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# Documentation Of Emergency Department Discharges Against Medical Advice

Marie Schaefer

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Documentation of Emergency Department Discharges Against Medical Advice

A Thesis Submitted to the  
Yale University School of Medicine  
in Partial Fulfillment of the Requirements for the  
Degree of Doctor of Medicine

by

Marie Ann Rymut Schaefer

2012

DOCUMENTATION OF EMERGENCY DEPARTMENT DISCHARGES AGAINST MEDICAL ADVICE. Marie A. Rymut Schaefer and Edward P. Monico. Department of Emergency Medicine, Yale University, School of Medicine, New Haven, CT.

In investigating information transfer during the discharge against medical advice (AMA) conversation, this research examined the ability of providers to transfer the appropriate quantity and quality of information to allow patients to make an informed decision. Additionally, the research determined an updated rate of AMA discharges.

A retrospective chart review was completed utilizing an eight-point screening tool created from policy and literature standards to measure documentation sufficiency over a one-year time interval. Data analysis indicated that healthcare providers documented medico-legal standards the following percentages of the time: (1) capacity (22.0%); (2) agreement of the signs and symptoms determined by documentation of the diagnosis (33.0%); (3) the extent and limitation (8.1%) of the evaluation; (4) documentation of the current treatment plan, risks, and benefits (3.8%); (5) risks and benefits (4.8%) of foregoing treatment; (6) alternatives to suggested treatment (5.7%); (7) an explicit statement the patient left AMA as well as stating what the patient was refusing (50.7%); and, (8) follow-up care including discharge instructions (67.5%). An AMA discharge rate was calculated to be 0.52%.

These results show that physicians are not conducting AMA encounters according to quality and safety domains set by oversight institutions and federal requirements. The calculated discharge AMA rate is lower than published studies suggesting the need to standardize the definition of AMA. Future interventions should standardize the discharge procedure with emphasis on provider education to increase safety and quality of care.

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## Introduction

I . . . understand that, against the advice of the fine doctors and staff here at Yale New Haven Hospital—I am checking out. Also I know the EKG said something *was* wrong but I *know* from past experience that EKG's on *me* have been wrong!!! So, I do not want angiograms, or sonograms or any other type of procedure. I'm good—no need to worry. *It's God's will.*

In the era of a patient-centered and consumer-driven healthcare, the patient, as long as he has full capacity, has the right and responsibility to make his own healthcare decisions (1, 2). Many patients, who have been cultured in medicine's paternalistic traditions of the past, are content to comply with everything the physician suggests, while others are more skeptical and hesitant towards care. Despite taking a thorough history, talking with family members, or consulting with the patient's other providers, it is impossible to know exactly how and why a patient comes to a decision. Only in rare events, such as with the above patient's written statement found while doing the research for this study, the healthcare provider has the unique opportunity to actually see the factors and biases that influenced a decision.

Regardless of medical specialty, a common patient action that makes healthcare providers intensely curious about the decision making process is when a patient decides to leave the hospital against medical advice. Why, despite all the warnings and explanations given by knowledgeable healthcare providers, does the patient wish to leave? Patients' rationale for their decision often does not take in to account their own health. They may be dealing with meritorious external factors such as providing employment income, childcare, or care for a demented spouse (3). Or, they may be feeding a drug habit, worrying about high healthcare costs, or dealing with numerous other commitments outside of the hospital (4). Conversely, time spent in the hospital

may contribute to patients' desire to leave secondary to negative relationships with providers, feelings of inadequacy of care, or resolving health issues (4, 5). Despite the patient's motivation, it is the healthcare providers' responsibility to supply the knowledge and information for the patient to reach an informed decision. This paper explores the caveats of that singular conversation and consequential repercussions not only on the health of the patient, but also on the professional responsibility of the healthcare provider.

### ***AMA Patients as a Healthcare Issue***

A discharge against medical advice (AMA) occurs when a patient chooses to leave the hospital before the healthcare provider recommends the patient's discharge at the completion of treatment (6). Patients that leave the hospital AMA comprise a small, but substantial group. Multiple independent research studies estimate that between 0.8% and 2.2% of inpatients from United States hospitals leave AMA (7-12). Studies from Canada estimate a lower AMA rate of 0.57% (13). Additionally, since 1988, the Agency for Healthcare Research and Quality (AHRQ) utilizing annual discharge data from five to eight million hospital stays has recorded inpatient AMA discharge rates ranging from 0.76% to 0.99% (14, 15). AMA discharges not only comprise a significant portion of patients, but patients are increasingly signing out AMA. The AHRQ reported that between 1997 and 2008 the number of AMA discharges dramatically increased by 40% accounting for an additional 105,000 AMA discharges (16). Of all inpatient subgroups, psychiatric admissions have a notoriously higher AMA discharge rate with studies suggesting rates from 1.6% to 51.0% (12, 17-19).



Slightly different from inpatients, in the emergency department, patients are considered to have left AMA if they have been seen by an emergency physician, but decide to leave during the workup or treatment or by refusing recommended hospital admission. Like inpatients, it is generally assumed that the hospital is aware that the patient is leaving (6). Alternatively, in the emergency department, a patient can be discharged as left waiting to be seen (LWBS), a term that has additionally emerged in the literature starting in the 1970s (20). In this situation, the patient has been screened by a triage nurse, but leaves before being seen by an emergency physician (21). Unlike AMA discharges, LWBS patients generally leave unannounced to any hospital staff (6). Patients more frequently leave without being seen than leave AMA (21) and are often cited as being associated with emergency department crowding (22-24). Research completed by two independent studies has shown that emergency department patients leave AMA at a slightly higher rate than that of inpatients at a rate of 1.6% to 2.7% (21, 25). However, it is important to note the definitions and methods of determining the AMA rate in the two studies. In one study, where an AMA rate of 1.6% was obtained, it was unclear as to how AMA patients were defined and how the rate was calculated (25). However, in the second study by Ding and colleagues completed in 2007 at a comparable institution to the first study, a higher AMA rate of 2.7% was recorded (21). In the protocol, patients were considered to have left AMA if they were seen by a physician, but left sometime before the completion of their care. Patients that simply got up and left without the opportunity to have the AMA discussion in the Ding study were counted as having left AMA as opposed to LWBS. The rate was found by dividing the number of AMA patients by the number of unique patients (as opposed to unique visits) that visited

the emergency department. The denominator excluded the patients that transferred or expired or had a disposition classification as unknown. These patients, logically, could not have possibly had the potential to leave AMA.

