CLINICAL DECISIONS
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Discharging Patients against Medical Advice

This interactive feature addresses the approach to a clinical issue. A case vignette is followed by specific options, neither of which can be considered either correct or incorrect. In short essays, experts in the field then argue for each of the options as assigned. Readers can participate in forming community opinion by choosing one of the options.

CASE VIGNETTE

A 35-Year-Old Man with Fever and Possible Endocarditis

Clement D. Lee, M.D.

A 35-year-old man presents to the emergency department with body aches and fever. He has a history of intravenous heroin use disorder, with previous emergency department visits for cellulitis, opiate withdrawal, and passive suicidal ideation.

On presentation, his vital signs are notable for a temperature of 38.6°C (101.5°F) and tachycardia, with a heart rate of 114 beats per minute. The physical examination reveals a new grade 3/6 holosystolic murmur heard best at the left lower sternal border; the murmur is louder with inspiration, and no associated right ventricular heave is heard. Bounding C-V waves are noted on examination of the jugular vein. Samples are obtained for a complete blood count, a comprehensive metabolic panel, measurement of levels of inflammatory markers, and blood cultures. Echocardiography is ordered because of suspected endocarditis on the right side of the heart, and acetaminophen and hydromorphone are administered for fever and pain, respectively. Empirical antibiotic therapy is initiated for endocarditis, and admission to the hospital is planned.

With his fever and pain now controlled, the patient reports amelioration of his symptoms and would like to leave the hospital. Medication-assisted treatment for his opioid use disorder is offered, but the patient declines. The potential for serious complications of untreated endocarditis, such as valve rupture, septic pulmonary emboli, heart failure, and death, is explained to the patient. He participates in the conversation and appears to comprehend the risk involved but still prefers not to stay for additional workup because he fears hospitals. As his treating physician, you must decide whether this patient, who has a potential life-threatening medical condition but defers further evaluation, should have his discharge documented as being against medical advice.

TREATMENT OPTIONS

Which one of the following approaches would you take? Base your choice on the literature, your own experience, published guidelines, and other information.

1. **Document this discharge as being against medical advice.**
2. **Do not document this discharge as being against medical advice.**

To aid in your decision making, we asked experts in the field to summarize the evidence in favor of approaches assigned by the editors. Given your knowledge of the patient and the points made by the experts, which approach would you choose?

OPTION 1

Document This Discharge as Being against Medical Advice

Owen Bradfield, M.B., B.S., B.Med.Sc., L.L.B., M.B.A., and Michelle M. Mello, J.D., Ph.D.

Discharge against medical advice heightens medical risk for patients and legal risk for physicians and hospitals. A discharge form that documents that the patient left against medical advice ensures that critical steps in the assessment and discharge process are completed[1] — steps that ultimately benefit the patient.

There are many legal advantages to documenting discharges against medical advice. First, letting the patient leave may constitute negligence, particularly if the patient's capacity may be impaired because of substance use or mental

illness. The care team's actions can be proved reasonable if there is evidence of the patient's decisional capacity and receipt and understanding of material information, including an appropriate discharge plan. Some states even grant physicians immunity in these circumstances.

Second, a patient's decision to leave against medical advice could help defend against a malpractice claim relating to the care provided before discharge. Damages for negligent care can be reduced if there is proof that the patient also acted unreasonably by leaving against medical advice and by doing so exacerbated the harm. Proving that leaving against medical advice was unreasonable requires reporting the patient's reason for leaving and documenting the precise risks that were disclosed. In some cases, fear, as reported by this patient, has been deemed a reasonable basis for declining care, so the details matter.

Third, the "assumption of risk" doctrine holds that plaintiffs cannot recover damages arising from risks they knowingly and voluntarily assume. Many discharge forms for patients leaving against medical advice include liability waivers. Although liability waivers are not enforceable when hospitals make them a condition of receiving care, courts often enforce waivers on such forms when the early discharge leads to harm.

Fourth, in the case of complaints that a discharge against medical advice violated the Emergency Medical Treatment and Active Labor Act (which prohibits patient "dumping"), government investigations focus on the reason for discharge and whether efforts were made to discourage the patient from leaving. Federal guidance urges hospitals to document these discussions and "take all reasonable steps to secure" written informed refusal of ongoing treatment.[2]

Finally, laws regarding health records require hospitals to maintain accurate clinical records. There is no evidence that insurers will refuse to cover patients' expenses if they leave against medical advice,[3] but payers may examine records to substantiate the amounts of reimbursement requested. Keeping accurate records can avoid billing disputes and fraud allegations.

