LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital (MGH) sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. Such consultations require the integration of medical and psychiatric knowledge. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss the diagnosis and management of conditions confronted. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

Mr Stern is a research assistant in the Department of Psychiatry at MGH. **Dr Silverman** is a clinical fellow in psychiatry at Harvard Medical School (HMS) and a fellow in addiction psychiatry at MGH and McLean Hospital. **Dr Smith** is the director of the Acute Psychiatry Service at MGH. **Dr Stern** is chief of the Psychiatric Consultation Service at MGH and a professor of psychiatry at HMS.

Dr Stern is an employee of the Academy of Psychosomatic Medicine, has served on the speaker's board of Reed Elsevier, is a stock shareholder in WiFiMD (Tablet PC), and has received royalties from Mosby/Elsevier and McGraw Hill. Drs Silverman and Smith and Mr Stern report no financial or other affiliations relevant to the subject of this article.

Corresponding author: Theodore A. Stern, MD, Department of Psychiatry, Massachusetts General Hospital, Fruit St, WRN 605, Boston, MA 02114.

Prim Care Companion CNS Disord 2011;13(1):e1–e5

Published online: January 27, 2011 (doi:10.4088/PCC.10f01047blu).

Prior Discharges Against Medical Advice and Withdrawal of Consent: What They Can Teach Us About Patient Management

Thomas W. Stern, BA; Benjamin C. Silverman, MD; Felicia A. Smith, MD; and Theodore A. Stern, MD

Have you ever had a patient who bolted from the operating room or a procedure suite, despite the fact that the planned procedure was of vital importance? Have you wondered if there was a relationship between a prior discharge against medical advice and a patient's current behavior? Have you ever considered how you might manage a patient's fear of procedures or loss of control?

If you have, then the following case vignette should serve as a stimulus for the tactical evaluation and management of patients who have precipitously refused interventions or left the hospital prematurely.

Every clinician who performs procedures has encountered a patient who withdraws consent at the eleventh hour. For some of these patients, their treatment refusal has been presaged by prior discharges against medical advice or by last-minute cancellations of procedures. Although few clinicians routinely inquire about a history of against medical advice discharges or abrupt refusals of procedures, this knowledge of why a patient has left the hospital or has refused procedures in the past may guide future care and management of patients.

Discharges against medical advice, defined as patient discharges from the hospital or health care facility before the treating physician recommends discharge, have emerged as a pervasive problem in general hospitals. Such encounters often lead to frustration and resentment on the part of clinicians and poor outcomes and worsening health for patients. In this article, we present a case vignette to illustrate an example of a discharge against medical advice, discuss the known characteristics and prevalence of such discharges, and highlight our management of the presented case as a guide to help clinicians with similar encounters.

CASE VIGNETTE

Ms A, a 52-year-old woman with peripheral vascular disease and posttraumatic stress disorder (PTSD), was admitted to the hospital for an aortobifemoral bypass graft to relieve worsening claudication and difficulty with ambulation. Four months earlier, she had been hospitalized for a similar problem. During this previous admission, she left the hospital against medical advice in a precipitous manner. Preoperatively, following administration of an intravenous anesthetic, a staff member in the operating room removed Ms A's underwear in order to place a catheter. The feeling of her underwear being pulled off triggered a flashback of a sexual assault that Ms A had sustained at the age of 21 years. She became verbally aggressive toward staff and demanded to abort the procedure and leave the hospital.

In a preoperative psychiatric consultation during her current admission, Ms A understood the need for the procedure but felt apprehensive about it given her previous experience. She was looking forward to having less pain and

CLINICAL POINTS

- *Discharges against medical advice*, defined as patient discharges from the hospital or health care facility before the treating physician recommends discharge, have emerged as a pervasive problem in general hospitals.
- Patients withdraw consent for both routine and potentially life-saving procedures and leave the hospital against medical advice for both medical and social reasons.
- Patients who leave the hospital against medical advice represent an at-risk group for greater morbidity and mortality, as well as for readmission.

better function, and she wanted to be able to care for her aging parents, rather than to have them care for her.

