Optimizing Outcomes When Patients Leave Against Medical Advice

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Abstract
- **Objective:** To examine the epidemiology of patients leaving against medical advice (AMA) and offer recommendations for delivering high-quality care.
- **Design:** Case presentations and review of the literature.
- **Main results:** The AMA discharge can be a high-risk situation for both health care providers and patients, and a thorough understanding of the issues surrounding the AMA discharge is necessary when faced with these encounters. It is important to recognize patient risk factors for leaving AMA, including drug and alcohol abuse disorders, lack of health insurance, and longer waiting times in the emergency department. Patient autonomy should be recognized and respected; however, an assessment of decision-making capacity is required to determine whether a patient can act autonomously.
- **Conclusion:** Being knowledgeable about the dangers of AMA discharge, patient risk factors for leaving AMA, and the concept of patient autonomy and decision-making capacity can help providers optimize care when the AMA discharge is unavoidable.

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 challenge. Although it may not be possible to prevent patients from leaving AMA, it is important to do all that can be done to ensure quality care. By recognizing patients who are at risk for leaving AMA and understanding the steps that should be taken when patients resist or refuse medical care, health care providers will be better prepared to act in the best way to minimize adverse patient outcomes. Using 3 case studies, we examine the epidemiology of patients leaving AMA and offer recommendations for delivering high-quality care.

**CASE 1**

Mr. Russell, a 71-year-old man, presents to the emergency department (ED) with a chief complaint of weakness. He states that he has been feeling weak for about a month, but his symptoms have progressed in the last week. He describes feeling short of breath at nighttime and when he walks up the stairs to his apartment, where he lives alone. He also says that he has had some mild right upper quadrant pain that seems unrelated to eating. He denies any known past medical history as well as any medications, allergies, or alcohol or drug abuse.

On examination, the patient is an obese man who appears slightly disheveled and in mild respiratory distress. Lung examination reveals bibasilar crackles as well as an elevated jugular venous pressure and S3 on cardiac examination. He also has 1+ pitting edema of his bilateral lower extremities. He has no abdominal tenderness. The remainder of his examination, including a digital rectal examination, is unremarkable. A chest radiograph reveals cardiomegaly and pulmonary edema. Laboratory studies reveal an elevated B-type natriuretic peptide level of 575 pg/mL, a troponin I of 0.06 mg/mL, a hemoglobin level of 11.1 g/dL, a platelet count of 54,000 cells/µL, an aspartate aminotransferase level of 215 U/L, and an alanine aminotransferase level of 105 U/L. An electrocardiogram (ECG) shows normal sinus rhythm without any significant abnormalities.

The patient is given intravenous (IV) furosemide, and his symptoms greatly improve. The ED physician discusses the findings of the initial tests with Mr. Russell and emphasizes concern about a new diagnosis of congestive heart failure (CHF). The physician recommends that Mr. Russell be admitted to the hospital for telemetry monitoring, serial cardiac enzymes, echocardiography, and further evaluation and treatment of his cardiac disease as well as the other abnormalities that were found. Mr. Russell explains that he now feels better and needs to go home to take care of his cat. He states that he does not want further testing and that he wants to leave AMA.

The physician expresses concern that the abnormalities found, including potentially his CHF, may be consistent with someone who has been a chronic, heavy alcohol user. Mr. Russell admits to drinking 8 to 10 beers daily and states that...
LEAVING AMA

he was initially too embarrassed to disclose this information. The patient is assured that he will be monitored closely and treated for any withdrawal symptoms while he is in the hospital as well as referred for longer outpatient treatment of his alcohol dependence. He is given the opportunity to call someone to arrange for the care of his pet. After much persistence on the part of the physician, Mr. Russell still refuses to stay.

The patient is clinically sober and fully understands his diagnoses, his treatment options, and the risks of leaving, including death. Because of the potential severity of his illness, the physician asks for Mr. Russell's permission to contact a family member to discuss the situation. Mr. Russell agrees to let the physician contact his daughter. Although the daughter is unable to convince her father to be admitted, Mr. Russell agrees to let his daughter stay with him that night. Because he has no primary care physician, a follow-up appointment is made for him in the internal medicine resident clinic for the following day. Mr. Russell is given his discharge instructions as well as a referral list for outpatient alcohol dependency treatment programs. Finally, the physician explains to Mr. Russell that he is welcome to return to the ED at any point for admission.

