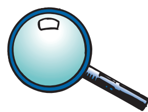

InFocus

Discharging Patients AMA: Who Leaves? What Happens to Them?

By James R. Roberts, MD

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Learning Objectives: After participating in this activity, the physician should be better able to:
1. Categorize patients at risk for leaving the hospital against medical advice (AMA).
2. Appraise the potential outcomes of an AMA discharge.
3. Select various strategies to minimize bad outcomes.

Emergency physicians have a lot to consider when diagnosing and treating complex ED patients. We all have been in the situation where, after spending considerable time, effort, and resources, a seemingly cooperative patient quite abruptly and unceremoniously decides he (usually he) does not want to take our advice, and opts to leave the hospital. This is a frustrating dilemma fraught with potential and real complications for the patient and physician.

There is no universal standard of care regarding discharges against medical advice. Last month I discussed the value of a standard AMA form. Contrary to common physician belief, the hastily signed vague and incomplete AMA forms we have used for decades do not protect the hospital or physician when there is a bad outcome. In general, good charting equates to good medicine, and a poorly written AMA document is literally asking for medical and legal problems. Merely having a noncompliant patient sign a piece of paper does not give blanket immunity to caregivers. A fully informed and competent individual has the right to refuse any medical intervention for himself and his children, but everyone loses in an AMA discharge. There is no law against a patient being in denial, stubborn, or simply ignorant, but patients must be reasonably informed and deemed competent to leave your ED, and the chart should clearly confirm this.

Dr. Denis Dollard, the ED director at Mercy Philadelphia Hospital, attempts to dissuade this young HIV-positive man with a substance abuse problem from leaving the ED because he is not being seen fast enough or with the expected niceties. The egressing patient has no private physician and unsolvable medical and social problems, but needs admission for workup of a fever. Multiple strategies can be tried, but in the end, an informed and competent patient (ideally both conditions are meticulously documented on the chart) can refuse any medical intervention, and there is little the clinician can do to thwart all bad patient decisions. There was no family to help, and no financial or psychiatric issues, so this patient was given copies of the current ED tests and an amicable invitation to return if he changed his mind. Like many AMA patients, he came from a low socioeconomic environment, and may have been homeless. He was clearly fed up with the medical system.

We don't know much about eventual outcomes, but it turns out that AMA patients often return for an extended and expensive hospital stay, occasionally in a worsened condition, but not necessarily to the same hospital from which the egress occurred. True disasters are few and far between, but these can be high-profile cases. A death after a recent ED visit is met with great delight by the always-critical 6 o'clock local news. This remains a thorny issue for all EPs.

After reading this article, emergency physicians should be able to categorize patients at risk for leaving AMA, appraise the potential outcomes of an AMA discharge, and select strategies to minimize bad outcomes.

What Happens to Patients Who Leave Hospital Against Medical Advice?
Hwang S, et al
CMAJ
2003;168(4):417

Patients who leave AMA are at risk for bad outcomes and subsequent readmission, often with longer and more expensive hospital stays. This study examined the rate and predictors of readmission of patients who had left the hospital against medical advice. The authors at an urban Toronto hospital treating indigent and homeless patients, studied 97 consecutive patients who left AMA from the general medical service using records and personal interviews.

The overall AMA discharge rate for inpatients at U.S. hospitals is one percent to two percent, a figure that is higher for the lower socioeconomic class, those who lack insurance, and patients from disadvantaged urban areas. Patients from urban hospitals in low-income areas have significantly higher AMA discharges than one would suspect, although the exact number is difficult to obtain. A primary issue of an AMA discharge is a subsequent adverse medical outcome, including a worsened condition on readmission and greater morbidity or mortality. It is well known that HIV-positive patients who leave AMA are regularly readmitted with a related diagnosis. Little information is available on actual outcome of general medical inpatients after AMA discharge.

An AMA discharge is defined as an elopement or a voiced decision to leave the hospital prematurely. In this study environment with a high percentage of low-income and homeless people, the AMA discharge rate was very high: Six percent. Control patients were those electively discharged.