Ms A described bouts of depression after her sexual assault that were partially ameliorated by antidepressants, as well as anxiety with panic attacks that typically resolved with diazepam. Shortly after her sexual assault (when "beaten and raped"), she had nightmares but denied flashbacks, avoidance, or dissociation.

The psychiatric consultation team determined that Ms A would benefit from being better informed about, fully prepared for, and in control of her preoperative routine. She was allowed to remove her own undergarments on the more familiar inpatient floor, and her family was made available to her upon awakening in the postoperative suite. The surgical procedure was successful, and Ms A avoided a psychological crisis.

REASONS WHY PATIENTS WITHDRAW CONSENT OR LEAVE THE HOSPITAL AGAINST MEDICAL ADVICE

Patients withdraw consent for both routine and potentially life-saving procedures and leave the hospital against medical advice for a number of individualized and varied reasons. Studies have shown that patients may withdraw consent and leave the hospital for both medical and social reasons (including personal, family, or financial issues; conflicts with staff; dissatisfaction with hospital care, environment, or treatment interventions; and misunderstandings based on underlying medical, cognitive, and psychiatric issues).[1–13] Examples include illness or death of a relative; reconciliation with a spouse or family members; a wish to attend to affairs outside of the hospital (eg, going to work, caring for children, addressing financial problems, or attending to legal issues, such as a court date); dissatisfaction with hospital milieu, staff, or specific treatments provided; a lack of interest in treatment or perceived improvement in illness; and organic confusion. Multiple studies have shown higher rates of discharge against medical advice on the day that public assistance or welfare checks are available, underscoring the importance of financial issues as reasons for patients to leave the hospital.[6,8]

As an example of organic confusion, one man who refused a life-saving liver transplant had cognitive impairment associated with metabolic abnormalities due to renal and liver dysfunction. Another, who demonstrated an inability to complete simple tasks (including, but not limited to, reciting the months of the year backward and naming simple objects), gave his medical team concern about his mental capacity.[14] Sudden cancelled consent by an elderly patient with senility should also raise concerns; a month after being deemed to have intact decision-making capacity (by a psychiatric consultant during a lucid period), an 88-year-old woman with mild Alzheimer's disease gave consent for a carotid endarterectomy. However, the following morning, she became agitated and adamantly refused surgery upon her arrival in the operating room.[15]

The mental status of medical and surgical inpatients is of paramount importance, as informed consent prior to a procedure serves as the cornerstone of ethical practice; it enshrines respect for a patient's autonomy.[16] If an adult is of sound mind, he or she has the right to determine what shall be done with his or her body.[17] Patients with underlying medical, cognitive, or psychiatric issues as described above, however, often lack the capacity to consent to, or refuse, interventions. As their mental status fluctuates over time, such patients may agree to a procedure (having the capacity to consent for the procedure) at a given time but then withdraw their consent at a later time.

CHARACTERISTICS OF PATIENTS WHO LEAVE THE HOSPITAL AGAINST MEDICAL ADVICE

Studies have examined patients who left the hospital against medical advice after hospitalization for a number of different conditions (eg, asthma,[11] pneumonia,[18] cardiac disease,[19–23] inflammatory bowel disease,[24] labor and delivery,[25] HIV infection,[6,8] and substance abuse[4,5,26–28]) in varied settings (eg, in the general emergency department[29,30]; on a medical floor,[1,7,31–39] pediatric unit,[10,13] or psychiatric ward[40–42]; and throughout the hospital[2,3,43]). A number of reviews have summarized different aspects of this literature.[44–48]

Table 1. Reasons for and Correlates of Withdrawal of Consent and Discharge Against Medical Advice

Impaired doctor-patient communication
Lack of a primary care physician
Cognitive impairment
Mental illness
Current or past substance abuse (including alcohol)
Terminal illness
Young age
Family and financial concerns
Living alone
Being male
Lower socioeconomic status
Medicaid or no insurance

