THE DILEMMA OF THE PATIENT WHO WISHES TO LEAVE THE HOSPITAL AGAINST MEDICAL ADVICE

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Clinicians should strive to provide high-quality, safe, and appropriate care for every patient. Therefore, the patient who wishes to leave the hospital against medical advice (AMA) represents a frustrating problem. Discharging a patient AMA poses a professional dilemma because it places 2 guiding principles of medical professionalism [1]—commitment to patient welfare and respect for patient autonomy—in direct conflict. In these situations, physicians face the difficult task of weighing patient welfare against patient autonomy while adhering to professional responsibilities set forth by the Charter on Medical Professionalism (**Table 1**) [1].

Physicians training or practicing in hospitals can expect to encounter patients who do not want to stay in the hospital to receive recommended care. While it may not be possible to prevent patients from leaving, it is important to do all that can be done to ensure patient welfare. By recognizing patients who are at risk for leaving AMA and understanding the process steps that should be taken when patients resist or refuse medical care, physicians will be better prepared to act in the best way to minimize adverse patient outcomes. In this article, 3 scenarios are presented to illustrate examples of the dilemma of the patient who wishes to leave AMA. In the discussions that follow, we examine issues underlying the conflict between patient welfare and patient autonomy and offer recommendations for addressing this conflict.

Weighing Patient Welfare

Case 1 Presentation

Mr. Sayres, a 71-year-old man, is brought to the hospital by EMS on a backboard and with a cervical collar after a fall at home from a standing height. Mr. Sayres lives alone in an apartment building and was found by a concerned neighbor, who heard the fall from next door. Mr. Sayres was found conscious but was unable to recall how he fell.

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On arrival to the emergency department (ED), Mr. Sayres is evaluated by Dr. Lewis, a second-year emergency medicine (EM) resident. The primary survey is intact, including a Glasgow Coma Scale score of 15. Secondary survey reveals only an occipital scalp laceration and mild ecchymosis to the left hip. Mr. Sayres has no known medical history and no allergies and does not recall his last tetanus shot. He complains of a mild headache and left hip pain. Computed tomography of the brain and cervical spine reveals only diffuse atrophy and degenerative joint disease, respectively. Radiographs of the left hip are negative for fracture. An electrocardiogram (ECG) shows nonspecific T wave inversions in the lateral leads; there is no old ECG for comparison. Laboratory studies are significant for a troponin I of 0.07 ng/mL and a blood alcohol level of 70 mg/dL.

Shortly after the laboratory results return, Dr. Lewis discusses the findings with Mr. Sayres. Dr. Lewis recommends that Mr. Sayres be admitted for observation, telemetry monitoring, serial cardiac enzymes, and further evaluation and treatment for likely syncope. Mr. Sayres explains that he feels fine and that he needs to go home to take care of his cat. He does not want further testing and states that he wants to leave against the advice of Dr. Lewis.

What is at Stake When Patients Leave the Hospital AMA?

Dedication to patient welfare, the first guiding principle defined by the Charter on Medical Professionalism [1], is the cornerstone of the medical arts. Three ethical principles are embodied in the physician's obligation to patient welfare: nonmaleficence (do no harm to the patient), beneficence (do all one can to help the patient), and fiduciary duty (place the patient's needs above all other considerations). Patient welfare is the highest priority when discharging patients AMA. If a patient leaves the hospital AMA, his/her health care needs are not addressed optimally or at all, placing the patient at risk for a perpetuated or worsened state of poor health. As illustrated in this case, Mr. Sayres is potentially at risk for a myocardial

Table 1. Principles and Professional Commitments of the Charter on Medical Professionalism

Guiding principles
Patient welfare
Patient autonomy
Social justice
Professional responsibilities
Commitment to:
Professional competence
Honesty with patients
Patient confidentiality
Maintaining appropriate relations with patients
Improving quality of care
Improving access to care
Just distribution of finite resources
Scientific knowledge
Maintaining trust by managing conflicts of interest
Professional responsibilities

NOTE: This charter was written by the Medical Professionalism Project, a joint effort of the American Board of Internal Medicine Foundation, the American College of Physicians–American Society of Internal Medicine Foundation, and the European Federation of Internal Medicine. (Data from Medical professionalism in the new millennium: a physician charter. ABIM Foundation. American Board of Internal Medicine; ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine; European Federation of Internal Medicine. Ann Intern Med 2002;136:243–6.)

infarction (MI) or arrhythmia; if he leaves the hospital now, he is risking a worse outcome from an acute cardiac event.