Given these considerations, documentation should reflect several aspects of a thorough process for discharge against medical advice.[4] Regarding the patient presented here, was his decisional capacity formally assessed? The administration of a sedative (hydromorphone) and his history of substance dependence, prior suicidality, and fear of hospitals suggest that his capacity may have been impaired. What was done to address the patient's reason for leaving against medical advice? Which risks of leaving were discussed and how did physicians confirm the patient's understanding of these risks? Simply obtaining a signature on the discharge form may be legally insufficient.[4] Finally, what steps were taken to make the discharge as safe as possible?[5]

Respectful, nonjudgmental language should be used. Notes should help subsequent care teams understand patients' concerns and not stigmatize patients. It is preferable to have a second person attest to having witnessed discussions.

In summary, properly documenting decisions regarding discharge against medical advice serves patients' interests and confers substantial legal benefits. Using forms that specify key steps in the discharge process may help physicians deliver the best possible care while also protecting themselves.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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OPTION 2

Do Not Document This Discharge as Being against Medical Advice

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It is undeniable that the patient in the vignette would be leaving the hospital against the advice of any competent medical professional. What is arguable, however, is whether the phrase "against medical advice" and the ethos underlying it do more good or harm. I argue here that the harms of designating a discharge as against medical advice outweigh the benefits, for at least three reasons.

First, the "against medical advice" mindset creates (or exacerbates) adversarial relationships between clinicians and patients. Framing patients' decisions to leave as being "against" our recommendation can engender conflict in the way we handle their discharges. Security is sometimes called, witnesses are documented, and many

clinicians believe that a patient who leaves against medical advice loses the "right" to return.[6,7] This abandonment of our role as patient advocate pits patients as our adversaries rather than our charges, compromising our commitment to patient-centered care. It is not surprising that approximately 20% of patients discharged against medical advice are reluctant to come back because they feel that they had angered hospital staff.[8]

Second, documentation of discharge against medical advice stigmatizes patients and may compromise their future care. Stigmatizing language in patients' medical records can influence the attitudes of future clinicians and compromise the care patients receive.[9] The term "against medical advice" — and the shorthand "AMA" — is itself stigmatizing. Moreover, notes written in the records of patients who leave against medical advice often use denigrating language.[10] Patients are described as "threatening" or "demanding" to leave. The documented reasons that patients provide, or do not provide, for leaving are framed as unreasonable or suspect (e.g., "He would not express why he needed to leave but repeated that 'he has to get out of here.'"). These characterizations put patients, who may already fear mistreatment in the hospital, at risk for further mistreatment.

Third, the rubric "against medical advice" places blame on the patient, prevents the hospital and staff from considering any role they may have played in patients' choosing to leave, and leads to missed opportunities to improve patient safety and quality of care. Many health care professionals consider a discharge against medical advice to be (at best) a voluntary act of an autonomous patient or (at worst) a deviant act of a person with poor judgment.[11] In reality, patients forgo recommended inpatient treatment for many reasons, including dissatisfaction with long wait times, inadequate communication, negative interactions with hospital staff, sleep interruptions, tediousness of the hospital setting, or inadequate pain management.[11] Forms for and documentation of discharge against medical advice, however, seek to place blame entirely on the patient. A better approach would be to treat discharges the same way we treat other instances in which patient safety is compromised, as a "sentinel event" representing a possible health system failure that should be investigated.[11]

To enhance our approach to these discharges, we should change the way we record and talk about them.[7,11] In this and in all situations, physicians must first establish and then document that patients have the capacity to make the decision to leave and have made it while understanding the benefits of further treatment and the risks of forgoing it. It is not, however, in patients' best interest, nor is it legally required, to have them sign a form to designate the discharge as against medical advice.[7] Continuing to use the terminology "against medical advice" will perpetuate the notion that these discharges represent deviant patient behavior, will foster stigma and hostility toward patients already at risk for receiving substandard care, and will prevent us from improving the quality of hospital care.

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