Pediatric Patients Leaving Against Medical Advice

By James R. Roberts, MD

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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/or 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 CME activity, the physician should be better able to:
1. Differentiate potential medical outcomes for children whose parents remove them from the ED AMA.
2. Create a profile of pediatric ED presentations that are likely to predict that parents will remove their children AMA.
3. Prepare a plan to discourage parents from prematurely removing their children from the ED.

When it comes to adults who opt to leave the ED against medical advice (AMA), patient autonomy generally supersedes physician recommendations. The only requirement for a patient to leave the ED abruptly and to refuse evaluation or treatment is being mentally competent after being adequately apprised of the risks. A properly executed AMA form may offer some protection to the physician and hospital but not blanket immunity if an adverse event occurs. Patients who leave AMA are at higher risk for untoward events and subsequent hospital admission, with an overall increased cost to all.

This month’s column tackles the unpleasant issue of children who are prematurely taken out of the ED by their parents. While the public might be somewhat sympathetic to a physician who does his best to keep a recalcitrant adult in the ED, particularly one that merely has a potential medical issue, emotions run high when a child is involved. You don’t want to be on the wrong end of a medical disaster involving a child who was plucked from the ED by his parents, with subsequent allegations that they were not fully informed of the medical issues or risks. After reading this article, emergency physicians should be better able to differentiate potential medical outcomes for children whose parents remove them from the ED AMA, create a profile of those parents most likely to leave AMA, and prepare a plan to discourage parents who want to prematurely remove their children from the ED.

Predictors of Pediatric Emergency Patients Discharged Against Medical Advice


This is one of a few articles in the medical literature that specifically deals with pediatric patients removed AMA from the ED by their parents. It’s a five-year retrospective chart review from St. Louis Children’s Hospital profiling parents who left AMA and the outcome of their actions. All children were evaluated by a physician or nurse practitioner, and parents removed their children from the ED before therapy was completed.

Subjects were excluded if they were not fully evaluated or left without notifying the staff (elopement). The authors compared 188 routinely discharged controls with 94 children removed AMA. The most frequent chief complaints were abdominal pain, upper respiratory infection, otitis media, asthma, trauma, or fever. There were no differences in the sex, race or ethnicity, or insurance status of the child between those who left and those who stayed. Time of arrival, time to be seen, and day of arrival were similar compared with controls. There was also no difference between AMA versus routine disposition based on age, mode of arrival, mother or father in attendance, or the use of a medical consultant. As one might suspect, chart documentation was poor.

About a quarter of the patients returned to the ED within 15 days, three times the rate of those routinely discharged. The medical complaint was similar in 96 percent of returnees, and the admission rate at the second visit was about 25 percent, not significantly different from controls. Adolescents over 15, especially those who self-registered with symptoms of sexually related infections did not stick around, likely due to concerns about their parents finding out.

There also was a consistent failure to document alternative therapy following

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MAA Discharge. The authors subsequently revised their AMA form to address parental knowledge of the diagnosis, proposed management, alternative therapies, risk of no treatment, and specific follow-up instructions. Focusing on adolescents and patients with more complex medical problems may decrease the incidence of pediatric AMA. 

Comment: There is minimal specific information in this article. Other than focusing one’s efforts on better documentation, and perhaps realizing that self-registered teenagers are problematic, the authors offer little clairvoyance. One can readily understand the reticence of teenagers with STD symptoms to stay in the ED, but adolescents who arrived alone were considered competent adults, and parents were not contacted, an unfortunate failure of the restrictive HIPAA laws.

It is universally suggested to document specific medical risks of leaving on the AMA form. By going to the ED, patients left prior to diagnostic testing, it’s difficult to identify clearly such specific risks other than to disclose that the diagnosis was “uncertain.”

“You could die” is a common warning, but it’s a bit tricky to chart that the child’s illness hurts. In this scenario, the child’s illness quotient is not clear. Thirty-two percent said they would request an AMA form prior to leaving, 19 percent stated they would request an AMA form prior to leaving, 19 percent stated they would allow the mother to leave but report neglect or abuse, an obviously serious illness, or an unstable patient. I wonder how many actually would carry out restriction or report child abuse in real life. It’s easier in a survey, but I strongly doubt that many physicians would be so aggressive.

In today’s vaccinated world, most fevers are benign, and febrile children are everyday denizens of the ED. Most do well with minimal intervention. It’s not surprising that the surveyed clinicians usually allowed unencumbered egress of the child from the ED. Of course, waiting time is always an issue; there’s no one can do about that. No one wants to wait, even for expert medical care for a child. Walk-in clinics and even drugstores are experiencing a boom in business. Not surprisingly, their results for minor problems are similar to prestigious children’s hospitals and a whole lot cheaper and faster.

In today’s world, physicians support parental autonomy to make decisions about their child’s health needs. It is also clear most would not restrain or take custody of the child, particularly when there was no evidence of parental neglect or abuse, an obviously serious illness, or an unstable patient. I wonder how many actually would carry out restraint or report child abuse in real life. It’s easier in a survey, but I strongly doubt that many physicians would be so aggressive.

