Against Medical Advice Discharge: A Narrative Review and Recommendations for a Systematic Approach

Emily G. Holmes MD, MPH[1], Benjamin S. Cooley, MD[1], Sheryl B. Fleisch, MD[2], and Donald L. Rosenstein, MD[3]

1. Indiana University, Department of Psychiatry, Indianapolis, IN
2. University of Florida, Department of Psychiatry, Gainesville, FL
3. University of North Carolina, Departments of Psychiatry and Medicine, Chapel Hill, NC

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Corresponding Author:

Emily Gifford Holmes, MD

Indiana University School of Medicine

Department of Psychiatry

355 West 16th Street

Suite 2800

Indianapolis, IN 46202

Email: egholmes@iu.edu

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Abstract:

Approximately 1-2% of hospitalizations in the United States result in an against medical advice (AMA) discharge. Still, the practice of discharging patients AMA is highly subjective and variable. AMA discharges are associated with physician distress, patient stigma, and adverse outcomes including increased morbidity and mortality. This review summarizes the AMA discharge research, proposes a definition for an AMA discharge, and recommends a standard approach to a patient's request for discharge AMA.

Introduction

An against medical advice (AMA) discharge is a clinical challenge for most physicians in the United States and abroad. In the largest national study, 1-2% of all hospitalizations end in an AMA discharge, and rates are increasing.[1]

Although AMA discharge is not uncommon, there is no formal definition of AMA discharge or standards for the designation. Whether a discharge is labeled AMA is determined by the discharging physician; an AMA discharge according to one physician may be a routine discharge to another.

Due to this subjectivity, AMA discharges are heterogeneous. The patient may elope; politely decline recommended medical care; become angry and insist on leaving immediately; or give advance warning and allow time for alternative treatment planning. A patient may or may not sign an AMA waiver.

This review summarizes the AMA discharge literature. Drawing upon these published reports and our clinical experience, we propose a definition for an AMA discharge, a set of AMA universal precautions, and an algorithm to help guide physicians when faced with these challenging cases. With a standardized approach, we believe that patient outcomes and physician satisfaction will improve.

Background

Risk Factors

The AMA discharge literature has identified consistent risk factors for AMA discharge including younger age, male sex, lower socioeconomic status, homelessness, substance use disorders, mental illness, and comorbidities such as asthma, cirrhosis, and human immunodeficiency virus. Additionally, patients who have previously been discharged AMA are more likely to have a subsequent AMA discharge.[1–6]

Reasons for Leaving AMA

Two studies explore the reasons that patients leave the hospital AMA and found consistent findings. One study conducted focus groups with patients and physicians and another reviewed medical charts. In both studies top reasons for leaving AMA included substance abuse and/or insufficient pain management, other obligations (such as work and childcare), wait time, communication problems, and the teaching hospital setting with multiple evaluations.[7,8]

Risks Associated with AMA Discharge

In contrast to the small number of studies exploring patient perspectives on AMA discharge, many studies have examined its consequences, especially readmission.

Dozens of studies across subspecialties show that AMA discharge is consistently associated with hospital readmission in general medical patients across a large variety of medical conditions and various time frames after discharge.(3,6,9–19) These readmissions are responsible for the 56% greater than expected costs associated with treatment for patients who leave the hospital AMA.[20]

Patients with an AMA discharge are also less likely to seek needed follow-up care due to concerns about being negatively judged by physicians. In one study, 25% of symptomatic patients failed to follow up after an AMA discharge due to concerns about judgment and stigma.[21]

AMA discharges are associated with increased morbidity, including asthma exacerbation, re-infarction after a myocardial infarction, and adverse pregnancy outcomes for the mother and the fetus.[6,13,22] Further, AMA discharges are associated with increased risk for mortality in both children and adults, including increased risk of suicide.[18,19,22–27] Women with pregnancy-induced hypertension who leave the hospital AMA may experience as much as a 3-fold greater risk of fetal death.[22]

Physician Perceptions and Clinical Practice

AMA discharges are a source of distress for physicians. In one-on-one interviews about AMA discharges physicians reported that their patients lacked insight into their medical conditions and expressed self-doubt about their own ability to convince the patients to remain in the hospital. Physicians struggled to balance the competing ethical obligations of beneficence and respect for patient autonomy. They wavered between guilt that they could not convince the patient to stay and a sense of futility and inevitability about the outcome.[28]

