

Discharge against medical advice: Ethico-legal implications from an African perspective

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Background. Discharge against medical advice (DAMA) is a problematic issue for physicians worldwide, which can disrupt the physician-patient relationship, have adverse medical outcomes and increase healthcare costs. This review aims to highlight the ethical and legal aspects of the issue from the perspective of developing countries in Africa, and make suggestions for resolving them.

Methods. A comprehensive literature review of articles relating to DAMA was performed using databases such as PubMed, Medline and Google Scholar. The search criteria used were 'discharge against medical advice AND ethics*', 'discharge against medical advice AND Africa', 'leaving against medical advice', 'discharge against medical advice AND legal issues' and 'self-discharge'. Relevant articles published from 1980 till 31 December 2011 were included.

Results. The conflict between the professional values (beneficence) of the physician and the autonomy (self-determination) of the patient is the most prominent ethical dilemma in cases of DAMA. The issue of DAMA is more complicated in developing countries, especially because of communal models of decision making. One important ethical dilemma is the rationing of hospital admissions, especially for chronic conditions with poor prognosis. We have suggested a communal model for dealing with the issues. The main legal issue found in this review is the possibility of medical doctors being sued for medical malpractice.

Conclusion. DAMA is associated with numerous ethical and legal issues of which physicians need to take cognizance.

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Discharge against medical advice (DAMA) occurs when a patient decides to leave the hospital against the opinion of the managing physician.¹ This form of discharge may be carried out by the patients, their relatives (in the case of adult patients with competency problems) or their parents (in the case of children). DAMA is a problematic issue for physicians because it interrupts their interaction with the patient, leading to frustration.² DAMA has also been associated with adverse health outcomes which increase healthcare costs.³

DAMA is a worldwide problem with a wide range of prevalence: in the USA, studies have found a prevalence of 1% - 2% among general hospital admissions, while in a Spanish study involving general hospitals the prevalence rate was 0.34%.^{1,4} Another study in general hospitals in Italy found a prevalence rate of 0.4% while the rates in Nigerian studies were between 1.2% and 5.7%,⁵⁻⁸ for patients admitted to the accident and emergency (A&E), surgery and paediatric wards only.

It is also important to highlight that DAMA prevalence worldwide is highest among psychiatric patients, documented at 3% - 51%.⁹ This is because drug and alcohol abuse have been identified as major contributory factors for DAMA.¹⁰ Other identified factors include the type of medical condition being treated, lack of medical insurance, lack of primary care physician at the time of admission, ignorance, race and age.¹¹⁻¹³ DAMA can also reflect a poor physician-patient relationship or an unresponsive healthcare delivery system.¹⁴

While some researchers have examined the prevalence and likely causes of discharge against medical advice, the legal and ethical implications of DAMA need to be examined, especially in the setting of a developing country such as Nigeria where relativism may apply when dealing with some of these issues. This paper aims to highlight some of these ethical and legal issues and suggest ways to address them.

Methods

A comprehensive literature review of articles relating to DAMA was performed using databases such as PubMed, Medline and Google Scholar. The type of articles considered included review articles, original research and case control studies. The search criteria used were 'discharge against medical advice AND ethics*', 'discharge against medical advice AND Africa', 'leaving against medical advice', 'discharge against medical advice AND legal issues' and 'self-discharge'. Relevant articles published from 1980 till 31 December 2011 were included in the review.

Results Ethical issues

The conflict between the professional values (beneficence) of the physician and the autonomy (self-determination) of the patients is the most prominent ethical dilemma in DAMA.

The Hippocratic Oath and the Declaration of Geneva recognise the importance of beneficence, i.e. doing good to patients or at

least not leaving them worse off than before their contact with the physician.^{15,16} This principle is one of the most important factors driving the physician-patient relationship, and anything that disrupts it may jeopardise a favourable outcome for the patient.