Several predictors of discharge against medical advice have been repeatedly identified. Patients who have left the hospital against medical advice tend to be younger,* to be male,† to have Medicaid or to be uninsured,‡ to come from a lower socioeconomic class,[11,22,25,32,39,50] and to have a history or a current pattern of substance or alcohol abuse§ or other psychiatric problems.[2,3,7,19,24,25,38] Repeatedly, current or past drug or alcohol problems have been consistently linked with leaving the hospital against medical advice. Other predictors have included the lack of a primary care physician,[51] an increased severity of medical problems,[11,18–20,25] living alone, and a higher number of hospital admissions.[41] Against medical advice discharges are also associated with shorter hospital stays, as would be expected by their premature endings.¶

The role of race and ethnicity as predictors of discharge against medical advice has been debated in the literature. A number of studies have suggested that nonwhite race is associated with a higher likelihood of such discharge.** For example, in an analysis of 3 years of hospital data, Franks and coworkers[53] found that black patients, when compared to white patients, showed a 2-fold higher age-gender adjusted odds of discharge against medical advice. The authors concluded, however, that with increasing adjustment for confounding variables, such as sociodemographic factors (including insurance type, degree of morbidity, and hospital of admission), this increased risk progressively diminished. At the same time, the study revealed that minorities were more likely to be admitted to hospitals with higher against medical advice discharge rates, a factor that has been described as "structural racism."[53] Hospital characteristics, such as quality, appear to mediate the relationship between race and such discharges, eg, nonwhite race has been associated with lower rates of against medical advice discharge at low-quality hospitals.[23] One significant factor mediating race as a risk factor for against medical advice discharges might be related to impaired doctor-patient communication when clinicians and patients have discrepant cultural backgrounds.

In sum, against medical advice discharges often involve complex matters (eg, doctor-patient communication, informed consent, and underlying medical and psychiatric issues; Table 1).

PREVALENCE AND OUTCOMES OF DISCHARGE AGAINST MEDICAL ADVICE

Against medical advice discharges from hospitals generally account for 0.3%–2.1% of hospital discharges from medical floors.†† In an analysis of a nationwide database of over 3 million discharges from acute care hospitals, Ibrahim and associates[39] found a against medical advice discharge rate of 1.4%, or approximately 1 in 70 hospital discharges. Rates of against medical advice discharge vary with different patient populations. Studies have shown rates as low as 0.1% in the postpartum population[25] and as high as 24.9% on a specialized HIV/AIDS ward.[8]

Patients who leave the hospital against medical advice represent an at-risk group for greater morbidity and mortality, as well as for readmission.[50,54,55] In a study of 97 consecutive general medical inpatients, those who left the hospital against medical advice were 7 times more likely than were those who did not to be readmitted within the next 15 days (21% vs 3% rates of readmission).[55] Moreover, patients who leave hospitals against medical advice are typically readmitted with the same diagnosis and often have worsened pathology since the previous hospitalization (leading to longer lengths of hospital stays in the follow-up admission).[6,11,22]

IMPACT OF PRIOR DISCHARGES AGAINST MEDICAL ADVICE ON RATES OF CONSENT AND REFUSAL

No literature has prospectively studied the impact of past against medical advice discharges on future consent or rates of treatment refusal in the general hospital. Retrospective studies have shown that a history of discharges against medical advice increases the likelihood of such discharges and withdrawal of consent due to repeated patterns of interactions in the general hospital.[4,19,23,32,38,51] After controlling for the number of previous hospital admissions, Onukwugha and associates[23] found the risk of discharge against medical advice in a current hospital admission when a prior admission ended in such a discharge to be 10 times higher than that of the comparator group. In

*References 2, 3, 7, 8, 11, 18, 19, 22–24, 27, 32, 37–39, 42, 49.
†References 2, 3, 7, 11, 18, 22–24, 32, 35, 37–39, 42, 43, 49.
‡References 11, 18, 22, 24, 25, 28, 29, 32, 35, 37, 39, 43.
§References 2, 3, 6–8, 18–20, 24–26, 31, 32, 35, 38, 41, 43, 49, 50.
¶References 3, 19, 22, 24, 38, 39, 41, 42.
**References 8, 18, 22–25, 28, 32, 39, 41, 43, 50, 52, 53.
††References 7, 11, 19, 35, 36, 38, 39, 43, 50, 52.

their community hospital experience, Seaborn et al[38] found that 28.6% of patients leaving the hospital against medical advice had such a discharge previously.

