

Discharge Against Medical Advice

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The Case

A 50-year-old man with a history of alcohol abuse and alcohol-induced dementia was admitted to the medical service with mild alcohol withdrawal. He was also found to have a proximal humeral fracture, and the orthopedic consult recommended surgical repair. The patient was treated with benzodiazepines for his alcohol withdrawal and remained medically stable. After hearing the risks and benefits of surgery from the physicians, the patient refused.

In light of the patient's chronic dementia and acute delirium due to alcohol withdrawal, formal mental status testing was performed, which indicated that the patient lacked the capacity to make medical decisions. A psychiatry consultation supported this determination.

On hospital day 4, at approximately midnight, the patient stated to his nurse that he wished to leave the hospital. Neither the floor nurse nor the charge nurse was aware the patient had been found to lack decision-making capacity. They contacted the nightfloat covering resident and informed her that the patient wished to leave. The resident glanced at the chart, asked the patient a few questions, and allowed him to leave against medical advice (AMA).

The primary medical team was informed the following morning about the discharge. They had no contact information for the patient, and he could not be located. What happened to him is unknown.

The Commentary

Providing high-quality health care is a challenge when patients do not adhere to their physicians' recommendations. The patient who insists on leaving the hospital AMA is an extreme example of non-adherence, and this situation creates high potential for serious errors.

Epidemiology of Discharges AMA

Patients who leave AMA account for 0.8%-2.2% of discharges from medical services at acute care hospitals in the United States.⁽¹⁻⁴⁾ In general, AMA discharge rates tend to be higher at urban hospitals

than suburban hospitals and higher at community hospitals than teaching hospitals.(1) At hospitals serving disadvantaged inner-city populations, as many as 6% of general medical patients (5) and 13% of patients with HIV/AIDS leave AMA.(6)

It is not clear why the patient in this case wanted to leave AMA, but he had a number of risk factors. Characteristics associated with an increased likelihood of leaving AMA include male sex, Medicaid coverage or lack of health insurance, lack of a primary care physician, admission through the emergency department, admission with a substance abuse–related diagnosis, and previous AMA discharge.(1-3) In a study of HIV-positive patients, injection drug users were more than four times more likely than non-users to leave AMA, and AMA discharges were three times more likely to occur on days when welfare checks were issued.(6) Unfortunately, there is no prediction rule that can accurately identify in advance which patients will leave AMA.

Patients leave AMA for a variety of reasons. When asked, they most commonly cite family problems or emergencies; personal or financial obligations; feeling bored, fed up, or well enough to leave; or dissatisfaction with their treatment.(5,7) Although many patients who discharge themselves AMA have substance abuse problems, few of them attribute their decision to leave to their addiction.

Patient Outcomes in Discharges AMA

It seems likely that discharge AMA puts patients at increased risk of adverse health outcomes. This concern is supported by several studies that found that patients who leave AMA have significantly higher readmission rates than other patients.(3,5,6) In a study of general medical patients, the readmission rate within the first 15 days after discharge was 21% in patients leaving AMA, compared with 3% in matched controls; the rate of readmission over the subsequent 75-day period was similar in the two groups.(5) No specific factors have been found to strongly predict readmission among patients discharged AMA.

It is uncertain whether patients leaving the hospital AMA face an increased risk of death, as no study has compared mortality rates among patients leaving AMA to those formally discharged. Among patients leaving AMA from an Australian hospital, the mortality rate was 3% within 28 days (8). In patients leaving AMA from a general medical service at a Canadian hospital, the mortality rate was 3% within 90 days.(5) Although a causal link is difficult to demonstrate, many physicians can recall anecdotal but sobering cases of patients who left AMA and died shortly thereafter. In an example from my own experience, a homeless man with schizophrenia was admitted with abdominal pain believed to be due to a volvulus. He was allowed to leave AMA in the middle of the night, only to be found a few hours later collapsed on the sidewalk within one block of the hospital. All efforts to resuscitate him were unsuccessful.

Reducing Errors and Adverse Outcomes Associated with Discharges AMA

How can health care professionals minimize the risk of errors and/or adverse outcomes in patients leaving AMA? Obviously, the prevention of AMA discharges would be ideal, although difficult to achieve in practice.(9) In a study of HIV-positive patients, 61% of whom were active injection drug users, in-hospital prescription of methadone reduced the odds of discharge AMA by 50%.(10) Interventions to enhance social supports in marginalized populations may also be useful.(10) In some cases, a patient who plans to leave AMA may have a specific concern (e.g., a pet at home), and he or she may be persuaded to remain in

hospital if the concern is addressed.

When a patient insists on leaving AMA, the goal should be to provide the best possible care under clearly suboptimal circumstances. Although existing research does not provide much guidance in this area, a number of recommendations seem reasonable. Hospitals should consider establishing a standardized AMA discharge protocol to ensure that important steps are carried out ([Table](#)). As illustrated by this case, nurses are usually the first to become aware of an impending AMA discharge. Their active involvement in the AMA discharge protocol is vital and can help promote better communication between nurses and physicians around the time of the discharge. Such protocols become particularly important when the patient leaves at night or on a weekend, increasing the risk that critical safeguards will be neglected.

Assessment of the patient's decision-making capability is essential; practical algorithms are available to help guide this process.⁽¹¹⁾ In an effort to balance patient autonomy and patient safety, physicians should ensure that a patient with a severe life-threatening illness has a very high level of decision-making capability before allowing him or her to leave AMA. Less stringent criteria may be applied to patients with conditions that are not immediately life threatening.