The morbidity and mortality risks associated with AMA discharges are not yet well-defined in the literature; however, leaving AMA likely does not favor the patient's well-being. Many studies note a higher percentage of readmission to the hospital in patients who leave AMA as compared with patients who are discharged with physician approval [2–6]. Weingarten et al [2] reported results of a retrospective case-control study of 472 patients discharged AMA from the medical service of an acute care hospital in Boston. The 7-day readmission rate for patients discharged AMA was 14% compared with 7% for control patients. Similarly, Hwang et al [4] conducted a prospective case-control study of patients discharged AMA from the general medicine service of an urban teaching hospital in Canada and found that readmission rates were significantly increased in the first 2 weeks after discharge in the AMA group compared with the control group (15% verses 3%). The authors note that their data suggest that the increased risk for readmission during the first 2 weeks reflects only the act of leaving AMA and not higher comorbidity, since readmission rates were similar in both groups after the first 15 days postdischarge [4].

Some studies have examined the impact of leaving AMA on disease-specific outcomes. For example, Lee et al [7] reported outcomes for 107 patients who left AMA from the ED of 3 university and 4 community hospitals after presenting with the chief complaint of chest pain. They found that patients who refused admission had a lower risk for MI than those who agreed to be admitted but a higher risk for MI than those for whom admission was not recommended. Although the majority of patients who left AMA suffered no morbidity, 14 (12%) were hospitalized within 3 days of their ED visit, 3 had a documented acute MI, and 1 person died after leaving the hospital the same day of the ED visit [7]. In a recently published study, Baptist et al [6] reported outcomes for 180 patients discharged AMA after hospitalization for an asthma exacerbation at 1 of 3 large Detroit hospitals. Compared with asthma patients discharged with physician approval, patients discharged AMA were more likely to have an asthma relapse within 30 days and to present once again to the ED (21.7% versus 5.4%) or be readmitted to the hospital (8.5% versus 3.2%).

Recognizing Patient Risk Factors for Leaving AMA

In order to target interventions toward preserving patient welfare, it is important to understand the factors that may contribute to the likelihood that a hospitalization will prematurely end with a discharge AMA. Patient risk factors for leaving AMA vary significantly based on the demographics of the patient populations cared for by different hospitals.

Drug abuse, particularly alcohol and narcotic abuse, is the one common risk factor pervading all hospital settings [3,4]. In 2002, the top 2 diagnoses related to AMA discharge were drug abuse disorders and alcohol abuse disorders (**Table 2**). This suggests that clinicians should maintain a high level of suspicion for potential drug and/or alcohol dependence when patients, including elderly patients, wish to leave AMA. Health care workers and physicians underestimate drinking in elderly patients [8,9]. One in 4 elderly patients consumes alcohol, and 1 in 17 is a self-reported "heavy" drinker [10]. Mr. Sayres' case

underscores the importance of considering alcohol dependence as a reason why patients want to leave AMA. In these cases, the physician must address the patient's concerns and, when necessary, convey a clear desire and ability to treat withdrawal symptoms.

Another common risk factor for leaving AMA is lack of health care insurance [2,3,11]. In 2003, 3.5% of uninsured patients in the United States who were admitted to the hospital left AMA, a rate that was 3 times higher than that for patients on Medicaid and 7 times higher than the rate for patients with private health insurance [12]. It is unclear why the rate of AMA is so much higher for patients without insurance, but the reason is likely multifactorial, including complex health care, societal, and individual factors. However, physicians must be aware of their own negative biases that contribute to the potential for patients to leave AMA.

Other patient characteristics correlating with leaving AMA that have been reported in the literature are somewhat less clear. Some authors have found that young men are at higher risk for leaving AMA, whereas other studies emphasize that the elderly comprise a significant percentage of the patients who leave AMA and suffer higher morbidity as a result [2,3,13,14]. In EDs, longer waiting times correlate with an increased number of patients who leave without being seen as well as an increase in those who leave AMA [13]. In a study of HIV-positive patients, Anis et al [5] found that the date on which welfare checks were distributed correlated with patients leaving AMA; in fact, it was found to be the most significant risk factor second only to drug abuse.