What Risks are Associated with Leaving AMA?

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. Several studies note a higher percentage of hospital readmission for patients who leave AMA as compared with patients who are discharged with physician approval [1–6]. Weingart et al [1] 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. Hwang et al [3] 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 higher in the first 2 weeks after discharge in the AMA group compared with the control group (21% vs. 3%). The authors note 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 15 days postdischarge [3]. Similarly, a recent study showed that patients who left AMA from a large urban university ED were significantly more likely to return to the ED within 30 days and be emergently hospitalized compared with patients who were either normally discharged, admitted to the hospital, or left without being seen [6].

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 EDs of 7 hospitals after presenting with the chief complaint of chest pain. They found that patients who refused admission had a lower risk for myocardial infarction (MI) than those who agreed to be admitted; however, the risk for MI was higher in patients 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 patient died after leaving the hospital on the same day of the ED visit [7]. In another study, Baptist et al [5] 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 re-present to the ED (21.7% vs. 5.4%) or be readmitted to the hospital (8.5% vs. 3.2%).

In general, the discharge period has been found to be a high-risk time for patients, even under normal conditions. Problems relating to the discharge itself and problems that occur during the early postdischarge period have been described. One study conducted at a tertiary care academic hospital evaluated 400 consecutive normal discharges and found that nearly 1 in 5 patients experienced an adverse event when transitioning to home from the hospital [8]. The majority of adverse events were related to adverse drug events, procedure-related events, nosocomial infections, or falls. Other studies have shown problems related to the accuracy of medications recorded on discharge summaries [9], problems with patients getting care they need at home [10,11], and problems with a lack of information [12].

Moore et al [13] performed a study at a large teaching hospital to evaluate the frequency with which workups recommended by inpatient physicians were completed after normal discharge. Nearly 36% of patients did not receive a recommended outpatient evaluation. Although further assessment was recommended in only 27% of discharged patients in this study, patients who leave AMA have not, by definition, completed their initial evaluation and treatment. As AMA discharges are often associated with poor communication and poor recommendations for follow-up [14], it is likely that patients who leave AMA are at even greater risk for a perpetuated or worsened state of poor health.

As more data become available, a growing body of evidence supports the conclusion that patients who leave AMA, and thus who do not complete their medical evaluation, are at risk for adverse outcomes. Therefore, AMA discharges may place providers in situations that conflict with the goal of delivering high-quality, safe, and appropriate patient care. This places the burden on the health care worker to optimize a discharge that will inevitably end AMA, knowing that the consequences of not doing so could lead to patient morbidity.
or mortality. Training that focuses on teamwork, communication, and use of AMA discharge protocols may help hospitals improve patient safety in these circumstances.

Who is Most Likely to Leave AMA?

In order to target interventions toward preserving quality care, it is important to understand the factors that may contribute to the likelihood that a hospitalization will prematurely end with an AMA discharge. Patient risk factors for leaving AMA vary significantly based on the patient demographics of each hospital.

Drug abuse, particularly alcohol and narcotic abuse, is a common risk factor pervading all hospital settings [2,3]. In 2002, the top 2 diagnoses related to AMA discharge were drug and alcohol abuse disorders (Table 1). This suggests that clinicians should maintain a high level of suspicion for potential drug and/or alcohol dependence when patients, including the elderly, wish to leave AMA.

Health care workers and physicians tend to underestimate drinking in elderly patients [7,15]. One in 4 elderly patients consumes alcohol, and 1 in 17 is a self-reported “heavy” drinker [16]. Case 1 reminds us to address alcohol dependence as a reason why patients may wish to leave AMA. In these situations, the patient’s concerns must be addressed and, when necessary, patients should be assured of our ability and desire to treat withdrawal symptoms. In case 1, the patient’s welfare was made the priority even though an AMA discharge was not avoided. Although this AMA discharge is considered a suboptimal encounter, the physician did much to avoid it (eg, provided reassurance, explained the risks of leaving AMA, called a family member) as well as attempted to deliver the highest quality of care possible. By being aware of patient risk factors for leaving AMA, physicians can help to address these issues with patients and perhaps avoid unwanted AMA discharges.

