture that requires open reduction and internal fixation and the next of kin wants to discharge the patient to use traditional bone setters, what should the doctor do? The current practice in Nigeria is that the doctor will oblige the next of kin. But this author submits that this position is wrong and ought to be challenged. The hospital and its agents through the instrumentality of the courts should be able to take decisions that will be in the best interest of the unconscious patient. But in doing this, certain criteria should be satisfied.[43] Firstly, this patient is incapable of consenting. Secondly, the medical practitioner who seeks to give the treatment considers the treatment necessary to meet an imminent risk to life or health of the person and that consideration is supported in writing by another medical practitioner who has personally examined the patient (unless in the circumstances it is not practicable to obtain such an opinion). And thirdly, the adult person, has not, to the medical practitioner's knowledge, previously refused to consent to the treatment. But there is a challenge. Who pays for the blood transfusion and the surgery? This will require a functioning strong health insurance system to be able to tackle the challenges.

Minors present peculiar challenges. For the purposes of informed refusal, minors can be categorized into various groups:

Minors indeed: For minors indeed, the practice in Nigeria today is that the parents take decisions for the minors. It is submitted that this is wrong. Where a decision is adjudged to be harmful to the minor and repugnant to natural justice, a clear cut procedure should be defined where the hospital agents or the courts as the case may be can take decisions that will be in the best interest of the minor. Under the doctrine of *Parens Patriae (*refers to the State's interest in the well being of the child), the physicians can and should treat emergency medical conditions of minors, even if the parents object.[23,24] In effect, on religious grounds, an adult may chose to become a martyr but should not be allowed by law to make his child to become a martyr as well. This doctrine appears to be silent in Nigeria.

Emancipated minors: These are minors who have been married, who live independently of their parents or who are in the military. Emancipated minors may consent to or refuse their own medical care.[25]

Mature minors: Mature minors are those who determined by a court to be intellectually and emotionally mature enough to comprehend risks and benefits of the proposed treatment and to that extent are able to consent to or

refuse their own medical care.

Can DAMA be refused?

DAMA can be refused under certain circumstance e.g. cases of infectious diseases like tuberculosis. In an American case, a successful claim was brought against a hospital by a lady who contracted tuberculosis in a dormitory from a tuberculosis patient who ordinary should be on admission in the hospital but was allowed to exercise her right to seek discharge against medical advice.[18] Also, if a patient is being investigated for a criminal matter or was already serving a jail term before he was brought to the hospital, then that patient may be unable to exercise his right in seeking discharge against medical advice. In addition, psychiatric patients (particularly the violent ones and those that have suicidal tendencies), particularly those that are on involuntary confinement may also not be allowed to obtain discharge against medical advice. Lastly, certain laws may also define categories of patients that should not be allowed to discharge themselves against medical advice.

Common errors that may lead to litigations

Inappropriate management of the process of discharge against medical advice may lead to litigations. One of the ways a physician minimizes the chances of litigation is to be aware of the common errors that could lead to litigation with respect to discharge against medical advice and strive at all times to avoid such errors. Inappropriate documentations and application of vital signs can give a ground for litigation. For example, if a patient's packed cell volume is 10% following a road traffic accident, then it is very unlikely that such a patient will be logical in his decisions. Another error that is very common is failure to involve the responsible doctor. Failure to complete the DAMA form and failure to insist that the patient signs the DAMA form before leaving the healthcare facility are common errors that may also lead to litigations. Another common error is failure to clearly document the DAMA process and the outcome of the interaction with the patient in the case note. It is an error also not to inform patient in very clear terms of the potential risks of the decision to obtain a discharge against medical advice. Failure to ascertain patient's decisional capacity is also a common error that can lead to litigation. Failure to inform the family members of the patient's decision to leave against medical advice is a potential issue for litigation.. Another common error is failure to note when the patient left the facility after taking the decision to obtain discharge against medical advice. It is most critical to note the time the patient left the unit in case such a patient were to be found dead, suffers a major morbidity or was involved in a crime after leaving the hospital. The commonest error perhaps is failure to attend to the patient who has come back to the same facility after a previous discharge against medical advice. This is a great error and must be corrected. If this caveat is not taken seriously, then it is a potential hot spot for litigation. Failure to get a witness during the DAMA process is also a potential focus for possible litigation.

Defences for the doctor

A sound knowledge of the common errors and

concerted efforts to avoid the errors provides the best defense for the medical practitioner.

A patient may refuse to sign the dama form – what next?

There may be occasions where the patient seeking discharge against medical advice refuses to sign the relevant DAMA forms. Under the circumstance, the doctor is not expected to compel the patient to sign. But there are steps the doctor must take in order to have a defense. First get a witness who will observe the interactions between the doctor and the patient. Ensure that there is adequate documentation. Inform the hospital authority and the hospital security outfit. Depending on the nature of the case and the peculiar attributes of the patient, one may need to inform the police.

Conclusion/recommendations

There is no substitute for good clinical care and thorough documentation. Before discharging a patient "against medical advice," a physician should ensure that the patient is mentally competent, fully informed, and does not meet the criteria for involuntary psychiatric hospitalization or any other form of involuntary admission. Once the physician is diligent enough to ensure that all these parameters are in place, then litigations related to discharges against medical advice can be reduced to a minimum.

It is recommended that medical ethics be emphasized in medical school curriculum Nigeria so that right from the medical school days, the medical doctors will be fully aware of the import of discharge against medical advice. Medical doctors should have training in medical ethics from time to time so they are continuously abreast of the entire concept of discharge against medical advice. It is also recommended that doctors must always have adequate documentations with regard to their interactions with patients particularly when it bothers on discharge against medical advice.

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