PTSD AS A RISK FACTOR FOR DISCHARGE AGAINST MEDICAL ADVICE IN THE GENERAL HOSPITAL

As in the case of Ms A, a patient's underlying psychiatric condition might be directly linked to him/her leaving the hospital against medical advice. As an example, events in the hospital course of Ms A triggered her PTSD symptoms, precipitating her demand to leave the hospital. PTSD is an anxiety disorder that may develop in patients of any age following their experiencing (or witnessing) a dangerous event (eg, war, physical or sexual assault, abuse, accidents, disasters). Symptoms of PTSD in general hospital patients typically involve re-experiencing (eg, flashbacks, bad dreams, frightening thoughts), avoidance (eg, staying away from places that remind one of the experience, feeling emotionally numb, losing interest in previously enjoyed activities), and hyperarousal (eg, being easily startled, feeling tense, having difficulty sleeping, having angry outbursts) that may interfere with planned medical care.[56]

Managing patients with PTSD involves multimodal care. A key to successful treatment is early detection of the disorder.[57] Once a diagnosis has been made, a 3-pronged attack comprised of therapy, medication, and social support is recommended. Counseling and therapy include involvement in a learning program that helps the patient cope with his/her traumatic event and memories, while medications (often an antidepressant) help to minimize neurovegetative symptoms and ameliorate reactions to the trauma.

A variety of approaches can reduce the suffering of those afflicted by PTSD; maintenance of privacy, safety, and open (bidirectional) communication are of paramount importance. In addition, it is crucial to validate the victim's emotional reactions, which may be painful and intense. The caregiver should minimize the emphasis placed on clinical terms and pathologizing language and communicate on a person-to-person basis. Those caring for afflicted individuals should also encourage patients to attempt to follow normal routines, to find familiar methods of relaxation, and to manage (often with professional help) the people, places, and situations that remind them of the traumatic event.

CONCLUSIONS

Our patient, Ms A, had a host of factors associated with sudden withdrawal of consent and discharge against medical advice; these factors (eg, PTSD, impaired doctor-patient communication, prior against medical advice discharge with associated withdrawal of consent) when appreciated and handled allowed for her effective management and successful surgery. Recognition and treatment of intense anxiety (eg, in the case of Ms A, precipitated by a sexual trauma and triggered by in-hospital disrobing) are predicated upon knowledge of the patient's medical and psychiatric history, enabling comprehensive and compassionate care to be administered. We recommend that all clinicians inquire into previous discharges against medical advice and withdrawals of consent when admitting and caring for patients in the general hospital.

