InFocus

Lack of Liability Protections with Standard AMA Forms

By James R. Roberts, MD

Author Credentials and Financial Disclosure: James R. Roberts, MD, is the Chairman of the Department of Emergency Medicine and the Director of the Division of Toxicology at Mercy Catholic Medical Center, and a Professor of Emergency Medicine and Toxicology at the Drexel University College of Medicine, both in Philadelphia.

Dr. Roberts has disclosed that he is a member of the Speakers Bureau for Merck Pharmaceuticals. All other faculty and staff in a position to control the content of this CME activity have disclosed that they and their spouses/life partners (if any) have no financial relationships with, or financial interests in, any commercial companies pertaining to this educational activity.

Learning Objectives: After participating in this activity, the physician should be better able to:

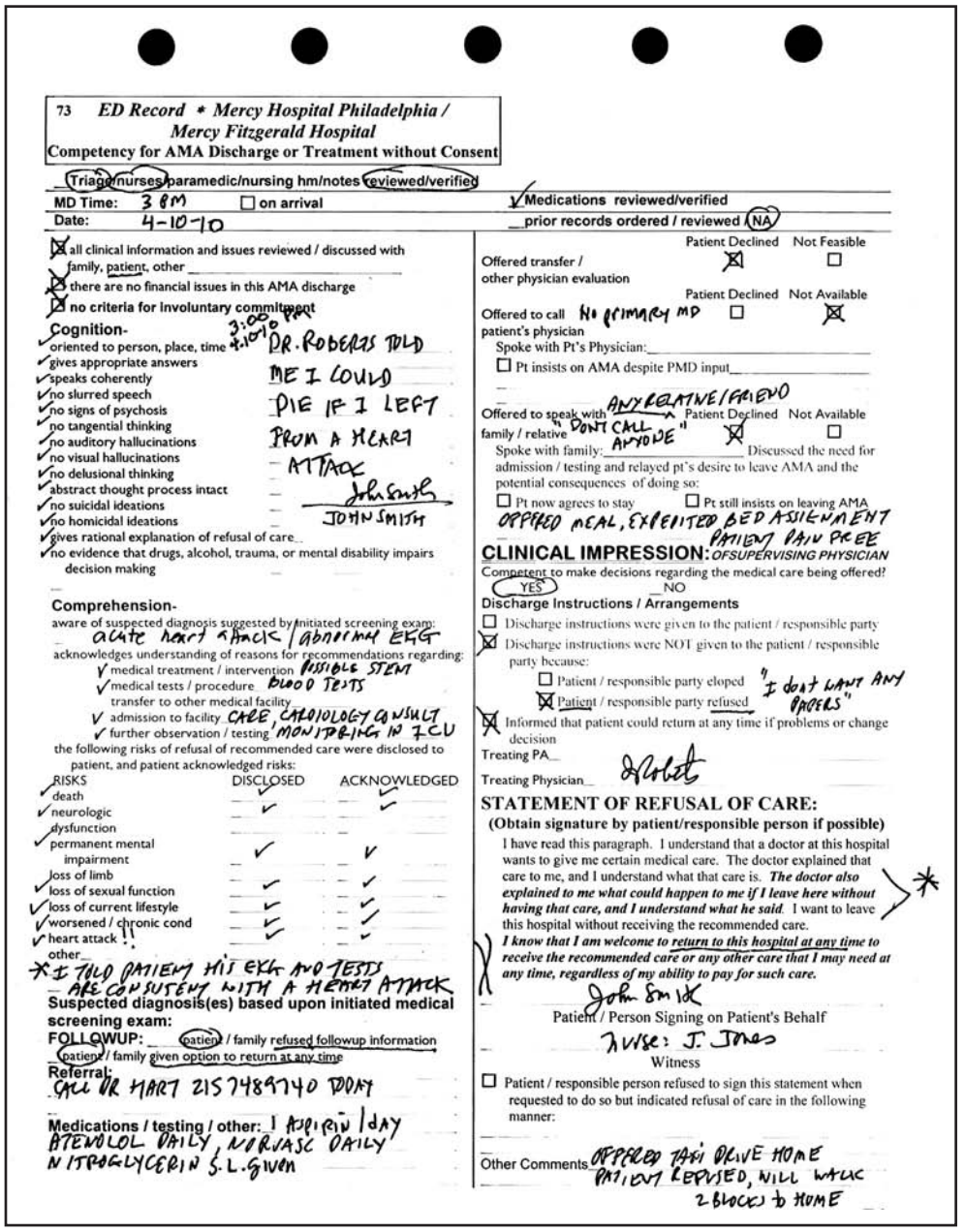
1. Construct a profile of patients most likely to leave the ED against medical advice.
2. Distinguish the parameters that should be addressed in an AMA discharge form.
3. Apply specific interventions to discourage adverse repercussions from an AMA discharge.