Case 1 Conclusion

Upon further questioning by Dr. Lewis, Mr. Sayres admits to daily alcohol use. Dr. Lewis assures Mr. Sayres that he will be monitored closely and treated for any withdrawal symptoms while he is in the hospital. Dr. Lewis also expresses his concerns regarding the abnormal ECG and troponin level, noting that a cardiac event may have caused Mr. Sayers' fall and that leaving AMA could result in a heart attack or even death. Mr. Sayres states that he understands the concerns, but he insists that he feels fine now and will not be staying for further evaluation. He is able to repeat back to Dr. Lewis both the benefits of staying and the risks of leaving.

Because of the potential severity of his illness, Dr. Lewis asks Mr. Sayres if it would be OK to contact a family member to discuss the situation. Mr. Sayres agrees to let the doctor contact his daughter. Although the daughter is unable to convince her father to be admitted, Mr. Sayres agrees to let his daughter stay at his home through the night. A follow-up appointment is made in the internal medicine (IM) resident clinic for the following day, as Mr. Sayres has no primary care physician. Mr. Sayres is given discharge instructions and is told to start taking a daily aspirin. Finally, Dr. Lewis tells Mr. Sayers that he is welcome to return at any point for admission.

Table 2. Top 10 Principal Diagnoses of Patients who Left Against Medical Advice in 2002

Drug abuse disorder
Alcohol abuse disorder
Chest pain
Affective or mood disorder
Coronary atherosclerosis
Pneumonia
Congestive heart failure
Diabetes mellitus with complications
Pancreatic disorder other than diabetes
Skin/subcutaneous tissue infection

Data from Merrill CT, Elixhauser A. Hospitalization in the United States, 2002. HCUP fact book No. 6. Rockville (MD): Agency for Healthcare Research and Quality; 2005. AHRQ Publication No. 05–0056.

In this case, the patient's welfare was made the priority even though an AMA discharge was not avoided. Although this AMA discharge is considered a suboptimal outcome, Dr. Lewis did all in his power to avoid it. Being aware of the risk factors for patients leaving AMA, as Dr. Lewis demonstrated with this patient with alcohol dependence, enables the physician to promptly address these issues with patients and may help to avoid unwanted AMA discharges.

Weighing Patient Autonomy

Case 2 Presentation

Ms. Maple, a 62-year-old woman with a history of schizophrenia and chronic obstructive pulmonary disease (COPD), presents alone to the ED with a chief complaint of shortness of breath. She is evaluated by Dr. Lin, a family practice resident rotating through the ED. Ms. Maple reports fevers and chills for a few days. She also admits to noncompliance with her usual medications, olanzapine and an albuterol/ipratropium inhaler. Her vital signs are significant for a temperature of 102°F and an oxygen

saturation of 82% on room air, which improves to 94% on 4L of oxygen by nasal canula. On physical examination, the patient is tachypneic with diffuse wheezes in all lung fields. A chest radiograph shows a left lower lobe pneumonia.

Dr. Lin informs Ms. Maple that she has pneumonia and requires hospital admission for treatment with oxygen, inhaled medications, steroids, and antibiotics. The patient agrees to nebulizers, oral antibiotics, and oral steroids in the ED but refuses any intravenous (IV) medications because she is afraid that the doctors will put medications into the IV line that will harm her. Upon admission to the medicine floor, Ms. Maple becomes increasingly agitated and paranoid. She refuses further care and states that she wants to leave the hospital.

What Defines Patient Autonomy?

Patient autonomy, the second fundamental principle of the Professionalism Charter [1], recognizes that patients are mature individuals (or parents, in the case of immature children) who have the right to refuse or accept medical care. Increasingly, the medical profession has acknowledged that patient care decisions should consider the values, needs, desires, and preferences of the patient and that the physician should seek to provide complete, honest counsel to guide these decisions. For many patients, the issue of autonomy can be resolved by clearly communicating the risks and benefits of diagnostic and/or therapeutic interventions and, thereby, allowing patients to make informed decisions.

In the case of a patient leaving AMA, it is important to be extremely vigilant in communicating and confirming a full understanding of the clinical situation so the patient can make an informed, autonomous decision. A conversation must take place with every patient leaving AMA, in which the patient verbalizes understanding to the physician. One technique to ensure clear understanding may be to have the patient repeat back the risks of leaving AMA and instructions for further care.