Patient interviews gleaned that the reasons for leaving were varied, including pressing family matters, feeling well enough to go home, dissatisfaction with treatment, feeling bored or fed up, and a general dislike of hospitals. Interestingly, 70 percent had a history of alcohol and drug abuse. While patients did not cite withdrawal or the need to drink or obtain drugs as the proximate cause, it likely played a role.

At 15 days, the readmission rate for the AMA group was impressive: 21 percent versus three percent for the control group. Readmission rates were higher at 15 days than at 90 days, although both time periods had high readmission rates. Although three of the patients discharged AMA died during the follow-up period, none of the deaths were considered directly related to premature departure. Interestingly, homeless patients left more often than domiciled individuals. Most left within two to five days, but some exited after more than six days of hospitalization. The overall longer length of stay in Canadian hospitals compared with U.S. hospitals may have influenced patients' AMA decisions.

The authors proposed specific follow-up appointments, providing appropriate prescriptions, and giving patients a written summary of the hospital stay for other health care providers. A significant number of patients will seek readmission at a different hospital.

Comment: Although this report characterizes patients leaving AMA from an inpatient medical service, it is reminiscent of ED patients who similarly discharge themselves. In the ED, we have precious little time to make a good first impression, or provide the

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AMA

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warm and fuzzies, such as meals and other expected comfort measures. Our clients are often in a distressed mental state already. No one wins with an AMA discharge. It does not seem fair that litigation is even an option if informed consent is appropriate, and the patient is otherwise competent. In my experience, charting issues (great doctoring but omnipresent poor documentation) was the plaintiff's best ammunition against the EP. Most of us spend hours with the patient yet only a few seconds on the paperwork that proves it. You tried your level best, and usually went above and beyond, but essentially you were charged with "allowing the patient to sign his life away." Whatever happened to the patient's duties and responsibilities?

Any EP reading this article would feel great empathy. Patients leaving AMA generally fit a profile: young men, having drug or alcohol issues, and having a poor understanding of and little patience with our inefficient health care system. (*Acad Emerg Med* 2007;14[10]:870.) Theirs is fast-food mentality: They want it their way, and they want it now. Many are frequent denizens of the ED, don't have a family physician or social support, and look to the hospital for the personal attention they crave for their impenetrable medical and social problems. Coming from a lower socioeconomic and disadvantaged home or homeless environment makes it difficult for physicians to get past extant issues with our lumbering system. Waiting 10 hours for an inpatient bed or a tardy, then rude, consultant frustrates clinicians also. We rarely ascertain the correct reasons for patients leaving the hospital. Patients may leave because they have to feed the cat, take care of a child or ailing family member, or obtain another drink or dose of heroin. Some are in denial about their condition or fear a large hospital bill. Interminable waits and delays for non-life-threatening problems define many ED elopements.

Weinhart et al reported an amazing 54 percent rate of readmission of patients discharged AMA from an urban teaching hospital, concluding that Medicaid status was an important predictor of premature discharge. (*J Gen Intern Med* 1998;13[8]:568.) Senior citizens on fixed incomes often feel an honest responsibility to pay their bills. One can certainly see how they would be concerned about the ubiquitous $10,000-a-day admission. Never make admission decisions based on finances. In borderline cases, it doesn't make sense to spend someone's social security income because of fear of discharging a patient with an unknown diagnosis or merely because of defensive medicine. If true financial issues sway a borderline admission and it's essentially a joint decision to go home, my advice is to construct a formal albeit amicable AMA discharge paragraph. Make it is crystal clear that you preferred admission or more testing. You want the patient to remember that it was his decision to leave; you did not obstruct admission because he did not have insurance.

The study could not predict which patients would be readmitted or offer ways to decrease incidence. I am not surprised that many went to another hospital. We all get frustrated when patients come to our ED without records after having just spent a week at another hospital. Seeing a patient who just left another ED is likewise outrageous. If you discharge someone AMA and you have paid attention to the intricacies of the properly executed AMA form, give the patient a copy of pertinent laboratory tests, CT scans, ultrasounds, etc., to make life easier on your colleagues. Also include a copy of the AMA form he just signed. On the rare chance that the patient will keep these documents or present them to the next ED, it might just save an annoying phone call from a similarly overworked and frustrated colleague. The patient's version of the story to the next physician, detailing exactly why he left your hospital, is rarely the same as yours; be prepared for an irate call from some similarly stressed out emergency physician when he hears his complex and unhappy patient was just in your hospital.