Part 1 in a Series

Emergency physicians have enough to worry about when it comes to treating difficult ED patients, and we have all been in the situation where, after spending considerable time and resources, a patient decides he does not really want to take our advice and announces, often very abruptly, his incipient exit from the ED. This is a frustrating dilemma fraught with potential and real complications for the patient and physician. After extending tremendous effort, it is human nature for the medical staff to be frustrated and simply comply with the patient's wishes. We all try to discuss the dangers of leaving against medical advice, but once a patient makes up his mind, it may be impossible to dissuade him. A normal reaction from an overworked, frustrated medical staff is to ask the patient to sign an amorphous form, branding him ignorant and ungrateful and letting him fend for himself. We have negotiating tactics, but it's difficult to change a patient's mind. Although a "good riddance" reaction may seem to settle the issue, things are much more complicated. If you think a simple signature on a patient's chart under the AMA moniker is a free pass for the clinician and hospital, you are dead wrong.

Contrary to popular belief, the garden-variety AMA form does little to protect the hospital or physician when there is a bad outcome. It's difficult for the family or general public to believe something more could not have been done to ameliorate the irrational behavior of someone obviously ill who did not comprehend the need for urgent treatment. While some are obnoxious or sobered-up alcoholics, many AMA patients are scared, confused, or in denial, but they still can have serious medical problems and experience a bad outcome.

This article will help clinicians create a profile of patients most likely to leave against medical advice, and apply interventions to discourage adverse repercussions from an AMA discharge.



73 *ED Record * Mercy Hospital Philadelphia / Mercy Fitzgerald Hospital*
Competency for AMA Discharge or Treatment without Consent

Triage nurses paramedic/nursing hm/notes reviewed/verified
MD Time: 3 PM ☐ on arrival
Date: 4-10-10
☒ all clinical information and issues reviewed / discussed with family, patient, other
☒ there are no financial issues in this AMA discharge
☒ no criteria for involuntary commitment

Cognition-
✓ oriented to person, place, time 3:00 PM 4-10-10 DR. ROBERTS TOLD
✓ gives appropriate answers ME I COULD
✓ speaks coherently DIE IF I LEFT
✓ no slurred speech FROM A HEART
✓ no signs of psychosis ATTACK
✓ no tangential thinking John Smith
✓ no auditory hallucinations JOHN SMITH
✓ no visual hallucinations
✓ no delusional thinking
✓ abstract thought process intact
✓ no suicidal ideations
✓ no homicidal ideations
✓ gives rational explanation of refusal of care
✓ no evidence that drugs, alcohol, trauma, or mental disability impairs decision making

Comprehension-
aware of suspected diagnosis suggested by initiated screening exam: ACUTE HEART ATTACK / ABNORMAL EKG
acknowledges understanding of reasons for recommendations regarding:
✓ medical treatment / intervention POSSIBLE STENT
✓ medical tests / procedure BLOOD TESTS
transfer to other medical facility
✓ admission to facility CARE, CARDIOLOGY CONSULT
✓ further observation / testing MONITORING IN ICU

the following risks of refusal of recommended care were disclosed to patient, and patient acknowledged risks:

RISKS	DISCLOSED	ACKNOWLEDGED
✓ death	✓	✓
✓ neurologic dysfunction	✓	✓
✓ permanent mental impairment	✓	✓
loss of limb		
✓ loss of sexual function	✓	✓
✓ loss of current lifestyle	✓	✓
✓ worsened / chronic cond	✓	✓
✓ heart attack !!	✓	✓
other		

* I TOLD PATIENT HIS EKG AND TESTS ARE CONSISTENT WITH A HEART ATTACK

Suspected diagnosis(es) based upon initiated medical screening exam:
FOLLOWUP: patient / family refused followup information
patient / family given option to return at any time
Referral: CALL DR HART 2157489740 TODAY
Medications / testing / other: 1 ASPIRIN / day ATENOLOL DAILY, NORVASC DAILY NITROGLYCERIN S.L. Given

✓ Medications reviewed/verified
__ prior records ordered / reviewed (NA)