A second risk factor for leaving AMA is a lack of health insurance [1,2,6,17]. In 2003, 3.5% of uninsured patients in the United States who were admitted to the hospital left AMA, a rate 3 times higher than that for patients on Medicaid and 7 times higher than the rate for patients with private health insurance [18]. It is unclear why the rate of AMA discharges is so much higher for patients without insurance, but the reason is likely multifactorial, including complex health care, societal, and individual factors.

Other patient characteristics correlating with leaving AMA are not as well defined. Some authors have found that young men are at higher risk for leaving AMA, while other studies show that the elderly comprise a significant percentage of patients who leave AMA and suffer higher morbidity as a result [1,2,19,20]. 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 [19]. In a study of HIV-positive patients, Anis et al [4] found that the date on which welfare checks are distributed correlated with patients leaving AMA; in fact, it was found to be the most significant risk factor second only to drug abuse.

Physicians must be aware of their own negative biases that can contribute to patients leaving AMA. Although physicians may believe they are acting without bias, there is some evidence to suggest that bias, prejudice, and stereotyping on the part of health care providers may contribute to differences in care, as conveyed in the 2003 report by the Institute of Medicine, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare [21].

CASE 2

Mrs. Wells, a 47-year-old woman with a history of schizophrenia, presents alone to the ED with palpitations. She is unable to accurately tell the ED physician how long she has had the palpitations and just states “for a while.” Her vital signs are significant for an irregular heart rate ranging from approximately 120 to 125 bpm and a blood pressure of 97/55 mm Hg. On physical examination, the patient has an irregular rhythm on cardiac auscultation with an otherwise unremarkable examination. An ECG shows that she is in atrial fibrillation with a rapid ventricular response. Her heart rate is controlled with a diltiazem bolus followed by an infusion, and she is anticoagulated with enoxaparin. Results of laboratory testing are unremarkable. Mrs. Wells’ blood pressure improves, and she is admitted to a telemetry bed for monitoring, evaluation, and management.

Because of hospital capacity issues, Mrs. Wells arrives in her room approximately 8 hours after being admitted by the ED physician. An internal medicine resident sees Mrs. Wells shortly after her arrival on the floor and finds the patient agitated, having removed her peripheral IV line. Upon

| Table 1. Principal Diagnoses of Patients Leaving Against Medical Advice in 2002 |
|----------------------------------|----------------------------------|
| Drug abuse disorders            | Alcohol abuse disorders          |
| Alcohol abuse disorders         | Chest pain                       |
| Affective or mood disorder      | Coronary atherosclerosis         |
| Pneumonia                        | Congestive heart failure         |
| Diabetes mellitus with complications | Pancreatic disorders other than diabetes |
| Skin and subcutaneous tissue infections |

questioning, the patient states she “feels fine” and is leaving. She denies any suicidal or homicidal ideation.

Initially, the resident is anxious that he may have to comply with her wishes to leave AMA, even though the patient has a serious medical condition that needs further treatment. The resident thinks back to training he has had on the topic and returns to question Mrs. Wells to establish her decision-making capacity. When questioned as to why she wants to leave, Mrs. Wells states, “because there is nothing wrong with me.” Her medical condition and the risks of leaving are again clearly explained to her, but when asked to repeat back the information, she only says, “I want to leave, there are no risks.”

The resident feels as though the patient does not understand her medical condition or the consequences of leaving, and she seems irrational without any evidence of reasoning behind her decision. He orders an intramuscular injection of haloperidol to treat her agitation and prevents her departure. Psychiatry is consulted, and after Mrs. Wells’ agitation subsides, she agrees to take her regular antipsychotic medication while in the hospital. She finishes medical therapy for her new diagnosis of atrial fibrillation and is eventually discharged home in good condition.

How Should Respect for Patient Autonomy Be Balanced with Patient Welfare?