The first common barrier to making an informed decision is language. Because of poor literacy or not being a native English speaker, a patient may not understand medical terminology used to describe alternative treatments or prognosis or legal information contained in a consent form. Clearly, a translator must be used when the patient's primary language is not English. Even in patients who are native English speakers, the AMA form may be difficult to understand. The AMA form is essentially a legal form and is often written at a higher literacy level (at an 11th grade level in most hospitals). In 1 study conducted in a university hospital ED setting to assess whether written material given to patients matched level of patient literacy, more than 40% of patients could not read at even an 8th grade level and 20% were functionally illiterate [15]. The AMA form at that hospital was written at an 11th grade level.

Even with clear communication, certain patients cannot be assumed to comprehend all the ramifications of refusing recommended care. In order to ensure appropriate respect for patient autonomy while preserving life, physicians must understand the concept of decision-making capacity. Assessing decision-making capacity is the most important aspect of the AMA discharge, as it determines whether a patient can act autonomously, even if leaving is considered to be medically dangerous. Decision-making capacity has 4 major components: the patient must have the ability to (1) communicate choices in the context of his/her own belief system, (2) understand relevant information regarding his/her illness and available treatment, (3) understand consequences of his/her actions, and (4) manipulate information rationally and share in the decision-making process [16]. If a patient meets these criteria, a physician can feel confident in documenting that the patient has full decision-making capacity. For a discussion of key process steps for obtaining consent in an acute care setting, the reader is referred to the review by Gisondi and Norris [17].

In routine clinical practice, decision-making capacity is assessed inconsistently and misconceptions are common. One of the most common misconceptions is interpreting competence as decision-making capacity [18]. Decision-making capacity is a clinical term. It is defined as the ability to understand and appreciate the nature and consequences of health decisions and to formulate and communicate decisions concerning health care. In contrast, competence is a legal term. A person who has been ruled incompetent is not able to make valid decisions and has an appointed guardian to make decisions. It is important to note that a person who is legally incompetent may have the capacity to make some clinical decisions. Conversely, someone who is generally competent may have a medical ailment that precludes his/her capacity to make a specific decision [18].

A second misconception is that psychiatrists alone can make an accurate assessment of decision-making capacity. In truth, all clinicians responsible for the care of patients should be able to perform routine assessments of decision-making capacity [18]. The clinician

who is personally responsible for a patient's care may be the best person to assess that patient's decision-making capacity at that moment. A primary care physician may be better equipped to assess whether the patient's decision is consistent with his/her long-term goals and values, whereas a specialist may be more familiar with the medical ailment in question and may be better able to explain risks and benefits more accurately.

In cases in which the patient has a major mental disorder, a psychiatry consultation may be appropriate. In this case, it may be unclear to the treating physician whether the psychiatric disorder is interfering with the specific decision-making process in question. For example, delusions may cause a patient to mistrust a clinical situation and thus refuse care irrationally, whereas depression may be a sign that a patient harbors suicidal ideation. The psychiatrist may also be useful in guiding treatment for the underlying psychiatric condition. It is important to note that having a psychiatric disorder does not negate decision-making capacity. Unless the patient is suicidal or homicidal or shows the inability to perform the basic functions of caring for oneself, the patient can still make his/her own decisions just like any other patient. In fact, clinical evidence suggests that despite alterations in thinking and mood, psychiatric patients are not automatically less capable than others of making health care decisions [19].

Case 2 Conclusion

The medical team consults psychiatry to evaluate Ms. Maple and to assess whether she has the decision-making capacity to risk leaving the hospital with untreated pneumonia. During the interview, Ms. Maple admits that she is afraid that the doctors are working for the FBI and want to assassinate her. The psychiatry team determines that the patient's underlying psychiatric condition is clearly responsible for her paranoia regarding her treatment and that she does not have intact decisional capacity.

Ms. Maple's agitation continues to escalate. Because she is not considered safe to leave, the medical team, in conjunction with the psychiatrist, orders an intramuscular injection of haloperidol to sedate Ms. Maple. After Ms. Maple's paranoia begins to subside, she agrees to restart her regular antipsychotic medication to stabilize her schizophrenia. She goes on to finish her medical therapy for her COPD exacerbation and pneumonia and is eventually discharged home in good condition.