Obviously, no standards exist, but clearly these physicians support parental autonomy to make decisions about their child’s health issues. It is also clear most would not restrain or take custody of the child, particularly when there was no evidence of parental neglect or abuse, an obviously serious illness, or an unstable patient. I wonder how many actually would carry out restraint or report child abuse in real life. It’s easier in a survey, but I strongly doubt that many physicians would be so aggressive.

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Another study created a patient profile based on 223 pediatric patients who left AMA, finding that those who left were not critically ill and usually did well. (Ann Emerg Med 1986; 15[6]:717.) Only three percent were subsequently hospitalized. Most cases occurred on weekends between 4 p.m.
and midnight, with more patients on welfare and without alternative health care. Most children presented with minor trauma and minor illnesses, and more than half of those leaving did not seek additional care. Sixteen percent went to another ED, and half were well in 48 hours. When contacted, most parents said they had waited too long (60%) or the medical complaint had spontaneously resolved (10%), but transportation issues, anger, and misunderstandings also were reasons cited. In about five percent of patients, a nurse allayed parents’ concerns prior to physician evaluation. Since 1986, waiting times have not decreased, but the authors don’t offer recommendations except to work faster and try to communicate better.

A study at Children’s Hospital of Boston found that children leaving AMA accounted for 2.5 percent of visits. (Ann Emerg Med 2008;52:4;599.) The authors said an urban location, self-pay insurance, less acute medical problems, arrival times, and race and ethnicity were factors associated with leaving AMA. Again, no suggestion was made on how to address the issues.

Comment: No one has an easy answer for why parents take their children from the ED before a complete evaluation. While there are understandable reasons for this, the problem is often on the wrong end of the situation. Who has resources these days to spend their days trying something up? Not only do EDs have to placate irate parents and apologize for lab inefficiencies and tardy consultants, they have to smooth over interpersonal problems with clerks, nurses, technicians, and interns. We continually make snap judgments about a child’s potential illness at the expense of minimal data. Some AMA discharges of an obviously well child can be sanctioned with nothing more than reading the complaint and vital signs (always read the nursing notes), coupled with a quick perusal of what they were told prior to departure goes a long way in allowing cooler heads to prevail. One cannot simply cite child abuse statutes for no good reason, and overestimating the danger to a legal entity can get you into trouble with the courts. The physician is clearly between a rock and a hard place with this one. Pay very close attention to the paperwork (AKA squeaky-clean charting) if this child leaves AMA.

A crack developer of cool games for the iPhone by day, Matt Roberts is just another distraught and exasperated parent of Liam, a cranky febrile 3-month-old, and overestimating the danger to a legal entity would even marshal court orders and would allow a parent to take a child away from parents wanting to leave AMA, but would if there were obvious child abuse or a knowing, life-threatening medical condition. This falls under the category of “What would you rather defend?” While you might think you are totally protected from litigation when you report suspected child abuse, think again. It’s all in the eye of the beholder. Leaving AMA with your child does not equal child abuse. A physician should rarely be surrogates for an ill child when the parents are in the room. A retrospective analysis, however, is a powerful tool, and a bad outcome is often taken as per se evidence of physician misconduct.

The long run, parents need to take responsibility for their child’s welfare, and cannot blame physicians for their own hasty mistakes or poor judgment. Guilt is powerful, however, and often parental guilt is lessened with attempts to blame the physician. The best one can do is to try to diffuse any hostile situations from the onset, let common sense prevail, and use all the warm-and-fuzzy techniques we have learned in dealing with adults who want to make foolish decisions. Pristine documentation should convey your gargantuan efforts. Unfortunately, the last thing one attends to in a stressful case is the paperwork, and it is rarely pristine enough for the court three years later. Even when the documentation is airtight, you can spend your vacation trying to convince a jury that your written story is more believable than the parent’s recollection of what they were told prior to unfortunate post-ED events. Good luck if your AMA form isn’t up to par. Although state laws allow parents to control health issues affecting their children, physicians are mandated to report suspected child abuse, and are legally at risk for not doing so. Child protective services have to prove or disprove our suspicions. While the party line is that we are assured legal immunity for reporting abuse, don’t be that naive. If you exaggerate or overestimate potential child abuse to make your point, you can be liable for repercussions from the accused care taker who may claim all sorts of distress from your seemingly altruistic actions.

Munchausen Syndrome by Proxy
Jani S, et al

This fascinating report examined possible Munchausen syndrome by proxy (MSP) in children discharged AMA or transferred from the University of Maryland. Amazingly, there were MSP characteristics in 64 percent of the AMA discharges and eight percent of transfers, and none in regular controls. It is difficult to believe that physicians also must consider that parents are not just irrational or have unrealistic expectations for medical care; we also have to intuit that they might just be psychotic themselves or trying to harm their children via this bizarre syndrome.

Between a Rock and a Hard Place: When Parents Refuse Treatment for their Children in the ED
McDonnell WM

This erudite and informative article gives a more legal slant to the conundrum of children being removed from Continued on next page
the ED AMA by their parents. It’s peppered with case law references, and although discouraging, it’s an easy read. The article should be studied in detail in journal club.

