Against Ethical Advice

Saying goodbye to the AMA discharge

Jim Wright, MD PhD CMD
Attending Physician, Legacy Care
Medical Director Our Lady of Hope and Lexington Court, Richmond VA
Medical Director The Memory Center, Midlothian VA
Disclosures

• I have no financial interest in any of the topics or services I will discuss here today
• No off label uses of medications will be discussed
Objectives

• Become familiar with typical AMA discharge process
• Learn ethical, legal and financial ramifications of AMA discharges
• Re-acquaint yourself with the ethical principles of patient autonomy and beneficence and how they impact your discharge processes and procedures
• Develop tools to help your facility provide a safer and legally sound discharge process
The case of Mr. G

- Mr. G is a 58 year old male with peripheral arterial disease
- Osteomyelitis of left foot, admitted on IV Zosyn and IV vancomycin for 6 weeks
- Has been caught smoking in the parking lot twice
- On day 2 post-admission, he demands to be discharged
  - “I’m not staying in this god(forsaken) place another minute”
  - Will not discuss his reasons with staff or physician
    - Physician informs patient that he could develop a life threatening infection without antibiotics. Mr. G says “I don’t give a (hoot), the taxi’s on its way”
  - Social Worker informs patient that Medicare will not pay for the past 2 days and he will receive a bill for services
  - Patient, DON and witness signs AMA form
  - Physician, per facility protocol (tradition?), does not write prescriptions or schedule follow up appointment
  - Physician writes on facility AMA form:
    - “Patient admitted for IV abx treatment of osteomyelitis, left foot. Left AMA”
  - Physician informs patient that he could develop a life threatening infection without antibiotics. Mr. G says “I don’t give a (hoot), the taxi’s on its way”
  - Social Worker informs patient that Medicare will not pay for the past 2 days and he will receive a bill for services
  - Patient, DON and witness signs AMA form
  - Physician, per facility protocol (tradition?), does not write prescriptions or schedule follow up appointment
  - Physician writes on facility AMA form:
    - “Patient admitted for IV abx treatment of osteomyelitis, left foot. Left AMA”
Examples of AMA forms

**RELEASE OF RESPONSIBILITY UNAUTHORIZED DISCHARGE**

I, ____________________________, hereby release this facility of all liabilities and responsibilities resulting from this discharge. I fully realize this discharge is against the medical practice of this facility and is being made without the written or verbal consent of my attending physician.

Date: ____________________________
Signature – Resident Representative

Date: ____________________________
Signature – Charge Nurse

Date: ____________________________
Signature – Witness

Date: ____________________________
Signature – Witness

| Resident/Representative refused to sign release.

Comments: ____________________________

---

**Our Lady of Hope**

**Discharge Against Medical Advice**

This is to certify that I, ____________________________, the responsible party for ____________________________, a resident of Our Lady of Hope, am requesting to discharge ____________________________ against medical advice.

The medical risks/benefits have been explained to me by a member of the medical staff and I understand those risks.

I hereby release Our Lady of Hope, its administration, personnel, and Dr. Wright from any responsibility for all consequences, which may result by my taking ____________________________ under these circumstances.

Medical risks include but are not limited to:
Discharge Against Medical Advice (AMA)

- Policy enacted by facilities in the event of an unplanned discharge home initiated by a patient or POA.

- Elements of AMA discharge
  - Waiver to absolve facility of responsibility ("patient signed out AMA")
  - can include
    - Refusal to set up follow up appointment
    - Refusal to call in medications
    - Refusal to give discharge summary to patient or POA
AMA Discharges: Characteristics

• How prevalent?
  • No studies of skilled nursing facilities or long term care facilities
  • Estimated that 2% of all hospital discharges are AMA

• Typical characteristics (hospitals)
  • More likely to have psychiatric diagnoses
  • Poor social support
  • Less likely to have a primary care physician
  • Substance abuse
  • male

Berger, JT. J Hosp Medicine 2008, 3(5): 403-408
Alefandre, D and Schumann, JH. JAMA 11/11/2013 (online)
AMA Discharges: common patient concerns

- Finances
- Loss of control
- Fear
- Stigma of Nursing Home/“Old Folks Home”
- Uncontrolled symptoms
- Loss of trust

Evans, J. “Against Medical Advice, Whatever That Is” in Caring for the Ages, June 2012
AMA Discharges: Consequences

• Re-admission rates 20-40% higher
• 30 day mortality rate 10% higher

Alefandre, D and Schumann, JH. JAMA 11/11/2013 (online)
AMA Discharges: Common Issues

- **Legal** - does the waiver protect you?
- **Financial** - is the patient liable for charges?
- **Ethical** - what are your responsibilities?
AMA Discharges: Legal aspects