Beyond research studies, the AHRQ, who has been collecting data on emergency department discharges since 2006, reports a range of discharge AMA rates between 1.52% and 1.64% (26). Additionally, the Centers for Disease Control and Prevention (CDC) has been collecting emergency department discharge data and reports an AMA rate of 1.0% (27). It is also important to consider in these instances how data is being collected and how rates are being calculated. In the history of reporting national statistics, initially only inpatient discharges were recorded and it has only been relatively recently that the advent of collecting emergency department dispositions has occurred (28). Consequently, there has been a lack of a clear definition as to where the distinction is between leaving without being seen and leaving against medical advice. For example, the AHRQ emergency department survey, which is simply an extension of an inpatient survey, records an AMA discharge rate between 1.52% and 1.64% utilizing a scoring system that does not include LWBS as a discharge choice, thus artificially increasing the rate of AMA patients (14, 26). Conversely, data collected by the CDC, which estimates an AMA rate at 1.0%, includes the categories “left or referred out from triage,” “left before medical screening exam,” “left after medical screening exam,” and “left against medical advice” (27). Patients classified as LWBS would fall in the categories “left or referred out from triage,” “left before medical screening exam,” and, potentially, “left after medical screening exam” if the AMA conversation was not initiated. By removing

most of the patients that LWBS, it can be argued that the CDC's lower rate more closely exemplifies the discharge AMA rate.

Despite the small percentages of patients choosing to leave AMA, these patients, when compared to counterparts that complete their treatment, are at an increased potential risk of morbidity and mortality. Patients who left the hospital AMA from a general medicine ward were more likely to be readmitted during the first fifteen days after leaving than control patients (29). Additional studies have reproduced similar result with medicine inpatients (10, 12) as well as with specific admission diagnoses. Patients admitted with asthma who left AMA were more likely than their routinely discharged counterparts to have an asthma relapse and end up in the emergency department or be readmitted within thirty days (30). Similarly, an AMA discharge has also been associated with an increased risk of readmission for patients admitted with alcohol abuse, acute myocardial infarction (AMI), and human-immunodeficiency-virus complications (29, 31, 32).

Even more notable, patients that leave AMA have an increased risk of morbidity. Patients have a statistically significant increase in morbidity within sixty days of leaving AMA (8). Another study showed that patients that left AMA after being admitted for an AMI had a significantly increased risk of death within ninety days of discharge and even two years after leaving AMA their risk of death was 60% greater than those patients than their counterparts (31). Patients being treated for alcoholism that left AMA had a significantly increased risk of death within the following six months when compared to controls (33).

Fewer studies have been completed about the morbidity and mortality rates of patients that leave the emergency department against medical advice; however, the studies suggest similar trends with those of inpatients. Patients that left the emergency department AMA were significantly more likely to return within thirty days with the risk being the highest during the first nine days (21). After following up on 52 AMA patients, one study found that 21.1% of patients that left returned to the emergency department within seven days (34). Another study showed that of the patients in an emergency department that left AMA, but returned for follow-up care, 50.7% of them had significant pathology (35). Specifically looking at patients that presented with acute chest pain, patients that left AMA had a clinical presentation that was less typical for AMI than the admitted patients; however, it was more concerning for AMI than the patients that completed the work up and were discharged home (36). Although both the incidence and prevalence of AMA patients are low, these patients have an increased risk of morbidity and mortality and are an important group to concentrate on in discussions of healthcare quality and safety.

Beyond healthcare, patients that leave AMA also pose an increased legal liability to treating providers and hospitals. First, because of the nature of providing emergency and trauma care to very sick and unstable patients, emergency medicine, as a specialty, is considered a high risk specialty in regards to legal liability (37, 38). Amongst all specialties, it was recently ranked fifteenth, above the average for all physicians, in the number of emergency medicine practitioners that face a malpractice claim annually (39). More specifically, in a field where patients press litigation more regularly than other fields, it has been suggested that AMA patients sue hospitals and physicians nearly ten

times as often as the typical emergency department patient (40). Compared to the average litigation rate of one in every 20,000 to 30,000 emergency department visits, it has even been estimated that an AMA case results in litigation once in every 300 cases (40). Specific examples of lawsuits will be presented later in the discussion section of this paper. Finally, underscoring the importance of the growing liability issue, the Institute of Medicine has recommended that Congress create a commission to examine the impact of lawsuits on the declining availability of emergency medicine providers (38).

Physicians and other healthcare providers, regardless of medical specialty, will likely come across patients that want to leave AMA. These patients account for a significantly increasing portion of discharges that are characterized by an elevated risk of patient morbidity and mortality and well as increased medico-legal risk for healthcare providers. Proper physician documentation of AMA encounters is an important and useful strategy for measuring and for increasing patient care quality and safety as well as a risk-reducing practice management technique. The research presented in this paper focuses on identifying the shortfalls in the transfer of information to a patient when discussing an AMA discharge in order to reduce medical and legal risks. It is first important to understand and identify which patients are likely to sign out AMA in order to determine how to guide the conversation.

### ***Who Leaves Against Medical Advice?***

Historically, the first patients studied and documented to leave the hospital against medical advice were patients being treated in isolation for pulmonary tuberculosis during

the 1950s (41, 42). It was estimated that of all the patients at a tuberculosis sanatoria approximately one-third to one-half left against medical advice (18). These patients, it has been suggested, commonly left AMA due to the anxiety and depression resulting from the inability to make interpersonal relationships while in isolation. Additionally, they were noted to have a “low tolerance for frustration” and in order to deal with this intolerance, they would turn towards “motor action” and run away (18).

Ever since the 1950s, research has focused primarily on four major groups of patients that leave AMA: inpatients, emergency department patients, psychiatric patients, and patients undergoing detoxification or substance abuse treatment. The majority of research on hospital discharges against medical advice has focused on defining the patient, provider, and hospital characteristics associated with a patient’s decision to leave. This section will review the known characteristics common to patients in these study groups. By acknowledging what types of patients are at risk, these studies suggest that physicians will be able to identify strategies to reduce AMA discharges (43). More importantly, healthcare providers, by learning basic demographics, will be better equipped to understand and anticipate the types of conversations that they will need to have with their patients in order to provide an adequate transfer of knowledge about the risks and protocols of an AMA discharge. Additionally, basic demographics found in the literature will later be compared to the demographics collected in this research study.

Inpatients are the largest potential group of patients, compared to all the other study populations, to leave the hospital against medical advice. In general, inpatients that leave AMA are younger, have had a previous AMA discharge, are less likely to have a primary care provider, are more likely to admit to current drug use, and have had clinical

signs of alcohol withdrawal (10, 12, 29). The most common admitting diagnoses of these patients were chest pain, pneumonia, and alcohol-related diagnoses (12). Additionally, having one of the following comorbidities also increased a patient's risk of leaving AMA: HIV/AIDS, liver disease, alcohol use, drug abuse, and psychiatric diagnosis other than depression (7). Lower risk factors for leaving AMA include diagnoses categories of arrhythmia, pulmonary circulatory, parathyroid disorders, hypothyroid disorders, lymphatic disorders, metastatic cancer, tumors (7). Another study found that AMA rates do not appear to be a function of the disease and more likely a function of being male, a Medicaid or self-paying patients (11).