Health care workers are obligated to recognize that adult patients are mature individuals 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 and honest counsel to guide these decisions. This initially can be addressed by clearly communicating the risks and benefits of diagnostic and therapeutic interventions. The concept of autonomy is complex and not easily resolved, and the physician and patient must work together to establish a shared, informed decision regarding medical care.

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

A common barrier to making an informed decision is language. Because of poor literacy or a lack of proficiency in English, a patient may not understand medical terminology used to describe alternative treatments or prognosis or the 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 it is often written at a high literacy level. In 1 study conducted in a university hospital ED to assess whether written material given to patients matched the level of patient literacy, more than 40% of patients could not read at an 8th grade level and 20% were functionally illiterate. The AMA form at the study hospital was written at an 11th grade level [22].

Even with clear communication, it cannot be assumed that certain patients comprehend all the ramifications of refusing recommended care. In order to ensure appropriate respect for patient autonomy while preserving quality, physicians must understand the concept of decision-making capacity. Assessment of decision-making capacity is the most important aspect of the AMA discharge because 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 the consequences of his/her actions, and (4) manipulate information rationally and share in the decision-making process [23]. If a patient meets these criteria, a physician can feel confident in documenting that the patient has full decision-making capacity.

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 [24]. Decision-making capacity is a clinical term, defined as the ability to understand and appreciate the nature and consequences of health care 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 [24].

A second misconception is that psychiatrists alone can make an accurate assessment of decision-making capacity. In reality, all clinicians responsible for patient care should be able to perform routine assessments of decision-making capacity [24]. The clinician 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. When available, the family of the patient may be
a helpful resource to determine if the patient is able to make decisions. A specialist may be more familiar with the specific medical ailment in question and may be better able to explain risks and benefits more accurately. A comprehensive discussion on the decision-making process is beyond the scope of this article, and the reader is referred a book by Buchanan and Brock for more information [25].

In cases in which the patient has a major mental disorder, a psychiatry consultation may be appropriate. In these cases, it may be unclear to the treating physician whether the psychiatric disorder is interfering with the decision-making process. 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. A psychiatrist may also be useful in treatment guidance for the underlying psychiatric condition. It is important to note that having a psychiatric disorder does not necessarily negate decision-making capacity. Unless the patient is suicidal or homicidal or shows the inability to perform the basic functions of daily living, the patient is often allowed to make his/her own decisions. 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 [26].

In case 2, the patient lacked decision-making capacity (eg, showed lack of insight into her illness, was unable to repeat risks of leaving to the physician), even though she did not have suicidal or homicidal thoughts. She was rightly not allowed to leave AMA. When patients are not able to make decisions regarding their medical care, and when leaving the hospital would lead to direct harm to the patient (as in case 2), discharging AMA is not an option. Physical and/or chemical restraints may be warranted to ensure patient safety. Patient autonomy, however, must be adhered to as soon as patients are able to make decisions for themselves. A standardized approach to assessing decision-making capacity may be useful (Figure).

CASE 3
Mrs. Boyd, a 59-year-old woman with no primary care physician and no known past medical history presents to the ED complaining of a headache. The headache is nonspecific and diffuse and has gradually worsened over 4 days. On review of systems, she admits to dyspnea and diaphoresis on exertion, which have occasionally occurred over the last month; her last episode was about 10 days ago. She is afebrile with an initial blood pressure of 210/112 mm Hg. The remainder of the examination is unremarkable, including fundoscopic and neurologic examinations. Laboratory studies, including electrolytes and troponin I, are normal except for a serum creatinine level of 1.7 mg/dL. Urinalysis shows large protein and sodium in the lateral leads with no old ECG for comparison. Computed tomography of the brain and a chest radiograph are unremarkable. After 2 doses of IV labetalol and an oral dose of hydrochlorothiazide, the patient’s blood pressure is 175/95 mm Hg. Her headache is still present, but improved. After discussing the results of her tests and the concerns that her symptoms may be caused by her uncontrolled blood pressure, the ED physician recommends admission to the hospital. In addition, the physician expresses concern that the patient’s episodes of shortness of breath may be caused by a cardiac condition and that she needs further evaluation. She states that she cannot afford to stay in the hospital and that she is the primary caregiver of a grandchild at home. After explaining the risks of leaving, including death, the physician is unable to convince the patient to stay. The patient is determined to have intact decision-making capacity, and the ED physician has his/her AMA form. She is given a prescription for a 2-month supply of hydrochlorothiazide, and the physician tells her that it is important to follow up for further testing.