• “Does Identifying a Discharge as ‘Against Medical Advice’ Confer Legal Protection?”
  • Medline and Lexis-Nexis review from 1983-1999
  • 8 relevant cases were AMA discharge

Devitt, PJ et al. J Fam Prac 2000, 49 (3):224-227
AMA Discharges: Legal aspects

- In all 8 cases, the decision of the judge or jury never rested on the signed AMA form or designation.
- In one case (Dedley v Kings Highway Hospital Center), a court found that the waiver was “contrary to public policy and therefore worthless”
  - In addition, the court found that the hospital could be subjected to additional legal action if it prevented the patient from leaving until she signed the form.
AMA Discharges: Legal aspects

- Decisions against the hospital or provider rested on:
  - If the patient was fully informed
  - If the patient’s competency had been assessed
  - The patient did not meet criteria for involuntary hospitalization in psych hospital
AMA Discharges: Legal aspects

- Careful documentation is the best legal defense
- Patient must be fully informed
- Patient’s competency must be assessed
- Psych consult should be sought for those patients with questionable capacity
- Failure to make appropriate follow up or alternative care for patient may be seen as a breach of a duty of care
- A waiver absolving the facility of any responsibility if the patient leaves AMA should be seen as worthless
AMA Discharges: Financial Issues

• Financial Penalties?
  • One study: 51% of attending physicians (71% of residents) told patients that “insurance will not pay for your stay if you are discharged AMA”

Journal of General Internal Medicine 27(7):825-30 2012
AMA Discharges: Financial Issues

• Journal of General Internal Medicine 27(7):825-30 2012
  • 46,319 inpatients at 13 Illinois Hospitals
  • 526 left AMA
  • Payment refused in 4.1% cases
  • Most were refused payment for administrative reasons
  • Not a single patient refused payment due to AMA status

• Medicare covers medically necessary care. Just because a patient terminates that care prematurely doesn’t make it retroactively unnecessary!
AMA Discharges - Ethical Principles

• Autonomy
• Non-Maleficence
• Beneficence
• Justice/Fairness
AMA Discharges - Ethical Principles

• Autonomy
  • Admission to your facility is voluntary, discharge is simply patient’s withdrawal of original consent
  • Everyone has the right to make their own bad decisions!
Examples of AMA forms

**RELEASE OF RESPONSIBILITY UNAUTHORIZED DISCHARGE**

I, ____________________________, hereby release this facility of all liabilities and responsibilities resulting from this discharge. I fully realize this discharge is against medical practice of this facility and is being made without the written or verbal consent of my attending physician.

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature – Resident Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature – Charge Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature – Witness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature – Witness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Resident/Representative refused to sign release)

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

---

**Our Lady of Hope**

**Discharge Against Medical Advice**

This is to certify that I, ____________________________, the responsible party for ____________________________, a resident of Our Lady of Hope, am requesting to discharge ____________________________ against medical advice.

The medical risks/benefits have been explained to me by a member of the medical staff and I understand those risks.

I hereby release Our Lady of Hope, its administration, personnel, and Dr. Wright from any responsibility for all consequences, which may result by my taking ____________________________ under these circumstances.

Medical risks include but are not limited to:
...the waiver was “contrary to public policy and therefore worthless”

- Who gives the ultimate authorization for admission?
- Who gives the ultimate authorization to discharge?
• Autonomy depends upon capacity
  • Does patient understand the ramifications of his/her actions?
  • Must be documented in the chart
Examples of AMA forms

RELEASE OF RESPONSIBILITY UNAUTHORIZED DISCHARGE

I, ____________________________, hereby release the facility of all liabilities and responsibilities resulting from the discharge. I fully realize this discharge is against the medical practices of the facility and is being made without the written or verbal consent of my attending physician.

Date: ________________________
Signature – Resident Representative

Date: ________________________
Signature – Charge Nurse

Date: ________________________
Signature – Witness

Date: ________________________
Signature – Witness

|  | Resident/Representative refused to sign release.

Comments: _____________________________________________________________

Our Lady of Hope

Discharge Against Medical Advice

This is to certify that I, ____________________________, the responsible party for ____________________________, a resident of Our Lady of Hope, am requesting to discharge ____________________________ against medical advice.

The medical risks/benefits have been explained to me by a member of the medical staff and I understand those risks.

I hereby release Our Lady of Hope, its administration, personnel, and Dr. Wright from any responsibility for all consequences, which may result by my taking ____________________________ under these circumstances.

Medical risks include but are not limited to:


Does the patient REALLY understand their situation?