It has been widely hypothesized that inpatients that leave AMA are more likely to be Black due to a higher level of dissatisfaction in inpatient care among racial minorities (44). Many studies have shown that being Black is a positive predictor of discharge AMA (9, 12, 44). However, in adjusting for place of hospitalization, income, and insurance, researchers found that neither Blacks nor Hispanics had higher discharge AMA rates over any other group (7). Rather, a "structural racism" created by low income, public hospitalization, and Medicaid insurance determined the likelihood that a patient would leave AMA independent of race (7). Other studies have also shown that race, as well as gender, employment, insurance, or living situation were not significant factors (10).

Beyond simply the patient, hospital and provider characteristics are correlated to the likelihood of a patient leaving against medical advice. Hospitals that see the highest rates of discharge AMA rates are likely to be medium sized and located in an urban environment with have a high proportion of minorities and patients on Medicaid (7, 9,

11). Of inpatients that leave AMA, 87% tend to leave within seven days of their hospital stay compared to only 67.5% of the controls (12). Additionally, though it was hypothesized that there were more AMA discharges associated with the beginning of the month due to distribution of welfare checks, there has never been found to be an association with season, day of week, or time of the month (13, 21). There has not been much research completed about characteristics of providers that leave AMA; however, one study estimated that providers spend on average 44 minutes with patients discussing the patients' decision to leave AMA (5). Providers were able to openly discuss with their patients, for the most part, as to why they were leaving AMA; but providers speculated that the patients' reasons were multifactorial and some part of the reason was withheld (5).

Similar to inpatients, emergency department patients that leave AMA are more likely to be uninsured or on Medicaid, younger, Black, and single (21). They also tend to have a lower triage acuity level than patient who stay, but have a higher triage acuity than patients who LWBS (21). Despite the belief that overcrowding in emergency departments is an impetus for patients to leave AMA, Ding and colleagues actually found that "crowding did not seem to influence patients who left AMA" (21). However, patients were more likely to LWBS when the emergency department was the most crowded. Patients who left AMA from the emergency department share significantly common chief complaints compared to patients who were admitted. In order of prevalence, patient that left AMA were likely to complain of nausea or vomiting, abdominal pain, nonspecific chest pain, alcohol-related mental disorders, headache (including migraines), and other lower respiratory diseases (21). Similar to inpatients,



during a 30-day follow-up period 4.4% of patients were emergently hospitalized which is significantly higher than patients who completed their appropriate course of treatment (21). The high recidivism rate suggests that patients who leave AMA are doing so prematurely and that the offered work-up and treatment plan are important to providing the appropriate care.

The final two groups of patients that have been commonly studied in the discharge AMA literature are psychiatric and substance abuse or detoxification patients. Psychiatric patients were the first and most documented patient population and estimates show an AMA rate historically ranging from 1.6% to 51.0% (12, 17-19). The large range is due to both the advent of psychotropic medications that decreased the need for hospitalization as well as the historic shifts in legislation and culture that occurred in the 1960s and 1970s that led to deinstitutionalization consequently allowing patients greater control over their treatment (19). Despite the incidence of psychiatric morbidity in medical inpatients and emergency department patients, the data regarding patient characteristics in the literature are too heterogeneous to allow for comparisons and are outside of the scope of this paper (45). Likewise, though patients seeking inpatient treatment for substance abuse or detoxification are prone to leave AMA, their background and reasons for leaving are more in line with the psychiatric literature. Discharge AMA rates are seemingly elevated for this group with as high a rate as 5.3% being recorded (46). In general, as with the inpatient and emergency department discharges, psychiatric and substance abuse patients that leave AMA are more likely to be readmitted and have a poorer outcome (10).

This, again, turns to the original question: why do these patients choose to sign out against medical advice? In the literature, more time has been spent on characterizing patients and comparing discharge AMA rates than on determining why people leave. By identifying these reasons, scholars suggest, the healthcare system can start to design preventative interventions (47). Research has attempted to answer that question by directly surveying or phone calling patients that left AMA. The overall results have been varied. One study of inpatients showed that the most common reported reason for leaving AMA was because the patient felt better followed by personal or financial obligations and drug or alcohol seeking (10). Only 2.5% of patients were unhappy with their care. In the emergency department, one study showed that 82% of patients that left the emergency department against medical advice did so because they did not agree with the management plan and the other 18% left because hospitalization would have been an inconvenience (34). In a detoxification unit, the majority of the patients left due to personal reasons that included family emergencies, financial or personal obligations, family reconciliations, or legal issues (46).

A study by Onukwugha and colleagues used interviews with patients, doctors, and nurses to provide multiple perspectives as to why patients choose to leave AMA (43). From interviews with focus groups (patient group, doctor group, and nurse group), seven themes emerged as reasons for leaving AMA: (1) drug-seeking behavior or leaving secondary to judgment of drug history; (2) pain management causing patients to feel like they are being judged as drug seekers; (3) other obligations; (4) wait time (did not anticipate a stay or test results took too long); (5) doctor's bedside manner; (6) confusing teaching-hospital setting; and, (7) communication (between providers and between

providers and patients). Patients were found not to be leaving AMA due to desiring a second opinion elsewhere, feeling better, lack of health insurance, or dirty hospital rooms. The doctor focus group blamed communication deficits with the patient on the nurses and the reverse was true with the nurse focus group. For example, doctors proposed that by the time they would get to the patient, the patient has made up his mind. Conversely, nurses said that because it takes so long for doctors to get there, the patient gets annoyed and frustrated by not having his questions answered. The patients suggested that the doctors should discuss more about the consequences of leaving AMA and that they should spend more time trying to convince patients to stay.

As can be seen by the conflicting research, the answer as to why patients choose to leave AMA is a complicated question with multiple confounders. However, it is important to understand both the motivations and the characteristics of these patients. Knowing that patients of a lower socioeconomic status with limited healthcare options are more likely to leave AMA, allows the provider to both flag the patient as having a higher potential to leave AMA and to guide the discharge conversation in a different manner than if the patient were a highly educated adult without financial or resource concerns. Likewise, each of the four different study groups, patients in the hospital, the emergency department, psychiatric wards, or detoxification units, have different characteristics and thought processes for leaving AMA. An inpatient that has been in the hospital for fifteen days has different motivations to leave than a patient coming through the emergency department that has only been receiving a workup for five hours. The physician needs to know how to best package his risk conversation and discharge instructions so that the patient fully understands the information that is being offered.