Four weeks later, Mrs. Boyd presents to the primary care clinic for a follow-up visit but forgets to bring her medication. Her headache is gone, but she now states that she feels weak. Both the medical record from the ED visit and the discharge paperwork are reviewed, but there is no mention of any diagnoses other than “hypertensive urgency.” In addition, there is no documentation of prescriptions given or a tentative plan of care; however, there is a notation that the discharge from the ED was AMA. At this visit, Mrs. Boyd’s blood pressure is 155/76 mm Hg. Comprehensive screening blood tests are drawn, and a 2-week follow-up appointment is made. She is given a booklet to record her daily blood pressures, which she will monitor with an automated blood pressure device at the local pharmacy, and is told to continue with the medication already prescribed and to make sure she brings it with her to her next appointment.

Two days later, the primary care physician receives the results of the patient’s laboratory tests, which show a potassium level of 2.3 mEq/L. An immediate call is made to the patient, who reports feeling weaker than before and describes an episode of chest pressure while walking to the bus yesterday. The patient is admitted to the hospital for a cardiac evaluation; electrocardiograph, and medication adjustment.

What Protocols Should be Followed When Discharging a Patient AMA?
The AMA discharge can be a risky and anxiety-provoking event for both the patient and health care provider. Physicians and other medical staff often struggle to balance providing the highest level of care with patient autonomy, as these objectives can sometimes conflict. In addition to concerns about the patient’s health, members of the care
team may be nervous that patients could use a poor medical outcome as a source of litigation. These situations can lead to coercion on the part of the provider as well as to an antagonistic interaction with the patient, neither of which benefits the parties involved. It is also important to note that insurance companies are not routinely informed of the nature of discharges and therefore cannot deny coverage for a reason-able presenting complaint. Familiarity with necessary documenta-tion and discharge procedure for patients who decide to leave AMA allows physicians and other medical staff to feel more comfortable with this practice.

The process of discharging a patient from the hospital AMA should be identical to a regular discharge. Patients need appropriate care when they leave the hospital as well, and this is especially true when they leave AMA. Patients require regular 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 the necessary medications and prescriptions.

In a study by Moore et al [13] that evaluated discharged patients with unresolved medical issues, having the recom-mended workup documented in the discharge summary in-creased the likelihood that a recommended workup would be completed. The authors of the study recommend that discharge summaries should therefore document pertinent details about patients’ discharge plans to ensure inpatient-to-outpatient continuity of care. Although communication with a primary care physician and follow-up may not be optimal in an AMA discharge, clearly documenting the recom-mended evaluation on the discharge form or summary may be beneficial.

In case 3, the initial care given in the ED was sound. However, improvements in the discharge could have potentially avoided the resultant morbidity suffered by the patient, even though the discharge was AMA. Improved documentation in the medical record, noting the prescribed medication on the discharge form, and explicitly communicating and documenting a plan of outpatient care are areas that could have improved the patient’s outcome.

One typical difference between AMA and regular hospital discharges is the requirement for patients to complete
Table 2. Necessary Documentation for Patients Leaving Against Medical Advice

<table>
<thead>
<tr>
<th>Patient has full decision-making capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient understands the following:</td>
</tr>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>Proposed treatment</td>
</tr>
<tr>
<td>Alternative treatments</td>
</tr>
<tr>
<td>Risks of leaving</td>
</tr>
<tr>
<td>Benefits of staying</td>
</tr>
<tr>
<td>Plan for follow-up</td>
</tr>
<tr>
<td>Patient is welcome to return for admission</td>
</tr>
</tbody>
</table>

Table 3. Sample Protocol for Discharging Patients Against Medical Advice (AMA)