REFERENCES

1. Albert HD, Kornfeld DS. The threat to sign out against medical advice. *Ann Intern Med*. 1973;79(6):888–891.
2. Long JP, Marin A. Profile of patients signing against medical advice. *J Fam Pract*. 1982;15(3):551, 556.
3. Holden P, Vogtsberger KN, Mohl PC, et al. Patients who leave the hospital against medical advice: the role of the psychiatric consultant. *Psychosomatics*. 1989;30(4):396–404.
4. Cook CA, Booth BM, Blow FC, et al. Risk factors for AMA discharge from VA inpatient alcoholism treatment programs. *J Subst Abuse Treat*. 1994;11(3):239–245.
5. Berg BJ, Dhopesh V. Unscheduled admissions and AMA discharges from a substance abuse unit. *Am J Drug Alcohol Abuse*. 1996;22(4):589–593.
6. Anis AH, Sun H, Guh DP, et al. Leaving hospital against medical advice among HIV-positive patients. *CMAJ*. 2002;167(6):633–637.
7. Duñó R, Pousa E, Sans J, et al. Discharge against medical advice at a general hospital in Catalonia. *Gen Hosp Psychiatry*. 2003;25(1):46–50.
8. Chan AC, Palepu A, Guh DP, et al. HIV-positive injection drug users who leave the hospital against medical advice: the mitigating role of methadone and social support. *J Acquir Immune Defic Syndr*. 2004;35(1):56–59.
9. Green P, Watts D, Poole S, et al. Why patients sign out against medical advice (AMA): factors motivating patients to sign out AMA. *Am J Drug Alcohol Abuse*. 2004;30(2):489–493.
10. Okoromah CN, Egri-Qkwaji MT. Profile of and control measures for paediatric discharges against medical advice. *Niger Postgrad Med J*. 2004;11(1):21–25.
11. Baptist AP, Warrier I, Arora R, et al. Hospitalized patients with asthma who leave against medical advice: characteristics, reasons, and outcomes. *J Allergy Clin Immunol*. 2007;119(4):924–929.
12. Onukwugha E, Saunders E, Mullins CD, et al. Reasons for discharges against medical advice: a qualitative study. *Qual Saf Health Care*. 2010;19(5):420–424.
13. Roodpeyma S, Eshagh Hoseyni SA. Discharge of children from hospital against medical advice. *World J Pediatr*. 2010;6(4):353–356.
14. Brody B. Who has capacity? *N Engl J Med*. 2009;361(3):232–233.
15. Jones JW, McCullough LB. The shifting sands of senility: canceled consent. *J Vasc Surg*. 2008;47(1):237–238.
16. Jones JW, McCullough LB, Richman BW. A comprehensive primer of surgical informed consent. *Surg Clin North Am*. 2007;87(4):903–918.
17. Bernat JL, Peterson LM. Patient-centered informed consent in surgical practice. *Arch Surg*. 2006;141(1):86–92.
18. Saitz R, Ghali WA, Moskowitz MA. Characteristics of patients with pneumonia who are discharged from hospitals against medical advice. *Am J Med*. 1999;107(5):507–509.
19. Baile WF, Brinker JA, Wachspress JD, et al. Signouts against medical advice from a coronary care unit. *J Behav Med*. 1979;2(1):85–92.
20. Ochitill HN, Havassy B, Byrd RC, et al. Leaving a cardiology service against medical advice. *J Chronic Dis*. 1985;38(1):79–84.
21. Ochitill HN, Byrd RC, Greene J. Leaving a cardiology service against medical advice: a follow-up study. *West J Med*. 1987;146(6):765.
22. Fiscella K, Meldrum S, Barnett S. Hospital discharge against advice after myocardial infarction: deaths and readmissions. *Am J Med*. 2007;120(12):1047–1053.
23. Onukwugha EC, Shaya FT, Saunders E, et al. Ethnic disparities,