The literature suggests that once the motivations of patients at a high possibility to leave AMA are determined, preventative intervention can then be designed (47). But motivations are difficult to predict and may not be honestly admitted by the patient. They are additionally, as suggested by Onukwugha, often perceived motivations based on the biases of healthcare provider (43). Consequently, preventative intervention focused on counteracting motivations for leaving is not wholly feasible. Instead, it is prudent to focus on providing the patient who wishes to leave AMA with the pertinent information in a format that is easily understandable by the patient and that allows the patient to make a well-informed decision. With that mindset, it is important to learn and understand what information is actually being transferred during the AMA discharge conversation.

### ***Information Transfer in the Emergency Department & EMTALA***

The emergency department is an ideal subgroup to begin to analyze the transfer of information that occurs when patients leave AMA. As has been suggested previously, patients that leave AMA from the emergency department often have true pathology and are at an increased risk of morbidity and mortality as well as recidivism. Additionally, there is an elevated AMA discharge rate from the emergency department compared to the general medicine wards allowing for a significant number of physician-patient conversations to be observed. From a practical perspective, the interactions in the emergency department occur over a very short, finite period of time. The researcher is not required to go back months in a complicated history to observe physician-patient interactions. Most importantly, due to regulations stipulated by the Emergency Medical Treatment and Active Labor Act (EMTALA) healthcare providers in the emergency

department are required to document encounters when a patient leaves AMA (48). Subsequently, patient charts can be reviewed to determine the quality and types of information that are currently being provided to patients.

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) issued by Congress in 1986 required that emergency department physicians obtain “written informed consent to refuse such examination and treatment” (48). In 2003, the Centers for Medicare and Medicaid Services (CMS), the executive agency directed to enforce EMTALA, further regulated that the written documentation of refusal to treat should include proof that the patient had “been informed of the risks and benefits of the examination or treatment, or of both” (49). Additionally, the documentation should include a description of the examination and treatment, or both, that was refused by the patient.

Like the regulations about documentation, the history and objective of EMTALA was to focus on risk management in the emergency department. The act was initially established with the intent of preventing “dumping” of poor and uninsured patients from private hospitals to public hospitals (50-54). In an effort to ensure that all people received emergency healthcare, the act required that hospitals that accepted Medicare patients to abide by the regulations of EMTALA. Roughly, EMTALA recognizes three legal duties that the hospital must perform to any patient that presents to the emergency department (48). First, the patient must be offered a medical screening exam to determine if there is indeed an emergency. If an emergency medical condition does exist, the hospital must stabilize the patient or *transfer* the patient to another facility that has the capability of stabilizing the patient. Finally, if a patient is transferred to a hospital that

has special capabilities necessary for the stabilization of the patient, that hospital must accept the patient.

The act itself defines a “transfer” as any “movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by . . . the hospital” (48). The only patients that cannot be considered for transfer are patients that are declared dead or those that leave the hospital of their own accord without the permission of a hospital affiliate (48). By definition, patients that leave without being seen do not qualify as transfers under the regulation. Continuing to follow the legal perspective, all patients that are “transferred” home, also known as a discharge, must fulfill all the requirements for transfer. This means that the patient must be medically stable; however, if the patient refuses to consent to further treatment, the patient may leave after the hospital after the physician discusses the risks and benefits of leaving as well as attempts to get informed written consent of the patient’s decision.

In the instances, which are the focus of this research, when a patient requests to leave against medical advice, courts rightfully presume that the patient presented at the emergency department to request medical care. The burden of proof falls on the hospital to demonstrate that the hospital completed all of its legal requirements as spelled out by EMTALA (50). The conversation with the patient, and the subsequent documentation, must include that the patient was offered a medical screening examination and that it, or any following treatment or transfer request, was refused without any coercion, primarily economical, and that the patient left voluntarily. Additionally, according to the changes enacted in 2003 by the CMS, the documentation must also include that the patient has been informed of the risks and benefits of the treatment and examination (49). This

amendment, though vague as to what should actually be included, is a very important regulation that attempts to ensure that patients are being provided with the information they need to make a fully informed choice when deciding to leave AMA. From a medical perspective, by following the stipulations laid out by EMTALA, physicians are actually able to better manage the risks posed to their patients (50).

### *Documentation Standards*

With the very broad requirements set out by EMTALA, what do healthcare providers need to include in their AMA conversation with the patients in order to “take all reasonable steps” to provide their patient with all the information to make a fully informed decision (49)? Initially, there was some conception that very little needed to be included in documentation because once a patient made the decision and left AMA, the healthcare provider was automatically released of all liability (55). However, a review of medico-legal literature and case law revealed that simply signing out a person “against medical advice” was not protective (55, 56). In fact, if a patient was not fully informed of all their risks and options, a patient’s decision to leave AMA may be reasonable with the limited information provided and thus holds the physician accountable for subsequent adverse outcomes (56). More importantly, if a patient with full capacity does not make an informed decision due to lack of information, there is an increased risk for that patient’s safety as well as a decrease in the quality of healthcare provided. So the question remains: what needs to be discussed?

Since the enactment of EMTALA, the literature has provided multiple documentation suggestions for physicians to follow. Commonalities suggest that

physicians document the patient's capacity to make decisions along with evidence that the patient understood his diagnosis and recommended course (25, 56-58). It is important to include evidence of any organic mental disorders as a disorder may deem a patient incapable of decision making (58). In documenting if a patient has capacity, it has even been suggested that it is important to directly document if the patient does or does not meet the standards for psychiatric involuntary commitment (56). Additionally, the risks and benefits of treatment and conversely the risks and benefits of refusing treatment should also be recorded (25, 56-58). The physician should also discuss with the patient, and consequently record, foreseeable complications, alternative care options, and discharge instructions with follow-up care and the option of returning to the emergency department (25, 56-58). Patients should also be afforded the explicit opportunity to ask questions (25).

As important as it is to include the actual medical facts of the patient encounter, it is equally important to document the patient's ability to process information. Simply writing that the patient "understood the risks involved with leaving" makes readers not only guess at what actual risks were discussed; but it also, assumes that the healthcare provider explicitly described, in enough detail, the risks at the level of the patient's understanding. The literature suggests some methods to ensure patient understanding of medical decisions. For example, by having the patient repeat orally the risks and benefits of both the treatment and the refusal, the physician can be more confident that the patient truly understands the implications of his decision (59). From a more observational standpoint, the healthcare provider must listen to the patient's logic and reasoning skills and assess if the patient's decision displays an internal consistency and that the patient



understands the implications especially if there is high risk of loss of limb or life involved (57, 58). A complete set of documentation will include the physician's assessment of the patient's decision making process.

