Patients who leave the hospital against medical advice (AMA) present a challenge and concern to health care providers. The term AMA is used when patients choose to leave the hospital without the recommendation of the physician and often despite the physician's wish for them to remain. Put simply, patients leave the hospital without a doctor's order. Patients may also “abscond” which is when they leave the hospital without telling hospital staff members or signing self-discharge forms. In these cases the patient has just walked out of the hospital without notifying anyone.

On average between 0.8% – 2.2% of patients leave acute care hospitals AMA in the United States.1,3 The AMA discharge rates are higher in urban hospitals than in suburban hospitals and higher in community hospitals than in teaching hospitals.1,3 Studies have identified several characteristics that are common in patients who leave against medical advice. These patients tend to be younger males who live in lower-income neighborhoods with a previous history of leaving against medical advice. Patients with substance abuse issues and/or mental and emotional problems are at significantly higher risk of leaving a hospital AMA.1,4 In fact, alcohol abuse and the male sex are two most significant predictors of patients leaving AMA.1,2

Lack of medical insurance, Medicaid coverage and lack of a primary care physician have also been identified as common factors.1

Patients may leave AMA for a variety of reasons. Many claim issues at home such as young children or elderly parents demand their attention. Often personal or financial obligations are given as a reason. Some patients express the wish to leave AMA because they disagree with their physician’s judgment and conflict has arisen between the patient’s caregivers and the patient. Delay in the discharge process compounded with a patient who refuses to wait may also lead to an AMA discharge.

If you are caring for a patient who wishes to be discharged AMA what would you do? Would you keep patients in the hospital against their wishes? Would you attempt to restrain the patient to prevent him or her from leaving or do you have the patient sign AMA paperwork and leave against medical advice? In some cases the decision is clear one – it may be that your patient has suffered a traumatic brain injury and does not have the capacity to make this decision. But what if that is not the case and the patient you are caring for is alert and clearly able to understand the risks of early departure?

NURSING RESPONSIBILITIES

If a patient states to the nurse that he or she wants to leave the hospital without an order - what actions should the nurse take? First, the nurse should attempt to discern the reason why the patient wants to leave. Are there financial concerns, a sickness within the family, an elderly parent or young children at home that requires their care? Are they concerned about their lack of finances and the medical bill? Do they have an addiction and need to leave the hospital for this reason? The nurse should try to find out how to best help the patient deal with the outside situation in order to facilitate comfort in staying.

While these discussions are occurring, the attending physician or their designee must be contacted and informed of the patient’s desire to leave. The patient needs an explanation of the risks of leaving AMA in language that the patient can easily understand. It is important to be specific about the possible dangers and consequences of early departure from the hospital. Involve the patient’s family or friends to either help you convince the patient...
to stay or to take care of the issues driving their desire to leave the hospital. Determine and document your patient’s Against Medical Advice mental status.

Always document the details of your conversation; if these conversations include family members or friends include them in you documentation by name. Document the exact words you used in speaking to the patient and be very specific. If any other hospital personnel such as a social worker were involved in the discussion document their involvement. Document that you notified the patient’s physician. Nurses need to be familiar with the AMA protocol at their organizations which may also include notification of the risk management or legal departments when a patient leaves AMA. Most institutions have a standardized AMA discharge protocol in place that clearly outlines all the steps of an AMA discharge. In some cases, the patient’s decision making capacity is noted as well. When possible, the patient should sign any hospital waiver forms which address the liability of the hospital.

Many nurses may still believe and practice under the assumption that when patients decide to leave AMA their health care providers are not responsible for their actions or what may occur to the patients after they leave. However – health care providers do have an obligation to the patient even if they leave with AMA status. The health care team is responsible for a discharge that is as safe and appropriate as possible.¹ The process for discharging a patient from the hospital as AMA should be identical to a regular discharge. Patients should be given discharge instructions describing home care, restrictions, and follow-up care. Information on symptoms for which the patient would need to seek medical care should be outlined as well as any follow-up appointments, medications and/or prescriptions.

