Discharge against medical advice – some causes and consequences

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Abstract

Patients who self-discharge against medical advice can pose clinical, moral, ethical and medico-legal problems. Reasons for self-discharge against medical advice include personal and/or financial obligations, refusal of inpatient treatment, desire to seek inpatient treatment at a different or private hospital, and to seek an alternative form of therapy. In general, self-discharge against medical advice has been associated with patient socio-economic and domestic disadvantage. The potential adverse complications of self-discharge include clinical deterioration and subsequent need for more intensive and expensive therapy, injury and property damage suffered by a third party and legal action by the patient or a third party for alleged malpractice. Allowing self-discharge against medical advice may expose clinicians to subsequent legal proceedings. Measures which may be taken to decrease potential problems include thorough, good clinical practice with impeccable documentation of inpatient treatment progress and procedures, and ensuring that patients, their relatives or representatives understand the possible consequences of self-discharge against medical advice.

Key words: self-discharge, against medical advice

Introduction

When patients undertake self-discharge against medical advice, they withdraw consent to undergo further inpatient treatment. The reported prevalence of self-discharge against medical advice ranges from 1% - 50% of all discharges, and varies with the patient cohort reported on. Stated reasons for self-discharge against medical advice by patients vary and may not be genuine. Self-discharge may result in complicated adverse clinical and medico-legal consequences. This review attempts to illustrate some of the problems and outline some measures which may be implemented to decrease these problems.

Prevalence

Approximately 1% of hospital discharges have been reported to be self-discharges taken against medical advice. Prevalence rates of 0.9%, 0.92%, 1%, 1.2% and 1.5% have been reported in general hospital patients (Endicott & Watson, 1994), short-stay hospital patients (Moy & Bartman, 1996), general medical patients (Aliyu, 2002), patients hospitalised because of pneumonia (Saitz, 1999) and general hospital patients (O'Hara *et al.*, 1996) respectively. However, reported prevalence rates for HIV/AIDS patients (Anis, 2002), psychiatric patients (Dalrymple, 1993), opiate dependent patients (Endicott & Watson, 1994) and paediatric patients in a hospital facing budgetary constraints (Gloyd *et al.*, 1995) were higher at 13%, 6-35%, 50% and 12% respectively.

Reasons

Patients may undertake self-discharge against medical advice (i) when symptoms have regressed and they feel better, (ii) when they have personal obligations to fulfil, (iii) when they have financial obligations to fulfil (Jeremiah *et al.*, 1995), (iv) when they are unable to afford the purchase of medicines and supplies necessary for inpatient treatment (Gloyd *et al.*, 1995), (v) when they decide to undergo treatment at a different hospital (Moissinac & Se To, 1999), (vi) when they decide to undergo treatment by practitioners of traditional healing (Moissinac & Se To, 1999), and (vii) when they perceive that there is no further benefit from hospitalisation. Patients admitted primarily to obtain relief from the stresses of life (Berg & Dhopesh, 1996) or to obtain substances of addiction will undertake self-discharges against medical advice when these are no longer necessary or obtainable.

Patient Profiles

In a general hospital patient cohort (Australia), clinical conditions associated with self-discharge included injuries, poisoning, circulatory and mental disorders (O'Hara *et al.*, 1996). On a

general medical service (USA), patients who undertook self-discharge were more frequently, young, male, without medical insurance, Medicaid applicants or recipients, admitted through the accident and emergency service and without regular on-going primary medical care (Weingart *et al.*, 1998).

Tuberculosis inpatients (Japan) who undertook self-discharge were more frequently, young, male, with no immediate family, no regular place of residence, with either intermittent menial type employment or no regular employment and, were disadvantaged socio-economically and psychologically (Saitz *et al.*, 1999). Psychiatric inpatients (USA) who undertook self-discharge were reported to be living alone, on substances of abuse, on psycho-active substances, having been previously hospitalised, and suffering from more severe symptoms on self-discharge (Pages *et al.*, 1998). Inpatients with HIV/AIDS who undertook self-discharge were more likely to be substance abusers and to depart on the day of issue of welfare cheques (Anis *et al.*, 2002).

Although self-discharge has been reported to be associated with socio-economic and domestic disadvantage, Cook *et al.* (1994) found that in a cohort of inpatients undergoing a Veteran Administrations alcoholic treatment programme, factors associated with self discharge were a college education, vocational or other training, being employed, and a history of previous self-discharges against medical advice.