Follow-up arrangements are of paramount importance. In general, physicians should offer outpatient therapies that may be helpful, even if they are suboptimal (e.g., oral antibiotics to treat an infection for which intravenous antibiotics are the standard of care). Patients who leave AMA sometimes do not fill the prescriptions that are given to them. Thus, if critical new medications are prescribed, they would ideally be dispensed by the pharmacy and given to the patient before he or she leaves. If the patient is at very high risk of serious health consequences, the physician can seek the patient's permission to follow up by phone call or home visit within the next few days. However, patients who leave AMA are often difficult to locate after discharge, as this case vividly demonstrates.

When a patient decides to leave AMA, good communication with other members of the health care team is especially important. Even in the middle of the night, it would not be unreasonable for a covering physician to immediately inform the patient's primary physician of the impending discharge. In this case, such action may have averted the AMA discharge, since the covering physician would have learned of the patient's diminished decision-making capacity. In addition, the physician should provide the patient with a brief written summary of the hospital stay. Such a summary may be particularly helpful if the patient subsequently seeks care from a different health care facility.

Physicians may be under the mistaken impression that discharging a patient AMA (with the patient presumably "consented" regarding the consequences of leaving) confers full protection against future legal action. In rare cases, physicians have been sued for medical malpractice after their patient left AMA. The successful defense of these physicians was based not on the fact that the patient left AMA, but on the grounds that there was no proof of negligence.⁽¹²⁾ Thus, assessment and documentation of the patient's decision-making capacity is crucial.

In summary, this case illustrates numerous points at which preventable errors can occur when a patient is discharged AMA. The covering resident did not adequately assess the patient's decision-making capacity, and the provider-to-provider communication that would have identified the patient's lack of capacity did not occur. Better attention to obtaining the patient's contact information and making follow-up arrangements

might have allowed the medical team to reduce the risk of a poor outcome. As is so often the case, the discharge AMA took place at an inconvenient time, highlighting the need for a pre-established protocol to ensure that critical safeguards are not neglected.

Take-Home Points

- Approximately 1%-2% of hospital discharges occur AMA. Patients who leave AMA have significantly higher readmission rates and may be at increased risk of serious adverse health consequences when compared with normally discharged patients.
- The use of a standardized protocol to address issues of decision-making capacity, follow-up arrangements, and communication may help reduce the risk of errors when patients are discharged AMA.
- Discharge AMA does not absolve the physician of responsibility for poor outcomes; as always, good clinical care and careful documentation are of paramount importance.

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References

1. Smith DB, Telles JL. Discharges against medical advice at regional acute care hospitals. *Am J Public Health*. 1991;81:212-215. [[go to PubMed](#)]
2. Jeremiah J, O'Sullivan P, Stein MD. Who leaves against medical advice? *J Gen Intern Med*. 1995;10:403-405. [[go to PubMed](#)]
3. Weingart SN, Davis RB, Phillips RS. Patients discharged against medical advice from a general medicine service. *J Gen Intern Med*. 1998;13:568-571. [[go to PubMed](#)]
4. Saitz R, Ghali WA, Moskowitz MA. Characteristics of patients with pneumonia who are discharged from hospitals against medical advice. *Am J Med*. 1999;107:507-509. [[go to PubMed](#)]
5. Hwang SW, Li J, Gupta R, Chien V, Martin RE. What happens to patients who leave hospital against medical advice? *CMAJ*. 2003;168:417-420. [[go to PubMed](#)]
6. Anis AH, Sun H, Guh DP, Palepu A, Schechter MT, O'Shaughnessy MV. Leaving hospital against medical advice among HIV-positive patients. *CMAJ*. 2002;167:633-637. [[go to PubMed](#)]
7. Green P, Watts D, Poole S, Dhopes V. Why patients sign out against medical advice (AMA): factors motivating patients to sign out AMA. *Am J Drug Alcohol Abuse*. 2004;30:489-493. [[go to PubMed](#)]
8. O'Hara D, Hart W, McDonald I. Leaving hospital against medical advice. *J Qual Clin Pract*. 1996;16:157-164. [[go to PubMed](#)]
9. Saitz R. Discharges against medical advice: time to address the causes. *CMAJ*. 2002;167:647-648. [[go to PubMed](#)]

10. Chan AC, Palepu A, Guh DP, et al. HIV-positive injection drug users who leave the hospital against medical advice: the mitigating role of methadone and social support. J Acquir Immune Defic Syndr. 2004;35:56-59. [[go to PubMed](#)]
11. Jones RC, Holden T. A guide to assessing decision-making capacity. Cleve Clin J Med. 2004;71:971-975. [[go to PubMed](#)]
12. Devitt PJ, Devitt AC, Dewan M. An examination of whether discharging patients against medical advice protects physicians from malpractice charges. Psychiatr Serv. 2000;51:899-902. [[go to PubMed](#)]

Table

Table. Important Steps When a Patient Is Leaving Against Medical Advice

Issues	Specific Actions
Decision-making capacity	• Assess the patient's decision-making capacity • Document the capacity assessment in the chart • Document the discussion with the patient regarding the severity of the patient's illness and the potential consequences of leaving AMA
Follow-up arrangements	• Discuss specific scenarios with the patient that should prompt an immediate return to the emergency department • Arrange for telephone follow-up, if indicated • Arrange for home care, if indicated • Arrange for an outpatient follow-up appointment (preferably within the next 7 days) • Provide prescriptions for any new medications (arrange for dispensing of medications to the patient, if possible) • Document the above in the chart
Communication	• Provide the patient with a brief written summary of his or her diagnoses, treatments, medications, and follow-up plans • Immediately inform the patient's primary medical team regarding discharge AMA and follow-up plans • Communicate with the patient's primary care provider (if different from the inpatient medical team) regarding discharge AMA and follow-up plans • With the patient's consent, communicate with the patient's next-of-kin regarding discharge AMA and follow-up plans • Document the above in the chart

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