Teachable Moment | LESS IS MORE

Avoiding Hospital Discharge Against Medical Advice
A Teachable Moment

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Story From the Front Lines

I was called by the nursing team to evaluate a patient requesting to be discharged owing to concerns about our care. The patient was about 60 years old and was undergoing treatment in the hospital for community-acquired pneumonia with intravenous antibiotics and oxygen. The patient shared a list of grievances: the snoring person on the other side of the curtain, the quality of dinner, and the frequent interruptions for medications and vital signs. I attempted to persuade the patient to stay, and after minimal progress, offered the option to sign out against medical advice. Both of us frustrated and tired, the patient accepted this option. I explained the risks of leaving the hospital prematurely, highlighting the word "death" on the form, and then guided my patient to the signature line. The patient left the unit but returned shortly thereafter, sitting on a bench by the elevators, looking defeated and dyspneic. The patient apologized and asked to be readmitted to continue treatment.

Teachable Moment

Approximately 1% to 2% of hospital discharges are designated as against medical advice (AMA).[1,2] Following an AMA discharge, patients have disproportionately high rates of readmission and adverse events, including death.[2] Designating a discharge as AMA creates stigma and labels patients in a way that can taint future interactions with the health care system.[3]

Misconceptions commonly exist regarding AMA discharges. One misconception is that patients will be liable for their hospital bill if they leave AMA. A study examining 453 AMA discharges found that no payment was denied owing to AMA discharge status in any of the cases.[1] Despite compelling evidence to the contrary, the authors' survey of academic internal medicine physicians in Illinois found that 68% of residents and 44% of attending physicians believed that patients would be financially responsible if they left AMA, and similar percentages of physicians reported informing patients of this.[1] The authors of that study reviewed 17 AMA forms and found that 2 of them actually included language disclosing potential financial responsibility.[1]

Another misconception relates to presumed legal protections conferred by designated AMA forms, which are commonplace. While signing a form is believed to absolve legal liability, this claim is mostly unfounded.[4] Liability appears to be lowest when the physician elicits patient values, uses a harm-reduction approach when the patient's preferences are incongruent with the physician's, and clearly documents these discussions in the medical record.[3]

Absent any apparent benefit to designating a discharge as AMA, it is perhaps unsurprising that no organizing body has published standards for defining or performing an AMA discharge, which allows variable practice patterns among physicians.[3] A preferred approach should include the ask-tell-ask method in which clinicians would explore patients' knowledge regarding the reason for hospitalization, fill gaps in their understanding, invite them to share in a decision, and then confirm that the decision is consistent with stated goals and preferences. If the patient decides to leave the hospital, standard discharge procedures should be followed.

The described case highlights a breakdown of the physician-patient relationship. The patient's ultimate concession implies a patient vs physician mentality to our conflict. Formalizing the failure with an AMA form is unlikely to benefit the patient's care. In this case, could I have responded with empathy and understanding and come to a shared decision with the patient to alleviate both of our concerns? Perhaps just acknowledging the patient's concerns and taking small steps to alleviate them would have changed the patient's mind (eg, limiting overnight vital signs or orchestrating a room change). Furthermore, recommending inpatient vs outpatient care for common medical conditions often relies on the physician's best judgement as opposed to evidence and is susceptible to bias. In this case, the patient clearly required inpatient care, but in cases when the decision is less clear, outpatient care should be considered.

If a patient insists on leaving and has the decisional capacity to do so, appropriate medication reconciliation and follow-up planning is still an essential part of the discharge process. Establishing a reasonable plan that does the least harm to the patient is likely to improve adherence to the plan and remove the adversarial component from the discharge. Many health systems have established transitional care or postdischarge clinics. Often staffed by hospitalists or the discharge team, these clinics are a potentially untapped resource for patients discharging prematurely because they can shorten the time to follow-up for patients unaffiliated with a primary care practice or for those who have long wait times with their usual health care clinician.[5]

Despite our best efforts, many hospitalized patients will leave against the recommendation of their physician. Designating these discharges as AMA is not beneficial to patients or physicians and must be avoided. The approach described herein can help reduce the stigma associated with these discharges and increase the probability that this marginalized group of patients receives high-quality post-hospitalization care.

ARTICLE INFORMATION

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