Consequences

Patients who self-discharged against medical advice have been reported to be frequently readmitted with a related diagnosis shortly after their self-discharge (Jeremiah *et al.*, 1995; Anis, 2002; Dalrymple *et al.*, 1993). As many as 54% of patients who self-discharged from a general medical service were subsequently readmitted with a related diagnosis (Weingart *et al.*, 1998). Patients who had a history of repeated self-discharges from a psychiatric inpatient service were more likely to be readmitted within one week than those who had only self-discharged on the first occasion (27% vs. 3%), (Dalrymple *et al.*, 1993).

When they are readmitted, patients who had previously taken self-discharge against medical advice frequently were more ill, had more severe symptoms, and required more intensive treatment which incurred greater hospital resource utilisation involving unnecessary additional costs. Patients who did not complete their previous treatment programmes and had self-discharged were found to have wasted already scarce healthcare resources and to cause demoralisation amongst their carers (Endicott & Watson, 1994). Many self-discharged patients who suffered from incompletely treated infective illnesses and who did not return for treatment may remain infective and pose a danger to others as was reported for Japanese tuberculosis inpatients who undertook self-discharge against medical advice (Sasaki *et al.*, 1993).

Patients referred and admitted for inpatient psychiatric treatment who self-discharged without completing treatment may pose a danger to themselves as well as to others. Potential complications which patients who self-discharge to seek treatment by traditional healers, may expose themselves to include thermal injury from cupping, dermatitis and ulceration induced by liniments and oils used in traditional massage, and sprains and dislocations secondary to over-enthusiastic traditional massage (Se To & Moissinac, 2001).

Medico-legal Implications

As there are regulations which enable clinicians to hold patients in hospital for treatment against their will, self-discharge against medical advice can pose medico-legal problems. Who is responsible when a mentally incompetent patient causes injury to others or damages public and private property after being allowed to self-discharge and leave hospital without the completion of necessary treatment? It would be difficult, if not impossible to ascertain whether such a patient was mentally compromised at the time of self-discharge, or whether mental incompetence occurred as a result of non-compliance with outpatient treatment, or perhaps both.

Although, there has not been such a medico-legal issue yet, it has been reported that medical practitioners have been sued for malpractice by patients who had previously self-discharged against medical advice (Devitt *et al.*, 2000a, Devitt *et al.*, 2000b). So far in all cases, where patients who self-discharged against medical advice had sued their medical attendants for malpractice, the defendants have prevailed. This was not because the self-discharge against medical advice provided legal immunity but because the plaintiffs were unable to prove negligence (Devitt *et al.*, 2000b).

Measures to alleviate the problem

The prevalence of self-discharge can be decreased and its untoward consequences minimised through patient and public awareness education programmes, efficient inpatient treatment, improved clinician awareness of the potential adverse consequences of self-discharge, thorough clinical practice with attention to detail, well-documented medical records, familiarity of hospital management personnel with protocols pertaining to the detention of involuntary patients and, familiarity of hospital management with the strengths, weakness and eccentricities of practicing clinicians at their institutions.

Education programmes can enhance public awareness and understanding of the indications, scope, contraindications, procedures and limitations of inpatient medical treatment, and the natural history of common medical conditions and commonly sustained trauma. Thorough and well documented clinical examination and investigation should be performed to assess the severity of illness and risk if the patient self-discharged against medical advice. When a patient intends to self-discharge, constructive dialogue is essential and the patient, their relatives and/or representatives must be informed of the risks involved, the benefits of inpatient treatment and any available alternative therapies (Devitt *et al.*, 2000a) including their potential complications. These proceedings should be meticulously documented. To deter self-discharge especially for those with a previous history of self discharge, expedient treatment, goal setting, and appropriate discharge planning (McGihon *et al.*, 1998) may decrease the risks of untoward consequences.

Patients who intend to self-discharge must be assessed either formally or informally, to determine their competence to understand and to accept the risk of the consequences of refusing medical care, whether can be responsible for taking care of themselves, and to deal with other matters (Masand *et al.*, 1998). Hospital management personnel familiar with laws and detention protocols should be readily available to assist clinicians in resolving discharge questions (McGihon *et al.*, 1998). Prior to allowing self-discharge it must be established that the patient, their relatives and/or representatives understand the diagnosis, the treatment required, the consequences of refusing the treatment, alternative treatment if available, and possible complications of alternative therapies.

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