<table>
<thead>
<tr>
<th>Decision-making capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess the patient's decision-making capacity</td>
</tr>
<tr>
<td>Document the capacity assessment in the chart</td>
</tr>
<tr>
<td>Document the discussion with the patient regarding the severity of the patient's illness and the potential consequences of leaving AMA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-up arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss specific scenarios with the patient that should prompt an immediate return to the emergency department</td>
</tr>
<tr>
<td>Arrange for telephone follow-up, if indicated</td>
</tr>
<tr>
<td>Arrange for home care, if indicated</td>
</tr>
<tr>
<td>Arrange for an outpatient follow-up appointment (preferably within the next 7 days)</td>
</tr>
<tr>
<td>Provide prescriptions for any new medications (arrange for dispensing of medications to the patient, if possible)</td>
</tr>
<tr>
<td>Document the above in the chart</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Communication</th>
</tr>
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<tbody>
<tr>
<td>Provide the patient with a brief summary of his/her diagnoses, treatments, medications, and follow-up plans</td>
</tr>
<tr>
<td>Immediately inform the patient's primary medical team regarding discharge AMA and follow-up plans</td>
</tr>
<tr>
<td>Communicate with the patient's primary care provider (it different from the inpatient medical team) regarding discharge AMA and follow-up plans</td>
</tr>
<tr>
<td>With the patient's consent, communicate with the patient's next-of-kin regarding discharge AMA and follow-up plans</td>
</tr>
<tr>
<td>Document the above in the chart</td>
</tr>
</tbody>
</table>


an AMA form. The AMA form was created to confer legal protection to the hospital and its employees and to inform patients that they cannot be held liable for any subsequent morbidity or mortality. Yet the AMA form has surprisingly little value for protecting the hospital and staff from liability and has 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. In fact, the court observed that “a hospital’s failure to release a patient unless it sought judicial relief would, undoubtedly, subject the hospital to an actionable tort” [27]. In a review of this and 7 other similar cases, Devitt et al [28] 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 malpractice 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 prove 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, not only to protect physicians from claims of negligence but also to protect patient welfare under less than optimal conditions (Table 2). It is essential to document that the patient understands the risks of leaving, benefits of staying, and proposed and alternative treatments. Providers must also 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.

Health care providers other than physicians (eg, nurses) should be familiar with the issues surrounding AMA discharges, as they may be the first to be confronted with these issues in the clinical setting. This may be especially important in situations where the physician may not be physically in the hospital, as in many smaller community hospitals. Hwang [29] advocates a team approach and a standardized protocol for discharging patients AMA, which may lead to less variability among team members and improved communication with providers and with patients (Table 3).

Although the necessary components to be documented when patients leave AMA are well outlined in the literature, few physicians practice this documentation. In a review of 52 consecutive AMA discharges, Dubow et al [14] 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, 57% documented that patients understood the clinical consequences of refusal of care, and 62% documented that patients received a follow-up referral upon discharge.

It is unclear 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 [30] 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 lawsuit in 338 AMA discharges [30].

CONCLUSION

Patient care is particularly challenging in cases in which a patient wants to leave the hospital AMA. The physician must attempt to preserve quality by emphasizing the benefits of continued hospital care while also being sensitive to issues that contribute to the patient’s desire to leave prematurely. Health care providers must keep in mind that the decision to leave AMA may be difficult for the patient. Patients may be faced with competing concerns and responsibilities, such as a difficult financial situation or the need to care for a loved one. Attempting to understand the patient’s perspective may give providers insight into the patient’s dilemma and may aid interactions and lead to the development of a shared plan.

Above all, the physician should provide the highest level of care possible and communicate clearly while the patient is still under his/her care. In terms of the patient’s health, avoiding an AMA discharge is always the best option. The limited evidence available supports the logic that patients who leave AMA are at greater risk of adverse health outcomes. In general, the physician must do everything to ensure that patient welfare and quality of care are preserved. 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. Being aware of risk factors, such as drug and alcohol abuse disorders and lack of insurance, can make the provider more cognizant of who may leave AMA and may help to avoid an unwanted discharge. 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 capable. When a patient decides to leave AMA, it is important to provide as much additional care as possible through follow-up, discharge instructions, and necessary prescriptions. Documentation of all of the components of an AMA discharge is essential. Following these guidelines may help optimize the process of AMA discharges for both the patient and the physician.

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