The principle of the patient's autonomy is based on the right of each individual to make informed decisions about personal issues.¹⁷ In healthcare, autonomy is the basis for informed consent, a concept which has been accepted worldwide as a *sine qua non* for clinical practice and research.¹⁸ Presently, there is a shift from the previously accepted paternalistic way of relating with patients towards a shared decision making or even wholly patient-centred model. This shift is more obvious in the developed countries, and could be attributed to factors including the human rights movement, the imposition of control by governments and medico-legal issues, among others. However, in the developing countries of Asia and Africa, the concept of autonomy is still very controversial and not wholly acceptable, mainly because of these countries' communal way of life. An individual is considered a part of a family, clan or community at all times and important decisions concerning them have to be taken by other members of the community – a sort of 'relational autonomy'.^{19,20}

The main ethical conflict that arises when a patient decides to leave the hospital against the consent of the managing physician is between these two principles of autonomy and beneficence. The question is, which of them takes precedence? We believe that there is no clear-cut answer and that individual cases have to be examined based on their peculiarities. Important factors include the setting; cost implications for the healthcare system; and the patient's competence/decision making capacity, family support system and best interests.

In terms of setting, issues regarding DAMA in developing countries are more complicated because, on top of the previously mentioned model of communal decision making, healthcare financing is also often communally based, due to a lack of institutionally organised health insurance. Note that while the communal model of decision-making is often associated with lack of resources, this is not always the case. In many developing countries, especially in Asia, decision making is still to some extent communal/family-based despite sound financial health and availability of robust health insurance.^{21,22}

One of the most important factors is the patient's competence or decision-making capacity. This is affected by the patient's maturity (age), and by pathologies that alter decision-making capacity. In many countries the legal age of adulthood is 18 years, and only then can the individual be classified as fully autonomous. Before this point has been reached, either the parent(s) or another relative stand as a surrogate decision maker on behalf of the minor or the incompetent adult. The question is, how well do these people actually protect the patient's 'best interests'?

In the traditional setting of many developing countries, sometimes even adults can't be said to be fully autonomous, because many decisions, including those related to healthcare, are made with significant input from family and clan members. Pertinent questions to ask are (i) When a decision to discharge a minor or an incompetent adult against medical advice is being made, will the surrogate/s be acting in the best interests of the individual, or pursuing other

interests?, and (ii) is the physician bound to insist on not discharging the patient if his/her life is in danger of deterioration or death?

In terms of (i), we have to ask who, in a communal/family setting, decides what is in the best interest of the patient? We believe that a consensus among the family members/community representatives and the medical team is necessary to determine this. In terms of (ii), a physician is expected to give emergency care when necessary, but unmerited admission of patients has its own ethical implications. These are discussed later in this paper.

These issues to help explain why the 'western type' self-determination model is not working in the setting of developing countries, and needs to be reviewed. The debate on the universality or otherwise of ethical principles is decades old, and the discourse has mainly focused on the ethics of clinical trials and research in developing countries.²³ Several international guidelines have been updated in this regard, with special attention to obtaining informed consent in communal settings.^{24,25} However, not much has been done in terms of other clinical situations, such as DAMA. We acknowledge the difference between the scenarios – being vulnerable (healthwise and financially) as an ill patient, versus being vulnerable (to unknown external influence) in the setting of clinical research.

Since the communal/family bond is usually very strong in developing countries, especially when a member of the group is ill, we believe that a model for communal decision-making will serve the interests of all parties. In the proposed model, it should be acceptable for close family members to decide either solely or together with the patient on issues relating to DAMA in disease conditions with very poor prognosis. A recent Nigerian study confirms that the leading diagnoses for DAMA patients were those with poor prognosis or requiring expensive treatment.²⁶ Our justification for this reasoning is based on the principle of distributive justice (rationing of healthcare resources) and will only be tenable in patients with a poor prognosis. A useful analogy is the rationing of ICU spaces in many developed countries of the world.^{27,28}

Patients are usually brought to the hospital and financed by family members, who we believe have their best interests at heart *ab initio*. A demand for DAMA does not mean these good intentions have changed. Studies have shown that most requests for DAMA are because of financial constraints.^{3,26} In the case of chronic disease with poor prognosis, hospitalisation will not achieve much except in cases of medical emergencies. On the contrary, it increases the risks of hospital-acquired infections, spiralling healthcare costs and a potential breakdown in the doctor-patient or doctor-relative relationship, especially when the patient's condition is not improving.^{10,14,29} The main question that arises with our proposed model is whether it is ethical to admit a patient with a chronic/terminal illness whose prognosis is poor, except in an emergency.