Physicians have biases about patients who leave AMA. A history of AMA discharge is considered a “red flag” behavior.[29] One study surveyed attending and trainee physicians and nurses to assess perspectives on patients who leave the hospital AMA. Although a significant majority of trainees (84%) and attendings (94%) agreed that patients who leave AMA should receive prescriptions at discharge, only 64% of nurses agreed. Also, 38% of nurses, 22% of trainees, and 6% of attendings felt that patients who leave AMA should lose the right to follow-up care.[5]

These biases compromise relationships and care. Threatening to withhold medications or follow-up appointments may be well-intentioned strategies to keep a patient in the hospital. However, such coercive physician behavior can often be experienced by the patient as punishment for “bad behavior.” In our experience, some physicians believe that providing a second-line treatment condones the patient’s decision to leave AMA, so they instead withhold all treatment.

The practice of AMA discharge is obfuscated by common misperceptions. In one study, 69% of residents and 44% of attendings erroneously believed that insurance companies would refuse to pay for hospitalizations that ended with an AMA discharge, relaying this misinformation to patients.[30]

Two studies examined documentation after an AMA discharge. Only 31-37% of charts documented a decision-making capacity (DMC) evaluation, 21-24% of charts documented prescribing

medications at discharge, and 26-31% documented plans for follow-up, suggesting that documentation of AMA discharges is inadequate.[2,5] A more recent study of physician practices showed that only 33% of patients had a follow-up appointment, but that a risk-benefit discussion took place in 69% of cases. Interestingly, this study did not show a relationship between physician discharge practices and risk of readmission.[31]

Arguments For and Against AMA Discharge

Given the lack of standardization of the AMA discharge process, why is it used? There are several reasons: demonstrating clinical concern for the patient's wellbeing; clarifying it was the patient's choice; distancing from potential deleterious outcomes; and providing a rationale for sub-optimal discharge planning.

Finances may also be a consideration. In 2012, the Centers for Medicare and Medicaid Services introduced the Hospital Readmission Reduction Program (HRRP), which monitors hospital readmission rates for Medicare patients admitted for certain medical conditions. Hospitals with high readmission rates are financially penalized. However, patients who leave the hospital AMA are not included in the analysis, potentially incentivizing healthcare systems to label discharges as AMA.[32]

Some believe that using the AMA designation and an AMA waiver provides malpractice protection. However, a study by Devitt et al. examined four lawsuits brought against a physician or hospital after a patient left AMA. The defendant won in all cases because the plaintiff was unable to demonstrate negligence, not because of the AMA designation or waiver. One judge ruled that the AMA waiver is "contrary to public policy and a nullity," suggesting that the waiver provides no protection.[33] The AMA waiver may provide false reassurance to the physician.

There are also reasons to forgo the AMA designation. The subjectivity and stigma associated with AMA risk factors - especially socioeconomic status, homelessness, HIV, substance abuse, and mental

health conditions - suggest that the AMA designation may be confounded by bias. Physicians often question the reason that patients provide for leaving AMA. Although a patient might provide one reason, such as going to work, the physician may document suspicion that the patient was leaving to use substances.[7] The physician's biases or assessment of the patient's reason for leaving the hospital may determine whether the discharge is labeled AMA; however, this has not been studied empirically.

There are calls to eliminate the AMA discharge designation altogether.[34] However, the AMA discharge is well-engrained in the medical system, and is likely here to stay, especially now that it is incentivized by the HRRP.[35]

Recommendations

We recommend the adoption of a formal definition of an AMA discharge as a discharge that: 1) is triggered by the request or insistence of the patient, *and* 2) occurs before the medically indicated workup, treatment, *or* discharge planning has been completed, *and* 3) the workup, treatment, and discharge planning cannot safely be performed on an outpatient basis *or* is highly unlikely to happen in the outpatient setting, *and* 4) the patient has decision-making capacity.

AMA discharge should be a target of quality improvement initiatives. AMA discharge often directly conflicts with the six characteristics of quality health care: safe, effective, patient-centered, timely, efficient, and equitable. AMA discharge can be both unsafe and ineffective due to its association with readmission, morbidity, and mortality. As commonly practiced, it values the priorities of the health care system or the physician above the patient. It is untimely and expensive, due to delayed care and increased costs. AMA discharge is associated with socioeconomic disparities and its application is vulnerable to bias.