WHAT IF YOU THINK THE PATIENT CANNOT MAKE THIS DECISION?

As mentioned previously, in some cases the answer is clear – the patient is intoxicated or is suffering from a traumatic brain injury which has impaired their cognition. The Against Medical Advice patient’s health care team needs to determine if the patient has the capacity to understand his or her condition and the risks of leaving AMA. Health care providers need to understand the concept of decision-making capacity which is one of the most important aspects of the AMA discharge process. Capacity refers to an assessment of the patient’s ability to form rational decisions along with the ability to understand and appreciate the nature and consequences of his/her health decisions. The term capacity used in this instance is frequently mistaken for competency. Competency is a legal term and only a judge in court can deem someone to be competent or incompetent. The determination of incompetence is a judicial decision – decided by the court. A person who has been ruled incompetent is not able to make valid decisions.

A second misconception is that psychiatrists alone can make an accurate assessment of decision-making capacity. All health care providers responsible for the care of the patients should be able to perform routine assessment of decision-making capacity.² In fact, the person who is responsible for the patient’s care may be the best person to assess that patient’s decision-making capacity at that moment. A psychiatric consultation may be appropriate for patients with a major mental disorder. We must realize, however, that the presence of a psychiatric disorder does not negate a person’s decision-making capacity. Unless the patient is suicidal or homicidal or exhibits an inability to perform the basic functions of caring for oneself, the patient can still make his or her own decisions just like any other patient.² If patients do not have this capacity, they should not be allowed to leave and may be detained in the facility by a physician’s order.

The significance of alcohol intoxication and its relationship to decision capacity is controversial. Simply noting that the patient is inebriated may not provide protection against liability. A detailed description of the patient’s mental status and overall appearance should be clearly documented especially if patients are being restrained against their wishes. In some instances intoxicated patients are in fact able to make choices and understand their ramifications.² Knowledge of your institution’s specific policies is necessary as well as consideration for consultation with risk management or the legal department may be helpful in these instances.

CAN YOU RESTRAINT A PATIENT TO PREVENT THEM FROM LEAVING?

Physical or mechanical restraints are considered to be the use of any device that is attached to or adjacent to a patient’s body so as to restrict movement. Chemical restraint is a form of medical restraint in which a drug is used to restrict freedom/movement of the patient or in some cases, to sedate the patient. False imprisonment can occur when restraining patients in order to prevent them from leaving the facility AMA if they are capable of making decisions. False imprisonment is the unlawful restraint of a person that affects that person’s freedom of movement and includes physical as well as chemical restraints.

HEALTH INSURANCE COVERAGE FOR AMA

Will the patient’s health insurance cover the hospital visit after the patient leaves the hospital AMA? Answer: This may vary depending on the type of insurance coverage. Health care providers, however, often use this as a reason to encourage a patient to stay in the hospital.
This type of statement may be perceived as coercive or threatening. Medicare and Medicaid will pay for services that are medically necessary even if the discharge is AMA. Unless a patient’s insurance provider has a specific policy rider that states the patient must comply with all the recommendations of the physicians—many insurance companies will pay the bill as long as what was done was considered medically necessary. Hospitals are not prisons. A patient had the right to refuse the recommendations of physicians, which includes refusal of further hospitalized care. Since the majority of patients are voluntarily admitted to a hospital, they have the right to refuse treatment which includes leaving a hospital against the advice of their physician.

The University of Chicago reviewed data of 526 patients admitted to a general medicine service who were discharged AMA over a 10 year period. None of these patients were denied insurance payments because of their self-discharge. This study also surveyed the beliefs of the attending physicians and resident physicians concluding that 68% of the resident physicians and 43.9% of the attending physicians believed that when a patient leaves the hospital against medical advice, insurance companies do not pay for the patient’s hospitalization. They also reported (70.6% of residents; 51.2% of attending physicians) that they informed their patients that they may be held financially responsible for their hospital bill if they leave AMA.