	Patient Declined	Not Feasible
Offered transfer / other physician evaluation	☒	☐

	Patient Declined	Not Available
Offered to call patient's physician	NO PRIMARY MD ☐	☒

Spoke with Pt's Physician:
☐ Pt insists on AMA despite PMD input

	Patient Declined	Not Available
Offered to speak with family / relative	ANY RELATIVE / FRIEND "I DON'T CALL ANYONE" ☒	☐

Spoke with family: Discussed the need for admission / testing and relayed pt's desire to leave AMA and the potential consequences of doing so:
☐ Pt now agrees to stay ☐ Pt still insists on leaving AMA
OFFERED MEAL, EXPEDITED BED ASSIGNMENT

CLINICAL IMPRESSION: PATIENT PAIN FREE OF SUPERVISING PHYSICIAN
Competent to make decisions regarding the medical care being offered?
(YES) NO

Discharge Instructions / Arrangements
☐ Discharge instructions were given to the patient / responsible party
☒ Discharge instructions were NOT given to the patient / responsible party because:
☐ Patient / responsible party eloped
☒ Patient / responsible party refused "I DON'T WANT ANY PROBES"
☒ Informed that patient could return at any time if problems or change decision
Treating PA
Treating Physician Robert

STATEMENT OF REFUSAL OF CARE:
(Obtain signature by patient/responsible person if possible)
I have read this paragraph. I understand that a doctor at this hospital wants to give me certain medical care. The doctor explained that care to me, and I understand what that care is. *The doctor also explained to me what could happen to me if I leave here without having that care, and I understand what he said.* I want to leave this hospital without receiving the recommended care. *I know that I am welcome to return to this hospital at any time to receive the recommended care or any other care that I may need at any time, regardless of my ability to pay for such care.*

John Smith
Patient / Person Signing on Patient's Behalf
Witness: J. Jones
☐ Patient / responsible person refused to sign this statement when requested to do so but indicated refusal of care in the following manner:

Other Comments: OFFERED TAXI DRIVE HOME PATIENT REFUSED, WILL WALK 2 BLOCKS TO HOME

Good charting usually leads to good medicine. No AMA form is perfect, and none can guarantee immunity from legal action stemming from a bad outcome. This template contains details that should be addressed in a perfect, albeit paranoia-driven, personalized AMA discharge. Capture the time the note was written, financial and involuntary commitment issues, cognition, comprehension of informed risks, temporizing treatment and follow-up, and possible contact with relatives and private physician. Note the nonjudgmental caveat encouraging the patient to return if he changes his mind, and the personalized note where the patient again acknowledges the most ominous bad outcome. If the patient elopes and you have attended to these basics, this form is also completed, noting the patient's unwillingness to sign.

Does Identifying a Discharge as "Against Medical Advice" Confer Legal Protection?
Devitt PJ, et al
J Fam Pract
2000;49(3):224

These psychiatrists from the State University of New York noted that AMA discharge from general hospitals range between one in 65 and one in 120 encounters. Patients are most likely young and male, live alone, and have been hospitalized frequently. Some studies note a higher AMA discharge rate in the elderly. Occasionally, psychiatric consultations are obtained to assess mental competency when the medical staff perceives imminent danger to the patient. Patients also leave AMA because of anger, frustration, and fear. Although patients discharged AMA may have inconsequential medical problems, many have serious illness, and leaving the hospital will result in adverse consequences, including exacerbation of illness, injury to the patient or others, and death. Even lacking physician negligence, an adverse medical consequence of the AMA discharge may lead to a malpractice suit.

If a patient rejects admission or interventions, many physicians and nurses think the AMA form confers legal protection. The literature is vague on this, and the authors attempted to determine whether an AMA discharge is totally protective, partially protective, or offers no protection at all. Using a computer literature search, the authors found only eight civil cases since 2000 in which AMA discharge was significant in a medical malpractice case.

