Research on Discharges against Medical Advice – Pursuing an Evidence-Based Path Forward in Service to Patients

David Alfandre MD, MSPH[1]

[1]*VHA National Center for Ethics in Health Care, Assistant Professor of Medicine and Population Health, NYU School of Medicine, New York, USA*

Conflict of Interest: None declared

This article has been peer-reviewed

Article Submitted on: 15th April 2015

Article Accepted on: 16th April 2015

Funding Sources: None declared

Correspondence to: Dr David Alfandre

Address: VHA National Center for Ethics in Health Care, Department of Medicine and Population Health, NYU School of Medicine, New York, USA

Email: david.alfandre@va.gov

Cite this article: Alfandre D. Research on discharges against medical advice-pursuing an evidence-based path forward in service to patients. J Pioneer Med Sci 2015; 5(3): 87-88

Discharges against medical advice (DAMA) continue to be a vexing problem with inpatient admissions. In the United States, up to 500,000 admissions per year end in a DAMA [1]. Both patients and hospital staff alike are frustrated and distressed by the phenomenon and both recognize the negative health effects that come with it. These discharges are associated with higher rates of readmission, morbidity and mortality, and may increase costs of care [2]. Furthermore, patients affected by DAMA are more likely to have a concomitant substance use disorder or psychiatric illness, or have limited health insurance−all potential vulnerabilities in accessing care.

A DAMA is an event that is the end result of a series of circumstances and factors related to the patient, hospital, and the patient's physician. In general, the stated intent of research on DAMA has been to identify specific elements from inpatient admissions in order to develop interventions to reduce the rate of DAMA. In spite of this broad aim, the majority of prior studies examining DAMA have focused primarily on collecting patient-related data [3]. If the hypothesis is accepted that DAMA is multifactorial, then studies that are done in diverse contexts and that examine broader ranges of hospital and staff level data will be more likely to provide greater illumination of the problem.

The study by Tabrizi et al [4] in this quarter's Journal of Pioneering Medical Science is another addition to the literature about this complicated problem. This cross-sectional study looked at 17 hospitals in Iran to evaluate the prevalence and associated variables with DAMA. The hospitals comprised a mix of teaching, public, private and social security institutions. The authors collected patient demographic data and DAMA reasons, as well as hospital level data. The authors found that the overall rate of DAMA was significantly higher in Iran compared to the United States; DAMA was more likely among female and younger patients, private and teaching hospitals and by certain months of the year. What can these new findings reveal about the complex hos-

-pital phenomenon of DAMA?

First, that there are likely significant differences in DAMA across countries and this may have implications for how the issue should be addressed. The data, in and of itself, is probably not sufficient to implement an effective intervention designed to reduce DAMA. Rather, this data suggests the complexity of this multi-determined phenomenon and may help stimulate additional research to elucidate some of these critical differences we see internationally. Both qualitative and quantitative research that examines the patient and physician perspective will help us to understand why this phenomenon is sometimes more common with one patient gender, certain comorbidities, and in certain wards or hospitals. After all, the decision to leave is the patient's, but the decision to formalize and label the discharge as against medical advice is the physician's.

Given the lack of medical or professional standards as to what constitutes a decision to leave the hospital "against medical advice," there is likely to be significant variability in how physicians and other staff apply the term and how patients behave when confronted with a conflict about their treatment plan.

Finally, differences in DAMA between countries may be due to varying cultural attitudes about the patient-physician relationship, the degree of patient-centeredness, and potential legal differences in liability regarding patients who decline recommended care. Further research can address these uncertainties.

Patients who leave the hospital against medical advice are likely to suffer negative consequences of their decision. This is especially important to recognize because the literature also suggests that patients who are discharged against medical advice report that they are less likely to follow up for medical care and feel stigmatized about their decision [5]. How then can the medical profession help when the ultimate decision rests with the competent patient?

First, we must follow in the footsteps of investigators like Tabrizi et al and continue to

research this issue so that we gain a better understanding of how and why it happens, in which settings, with which doctors, under which circumstances and to which patients [4].

Second, the medical profession should uphold its obligation to support patients in the spirit of patient-centeredness. In the absence of data to demonstrate that designating a discharge as DAMA substantively advances patient care, physicians should endeavor to support patients in their choices (even if the physician does not recommend it). Physicians can make their patients less vulnerable by finding ways to support them in ways the patient can accept. Continued research on DAMA can give us better data to inform clinical practices that can make these vulnerable patients less vulnerable.

DISCLOSURE:

The views expressed in this article are those of the author and do not necessarily reflect the position or policy of the U.S. Department of Veterans Affairs or the National Center for Ethics in Health Care.

REFERENCES

1. Alfandre DJ. "I'm going home": discharges against medical advice. *Mayo Clin Proc.* 2009; 84(3):255-260.
2. Glasgow JM, Vaughn-Sarrazin M, Kaboli PJ. Leaving against medical advice (AMA): risk of 30-day mortality and hospital readmission. *J Gen Intern Med.* 2010; 25(9):926-929.
3. Alfandre D. Reconsidering against medical advice discharges. *J Gen Intern Med.* 2014; 29(5):706.
4. Tabrizi JS, Jafarabadi MA, Ranai A. Discharge against medical advice in hospitals of Tabriz, Iran. *J Pioneer Med Sci.* 2015; 5(2):76-80
5. Jerrard DA, Chasm RM. Patients leaving against medical advice (AMA) from the emergency department-disease prevalence and willingness to return. *J Emerg Med.* 2011;41(4):412-7