The author, a pediatric emergency physician and lawyer, reiterates that courts recognize a strong public interest in allowing parents to make reasonable medical decisions on behalf of their children (citing nothing less than the 14th Amendment to the U.S. Constitution). The operative word here is “reasonable,” and that’s in the eye of the reviewer, and it’s often a retrospective eye at that. The rock and the hard place is the potentially conflicting issue of child welfare and parental autonomy. Physician obligations and parental rights can conflict, especially in a stressful ED where little rapport has been established in an already charged scenario of long waiting times, hostile counterparts, and ill children.

Case law confirms that a parent or parent must agree to evaluation prior to any physical contact. Failure to do so exposes the physician to potential claims of assault and battery. Of course, federal law (EMTALA) also requires that physicians provide an appropriate examination and stabilizing treatment to all. It’s easy when the patient is incompetent or unconscious, but less clear when dealing with only potentially ill children. Even critically ill patients have the right to refuse medical care. And that’s not only end-of-life decisions but also refusal of admission or further treatment for severe asthma. How’s that for an example of the quintessential gray area?

To make things even more complicated, the principle of parens patriae (parent of the country) deems the state to have an interest in the welfare of all adults and children. This concept is not a mechanism for the physician but for the state to override parental rights. It might help with feeding tubes and chemotherapy, but it is of minimal practical guidance at midnight when the parents want to take their febrile child home before the EP has a chance to evaluate the patient fully.

One must be careful when trying to protect the child through child abuse laws. Child abuse has only to be suspected, not proven, by physicians, who are liable if they don’t report child abuse. They may feel they have an exaggerated medical risk to institute care against parental wishes. It is not only the child, but also the physician who can get squashed between that rock and that hard place. ![](https://www.em-news.com/)

**AMC Participation Instructions**

To earn CME credit, you must read the article in *Emergency Medicine News*, and complete the evaluation questions and quiz, answering at least 80 percent of the questions correctly. Mail the completed quiz with your check for $12 payable to Lippincott Continuing Medical Education Institute, Inc., Two Commerce Square, 2001 Market St., Third Fl., Philadelphia, PA 19103. Only the first entry will be considered for credit, and must be received by Lippincott Continuing Medical Education Institute by September 30, 2011.

**September 2010 Questions:**

1. What is the most likely outcome of a child with suspected URI symptoms who is removed AMA from the ED prior to complete evaluation?
   - A. The child will likely do well without further evaluation.
   - B. About 30 percent will return in one week with pneumonia.
   - C. Many parents will institute harmful therapy on their own.
   - D. The child will usually be returned to the same ED in 24 hours.

2. Which of the following pediatric patient scenarios describes a situation in which parents will likely not remove their child AMA from the ED?
   - A. The child has an undiagnosed head injury from a motor vehicle crash.
   - B. The child is not seriously ill, but has undiagnosed recurrent abdominal pain.
   - C. The child has no pediatrician, and arrives at midnight with vague complaints.
   - D. The child has symptoms of an upper respiratory infection, and has been waiting for a chest x-ray for more than four hours.

3. The parents of a febrile but well appearing 2-year-old want to leave the ED before the physician completes the child’s evaluation. What is the most reasonable response from the physician?
   - A. Call security to restrain the parents, and order a chest x-ray.
   - B. Call social services after filing child abuse forms, and begin a workup.
   - C. Explain the risk of child abuse.
   - D. Document that the parents were completely informed and consented to all.

4. How do American case law and the American College of Emergency Physicians’ guidelines view parents who want to take their child from the ED against medical advice?
   - A. Physicians have the ultimate right to override parental wishes in all cases.
   - B. Any physician can become the surrogate parent if the child appears ill.
   - C. The autonomy of parents to decide medical care for their children is strongly supported.
   - D. Child abuse should be considered and documented in all AMA cases to ensure follow-up.

5. What best describes the medicolegal outcome when children are treated against the wishes of their parents?
   - A. Courts will not allow litigation against physicians based on Good Samaritan laws.
   - B. Litigation can proceed against any physician and hospital for forcing medical care.
   - C. If the child is ultimately shown to have no medical problems, physicians are automatically liable for assault and battery.
   - D. If the child has osteogenesis imperfecta, child abuse charges cannot be filed for broken bones.

**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:**

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Differentiate medical outcomes for children whose parents remove them from the ED AMA.

Create a profile of parents most likely to remove their children AMA.

Prepare a plan to discourage parents from prematurely removing their children from the ED.

Please indicate how well the activity met your expectations:

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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 not change, 5=Definitely will change)

How will you apply what you learned from this activity?

(1=All that apply)

In diagnosing patients
In monitoring patients
In educating students and colleagues
To confirm current practice
For maintaining board certification

For maintaining licensure.

Please complete these overall activity assessment questions.

Did you perceive any bias for or against any commercial products or devices?

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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=Excellent)

Future activities concerning this subject area are necessary.

(1=Strongly disagree, 5=Strongly agree)

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.)**

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