“I fully realize this discharge is against the medical practices of this facility”
AMA Discharges: Ethical Principles

Beneficence

- The healthcare professional is ethically bound to work in the patient’s interest
AMA Discharges: Ethical Principles

- Beneficence
  - if facility policy includes abandoning normal discharge procedures (discharge summary, calling in meds, setting up appointments), then the facility/provider may be in violation of their duty of care
AMA Discharges: We Can Do Better!
The AIMED approach

• Assess
• Investigate
• Mitigate
• Explain
• Document

The AIMED approach - Assess (Autonomy)

• Assess
  • Capacity
    • Does patient have ability to sign themselves out AMA?
  • Degree of illness
    • How critical is it that patient receives treatment now?
  • Risk
    • What would happen if patient refuses treatment?
    • The higher the risk, the more important it is that you establish capacity
Medical Capacity Components

• Must be able to communicate
• Must show understanding of treatment options including the ability to refuse treatment
• Understanding of likely consequences of choices
• Ability to explain why they are making the choice
• Decisions should not be influenced by delusions or psychoses
Medical Capacity - The Script

• Do you understand your medical problem(s)?
  • Tell me what you’re in here for
  • What’s your most serious medical problem?

• Do you understand the proposed treatment?
  • What are we trying to do for you here?
  • Can you tell me the possible treatments you can have?

• Do you understand the consequences of refusing the treatment?
  • What could happen to you if you don’t stay and get the treatment?
Capacity Tool - the ACE

- The Aid to Capacity Evaluation (ACE)
- www.utoronto.ca/jcb/_ace
Mr. G is a 78 year old male with peripheral arterial disease

Osteomyelitis of left foot, admitted on IV vancomycin for 6 weeks

On day 2 post-admission, he demands to be discharged
- “I’m not staying in this god(forsaken) place another minute”
- Will not discuss his reasons with staff or physician
  - Physician informs patient that he could develop a life threatening infection without antibiotics. Mr. G says “I don’t give a (hoot), the taxi’s on its way”
  - Social Worker informs patient that Medicare will not pay for the past 2 days and he will receive a bill for services
- Patient calls cab
- At request of administrator, physician signs AMA form
- Physician, per facility protocol (tradition?), does not write prescriptions or schedule follow up appointment
- Physician writes on facility AMA form:
  - “Patient admitted for IV abx treatment of osteomyelitis, left foot. Left AMA”
At the time of my evaluation, Mr. G was able to express to me the nature of his illness, the available treatment options and the consequences of refusing treatment. I deemed him to have medical capacity to make decisions regarding his care.

At the time of my evaluation, Mr. G was able to tell me that his main medical problem was “an infection in the bone in my foot”. He was aware that the best chance of successful treatment was “antibiotics through that tube in my arm”, and he also noted that “I could lose my foot” if he did not receive treatment. When asked if he knew he could die, Mr. G responded, “I know that.” Despite multiple attempts, he refused to give me his rationale for refusing antibiotics. I determined that Mr. G had understanding of his illness, the proposed treatment and the consequences of refusing treatment and therefore had medical capacity to refuse the proposed treatment.
The AIMED approach - Assess

• What if they don’t have capacity?
  • You are obligated to attempt to keep patient under your care until surrogate decision maker is found

• What if they walk out the door anyway?
  • Unless your facility is qualified to restrain incapacitated patients (geriatric psych ward), you may have to let them go
  • Contact APS or Police, especially if risk of harm to patient is high
The AIMED approach - Investigate

• Why does the patient want to leave?

• What concerns can be addressed?
  • Uncontrolled pain
  • Nausea
  • Nicotine/Opioid/Alcohol Withdrawal

• Can you find allies to help convince patient to stay?
  • Can you become that ally?
  • “I am worried about you. Can I do anything to help you to stay until your treatment is finished?”
AIMED - Mitigate Harm (Beneficence)

• You are obligated to do your best to help patient
• Offer maximal acceptable treatment to patient
  • Offer another dose of IV antibiotics just before they leave
• Provide prescriptions
  • Oral antibiotics if patient refuses IV
• Have facility set up follow up appointment
• Do you put yourself at risk by offering substandard care?
  • Less risk than offering no care at all
AIMED - Explain Risks and Benefits

• Should have done this already in capacity evaluation
• One part of informed refusal is that patient should be able to state back to you in their own words the consequence of refusal
• Offer (pending approval by administration) admission back to facility should they choose to return
• Document each of the above elements in the chart

• Successful lawsuits tend to have one thing in common: poor documentation

• Document
  • Exam and assessment of disease
  • Discussion of treatment and patient’s knowledge of consequences of refusal
  • Patient’s reason for refusal
  • Efforts at negotiating with the patient
  • Efforts made to mitigate harm, set up follow up
  • Capacity eval
AMA: Let’s say goodbye to AMA Discharges!