As part of the AMA discharge process, healthcare providers are also encouraged to follow certain procedural guidelines. First, in order to facilitate comprehensive follow-up care, it is suggested that the emergency department care providers contact the patient's primary care provider (57). Secondly, hospitals often make it protocol to fill out an AMA form or provide AMA-specific discharge instructions that pre-populate with information encouraging the patient to return and providing other follow-up instructions. EMTALA specifically states that the medical record in the case of an AMA discharge should include a "written informed refusal" (48). As it is directly acknowledged, many separate sources emphasize including a patient's signature on the AMA form (6, 57, 58). One source even suggests that the signature itself may even be thought of as a way to determine if a patient has an organic mental disorder (58). If the signature is "uncharacteristic" of the patient when it is signed on a firm, flat surface, the physician may assume that there is an organic cause limiting the patient's capacity and has cause to merit further capacity assessment (58). However, legal precedents show that the signature or even the AMA form itself does not represent informed consent (57).

Like signatures, it has become a widely accepted that the AMA form itself is not a guarantee of legal liability protection (55, 57, 58). This will be discussed extensively in the next section using case law examples. Beyond legal protections, forms may also not be good for patient care as physicians and other healthcare providers become more reliant on the form to complete an AMA discharge rather than their own clinical judgment (55,

60). As technology and the use of the electronic medical record expands, there is also the concern that physicians and other healthcare providers are become immune to filling out checkboxes and copying and pasting simply to complete the paperwork without being truly cognizant of what they are filling out resulting in a decrease of quality of care (60, 61). The uses of checklists and forms will be further analyzed in the discussion.

Similar to an AMA form, hospitals often require signing a release statement that necessitates that the patient accepts all subsequent risks and liabilities after leaving the hospital. For example, at Yale-New Haven Hospital, the current emergency department “Discharge Against Advice” form requires that the patient and a witness sign that the patient is leaving voluntarily from the hospital and that he releases the physician “and the Yale-New Haven Hospital from any and all liability in connection herewith” (see Appendix D for a copy of the AMA form). However, case law has demonstrated in *Dedely v. Kings Highway Hospital Center* that waivers violate public policy and are therefore not legally binding (62). Despite the emphasis that is often placed on signatures, forms, and waivers by healthcare providers, these items alone are not sufficient in a court of law. More importantly, they do not ensure that a patient has received the information needed to make a safe and sound decision.

Instead, in order to ensure a fully informed decision, a proper AMA discharge transfer of information from provider to patient is essential. Providers should attempt to discuss all aspects of leaving AMA has been previously reviewed in this section. As a quick benchmark summary, Levy and colleagues suggest that there are three primary parts of a proper AMA discharge that need to be included: (1) the patient must be deemed to have capacity; (2) all potential risks must be disclosed by the healthcare

provider; and, (3) the chart should contain proper documentation of the AMA conversation (57). As the next section emphasizes, reviewing each of the primary aspects of a proper discharge is essential for legal protection in a courtroom.

### *Court Standards*

The medico-legal standards suggested by the literature take in to account an ideal encounter where there is time and compliance on the patients' part in making their decision. But, there are often limitations including time and a patient's eagerness to leave that play an active role in discharging a patient AMA. In attempting to create a standard discharge AMA procedure, this next section reviews the relevant case law to showcase what actually occurs when healthcare providers are brought to court.

### *Hopf v. Timm*

In the first case, Mr. Hopf, a 66-year-old man presented to Dr. Timm in the emergency department with complaints of chest pain radiating across his chest and down both of his arms (63). Despite having a history of abnormal electrocardiograms (EKGs), Dr. Timm did not order an EKG in the emergency department and sent Mr. Hopf home with a diagnosis of musculoskeletal pain. Mr. Hopf was found dead the next morning with autopsy revealing a recent myocardial infarction. The plaintiff alleged that the physician was negligent, while the defense contended that Mr. Hopf refused hospital admission. However, there was no indication in the medical record that Hopf refused care. Without any documentation of the patient's choice to leave and much less any documentation of purported risks, patient capacity, or any other medico-legal standards, the defendant was not able in any way to substantiate his claim. Though this is an

extreme example where little to no documentation was included in the chart it is important to note that in this current study there were charts where no or only a few medico-legal standards were noted and thus the situation in this case is indeed feasible. Using to Drane's sliding scale of competency, the more serious the consequences of allowing a patient to leave AMA, the more stringent both the discussion and documentation of the transfer of information from physician to provider must be (64, 65).

*Battenfeld v. Gregory*

Although this second case does not strictly occur in the emergency department, it shows the importance of an informed discharge versus simply using a form. In this case, the plaintiff, who was five months pregnant, was admitted to the hospital with sharp abdominal pains, nausea, and vomiting (66). She eventually miscarried and despite continuing to have a fever as well as tachycardia and an elevated white blood cell count she asked to leave the hospital. The treating physician allowed her to leave after signing an AMA form. Days later she was readmitted and upon exploratory laparotomy she was found to have a ruptured appendix. The patient sued claiming that she would have stayed had she known that she had a serious infection. As has been noted previously, the mere fact that she signed a form was not able to supersede the physician's lack of providing information that would allow the patient to make an informed decision. The physician was determined to be negligent in not disclosing information to the patient and was required to partially pay the patient for personal injury damages.

In this instance, it was found in court that there was a severe lack in the attending physician's transfer of information to the patient. As was seen in this research, providers

often forgo telling patients, during an AMA conversation, about the signs and symptoms of the evaluation as well as the physician's differential diagnosis. Though this information is often recorded ad nauseam in the physician portion of the chart, it cannot be assumed that the patient understands what a fever for multiple days indicates, as in this example. It also exemplifies that emergency physicians need to specifically describe the risks that result when a patient leaves (57). Perhaps most importantly, this case shows how weak a form that simply collects signatures is in providing true informed consent.

*Lyons v. Walker Regional Medical Center, Inc.*

The next case occurred in 1994 when Kenneth Cook, who was a prisoner at the Walker County Jail, was brought to the Walker County Regional Hospital with complaints of lower abdominal pain, nausea, and vomiting blood for two weeks (67). After blood work was drawn, a nasogastric tube was attempted to be placed; however, the patient could not tolerate the placement and refused the tube. He was then, according to witness testimony, belligerent and opined that he wished to go back to jail. A nurse discussed with Cook that if he left, despite not knowing what was wrong with him, that "after signing out AMA . . . [he] could die or something else could happen to [him]" (67). Cook proceeded to leave the emergency department against medical advice after having an AMA form read to him where he verbally agreed to the conditions. After he left, the laboratory test confirmed that Cook had diabetic ketoacidosis and he died in prison three days later.