In this case, Ms. Maple demonstrated that she did not have intact decision-making capacity and therefore she could not be allowed to leave AMA. When a patient is unable to make decisions regarding his/her medical care, leaving AMA is not an option, as seen in this case in which an uncontrolled psychiatric illness would have led to direct harm to the patient. Physical and/or chemical restraints may be warranted to ensure patient welfare. However, patient autonomy must be adhered to as soon as the patient is able to make decisions for him/herself. A standardized approach to assessing decision-making capacity may be useful (**Figure**).

Balancing Patient Autonomy with Patient Welfare

Case 3 Presentation

Mr. Conner, a healthy 42-year-old man, presents to the ED accompanied by his wife. An hour earlier, Mr. Conner experienced an acute episode of 5 minutes of chest discomfort with mild shortness of breath but no diaphoresis, nausea, or arm pain. While he felt it was probably nothing, his wife wanted him to have it checked out just in case.

Mr. Conner is evaluated in the ED by Dr. Vincent, a resident in the hospital's combined EM/IM training program. The physical examination is within normal limits as are results on ECG, chest radiograph, and initial blood analyses. Still, Dr. Vincent believes it is best for Mr. Conner to be admitted to the hospital's observation unit for serial cardiac enzymes and a cardiac stress test in the morning. Dr. Vincent asks one of the ED nurses to inform Mr. Conner of her recommendation while she evaluates another patient.

When given the news, Mr. Conner tells the nurse that his mother recently died and he is in town for her funeral that evening. He feels the discomfort is likely related to anxiety. After consulting with his wife, Mr. Conner tells the nurse that he has decided to leave the hospital AMA, although he appreciates the clinical team's care. Distressed, the nurse urges him to stay and emphasizes that if he leaves, he will not receive discharge instructions, prescriptions, or any coverage by his medical insurance. Mr. Conner is shocked to hear this but reiterates his decision. An ED attending who happened to be near enough to hear the nurse's comments to Mr. Conner steps in as the nurse is presenting Mr. Conner with the AMA form waiving the hospital from all liability regarding his care.