STRATEGIES FOR PREVENTING AMA SITUATIONS

On admission assess the capacity of a patient to make his/her own decisions and update this assessment daily and/or with any changes in the patient’s condition. Have very clear conversations with patients at the beginning of their hospitalization and explain the expected course of care. This discussion should include the treatment plan, anticipated plans for discharge and what may hold up the discharge. Help patients understand what is involved in all the aspects of their care; for example, when a procedure or test is ordered explain approximately how long it will take. Poor communication from health care providers leads to frustration and dissatisfaction. Be knowledgeable on which patients are at highest risk of leaving AMA. It is important to recognize those patients and proactively address any substance abuse issues or psychological factors early in the hospitalization.

WHAT ABOUT PATIENTS WHO HAVE ABSCONDED?

When a person discovers that a patient is missing from a patient care unit that person should notify the patient’s bedside nurse immediately. The nurse should then search the area around the department and should notify their charge nurse or nursing supervisor that the patient is missing. If the patient still cannot be located within the immediate area refer to the organization’s policy which may include the notification of Security to dispatch officers to search for the missing patient. The patient's attending physician or designee should be contacted and, based upon the patient’s clinical condition, the decision should be made as to whether the security team needs to continue the search and return the patient to the unit.

Patients who may not leave on their own include patients on 1:1 observation for suicidal risk or those at risk of danger to themselves or others; patients without decision making capacity and patients who have invasive medical equipment or treatments in place such as a chest tube or central line.

WHAT HAPPENS TO PATIENTS WHO LEAVE THE HOSPITAL AMA?

Studies have demonstrated that patients who leave a hospital AMA are much more likely than patients who are discharged in the traditional manner to be re-admitted within 15 days. Among the patients who have left AMA the males and those patients having a history of alcohol abuse were significant predictors of re-admission with the 15 day time frame. In the general medical patient population, patients who left AMA have a 7 times more likely risk of being re-admitted within 15 days; almost always for the same diagnosis. Patients who leave the hospital AMA in today’s environment of shorter hospital stays places them at an increased risk for complications as well as re-admission secondary to and with worsening symptoms including death.

CASE STUDY

A twenty-two year old male was admitted to the trauma service after a motor vehicle collision. The pre-hospital report indicated that the patient was the un-restrained driver of a car that struck a tree. The patient was conscious upon paramedic arrival but amnesic to the events and repeatedly asking the same questions. He was noted to have several facial abrasions and was complaining of left chest wall and abdominal wall pain.

The trauma flow sheet documented that the patient arrived in the emergency department with a cervical collar in place along with a non-rebreather oxygen mask delivering 100% oxygen. His airway was patent. Breaths sounds were diminished on the left side and his left chest wall was tender to palpation. Respirations were 26 breaths per minute, nonlabored with an oxygen saturation of 100%. Skin was cool but pink with palpable peripheral and central pulses. The remainder of his vital signs consisted of a heart rate of 114 and blood pressure 108/60.
On secondary survey the patient had several superficial abrasions to the face that were not actively bleeding. Examination of the cervical spine revealed the neck to be non-tender to palpation and remained immobilized in a hard cervical collar. Breath sounds remained diminished on the left side with pain upon palpation. Abdominal examination revealed a soft, non-tender, non-distended abdomen. There was no rebound tenderness or ecchymosis noted. Inspection and palpation of the pelvis, back and extremities elicited no pain and revealed no signs of injury.

The patient was able to relay that he had no past medical or surgical history, did not take any medications or supplements, and had no known drug allergies. He admitted to smoking tobacco and marijuana and reported that he had drunk “few beers” prior to the collision. Initial lab work revealed a normal chemistry panel, hemoglobin of 12.7 g/dl, hematocrit of 36.9% and white blood cell count of 4.6/μl. Alcohol level was 165 with a toxicology screen positive only for Cannabis.