When brought to court, the defendants attempted to prove that Cook was contributory negligent and his death was due to his decision to leave the hospital

prematurely. However, the court eventually ruled that the blanket statement “you could die” quoted by the nurse would not have been enough for the patient to truly understand his condition. Instead they stated that “[i]n order to prove contributory negligence, the defendant must show that the party charged: (1) had knowledge of the condition; (2) had an appreciation of the danger under the surrounding circumstances; and (3) failed to exercise reasonable care, by placing himself in the way of danger” (67). The hospital and the nurse could be held liable for the damages. Like the first example, the patient needed to be informed of the signs and symptoms of the evaluation. Even though in this situation, the patient left before the blood work came back providing a definitive diagnosis, the medical providers would have created a preliminary differential diagnosis from his history and exam that they could have shared with the patient. From that differential diagnosis, they would have been able to provide the patient, as EMTALA mandates, with the risks of his current medical situation. Likewise, as noted earlier in this research, providers most commonly document the risks of leaving, including often using some iteration of the phrase “you may die if you leave.” This case shows that not only must the provider be specific in discussing risks with patients, but also it is equally important to discuss the patient’s current medical situation with the patient.

#### *Sawyer v. Comerci*

The defense of contributory negligence again comes into play during the case of *Sawyer v. Comerci* when a patient decides to leave the emergency department AMA. The case occurred on April 2, 1997 when Norman Plogger presented to the emergency department with complaints of right lower quadrant abdominal pain (68). At the time, he

also had an elevated white cell count along with blood in his stool and consequently a surgery consult was called to rule out the need for emergent surgery. After the consultant suggested that he follow up with his family physician, Mr. Plogger and his wife were anxious to leave the emergency department due to an appointment the next day out of town. Dr. Comerci, the emergency department physician, pleaded with Mr. Plogger to stay, but Plogger was unwilling and Dr. Comerci noted in the chart that “[p]atient and especially the patient’s wife are difficult to talk with and despite repeated explanation do not seem to understand the possibility of the seriousness of his condition; however, agree to follow up with Dr. Hamilton on Friday” (68). There was no AMA form signed, as the physician was unaware if those forms were available in the emergency department. Mr. Plogger returned three days later with a sore throat diagnosed as oral candidiasis or thrush and was encouraged to see his family physician, as he had not yet done so. On April 7, Mr. Plogger was brought to the hospital via ambulance and expired on April 8 of septic shock.

In the courtroom, similar to the events in *Lyons*, the defense attempted to argue that Plogger could be considered contributory negligent because he left despite a warning by Comerci. However, the court ruled that there was no evidence in the record that Plogger understood the severity of his condition and the risk of death if he were not admitted to the hospital. Dr. Comerci even admitted during testimony that despite her pleading if she would have told Plogger that leaving might be fatal he perhaps would have stayed. The case rested on whether or not the plaintiff was contributory negligent in his own death and, because of the lack of record, it became the job of the court to determine if what the physician meant to convey in her discussion with Plogger

conflicted with what the patient actually understood. By appropriately documenting the interaction, the physician would have recorded all the salient points that were argued in court including what was explained to the patient about the nature of his condition and test results; the risks of leaving; the alternative therapy choices; and the consults from other physicians. If these were documented, there would be no confusion as to what happened and what information was exchanged between the patient and physician. The case was eventually ruled in favor of the physician; however, it would have been quite obvious with documentation that the physician was not negligent in providing information and risks to an AMA patient and that the patient's contributory negligence led to his own demise. This case highlights the importance of documentation in general, with or without the aid of an AMA form. It also shows that it is equally important for emergency physicians to ensure that consulting services also understand the importance of documentation and similarly record that information on the chart.

*Dick v. Spring Hill Hospital, Inc.*

The final case looks at the difficulty in determining what information has been transferred without proper documentation. After being treated and released from a prolonged hospital stay for a fractured leg and concussion secondary to a motor vehicle accident, Mr. Dick came to the emergency department with pain in his fractured leg (69). The emergency physician treated the phlebitis and acknowledged the possibility of a blood clot in the leg and recommended a hospital admission. The patient left AMA without signing a form and suffered a pulmonary embolism and expired the next day. The plaintiff claimed that if Mr. Dick had been informed of the serious nature of the



blood clot that he would have stayed. However, a summary judgment was granted and affirmed on appeal for the defendants since there was no evidence that the patient was not advised of the risks. Because Mr. Dick had full capacity and talked to the emergency physician in private without his other family members, the nonmoving party, Mr. Dick's family, had to prove that Mr. Dick was not informed. In this instance, there was limited documentation and no AMA form signed; however, the physician eventually won, as he could not be found negligent.

The situation could have been avoided with proper documentation. But, unlike the Hopf case where there was inadequate documentation for a very severe situation with a high probability of a poor outcome, the chance of an embolism in this case was very unlikely according to the testimony of the physician. During the appeal, the physician noted that he would have utilized an AMA form had he thought that the situation would be more serious. Since bad outcomes are not always easy to predict and patients that leave AMA are at a higher medical risk level in general, it is important to always keep a level of high suspicion that something may go wrong. Though the physician was not negligent in that he provided most of the information that is reviewed by the medico-legal standards presented in this paper, his claims would be irrefutable if he had documented them appropriately.

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As is seen by the cases presented, the most effective way for physicians and other healthcare providers to protect themselves legally is to have an appropriate conversation with their patients that allows for information to be openly shared and informed decisions to be made. The cases also confirm that simply signing an AMA form does not

necessarily hold up in court despite the insistence by EMTALA that patient signatures be obtained. It also must be pointed out that in many of these circumstances the physician often did not have appropriate documentation, but was still able to avoid fault primarily because he provided the information to the patient that a court of law determined was sufficient for a patient to make an informed decision. Documentation is the most effective way to provide evidence that the transfer of information did actually occur. It is also a way for the physician to actively review the conversation and to see from a written statement what information was provided to the patient and what information was neglected. It allows the provider to go back to the patient, if the patient is still present, and review any neglected information.

It also becomes obvious by reviewing these cases that if each of the medico-legal standards suggested in both the literature and this research were met, there would be little room for any of these cases to stand. A common thread in most of the plaintiffs' cases was that the patient did not know the serious nature of the problem and if he had known it, he would have chosen to stay in the hospital thus putting the hospital and the providers in the position of defending their AMA conversation. In each case, after review of the medical situation, no court utilizing expert witnesses and the medical standards was able to say that the physician or other care provider was actually negligent or provided a sub-standard level of care; however, because the AMA transfer was not completely documented, the court instead needed to rely more heavily upon witness testimony and expert opinions regarding medical decisions. The best way for healthcare providers to effectively prevent liability implications is through the use of good care, informed transfer or information, and proper documentation.