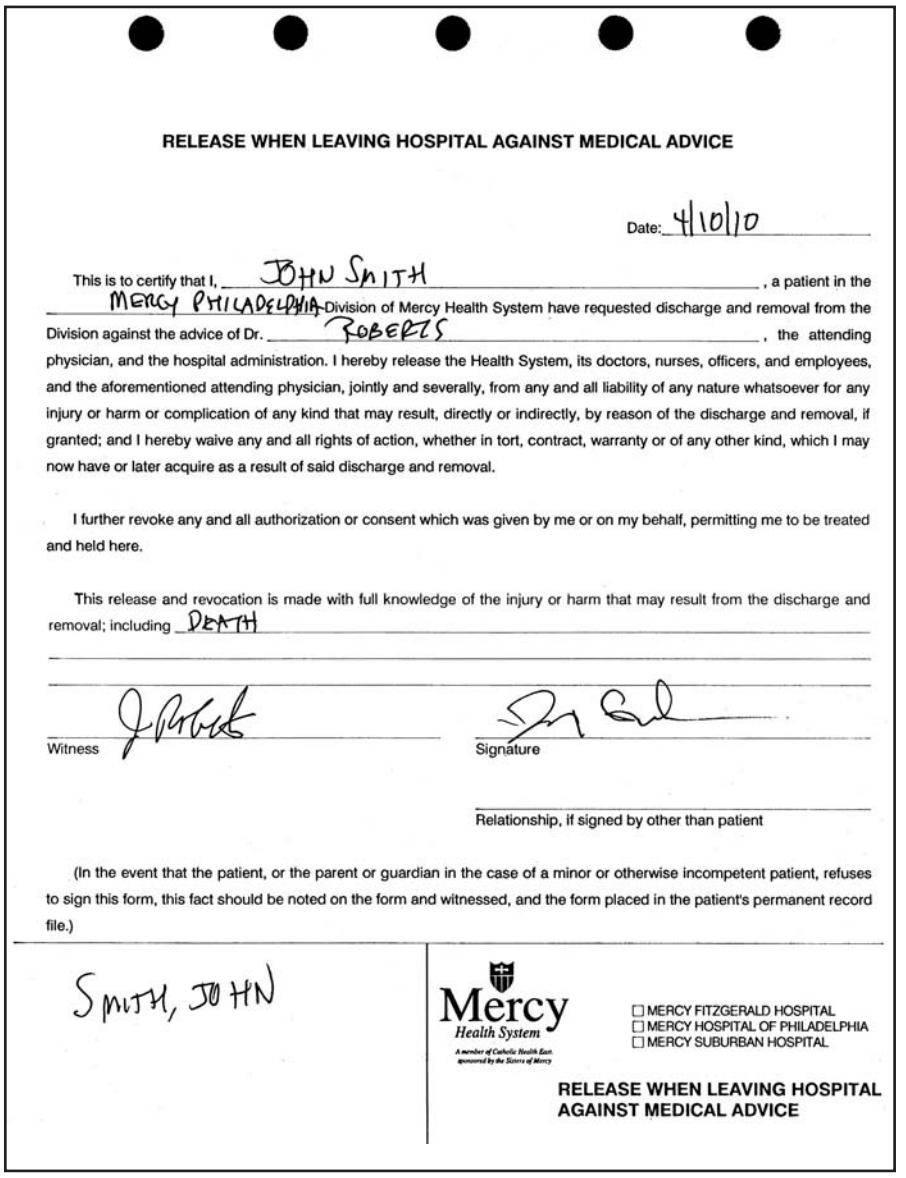
A common defense tactic for an adverse outcome is to claim that the patient contributed to the complications by discharging himself AMA; this is termed contributory negligence. The authors cite a woman who, after many years of chronic abdominal pain and four weeks of hospitalization, discharged herself AMA before a definitive diagnosis was made. She eventually died from

ischemic bowel disease. In a somewhat confusing explanation, a jury said the patient did not act unreasonably when she discharged herself, and to claim contributory negligence, one has to show the patient acted unreasonably. For some bizarre reason, the court found that because she had been ill for years, had been in and out of hospitals, had a number of tests, and was frustrated, it was not unreasonable for her to leave the hospital against advice. In another case, the court found the adverse outcome was the hospital's responsibility although the patient left AMA, missed two appointments, failed to take his medications, and abused drugs.

As a rule, patients are admitted voluntarily to an ED or hospital, and an AMA discharge is merely withdrawal of consent for treatment. Although competent adults possess the legal ability to make this decision, physicians and hospitals must ensure the patient is fully informed of the risks and alternatives to treatment, possesses mental competency to make a decision, and does not meet criteria for involuntary psychiatric hospitalization. Unless all three are documented, physicians and hospitals may not be legally protected if an adverse outcome occurs. The term "against medical advice" is not protective. Physicians should thoroughly document that a patient is mentally competent and fully informed. Unless documented, the courts assume that did not occur.