hospital quality, and discharges against medical advice among patients with cardiovascular disease. *Ethn Dis*. 2009;19(2):172–178.
24. Kaplan GG, Panaccione R, Hubbard JN, et al. Inflammatory bowel disease patients who leave hospital against medical advice: predictors and temporal trends. *Inflamm Bowel Dis*. 2009;15(6):845–851.
25. Fiscella K, Meldrum S, Franks P. Post partum discharge against medical advice: who leaves and does it matter? *Matern Child Health J*. 2007;11(5):431–436.
26. Pérez de los Cobos J, Trujols J, Ribalta E, et al. Cocaine use immediately prior to entry in an inpatient heroin detoxification unit as a predictor of discharges against medical advice. *Am J Drug Alcohol Abuse*. 1997;23(2):267–279.
27. Armenian SH, Chutuape MA, Stitzer ML. Predictors of discharges against medical advice from a short-term hospital detoxification unit. *Drug Alcohol Depend*. 1999;56(1):1–8.
28. Blondell RD, Amadasu A, Servoss TJ, et al. Differences among those who complete and fail to complete inpatient detoxification. *J Addict Dis*. 2006;25(1):95–104.
29. Ding R, Jung JJ, Kirsch TD, et al. Uncompleted emergency department care: patients who leave against medical advice. *Acad Emerg Med*. 2007;14(10):870–876.
30. Jerrard DA, Chasm RM. Patients leaving against medical advice (AMA) from the emergency department: disease prevalence and willingness to return. *J Emerg Med*. 2010.
31. Jankowski CB, Drum DE. Diagnostic correlates of discharge against medical advice. *Arch Gen Psychiatry*. 1977;34(2):153–155.
32. Schlauch RW, Reich P, Kelly MJ. Leaving the hospital against medical advice. *N Engl J Med*. 1979;300(1):22–24.
33. Wylie CM, Michelson RB. Age contrasts in self-discharge from general hospitals. *Hosp Formul*. 1980;15(4):273, 276–277.
34. Link K, Brody CE, Chan J. Leaving a medical service against advice. *Va Med*. 1983;110(2):100–102.
35. Smith DB, Telles JL. Discharges against medical advice at regional acute care hospitals. *Am J Public Health*. 1991;81(2):212–215.
36. O'Hara D, Hart W, McDonald I. Leaving hospital against medical advice. *J Qual Clin Pract*. 1996;16(3):157–164.
37. Weingart SN, Davis RB, Phillips RS. Patients discharged against medical advice from a general medicine service. *J Gen Intern Med*. 1998;13(8):568–571.
38. Seaborn Moyse H, Osmun WE. Discharges against medical advice: a community hospital's experience. *Can J Rural Med*. 2004;9(3):148–153.
39. Ibrahim SA, Kwoh CK, Krishnan E. Factors associated with patients who leave acute-care hospitals against medical advice. *Am J Public Health*. 2007;97(12):2204–2208.
40. Brush RW, Kaelbling R. Discharge of psychiatric patients against medical advice. *J Nerv Ment Dis*. 1963;136(3):288–292.
41. Pages KP, Russo JE, Wingerson DK, et al. Predictors and outcome of discharge against medical advice from the psychiatric units of a general hospital. *Psychiatr Serv*. 1998;49(9):1187–1192.
42. Sclar DA, Robison LM. Hospital admission for schizophrenia and discharge against medical advice in the United States. *Prim Care Companion J Clin Psychiatry*. 2010;12(2): e1–e6.
43. Aliyu ZY. Discharge against medical advice: sociodemographic, clinical and financial perspectives. *Int J Clin Pract*. 2002;56(5):325–327.
44. Jeffer EK. Against medical advice: part II, The Army experience 1971–1988. *Mil Med*. 1993;158(2):73–76.
45. Jeffer EK. Against medical advice: part I, a review of the literature. *Mil Med*. 1993;158(2):69–73.
46. Brook M, Hilty DM, Liu W, et al. Discharge against medical advice from inpatient psychiatric treatment: a literature review. *Psychiatr Serv*. 2006;57(8):1192–1198.
47. Berger JT. Discharge against medical advice: ethical considerations and professional obligations. *J Hosp Med*. 2008;3(5):403–408.
48. Alfandre DJ. "I'm going home": discharges against medical advice. *Mayo Clin Proc*. 2009;84(3):255–260.
49. Corley MC, Link K. Men patients who leave a general hospital against medical advice: mortality rate within six months. *J Stud Alcohol*. 1981;42(11):1058–1061.
50. 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.
51. Jeremiah J, O'Sullivan P, Stein MD. Who leaves against medical advice? *J Gen Intern Med*. 1995;10(7):403–405.
52. Moy E, Bartman BA. Race and hospital discharge against medical advice. *J Natl Med Assoc*. 1996;88(10):658–660.
53. Franks P, Meldrum S, Fiscella K. Discharges against medical advice: are race/ethnicity predictors? *J Gen Intern Med*. 2006;21(9):955–960.
54. Saitz R, Ghali WA, Moskowitz MA. The impact of leaving against medical advice on hospital resource utilization. *J Gen Intern Med*. 2000;15(2):103–107.
55. Hwang SW, Li J, Gupta R, et al. What happens to patients who leave hospital against medical advice? *CMAJ*. 2003;168(4):417–420.
56. National Institute of Mental Health. Posttraumatic stress disorder (PTSD). NIH Publication 08(6388). http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-ptsd/complete-index.shtml. Accessed October 28, 2010.
57. Southern Medical Association. Patient's page. Managing post traumatic stress disorder. *South Med J*. 2007;100(8):858.