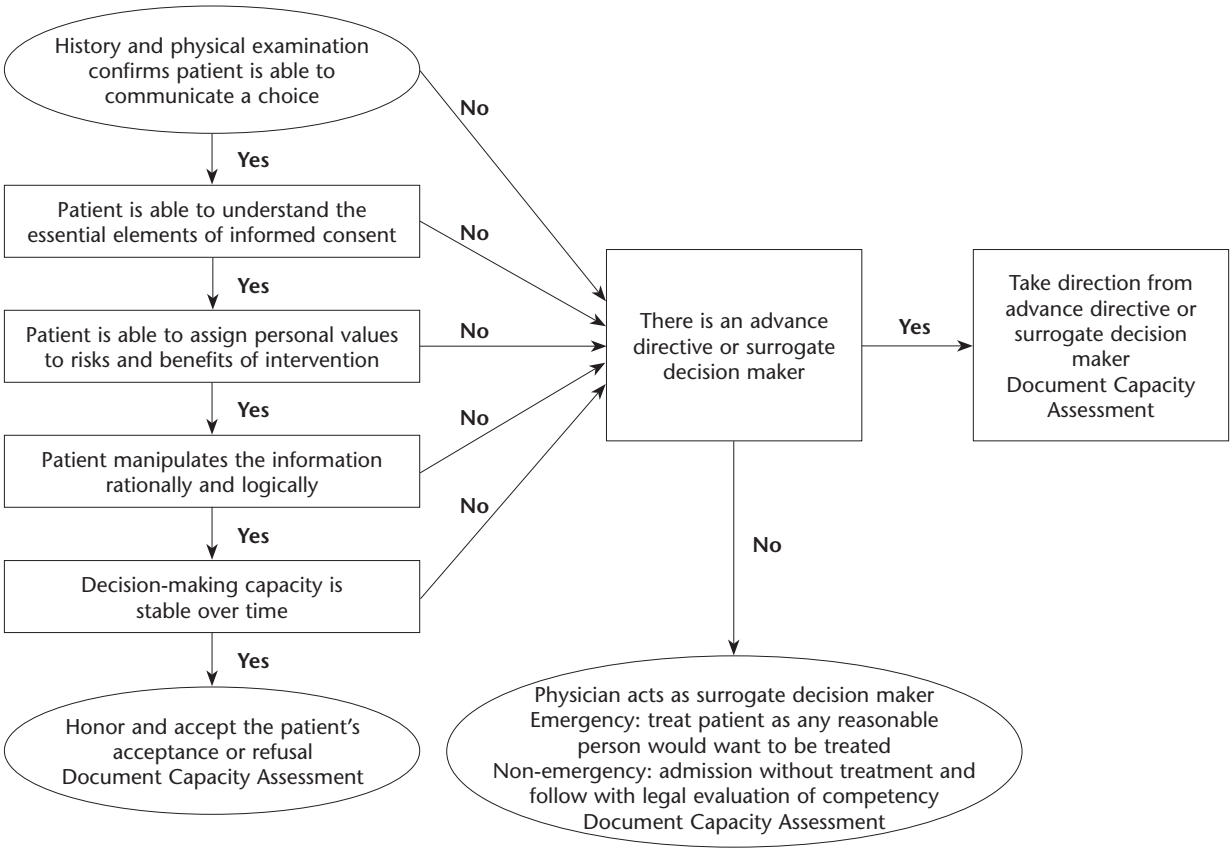

Figure. Algorithm for assessing decision-making capacity. (Adapted from Miller SS, Marin DB. Assessing capacity. Emerg Med Clin North Am 2000;18:240. Copyright 2000, with permission from Elsevier.)

The Process of Discharging Patients AMA

Physicians and other medical staff struggle to balance patient welfare with patient autonomy. The goal to preserve life may conflict with a patient's decision regarding his/her care and might lead to coercion on the part of the provider. In addition to concerns about patient welfare, members of the care team may be nervous that patients could use poor medical outcome as a source of litigation. Unfortunately, the misguided nurse in this case has resorted to a coercive tactic of threatening Mr. Conner that his insurance will not cover his ED visit and that he will not receive discharge instructions and prescriptions if he leaves AMA. Familiarity with necessary documentation and discharge procedure for patients who decide to leave AMA will allow physicians and other medical staff to feel more comfortable with the process.

The process of discharging a patient from the hospital AMA should be identical to a regular discharge. Patients need as much care as possible when they leave the hospital, and this is especially true when they leave AMA. Patients require discharge instructions describing how they should care for themselves at home, the symptoms for which they should seek medical care, and who to contact for a follow-up appointment. In addition, patients should be provided with necessary medications and prescriptions. Insurance companies are not routinely informed of the nature of discharges and, therefore, cannot deny coverage for a reasonable presenting complaint. One typical difference from regular hospital discharges, however, is the requirement for patients to complete an AMA form.

The AMA form was created to confer legal protection to the hospital and its employees and to inform patients that the hospital and its employees cannot be held liable for any subsequent morbidity or mortality. In itself, however, the AMA form has surprisingly little value for protecting the hospital and staff from liability and has even been found to be unlawful in some courts of law. Patients are required to sign the form waiving the hospital of all liability, although

by definition they have already been under the care of a treating physician. In *Dedely by Dedely v. Kings Highway Hospital Center*, the AMA form was found to be contrary to public policy and a nullity [20]. In a review of this case and 7 other similar cases, Devitt et al [21] concluded that health care providers "may not, as a condition of allowing a patient to leave against medical advice, require the patient to sign a form releasing the hospital from liability for malpractice claims by the patient." In this same review, there were 2 cases in which the patient signed an AMA form but the physician lost the case due to negligence in documenting adequate recommended outpatient follow-up. Although the AMA form may be a symbol that the physician had hoped to further diagnose or treat the patient, it does little else.

Because the AMA form cannot prove intent to provide further medical care, it is more important that the medical chart include adequate documentation to protect physicians from claims of negligence in these circumstances (**Table 3**). It is essential for the physician to document that the patient understands the risks of leaving, benefits of staying, proposed treatment, and alternative treatments. The physician also must document that the patient has an adequate plan for follow-up and understands that he/she is welcome to return at any time for further care. Finally, it is essential to document that the patient has full decision-making capacity.

Although the necessary components to be documented when patients leave AMA are well-defined in the literature, few physicians practice this documentation. In a review of 52 consecutive discharges AMA, Dubow et al [22] noted extremely poor documentation. Only 67% of the charts documented the patient's decision-making capacity, 36% documented that patients understood their diagnosis, 44% documented that patients understood the proposed treatment, 2% documented that patients understood the alternative therapies, and 57% documented that patients understood the clinical consequences of refusal of care. Finally, only 62% of charts documented that patients received a follow-up referral upon discharge.