• “Against Medical Advice” discharges offers no protection against legal action
• Using AIMED approach will mitigate risk much better than an AMA form
• AMA turns the patient into an adversary
• Can involve coercion (“your insurance won’t pay”)
• Can increase patient’s tendency to sue
• It’s a bad idea to be “against” your patients!
AMA Alternative: “Departure Prior to Completion of Treatment” (DePCoT?)
Departure Prior to Completion of Treatment Protocol

**Process:**

1. Patient or Power of Attorney states intention to leave prior to completion of treatment plan.
   a. Determine if patient has uncontrolled symptoms.
   b. Determine if patient has pressing outside responsibilities.
   c. Address those possible causes of early departure if possible.

2. Nursing supervisor/DON or Healthcare professional investigates cause for early departure:
   a. Patient or POA is able to understand treatment plan and consequences of refusal.
   b. Patient or POA is not found to be incapacitated by mental illness.

3. Healthcare professional (Physician, PA or NP) assesses capacity:
   a. Patient or POA is able to understand treatment plan and consequences of refusal.
   b. Patient or POA is not found to be incapacitated by mental illness.

4. Healthcare professional explains treatment plan and alternatives:
   a. Original treatment plan explained.
   b. Dangers of failure to follow treatment plan explained.
   c. Alternative plan explained.

5. Healthcare professional identifies alternative plan to mitigate any possible harm to patient:
   a. Offer maximal necessary treatment acceptable to patient.
   b. Provide prescriptions or call in prescriptions to pharmacy.
   c. Provide discharge instructions and follow-up plan.

6. Social worker or unit clerk will make follow-up appointment with Primary Care Provider.
7. Administrator or Admissions office details options regarding return to facility if possible.
8. Patient or POA signs "Departure Prior to Completion of Treatment" form.

9. Documentation:
   a. Healthcare professional will document:
      i. Medical capacity evaluation.
      ii. Discussion regarding initial treatment plan, alternative plan and possible consequences of refusal.
      iii. Efforts to convince patient and/or POA to complete treatment.
      iv. Patient reason for refusal.
      v. Departure instructions.
   b. Unit supervisor will document:
      i. Investigation as to cause of early departure.
      ii. Efforts to convince patient or POA to continue with proposed treatment.

10. Checklist will be completed by DON:
    a. DON will ensure that all involved parties have completed and signed checklist.
Departure Prior to Completion of Treatment

Release Form

[Printed Form Details]

Patient or Power of Attorney

Date

Nursing Supervisor

Date

Signature of Medical Professional

Printed Name and credentials

Signature of Medical Professional

Printed Name and credentials

[Additional Information]

At the time of my evaluation, __________ was able to express to me the nature of his/her illness, the available treatment options and the consequences of refusing treatment. I deemed him/her to have medical capacity to make decisions regarding his care.

The patient has been offered appropriate prescriptions and follow up appointment(s) to mitigate any harm caused by the patient's voluntary discharge prior to completion of treatment.
# Checklist for Departure Prior to Completion of Treatment

<table>
<thead>
<tr>
<th>Task</th>
<th>Signature</th>
<th>Title/Position</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Supervisor or DON investigates cause for early departure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/PA/NP Determines capacity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient or POA has capacity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APS or Police called if patient deemed unsafe or without capacity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APS called</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police called</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not necessary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare Professional Offers and explains alternative treatment plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescriptions written by provider or called in by floor nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Summary given</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker makes follow up appointment with PCP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrator/Admissions office explains process of re-admission to facility if desired</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient or POA signs “Departure Prior to Completion of Treatment” Release form, Consented by Nursing Supervisor and Medical Provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Supervisor documents departure process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare provider documents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>capacity evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion of benefits/risks of treatment adherence or refusal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Efforts to convince patient to remain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient reason for refusal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Instructions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
AMA alternative: Departure Prior to Completion of Treatment (the DePCoT)

- Implement these changes at your facility
  - Meet with DON and Administrator - need their buy-in!
    - May need buy in from ownership and corporate lawyer
  - Re-name “AMA Discharge”
    - “Departure Prior to Completion of Treatment” (or something more catchy)
  - Design protocol with DON and Administrator
  - Your facility will still want a release of responsibility form
    - Redesign to incorporate some of the ethical principles we talked about
  - Make a checklist to ensure protocol is followed
Departure Prior to Completion of Treatment

• Tools and Presentation available from:
  • jwright@lgslegacycare.com
Panel Discussion

- **Kelly Carter**, BSW, LNHA, Administrator, Laurels of University Park
- **Andrew Heck**, PsyD, ABPP - GeroPartners, LLC
- Attorney **Christopher McCarthy** of White & McCarthy, LLP
  - Certified in Elder Law by the National Elder Law Foundation
  - Member of the Council of Advanced Practitioners, National Academy of Elder Law Attorneys
- **Katherine Kane**, B.S.W., M.S. (Gerontology) - Our Lady of Hope Health and Rehabilitation
Thank You!