The authors could not find consistent evidence that a patient discharged AMA lacked the legal ability to sue a hospital and physician successfully for adverse outcome. Although thorough documentation is the first line of defense, the requisite nuances often aren't in place. Physicians must be able to show that patients were fully informed of the risks of leaving, and that alternative venues of care exist. Failure to try to arrange follow-up or alternative care can be considered negligent. The authors believe requiring a patient to sign a waiver releasing the hospital from responsibility is legally worthless. Although the AMA form may provide partial protection, it is not a guarantee of legal immunity.

Comment: I found this article difficult to decipher, but agree with its conclusions. It is a myth that having a patient sign an AMA form protects the physician or hospital from successful litigation when the patient or someone else suffers an adverse outcome. Not only are there consequences for the patient, there may be collateral damage when a patient injures someone else (driving a car while intoxicated), is under the influence of a medication given in the ED, or a psychiatric illness is underestimated or unappreciated.



RELEASE WHEN LEAVING HOSPITAL AGAINST MEDICAL ADVICE

Date: 4/10/10

This is to certify that I, JOHN SMITH, a patient in the MERCY PHILADELPHIA Division of Mercy Health System have requested discharge and removal from the Division against the advice of Dr. ROBERTS, the attending physician, and the hospital administration. I hereby release the Health System, its doctors, nurses, officers, and employees, and the aforementioned attending physician, jointly and severally, from any and all liability of any nature whatsoever for any injury or harm or complication of any kind that may result, directly or indirectly, by reason of the discharge and removal, if granted; and I hereby waive any and all rights of action, whether in tort, contract, warranty or of any other kind, which I may now have or later acquire as a result of said discharge and removal.

I further revoke any and all authorization or consent which was given by me or on my behalf, permitting me to be treated and held here.

This release and revocation is made with full knowledge of the injury or harm that may result from the discharge and removal; including DEATH

Witness

Signature

Relationship, if signed by other than patient

(In the event that the patient, or the parent or guardian in the case of a minor or otherwise incompetent patient, refuses to sign this form, this fact should be noted on the form and witnessed, and the form placed in the patient's permanent record file.)

SMITH, JOHN

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☐ MERCY HOSPITAL OF PHILADELPHIA
☐ MERCY SUBURBAN HOSPITAL

RELEASE WHEN LEAVING HOSPITAL AGAINST MEDICAL ADVICE

A quick perusal of this standard AMA discharge form used in most hospitals leads one to conclude that using it is a recipe for a medicolegal disaster if there is a bad outcome. It cannot adequately relay a conscientious attempt to provide pristine medical care to an adequately informed and mentally competent patient who has opted to reject the clinician's medical advice.

These authors found only eight cases, but I know of three malpractice cases involving bad outcomes in patients who left AMA. To my analysis, there was no physician negligence, but the impression of the injured party and family was that the AMA discharge should not have been allowed. All cases involved signing AMA forms, and some forms were better than others, but clinicians nonetheless found themselves in court on the wrong end of a medical disaster. If you think the AMA form is an easy way out, get ready to spend you vacation in front of a jury.

About one percent to two percent of ED patients leave AMA. The number is relatively constant, and occurs almost every shift. Those most likely to leave tend to be male, younger, substance abusers, lacking insurance, and from a lower socioeconomic class. (*Mayo Clin Proc* 2009;84[3]:255.) Others found the lack of a primary physician, prior AMAs, or having HIV associated with AMA discharges. (*J Gen Intern Med* 1995;10[7]:403.) Under the law of patient autonomy, competent individuals are allowed to make decisions about their health and medical welfare of their children, and the American College of Emergency Physicians clearly states that clinicians must respect their autonomy. (Code of Ethics for Emergency Physicians, June 2008; http://bit.ly/ACEPama.)

There is no law against making a bad decision if the issues are straightforward. It's easy to prevent someone from making the wrong decision if he is drunk, drugged, or mentally impaired. Such patients are simply not allowed to leave, and often they have to be restrained, a gargantuan but common occurrence in most EDs. Despite our best efforts, some crafty elopers make it out of the ED. I had one inventive patient who climbed into the ceiling, and crawled to another room to make his escape. If patients do elope, efforts should be made to find them, even calling the police.

I could find little in the emergency medicine literature that offered stellar advice about AMA discharge. Over the years I have developed some experienced-based concepts about AMA discharges, and I think they will help you stay out of court or win a case if it comes to that.