AMA discharge of an indigent patient does not help the hospital's financial bottom line; readmission of an AMA discharged patient is extremely expensive. (*Int J Clin Pract* 2002;56[5]:325.) In one study, the average length of stay for the primary admission was 2.3 days compared with a length of stay on readmission of 4.7 days. The cumulative cost of a discharge-readmission was calculated to be 56 percent higher than expected for the specific problem.

Profile of AMA Discharges

- The overall AMA discharge rate from a medical service and the ED is one to three percent but up to six to seven percent in patients fitting a high-risk profile.
- Psychiatric services may experience AMA discharges up to 35 percent to 50 percent.
- A lower socioeconomic status or disadvantaged urban population has a higher AMA discharge rate.
- Other AMA variables include feeling better, lack of a primary care physician, lack of insurance, patient-physician friction, a child or impaired relative at home, denial, and feeling bored or frustrated.
- AMA discharge rates are higher among young men and patients with HIV disease, drug or alcohol abuse, and homelessness.
- Readmission rates for AMA discharged patients may be as high as 20 percent within 90 days.
- The cost of readmission of an AMA discharge is significantly higher than an extended first stay.
- The best way to thwart an AMA discharge is unknown.
- The outcome of ED AMA discharges has not been clarified, but ED patients may have a lower acuity and leave because of long waiting times.
- There are no specific medical diagnoses, conditions, or initial complaints that are identified as high risk for ED AMA discharge.

Discharges Against Medical Advice: A Community Hospital Experience
Seaborn MH, Osmun WE
Can J Rural Med
2004;9(3):148

These authors note that a Canadian community hospital experience with AMA discharges is probably less dismal than those of an inner-city indigent hospital. Their AMA discharge rate was only 0.6 percent. Patients leaving this hospital were also more likely to be male and have more substance abuse and psychiatric conditions. Canadian physicians' charting habits were dismal, worse than their American colleagues; only 80 percent of the charts had AMA documentation, and only 23 percent included evaluation of patient competency. These authors also frustratingly conclude that potential interventions to limit AMA discharge are limited. They suggest that early identification of patients at risk may facilitate the outcome, decrease AMA discharges, and improve eventual health outcomes. Exactly how this can be determined or implemented is quite elusive.

Comment: Exactly why patients sign out AMA is somewhat inscrutable. It's probably not just because they are angry or totally dissatisfied with the ED interaction. Dubow et al contacted 52 ED AMA discharged patients, and found a surprisingly high satisfaction score for the hospital and treating physician: An amazing 70 percent. (*J Emerg Med* 1992;10[4]:513.) But 82 percent "did not agree" with their physician's treatment plan. Curiously, the majority of patients said they would leave AMA again under similar circumstances. I can never figure out what is more important or pressing at home than their health — go figure.

Green et al suggest that the majority of patients leave for personal reasons, such as sickness or disability of a family member, financial problems, and legal issues, such as a court date. (*Am J Drug Alcohol Abuse* 2004;30[2]:489.) I think the real reason patients leave AMA is rarely clear cut or forthcoming. In the long run, we never get the true answer, and most nurses and doctors, out of human nature, simply don't care. In fact, doctors tend to be indignant and angry that an ungrateful patient has just decided to up and leave. It's difficult to ameliorate that mindset after you spent countless hours and tax dollars trying to unravel the vagaries and complaints of a drug abuser, alcoholic, or psychiatric patient.

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: In your recent article about the treatment of gout, you excluded feboxustat. Any reason? Thank you. — ***Dr. James Komara***

Dr. Roberts responds: I don't use febuxostat, and don't know much about it. It's one of the few new treatments for chronic, not acute, gout introduced over the past 40 years. The drug is a xanthine oxidase inhibitor used to lower hyperuricemia by decreasing urate synthesis (same mechanism as allopurinol). Long-term control of hyperuricemia is not usually up to EPs, but febuxostat seems to have an edge over allopurinol. While generally safe and well tolerated, it's not the Holy Grail for recurrent gout. (*Med Lett Drugs Ther* 2009;51[1312]:37; *Arthritis Rheum* 2005;52[3]:916.)