### *Documentation of Emergency Department Patients that Leave AMA*

How can physicians and other healthcare providers ensure that they are providing patients leaving AMA the information that the patient needs to make an informed decision? First, physicians need to be educated as to the types of information that they are required to provide by both the law and by the necessary threshold to allow their patients to make informed decisions. Once they are able to provide patients with the depth of required information, healthcare providers also need to document the conversation and other important features of the visit so that the quality of the transfer of information can be monitored. Like protocols for other medical procedures, discharging a patient AMA is a complex task that would be best serviced by creating universal guidelines.

The first step in creating guidelines and educating physicians in performing medically and legally responsible discharges is to understand the current level of physician discharge and documentation procedures. Knowing what physicians already identify as important to include and recognizing what is not being included will guide the education and quality control process. To date, the literature only describes two instances of auditing AMA discharge procedures. In a study performed in 1991 by Dubow and colleagues, it was found in a group of 52 AMA patients, that emergency physicians explicitly noted the following items on the patients' charts: competence (67%), understanding of their diagnosis (36%), proposed treatment (44%), alternative treatment (2%), clinical consequences of refusal (57%) (34). Additionally, 62% of the time the emergency department note contained a referral to a physician (34). The second study was performed by Seaborn Moyse and Osmun in 2004 that included 35 patients that left

AMA from all units of an Ontario hospital (13). The study primarily looked at patient demographics, but also noted that in the AMA discharge note, physicians documented competency in only 22.9% of the charts (13).

The information that is known about AMA discharge documentation is sparse with small sample sizes and needs to be updated to direct current education about documenting AMA discharges. With the multiplicity of theory from both the medical and legal literature about how to handle and document an AMA discharge, there is no real picture of what is actually occurring in practice. The research performed in this paper takes an in depth look at the current practices of information transfers that occur during the AMA discharge conversation at a large urban academic institution. It provides a threshold determination of the sufficiency of extant documentation practices to guide in the creation of an appropriate discharge against medical advice protocol that will increase the quality and safety of patient care in the United States.

## **Statement of Aims and Hypotheses**

### ***Specific Aims***

This research seeks to determine an updated and accurate rate of emergency department discharges against medical advice. Interventions in the transfer of information during a potential AMA discharge conversation, suggested by the second aim of this research proposal, seek to decrease the number of patients, who are at an increased medical risk, from leaving the emergency department prematurely. By determining an accurate baseline rate utilizing a standard definition, future interventions can be assessed for their success in decreasing the overall rate of AMA discharges.

In investigating the current practices of the information transfer during the discharge against medical advice conversation, it is the aim of this research to understand current practices and the level of healthcare provider compliance with both legal and theoretical standards. Determination of the current perceived knowledge and implementation of the AMA discharge process will guide future hospital and national policy steps in creating universal discharge against medical advice guidelines and protocol in order to increase the quality and safety of patient healthcare.

### ***Hypotheses***

It is first hypothesized that the discharge AMA rate from the emergency department will be low. There is no agreed upon definition as to when a patient becomes classified as AMA versus LWBS and it is suggested that the current published rates are an overestimation the number of patients actually leaving AMA and having the opportunity to directly speak to a healthcare provider about their choice.

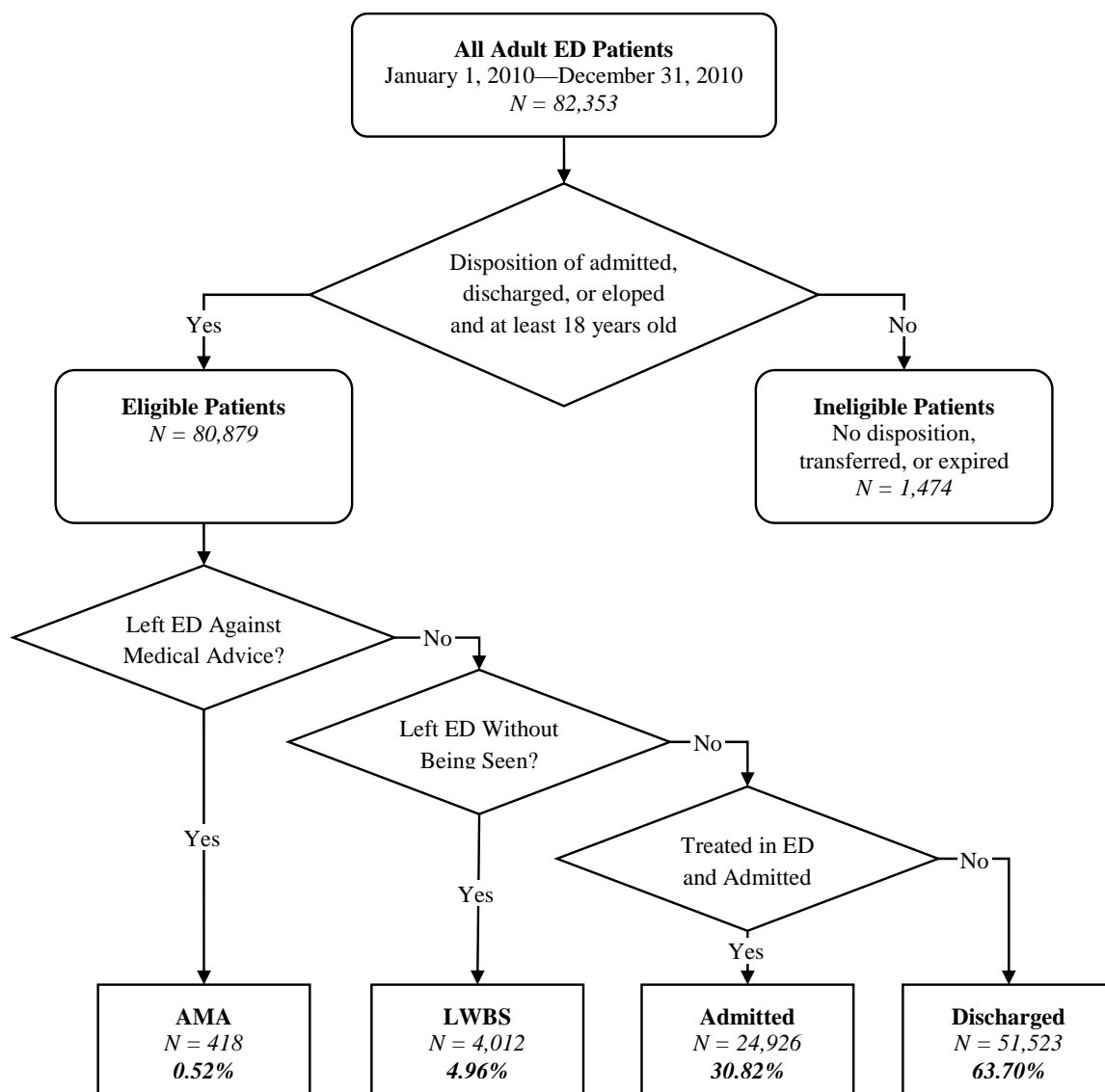
Secondly, it is hypothesized that it is not the current practice of emergency medicine physicians, physician associates, and advanced practice nurse practitioners at Yale-New Haven Hospital to provide and properly transfer the appropriate quantity and quality of information in order to allow patients that wish to leave AMA to make a fully informed decision. Additionally, emergency healthcare providers do not document this encounter according to EMTALA regulations and best practices defined by the literature.