It's All about the Medical Record

Chart documentation is key, especially three years later when reconstructing the AMA scenario you diligently pursued. Good charting usually adds up to good medical care. The current standard of care appears to allow a hospital-wide AMA form to be universally used in the ED. While you might conform to the current standard, you should be paranoid about every AMA discharge, and document the heck out of the chart. Not all patients have known life-threatening problems, and those who need observation or testing also fit the AMA bill.

In my opinion, the standard AMA form hurriedly signed by the patient as he is leaving is worthless. Try reading the one that your hospital uses, and then show it to a nonmedical neighbor or lawyer friend for an opinion. Generally, it's one long sentence in print too small to read without a magnifying glass and some unintelligible legal mumbo-jumbo written by a hospital lawyer 10 years ago. A one-size-fits-all document might be what everyone uses, but it might not play well in court. It certainly does not force you to comply with my appropriate paranoia. Every case is different and every patient is an individual, and each patient should have an individualized AMA form. A template meets most of the criteria for a personalized document, but customize it to address patient cognition, risk comprehension, ability to make an informed decision, follow-up, and your attempts at defining specific risks. Better yet, write an additional AMA note every time to fit the specific scenario — and have him sign it again. "Oriented x 3" is a common expression well appreciated by the medical profession, but a more complete mental status examination would be better for laymen.

Patients with psychiatric or substance abuse issues who decide to leave AMA require special attention. It is difficult to convey on paper that a patient with a positive drug screen, elevated alcohol level, or past history of psychiatric disease on multiple medications completely understands medical terminology or consequences of leaving. Psychiatric patients are impulsive, argumentative, and adept at

Continued on next page

AMA

Continued from previous page

manipulating the medical system to their advantage, but they do kill themselves and kill and injure others. If a paranoid schizophrenic patient kills someone or a bipolar patient commits suicide soon after leaving your ED AMA, it would be difficult to convince anyone that he had a normal mental status or was not suicidal or homicidal in the ED. Although a psychiatric consultation is expected by the public under such circumstances, I have not found that useful. ACEP says the EP should be an expert; I agree. No mere human can ultimately prevent suicide, and those intent on self-harm often don't telegraph their intentions loudly. I don't know how a psychiatrist would be more astute in predicting subsequent behavior than an EP who has seen the events unfold and spent more time with the patient. Having a psychiatrist clear a patient for an AMA discharge may save the EP from some portion of the litigation, but it is not standard and not the ultimate answer.

It's also helpful to involve others in proving you are a patient advocate and did everything possible to keep the patient from making the wrong decision. Although often not feasible or even HIPAA-compliant, one can offer another physician evaluation, to call the patient's physician, or to speak to a friend or relative. With HIPAA rules, some of these interventions may be questionable. Having a drunk spouse or hostile boyfriend complicate matters is not helpful, but a relative or significant other can often convince a patient to stay. If the patient allows it, you can contact his doctor or relative. Hand the phone to the patient, and document that, and who was on the line.

The authors of this study suggest making a genuine attempt at follow-up or alternative care. Failure to do so can be interpreted as a breech of duty. Just because a patient with chest pain and suspected unstable angina or MI wants to leave, that's no reason to withhold nitroglycerine, beta blockers, or aspirin or not to provide the patient with a cardiologist's phone number. Similarly, providing the patient with an antibiotics prescription for an infection that should be treated in the hospital could be considered proactive and patient-friendly, albeit not a current ID recommendation.

The departure should be friendly, if possible. It also should be made clear that the patient may return to the ED anytime if he changes his mind or gets worse: "No hard feelings, sir. Come back if you change you mind." It may be difficult to have an amicable separation under AMA circumstances, but it's best to maintain an open and supportive environment. It's only human nature for a disgruntled patient to feel too embarrassed or angry to return to the hospital, but if he leaves on cordial terms, he may return when he rethinks the decision or when the problem persists or becomes worse. The door to the ED should always be open, and the patient should not feel that the ED will hold anything against him simply because he chose to leave.

Patients also leave the ED because they fear a large medical bill or have no insurance. The ability to pay should never be an issue with emergency care, and it should be stated explicitly in the medical record that patients are not discriminated against because they do not have insurance or money. I state in no uncertain terms that the inability to pay has not clouded my decision, the patient's decision, or his access to the system. Don't try to save anyone's money (the patient's or Medicare's) by risky outpatient care. If the patient does not want a gargantuan hospital bill, that's fine. But a friendly "come back tomorrow for a recheck" on the AMA form goes a long way when he claims, "They did not admit me because I had no insurance."