Berger emphasizes that noncompliance to urgent ED medical advice parallels noncompliance to multiple less urgent outpatient medical interventions. (*J Hosp Med* 2008;3[5]:403.) Noncompliance is posited to be related to treatment side effects, costs, inconvenience, child care or pressing family needs, psychosocial burden, and patient-physician relationships. In fact, if office advice for chronic conditions is heeded 20 percent of the time, that's considered "good."

Little data exist specifically about ED AMA discharges. Fernandes et al concluded that ED AMA patients have low acuity, and often leave because of waiting times, but I have not seen any good data about the outcome of ED patients who leave or strategies to decrease incidence. (*Ann Emerg Med* 1994;24[6]:1092.) Lee et al reported that the seriousness of cardiac disease in ED AMA discharges for chest pain had a varying prognosis, not always benign. (*J Gen Intern Med* 1988;3[1]:21.) Leaving AMA after three or four days in the medical service is probably safer than leaving after a few hours in the ED. Contrary to my intuition, it has not been proven that adverse outcomes and revisits to other hospitals are higher in ED patients than for patients leaving the general medical ward.

HIV patients have a high incidence of AMA discharge: Anis et al noted a 13 percent AMA discharge rate in Vancouver. (*CMAJ* 2002;167[6]:663.) Chan et al reported that AIDS patients who are IV drug abusers have an AMA discharge rate of up to 25 percent. (*J Acquir Immune Defic Synd* 2004;35[1]:56.) Offering inpatient methadone therapy reduced that rate in this high-risk group.

A truly disastrous medical outcome from an AMA discharge is likely uncommon, but you don't want to be on the wrong end of a high-profile problem. No one has come up with an insightful plan to prevent the AMA discharge of a bona fide sick or potentially problematic patient. In some cases, you can intuit that a patient won't stay for very long and skillfully try to derail the AMA before it happens, using all of our common tactics. That's a pretty hefty mandate in the ED, but worth a try. Getting the family involved, apologizing for inconvenience, treating withdrawal, expediting tests and admission, and minimizing financial concerns are partial strategies, but in many cases, you just can't win.

Next month: The next time you are at your wit's end with a bipolar patient in the ED, consider the plight of your psychiatric colleague. The AMA discharge rate for psychiatric patients is as high as 50 percent. EMN

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July 2010
Questions:

1. Which of the following does not categorize a patient as high risk for an AMA discharge?
   - ○ A. HIV-infected.
   - ○ B. Concern for an aging parent at home.
   - ○ C. A psychiatric diagnosis.
   - ○ D. A clinical diagnosis of pneumonia.

2. Which is *not* a likely or potential outcome of an AMA discharge?
   - ○ A. Medicolegal repercussions against physician.
   - ○ B. Readmission within 90 days.
   - ○ C. Loss of income to the hospital.
   - ○ D. Worsening of the medical condition.

3. Which of the following will *not* decrease the incidence or ameliorate adverse outcomes of an AMA discharge?
   - ○ A. Encourage a revisit if the patient changes his mind.
   - ○ B. Give the patient copies of lab test already done.
   - ○ C. Call a family member.
   - ○ D. Complete a detailed AMA discharge form.

4. Which of the following ED diagnoses likely predicts an AMA discharge?
   - ○ A. Chest pain and shortness of breath.
   - ○ B. Pneumonia.
   - ○ C. Weak and dizzy.
   - ○ D. None of the above.

5. Which of the following strategies might minimize a bad outcome?
   - ○ A. Treat withdrawal.
   - ○ B. Apologize for the inconvenience and wait.
   - ○ C. Expedite tests and admission.
   - ○ D. All of the above.

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
Categorize patients at risk for leaving against medical advice.	○	○	○	○	○	○	○	○	○	○
Appraise the potential outcomes of an AMA discharge.	○	○	○	○	○	○	○	○	○	○
Select various strategies to minimize bad outcomes.	○	○	○	○	○	○	○	○	○	○

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.

____

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☐ ***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.)***

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