It is not clear whether discharging more patients AMA leads to increased risk for litigation. To our knowledge, only 1 study has attempted to answer this question. Quinlan and Majoros [23] reviewed 46,941 discharges, of which 0.7% were AMA, and found that 0.3% of AMA discharges led to litigation versus 0.05% of regular discharges. Unfortunately, the rate of litigation for AMA discharges was based on only 1 suit in 338 AMA discharges [23].

Table 3. Necessary Documentation for Patients Leaving Against Medical Advice

Patient has full decision-making capacity
Patient understands the following:
Diagnosis
Proposed treatment
Alternative treatments
Risks of leaving
Benefits of staying
Plan for follow-up
That he/she is welcome to return for admission

Case 3 Conclusion

Dr. Gill, the ED attending physician, politely interrupts the discussion between Mr. Conner and the nurse and explains the risks of leaving the hospital now as well as alternative options, such as staying for a repeat ECG and a repeat set of cardiac markers. In evaluating whether this is more important than missing his mother's funeral, Mr. Conner again decides to leave AMA, since his chest discomfort has resolved. Dr. Gill ensures that Mr. Conner understands the risks of leaving, including MI and death, by having Mr. Conner verbalize the risks of leaving to her. Dr. Gill documents the discussion as well as the fact that Mr. Conner has full decision-making capacity. Dr. Gill explains to Mr. Conner that he is welcome to return at any time for further evaluation. She provides discharge instructions, including the recommendation that Mr. Conner take a daily aspirin. Finally, Dr. Gill calls Mr. Conner's primary care physician who agrees to see Mr. Conner as soon as possible.

Although ideally Mr. Conner would have been admitted to the observation unit for further evaluation of his chest pain, the discharge AMA performed by the attending physician was completed without coercion and utilized the proper steps in discharging a patient AMA. Some authors advise creating a standardized protocol for discharging patients AMA (**Table 4**), which may lead to less variability within team members and improved communication among providers and with patients.

Conclusion

Patient care is particularly challenging in the case of a patient who wants to leave the hospital AMA. The physician must promote patient welfare by

Table 4. Sample Protocol for Discharging Patients Against Medical Advice (AMA)

Issues and Specific Actions
Decision-making capacity
Assess the patient's decision-making capacity
Document the capacity assessment in the chart
Document the discussion with the patient regarding the severity of the patient's illness and the potential consequences of leaving AMA
Follow-up arrangements
Discuss specific scenarios with the patient that should prompt an immediate return to the emergency department
Arrange for telephone follow-up, if indicated
Arrange for home care, if indicated
Arrange for an outpatient follow-up appointment (preferably within the next 7 days)
Provide prescriptions for any new medications (arrange for dispensing of medications to the patient, if possible)
Document the above in the chart
Communication
Provide the patient with a brief written summary of his/her diagnoses, treatments, medications, and follow-up plans
Immediately inform the patient's primary medical team regarding discharge AMA and follow-up plans
Communicate with the patient's primary care provider (if different from the inpatient medical team) regarding discharge AMA and follow-up plans
With the patient's consent, communicate with the patient's next-of-kin regarding discharge AMA and follow-up plans
Document the above in the chart

Adapted with permission from Hwang SW. Discharge against medical advice. AHRQ WebM&M [serial online]. May 2005. Available at http://webmm.ahrq.gov/case.aspx?caseID=96. Accessed 29 Jan 2007.

emphasizing the benefits of continued hospital care, while being sensitive to issues that contribute to the patient's desire to leave early. Above all, the physician should provide the highest level of care possible and clear communication while the patient is still under his/her care.

Attempting to prevent a discharge AMA is warranted if performed altruistically and without coercion. In general, everything that is within the power of the physician should be done to preserve patient welfare. This may include taking additional steps such as contacting the patient's family members or friends, if allowed by the patient, if harm is likely to befall the patient should further care not be provided. At the same time, the physician must evaluate the patient's decision-making capacity and allow the patient to make autonomous choices if he/she is able. When a patient does decide to leave AMA, it is important to provide as much additional care as possible through follow-up, discharge instructions, and necessary prescriptions. It is always important to document all of the components of an AMA discharge. Following these guidelines may help optimize the process of discharges AMA for both the patient and the physician.

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