Diagnostic studies performed included a chest radiograph, a focused abdominal sonogram for trauma (FAST) and CT scans of the head, cervical spine, chest, abdomen and pelvis. The patient was admitted to a transitional care unit to a bed the diagnoses of concussion, facial abrasions, left rib fractures 3-7, small left pneumothorax, and a Grade 3 splenic laceration.

The treatment plan was for serial abdominal examinations, hemoglobin and hematocrit monitoring, pulmonary toileting which would include instruction and use of incentive spirometry followed by deep breathing and coughing, and pain management. The patient was to have nothing by mouth and was to be maintained on bed rest. A repeat chest x-ray was to be obtained in the morning to evaluate for any progression in the pneumothorax.

The next morning the patient was seen on trauma rounds and found to be hemodynamically stable. The patient was pulling only about 750 milliliters on the incentive spirometer and still was in considerable pain despite receiving pain medication throughout the night. His hemoglobin and hematocrit were stable throughout the night and his morning white blood cell count was within normal range. Repeat chest revealed no progression in the pneumothorax but did show atelectasis left lung base. The plan was for the patient to remain in the transitional care unit for continued observation and aggressive pulmonary toileting which was communicated to the patient and his nurse. His pain regime was adjusted to provide better control to allow more effective coughing and deep breathing.

Later that morning the patient informed his nurse that he wanted to leave. His nurse, knowing the treatment plan, advised the patient that the trauma team would like him to stay a few additional days for observation. The nurse further explained the risks involved if he chose to leave the hospital. The nurse attempted to elicit from the patient his reasons for wanting discharge but was unable to obtain any further insight. The patient was insistent on leaving and becoming agitated. The trauma advanced practice nurse (APN) who was managing the patient’s care was called and informed of the patient’s request.

The trauma APN spoke to the patient and his uncle who was present at the patient’s bedside. The treatment plan as well as the risks of leaving AMA was again outlined after which the patient appeared placated and agreed to remain hospitalized. However, an hour later the patient pulled out his intravenous line, removed the cardiac monitor, pulled on a pair of pants and stated he was leaving with his uncle. A second conversation regarding this action was met without success; the patient was adamant on leaving. His discharge paper work was completed with instructions regarding after care following rib and splenic injuries.

The patient was provided with a prescription for pain medication and the phone number to schedule a follow-up appointment with trauma outpatient services. Two days later this patient presented to a near-by community hospital complaining of fever and pain in left flank and abdomen. His blood pressure was noted to be 90/60 mmHg with a heart rate of 122 beat per minutes and temperature 30.0 F. His oxygen saturation was 93% on room air. A chest x-ray was obtained that revealed and left lower lobe infiltrate. The patient informed the providers at the community hospital of his prior trauma and the injuries he sustained. Intravenous access was obtained, the Level 1 Trauma Center called and the patient was rapidly transported back to the trauma center where he was re-evaluated and admitted for intravenous antibiotics and pain management. Despite the efforts of the APN at the time of the patient’s AMA discharge the patient developed complications which required re-admission and a further hospital stay.

CONCLUSION

Nurses play a vital role in patients considering an AMA discharge. The bedside nurse can proactively address any concerns the patient/family may express on daily patient care rounds and ensure that patients’ questions are answered to their satisfaction and that all concerns are addressed. The nurse can contact social services, case managers, substance abuse counselors and/or psychiatric service and see that they become involved early in the hospital stay. Most of all, nurses can help by not perpetuating the concepts that AMA means you leave...
with nothing. Nurses must ensure that the patient leaves with information about their injuries, possible issues of concern after discharge, medications or prescriptions for medications and follow-up information and always stress to the patient that at any time they may return to the hospital for additional care.

REFERENCES

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