Physician responses to AMA discharge can include discouragement, frustration, and indignation. Reducing these fraught patient interactions and having a clearer command of how to respond systematically will improve these interactions for both patients and physicians.

The clinical management of AMA discharge is not routinely taught in medical training. As a result, physicians learn about AMA discharge via the hidden curriculum, resulting in perpetuation of myths and the absence of a consistent framework. Some AMA discharges are inevitable, but we believe that many are preventable. Here, we suggest a strategy to prevent and systematically respond to AMA discharges.

AMA Prevention: AMA Universal Precautions

We recommend four specific steps that comprise "AMA universal precautions" to prevent AMA discharge: 1) treat substance withdrawal and pain, 2) communicate compassionately and non-judgmentally, 3) proactively manage bothersome physical and emotional symptoms, and 4) utilize psychiatric consultation early.

Substance withdrawal and uncontrolled pain are the top reasons that patients request discharge.[7,8] Therefore, adequately treating substance withdrawal, including nicotine withdrawal, should be prioritized. Promising data show that treating nicotine and opioid withdrawal can reduce AMA discharges by 50-60%.[36,37]

An acute medical hospitalization is usually not the ideal time to reduce opioids and benzodiazepines. Instead, we recommend keeping patients comfortable, yet safe, so that they can receive treatment for the immediate medical problem at hand. It is also important to recognize that patients on chronic opioids may need higher than expected opioid doses in the hospital and that drug-drug interactions may result in reduced medication levels. Being forthcoming with patients about addressing

withdrawal can support the patient-physician alliance and ultimately facilitate discussions of treatment for substance use disorders.

Poor communication is another top reason for requesting early discharge. In one study, 75% of patients who left the hospital AMA gave warning about their intention to leave.[2] Although some worry that mentioning AMA discharge to a patient may provoke the patient to leave, speaking directly with patients about their intentions can be helpful in proactively addressing concerns and initiating disposition planning.

Additional investment in time may be necessary to improve communication with some patients. This should include attentively soliciting the patient's concerns and describing necessary work-up and treatment, including realistic estimates about length of hospital stay. Using white boards in the hospital room may be especially helpful. We recommend a stance of under-promising and over-delivering. With open and non-judgmental communication, the team can identify psychosocial stressors and enlist supports such as family and friends, social work, patient advocacy, and other resources. In our experience, trusted supports can be particularly helpful in reinforcing the medical plan.

We recommend early and targeted treatment of distressing symptoms, including nausea, anxiety, insomnia, and fear of procedures. Psychiatry and/or palliative care consultations can be particularly helpful. One study found that *early* psychiatric involvement can reduce AMA discharges: of 11 patients who received a psychiatric consultation within 24 hours of admission, only 1 left AMA, but AMA discharge rates were approximately 50% when psychiatric consultation was delayed.[38] In our experience, psychiatry is often consulted late, in response to a moment of crisis when the patient is requesting discharge. We suggest involving psychiatry early to help manage symptoms and communication barriers. The case below demonstrates how AMA Universal Precautions can prevent an AMA discharge.

Case:

A 45-year-old woman with a history of alcohol abuse, anxiety, and tobacco dependence was admitted for non-uremic cutaneous calciphylaxis, felt to be due to alcohol use. Additional work-up was needed to rule out malignancy. The treatment was thrice-weekly infusion of sodium thiosulfate, but the patient lacked health insurance and needed to remain in the hospital until she could get insurance and transition to outpatient infusion. Psychiatry was consulted on hospital day two for anxiety. On evaluation, the patient mentioned wanting to leave the hospital early. She reported loneliness because she was far from family. Having a shared hospital room was anxiety-provoking and interfered with her sleep. Psychiatry recommended gabapentin for subacute alcohol withdrawal and anxiety, citalopram for anxiety, trazodone for sleep, and a nicotine patch. Psychiatry advocated for the patient to move to a single room and consulted art and music therapy to reduce boredom. Psychiatry visited daily to provide support and reiterate the medical plan. Ultimately, she was hospitalized for three weeks until her workup was complete and outpatient infusion was arranged.

