

VIEWPOINT

What Is Wrong With Discharges Against Medical Advice (and How to Fix Them)

David Alfandre, MD, MSPH

VA National Center for Ethics in Health Care, NYU School of Medicine, New York, New York.

John Henning Schumann, MD

Department of Internal Medicine, University of Oklahoma School of Community Medicine, Tulsa.

It is estimated that as many as 2% of all US hospital discharges (approximately 500 000 per year) are designated as against medical advice¹; that is, a patient chooses to leave the hospital before the treating physician recommends discharge. The risks to these patients are significant. Compared with patients discharged conventionally, readmission rates for patients discharged against medical advice are 20% to 40% higher, and their adjusted relative risk of 30-day mortality may be 10% higher.² Furthermore, physicians and other health care staff report feeling distressed and powerless when patients choose suboptimal care, and disagreement over a discharge against medical advice can cause patient-physician and intrateam conflict.³

Although these harms have been well described, the stigmatizing effect on patients of discharges against medical advice has rarely been examined. Compared with how the profession handles clinical disagreements in other settings (eg, outpatient), an "against medical advice" designation is an outdated concept un-supportive of patients. In this Viewpoint, starting from a core value of patient centeredness, we aim to highlight the problematic aspects of discharges against medical advice and suggest a new approach.

Designating a discharge as against medical advice is a clinical practice not subject to professional standards. There is no clear medicolegal rationale for this designation and no professional consensus on what constitutes a discharge as against medical advice. If a competent patient or his or her authorized surrogate declines further inpatient care, physicians should fulfill their legal and ethical obligations to obtain informed consent for the patient's decision and document that decision and the patient's reasons for it in the patient's record. But the physician's subsequent choice to designate the hospital discharge as against medical advice and pursue the formalized process associated with it (eg, specialized discharge forms) has no evidence-based utility for patient care, is not legally required, and has been shown to be associated with a reduced willingness for the patient to return for future care.⁴

Furthermore, there is no consensus about what clinical criteria warrant a "discharged against medical advice" designation. This lack of clarity leads to greater variability in its clinical use, lacks transparency, and impedes standardization of a common medical practice. Although a more specific definition of discharge against medical advice could improve research and clinical processes, the term is an anachronism that has outlived its usefulness in an era of patient-centered care.

Recent studies have highlighted problematic informed consent practices for discharges against medi-

cal advice by identifying that a majority of house officers and attending physicians mistakenly believe and inform patients that if they sign out against medical advice, their insurance may not pay for the hospitalization. In a cross-sectional survey of physicians conducted by Schaefer et al,⁵ 85% of residents and 67% of attending physicians reported that they informed patients about denial of insurance payment so that patients would reconsider remaining in the hospital. These studies suggest that the use of misleading information in discharges against medical advice threatens to undermine a patient's voluntary choice and insinuates that coercion is an acceptable and oft-repeated practice.

The use of specialized discharge forms that document a patient's risks and liability is common hospital practice in discharges against medical advice. Despite apparent widespread use of these documents, there is no evidence that they advance patient care. Although health professionals generally support the use of discharge against medical advice forms because they believe it is required to protect themselves and their institutions from legal liability, these presumptions are not valid.⁶ Indeed, the contrary may be true. Malpractice claims are associated with poor physician communication and patient perceptions of feeling deserted or devalued.⁷ If discharges against medical advice occur when there are breakdowns in communication, it is possible that such discharges may contribute to increased liability. At a minimum, there is limited understanding of whether the desire to protect clinicians and institutions from legal liability by using a specialized discharge form interferes with the care of the patient.

Because clinical care decisions for hospitalized patients are sensitive to patient preference, shared decision making (SDM) has a role in achieving more patient-centered care in decisions related to discharge against medical advice. Although SDM is well accepted in overtly value-laden clinical decisions such as prostate-specific antigen testing and mammography screening, the principles of SDM apply to a broad range of health care decisions, discharges against medical advice included. Contrary to the principles of SDM, a discharge against medical advice sends the undesirable message that physicians discount patients' values in clinical decision making. Accepting an informed patient's values and preferences, even when they do not appear to coincide with commonly accepted notions of good decisions about health, is always part of patient-centered care.

The active engagement of the medical community will be necessary to reform the practice of discharges against medical advice. Physicians can begin with individual patients, but they also can support research in this area and in establishing standards for such discharges.

Corresponding

Author: David Alfandre, MD, MSPH, VA National Center for Ethics in Health Care, NYU School of Medicine, 423 E 23rd St, 10P6, New York, NY 10010 (david.alfandre@va.gov).

Over the last 40 years the majority of research related to discharges against medical advice has focused on establishing patient-related factors that predict those discharges, but none have examined physician-related factors. Given that the decision to leave the hospital lies with the competent patient, but the choice to designate a discharge as against medical advice lies with the physician, studying physicians' role and responsibility for this practice should be a priority to enable them to intervene more effectively in the future.

Surely there will be disagreements with patients, but how physicians negotiate these complex interactions can make all the difference. Rather than using discharge against medical advice forms as a legalistic cudgel, using harm-reduction approaches to reduce risk is a preferable way to refocus on the patient's welfare. Physicians can and should empathetically counsel patients when they believe their informed decision is inadvisable, and such discussions must be documented clearly in the medical record. But when physicians recognize that the vision of a completely adherent patient is ideal-

ized, it is easier to accept other options for the patient's care. Accepting a patient's preferences for care, even when such preferences deviate from the physician's own judgments, can still be acceptable, if not ideal.

It is time to rethink the approach to this issue. For a profession accountable to the public and committed to patient-centered care, continued use of the discharged against medical advice designation is clinically and ethically problematic. Designating a discharge as against medical advice is a clinical practice without standards, legal requirements, or demonstrated benefits to patients, and there is evidence of its harm. The more relevant and pressing question should be, "Why *would* you discharge a patient against medical advice?" Without a compelling answer to that question, continued use of the practice does not seem justified. Taking leadership on this problem through enhanced research, teaching, and quality patient care ensures that the profession will honor its commitment to providing patient-centered care and improving clinical outcomes.

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REFERENCES

1. Fiscella K, Meldrum S, Barnett S. Hospital discharge against advice after myocardial infarction: deaths and readmissions. *Am J Med.* 2007;120(12):1047-1053.
2. Glasgow JM, Vaughn-Sarrazin M, Kaboli PJ. Leaving against medical advice (AMA): risk of 30-day mortality and hospital readmission. *J Gen Intern Med.* 2010;25(9):926-929.
3. Schumann J. Can Ignoring Medical Advice Hurt Your Wallet? Marketplace website. <http://www.marketplace.org/topics/life/commentary/can-ignoring-medical-advice-hurt-your-wallet>. March 23, 2012. Accessed September 20, 2013.
4. Alfandre D. Reconsidering against medical advice discharges: embracing patient-centeredness to promote high quality care and a renewed research agenda [published online July 2, 2013]. *J Gen Intern Med.* doi:10.1007/s11606-013-2540-z.
5. Schaefer GR, Matus H, Schumann JH, et al. Financial responsibility of hospitalized patients who left against medical advice: medical urban legend? *J Gen Intern Med.* 2012;27(7):825-830.
6. Devitt PJ, Devitt AC, Dewan M. Does identifying a discharge as "against medical advice" confer legal protection? *J Fam Pract.* 2000;49(3):224-227.
7. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice: lessons from plaintiff depositions. *Arch Intern Med.* 1994;154(12):1365-1370.