Finally, the issue of restraining patients against their will is omnipresent. Most physicians will say the patient has the ability to make a poor decision that may ultimately affect his health significantly. While this is true, many cases are fraught with nuances impossible to convey in the medical record. Ask yourself this: Would you rather defend restraining a patient, sedating him against his will (AKA assault), or sending him home with a medical condition you thought could kill him

AMA Guidelines

Competent patients have the final and ultimate right to make informed decisions about medical interventions, but consider:

Careful and thorough documentation is the best tactic for all involved, and the best defense in cases with a bad outcome.

Good charting usually adds up to good medical care.

An individualized AMA form is better than the standard generic declaimer that attempts to provide blanket immunity to the hospital and physician.

The patient must be fully informed with regard to the consequence of their decision to leave the hospital.

The patient's competency to make this decision must be assessed and documented.

The patient must not meet criteria for involuntary commitment.

A friendly non-confrontational AMA discharge, with the expressed ability of the patient to return if an alternate decision is reached, is the best policy.

Involving a family member, primary physician, or significant other demonstrates ultimate patient proactive efforts, but may not be possible under patient privacy laws.

Failure to make a genuine attempt at follow-up, temporary, or alternative care may be interpreted as breach of duty of care.

Prior to discharge, reconcile any initial chart notes describing extenuating circumstances, such as alcohol/drug use, abnormal behavior, psychiatric issues, unusual thought processes, or conditions that might alter cognition or raise concerns about competency.

Never make finances an issue, but use the AMA form for everyone who does not allow testing, treatment, or admission.

Documentation waiving the hospital from any responsibility if the patient leaves against medical advice should be regarded as being unable to fully protect care givers if there is a bad outcome, although attention to all details is extremely helpful.

Both physician and nurse should document the AMA details, with the physician taking the lead.

Reader Feedback: Readers are invited to ask specific questions and offer personal experiences, comments, or observations on InFocus topics. Literature references are appreciated. Pertinent responses will be published in a future issue. Please send comments to emn@lww.com. Dr. Roberts requests feedback on this month's column, especially personal experiences with successes, failures, and technique.

Dr. Roberts: We old guys have had a lot of experience with strange presentations of gout before the days of allopurinol. We only had colchicine and probenecid. I had a man who had been treated for three years for a resistant "otitis externa" by several physicians, including myself. It was frustrating, and every time I looked in his auditory canal, I saw a white powder which I thought was residue from all the ear drops he had been prescribed. I finally fished some of the powder out, and looked at it with the microscope. Uric acid crystals! His ear pain and inflammation was cured with gout treatment. — ***Marshall Thompson, MD, Davenport, WA***

Dr. Roberts responds: That's a new one for me, Dr. Thompson. Sounds like the patient had a tophus of the ear canal. Rather odd, if not bizarre. This is fodder for a case report if you can find the records.

or leave him significantly impaired? Concerns of unlawful restraint are not moot, however, and physicians have been sued for forcing a lumbar puncture on a child whose parents objected. Many voiced threats go no further than an angry outburst or a nasty letter to an administrator.

Although every patient does not need an alcohol level or drug screen before an AMA discharge, you must be certain that potential issues raised on admission are addressed by the clinician at discharge. Conditions documented before you entered the room, such as alcohol on breath, needle tracks, or a triage note describing intoxication, slurred speech, prior psychiatric issues, unsteady gait, suicide ideations, or bizarre behavior, must be reconciled before discharge. Drunks do sober up, and irrational behavior can wane; just write a follow-up note to explain after observation.

Unfortunately, many times today physicians just can't win, and AMA discharges are high on that list. If a patient leaves AMA and the outcome is not perfect, no one wins. In today's guilty-until-proven-innocent medical milieu, the physician is often portrayed as a scoundrel or villain. Of course, any untoward outcome can be construed by a skilled attorney as the physician's failure to establish good rapport, inability to convey the seriousness of the condition, failure to obtain informed consent, inability to understand the patient's viewpoint, and failure to address issues that can be corrected. It's not fair — it's actually reprehensible — but a callous or nonchalant physician attitude is often assumed when a patient leaves AMA and the outcome is poor. We all wonder what became of individual responsibility, and living with the consequences of bad behavior.