Refusing to admit a patient could be seen as unfair, unethical or even wicked by many in developing countries like Nigeria. We therefore advocate a counselling session for patients/relatives after the patient is fully assessed. The session should discuss the full diagnosis, modes of treatment (if any and if available), evidence-based prognosis of the disease condition and whether the patient can be managed adequately in the facility or at home with minimal supervision.

A contributory factor that has some ethical implications is the lack of appropriate communication between physicians, or healthcare workers in general, and the patient/relatives. Studies have cited poor communication as a major reason for DAMA in some cases.³⁰ In most regions of Nigeria, physicians are very highly regarded and can therefore tend to take a paternalistic approach that may cause conflict with patients or their relatives. Physicians and the medical team in general should keep communication with the patient/relatives open at all times to promote a cordial relationship. We believe this will make it easy for the patient/relatives to decide whether the patient should be admitted or not.

Medical doctors, especially in developing countries, need to know that in some cases it may be ethical not to admit patients, and rather opt for palliative care on a community- or home-based level. The importance of community nursing in the care of chronically ill patients has been shown in studies from Thailand and Australia.^{31,32} Other countries also have measures in place to reduce hospital admissions, as a way of cutting back spiralling healthcare costs and dealing with limited numbers of hospital beds.^{33,34} At the policy-making level, hospitals should be encouraged to develop guidelines that will determine admission criteria for patients generally, and particularly for those with medical conditions with poor prognosis. This step will (i) clearly outline for doctors the patients to be admitted, keeping in view the peculiarity of each case, and create a sort of institutional protection for the attending physicians; and (ii) adequately address the ethical issue of unjust waste of healthcare resources, by minimising unnecessary and prolonged hospital admissions.

For disease conditions that are not terminal or those with fair prognosis, we believe that the weight of the decision making still rests with patients or their chosen representatives.

A major debate in Nigeria is whether patients who underwent DAMA should be readmitted if they re-present in the hospital. We presume that many of these patients do not return to the hospital even if their symptoms worsen, because of ignorance and fear of rejection. In most cases, before patients leave the hospital against medical advice, there is some sort of breakdown in the relationship between them, their relatives and the medical team. Therefore many patients might not return to the hospital because of fear of rejection or embarrassment.

It is the right of the patient to choose when, how and where to be treated and they should not be denied this privilege. We believe that deciding to leave the hospital against medical advice signifies a withdrawal of the initial consent given by the patient or their family. If the patient seeks re-admission, it should be seen as a renewal of that consent. However, there is a need to educate healthcare personnel regarding this renewal of consent. In addition, institutional guidelines should be put in place to safeguard this prerogative of the patient.

Legal issues

Legal issues that may arise in the context of DAMA include the possibility of being sued for medical malpractice. Devitt *et al.* described four cases of malpractice litigation following DAMA, and concluded that while the fact of DAMA may provide some protection, it does not grant full immunity from the law.³⁵ The need to properly assess, counsel and educate the patient and their relatives cannot

be overemphasised. Patients and/or family members should also be made aware of the possibility of re-admission if and when they change their minds or the symptoms worsen. The physician should ensure that all these steps are properly documented in the patient records and that the authentic signature of the patient or the designated surrogate decision maker is appended on the discharge form in the presence of a witness.

We propose a discharge form similar to the informed consent document (though much simpler) where the patient's understanding of the disease condition, the possible consequences of premature discharge and their reasons for DAMA would be highlighted. This form should also be translated into the patient's own language for better comprehension. In cases where physicians aren't completely convinced that the patient fully comprehends the situation, or that the surrogate decision makers are protecting the patient's best interests, they can approach the courts for permission for involuntary or compulsory hospitalisation.

Conclusion

DAMA is associated with numerous ethical and legal implications. In a developing country like Nigeria, these most important ethical issues relate to patient autonomy and unjust use of healthcare resources. The conflict between the principles of autonomy and beneficence, as well as issues relating to the physician's autonomy, has a more global distribution. We have proposed a framework for dealing with DAMA, especially when patients have an evidence-based poor prognosis. We have highlighted the need for proper counselling of patients and their relatives about their disease condition, treatment and possible consequences of premature discharge. If the patient still insists despite all the efforts of the medical team, the counselling and discharge process should be properly documented.

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