Management: A Standardized Approach to AMA

Despite all efforts, some patients still request early discharge. Therefore, we created an algorithm to systematically respond to the AMA discharge request (Figure 1).

First, the physician should attempt to understand the patient's rationale for leaving and elicit bothersome symptoms or social circumstances that make staying difficult. With reassurance and appropriate interventions, the patient may choose to stay. In our experience, enlisting trusted supports can be particularly helpful. The recruitment of chaplaincy, a patient advocate, or social work may help. However, coercive strategies, such as withholding necessary prescriptions, not arranging follow-up appointments, or saying that insurance will not pay for the hospitalization should be avoided.

If the patient still insists on discharge, the physician should consider whether the discharge *truly* warrants an AMA designation; just because the discharge is earlier than anticipated does not mean that it

must be AMA. Is the workup and treatment complete? If not, can work-up and treatment be completed on an outpatient basis? Is there an acceptable second-best option? Weigh the risks and benefits of the early discharge and the risks and benefits of the use of the AMA label. If the patient and physician can agree on an alternative treatment plan, the discharge could be considered routine, with thorough documentation of the decision-making process and provision of appropriate prescriptions and follow-up.

If the physician deems the discharge medically risky and believes the AMA designation is necessary, the physician will need to assess the patient's DMC to leave AMA. Physician concerns about patient insight, correlation between psychiatric conditions and AMA discharge, and the lack of documentation of capacity evaluations suggest that DMC evaluations are necessary yet insufficiently documented.[1,2,4,5,7] Psychiatric consultation is not required to assess DMC, but in challenging cases a psychiatric consult may be helpful. Please refer to work by Applebaum and Grisso on assessing DMC, which is beyond the scope of this article.[39]

If a patient lacks capacity to leave AMA, he should be prevented from leaving, and the patient's surrogate decision-maker should be contacted. Holding a patient in the hospital who wishes to leave AMA but lacks DMC can be logistically challenging. For many years involuntary psychiatric commitment paperwork was filed to hold a patient, as hospital police in some institutions required this before physically restraining a patient. While this policy continues in some hospitals, support for involuntary medical holds is growing. A medical hold allows hospital security to hold incapacitated patients, if necessary, without invoking the psychiatric commitment process.[40]

If at any point the patient decides to stay in the hospital the team should continue to practice AMA universal precautions to prevent a subsequent request for early discharge.

If the physician feels that the AMA designation is needed *and* the patient with DMC opts not stay despite thorough review of risks/benefits, the physician may discharge the patient AMA. Weighing the risks and benefits of the AMA waiver, we do not recommend using the form, which is unlikely to provide

medicolegal protection, may thwart creation of a safe discharge plan, and fosters distrust. However, if the medical team favors using the AMA waiver, we recommend adapting it to be more patient-centered with best practice reminders for the physician.

Regardless of the reason for the AMA discharge, the patient should be provided with necessary prescriptions, follow-up appointments, return instructions, and explicit guidance that they are welcome to return if needed. Providing contact information for the discharging team can reiterate support if questions arise.

After the AMA Discharge: Documentation

Due to the risks associated with AMA discharge, we recommend being particularly diligent as the patient leaves the hospital. The AMA form will not protect the physician, but good decision-making and documentation will.

The physician should record the specific events leading up to the AMA discharge, use descriptive, fact-based information, and avoid emotionally laden language. The language should objectively describe attempts atollaborative decision-making with the patient. The patient's rationale for discharge, attempts to encourage the patient to stay, description of the completed capacity evaluation, medications prescribed, recommended follow-up, and return instructions should all be documented.

Summary

AMA discharge affects every inpatient medical specialty but is under-explored in medical training, clinical care, and research. As a result, misinformation has persisted, and clinical practice is suboptimal.[2,5,30] This article summarizes relevant research, proposes an AMA discharge definition, and describes a strategy to respond to AMA requests more consistently.

AMA discharge is a preventable adverse outcome that should be rigorously studied to improve quality of care. We have proposed an approach to prevent AMA discharges and respond in a more safe, consistent, patient-centered, and compassionate manner when patients ask to leave. Improving the management of AMA discharges is critical for patients, physician, and the healthcare system.

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