It doesn't make sense that the patient in the throws of an MI wants to go feed his cat, but instead of reaching for the AMA form when this excuse is given, offer to call a neighbor to feed the feline. If the patient is determined to leave despite your efforts, it's his right. Just make sure the documentation clearly proves your prodigious attempts at righting the ship. Many hospitals allow nurses to orchestrate the AMA form. While that may be standard, I think this is the physician's responsibility. I suggest asking the nurse to write his version of your valiant attempts to provide informed consent, again emphasizing that the individual is capable of making an informed decision about his medical care.

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June 2010
Questions:

1. All of the following are characteristics of patients associated with AMA discharge except:
   - ○ A. Lack of a primary care provider.
   - ○ B. Lack of insurance.
   - ○ C. Female gender.
   - ○ D. Lower socioeconomic status.

2. Which of the following is the most important issue to address in an AMA form?
   - ○ A. Informed about risks of discharge.
   - ○ B. Documentation of nursing involvement.
   - ○ C. Compliance with HIPAA laws.
   - ○ D. Referral for psychiatric evaluation.

3. What best describes the medicolegal protection afforded by an AMA form?
   - ○ A. Hospital immunity is assured.
   - ○ B. Physician immunity is assured.
   - ○ C. All personnel immunity is assured.
   - ○ D. No immunity is assured.

4. Which of the following should *not* be included on an AMA form?
   - ○ A. Specific risks of leaving described.
   - ○ B. Documentation of patient's understanding of risks of leaving.
   - ○ C. Unquestioned ability of the patient to return anytime.
   - ○ D. Demographic data and insurance status.

5. Which is the best strategy to discourage repercussions from adverse events stemming from an AMA discharge?
   - ○ A. Have the patient sign the AMA form in multiple places.
   - ○ B. Document all parameters of a properly executed AMA discharge.
   - ○ C. Do not allow an AMA discharge for any reason.
   - ○ D. Give a copy of the form to the patient.

Directions
Your successful completion of this activity includes evaluating it. Please indicate your responses below filling in the blanks or by darkening the circles with a pencil or pen.

Please rate your confidence in your ability to achieve the following objectives, both before this activity and after it: 1 (minimally) to 5 (completely)

	Pre 1	2	3	4	5	Post 1	2	3	4	5
Construct a profile of patients most likely to leave the ED against medical advice.	○	○	○	○	○	○	○	○	○	○
Distinguish the parameters that should be addressed in an AMA discharge form.	○	○	○	○	○	○	○	○	○	○
Apply interventions to discourage adverse repercussions from an AMA discharge.	○	○	○	○	○	○	○	○	○	○

Please indicate how well the activity met your expectations: 1 (minimally) to 5 (completely)

	1	2	3	4	5
Was effective in meeting the educational objectives	○	○	○	○	○
Content was useful and relevant to my practice	○	○	○	○	○

Please address the practical application of this activity below
How many of your patients may be affected by what you learned from this activity? _____

Do you expect that the information you learned during this activity will help you improve your skill or judgment within the next 6 months? (1-Definitely will not change, 5-Definitely will change) **1** ○ **2** ○ **3** ○ **4** ○ **5** ○

How will you apply what you learned from this activity? (Mark all that apply.)
- ○ In diagnosing patients
- ○ In monitoring patients
- ○ In educating students and colleagues
- ○ To confirm current practice
- ○ For maintaining board certification
- ○ In making treatment decisions
- ○ As a foundation to learn more
- ○ In educating patients and their caregivers
- ○ As part of a quality/performance improvement project
- ○ For maintaining licensure

Please complete these overall activity assessment questions.
Did you perceive any bias for or against any commercial products or devices? Yes ○ No ○
If yes, please explain: _____

Compared with other educational activities in which you have participated over the past year, how would you rate this activity? (1-Needs serious improvement, 5-A model of its kind) **1** ○ **2** ○ **3** ○ **4** ○ **5** ○

Future activities concerning this subject are necessary. (1-Strongly disagree, 5-Strongly agree) **1** ○ **2** ○ **3** ○ **4** ○ **5** ○

My biggest clinical challenges related to this topic are: _____

Please use the space below to provide any additional information that will help the activity planners and faculty evaluate this activity.
_____
_____

☐ ***Yes, I am interested in receiving more information on this topic and future CME activities from Lippincott CME Institute. I am willing to help evaluate the outcomes of this activity. (Please place a check mark in the box.)***

Name _____

Street Address _____
_____
_____

City _____ **State** _____ **ZIP Code** _____

Telephone _____ **E-mail** _____