## **Methods**

### ***Study Protocol***

A retrospective chart review was performed on one year of consecutive discharges against medical advice from the Yale-New Haven Emergency Department. The Emergency Department is a Level 1 Trauma Center within an urban, teaching hospital treating approximately 82,000 visits annually. The emergency department is staffed by attending and resident physicians, physician assistants, and advanced practice nurse practitioners that provide diagnostic and therapeutic services. The study was exempted from Institutional Review Board review under federal regulation 45 CFR 46.101(b)(4).

The electronic medical record using Lynx electronic medical record (EMR) computer software was searched from January 1, 2010 to December 31, 2010. Patients were aggregated by their disposition designations of “admitted,” “discharged,” “eloped,” “transferred,” “expired,” and “no disposition assigned.” Eligible patients included all Emergency Department patients over 18 years of age at Yale-New Haven Hospital with the discharge designation of “admitted,” “discharged,” and “eloped.” Patients with a discharge designation of “transferred,” “expired,” and “no disposition assigned” were ineligible to be included in the study as they had no potential opportunity to leave AMA. The study population is summarized in the flowchart seen in Figure 1.



**Figure 1. Study population flowchart. AMA = Against Medical Advice; LWBS = Left Without Being Seen**

All charts of patients who met the inclusion criteria with a discharge of “eloped” were reviewed by this author. Patients were individually classified as either “discharged against medical advice” (AMA) or “left without being seen” (LWBS) according to the definitions provided in Table A.



**Table A. Classification Definitions of "Eloped" Study Group**

<b>Groups</b>	<b>Definitions</b>
Left Without Being Seen (LWBS)	<ol style="list-style-type: none"> <li>1. Seen by triage nurse in waiting room, left before name was called.</li> <li>2. Brought back to exam room, left before being seen by a provider.</li> <li>3. Seen by provider in exam room, left without informing provider or staff of leaving (no opportunity was given for discharge conversation).</li> </ol>
Discharged AMA (AMA)	<p>Seen by a provider and patient informed provider that he was leaving. Provider subsequently was able to discuss discharge.</p>

The charts of patients classified as discharged AMA were further reviewed for demographic and other background information. Basic demographic information for each patient was collected from the Centricity EMR including the patient's age at presentation, gender, race, health insurance for the present visit, diagnosis utilizing the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* codes, primary language, primary care physician, and time of triage and discharge from the emergency department. The written emergency department encounter, which was digitally scanned into the Lynx EMR per department protocol, was then reviewed for the presenting chief complaint, the presence or absence of conservatorship, and any past medical history of substance abuse.

The handwritten charts scanned into the Lynx EMR database were then specifically reviewed for documentation of the discharge AMA process. The location of the discharge AMA documentation in the chart and the training level of the primary documenter were first explicitly noted. Beyond that, the presence or absence of a formal

discharge against medical advice form or AMA discharge instructions along with the presence or absence of signatures of the patient, treating healthcare provider, and witness were recorded. It was also noted in the instance of non-English speaking patient, if a translator provided by the hospital was utilized. Finally, it was recorded if the medical team notified the patient's primary care physician about the decision to leave AMA.

Additional information about the documentation of capacity was collected. First, it was noted if the documenter used the terminology "capacity" versus the often misused "competence" in the record. Secondly, it was noted if the documenter discussed any presence or absence of any condition, organic or otherwise, that would impede capacity. Finally, the patient's orders were scanned for the presence or absence of any administered pharmacologic agents that would potentially alter a patient's capacity to make decisions.

All parts of the medical record including pre-populated discharge instruction and any attached forms were then audited for specific information regarding the discharge AMA conversation. Using documentation guidelines published in the literature and reviewed in the introduction section of this thesis as well as the documentation guidelines required by EMTALA, eight medico-legal standards that comprise ideal documentation practices were identified, which include (1) a capacity assessment; (2) an agreement of the signs and symptoms determined by documentation of the diagnosis; (3) the extent and limitation of the evaluation; (4) documentation of the current treatment plan, risks, and benefits; (5) risks and benefits of foregoing treatment; (6) alternatives to suggested treatment; (7) an explicit statement the patient left AMA as well as explicitly stating what the patient was refusing; and, (8) follow-up care including discharge instructions (25, 56-58).

The charts of the patients classified as having been discharged AMA were audited for the presence or absence of documentation criteria derived from the eight medico-legal standards. The complete abstraction tool can be found in Appendix A. For each criteria question, a rating of “yes” or “no” was assigned. Credit was given if the criteria questions were either answered directly or if it was mentioned that the criteria were discussed with the patient. For example, regarding the question “did the healthcare provider document the diagnosis?,” the chart received credit for documentation if the differential diagnosis was directly listed in the chart or if there was a note that the differential diagnosis was discussed with the patient without the actual differential diagnosis being listed in the chart. The level of patient understanding did not play a role in determining fulfilment of the criteria, except with the second medico-legal standard that requires both the patient’s and the physician’s understanding of the presenting signs and symptoms. Rates of compliance with each of the criteria questions were then determined. In order to determine if a medico-legal standard was met by chart documentation, all criteria questions in that medico-legal standard’s category must have been assigned a “yes.” The charts were selected and reviewed solely by this author. The author met frequently with her research advisor to resolve disputes and a standardized abstraction form was utilized to maintain consistency.

### ***AMA Rate Determination***

In determining the AMA discharge rate, the number of AMA patient visits, as determined after manual chart review using the definition in Table A, was divided by the number of individual visits to the emergency department that were eligible for an AMA

discharge. In determining the denominator, it was important to exclude all transfers and expirations as well as all patients that did not have an assigned disposition, as seen in Figure 1, as these patients did not have the potential to leave AMA.

### ***Data Analysis***

Data was analyzed using both Microsoft Excel and SPSS software. The primary outcome measure was the percentage of medical-legal standards defined by the literature and documented by physicians on the medical chart of patients that leave against medical advice. Additionally, statistical analysis was used to determine demographic trends and the overall discharge against medical advice rate. To interpret diagnoses of patients discharged AMA, ICD-9-CM codes collected from billing information were grouped into clinically meaningful categories using Clinical Classification Software (CCS) protocols (70, 71). The CCS was originally created for inpatient research; however, it has been validated for use with emergency department diagnoses as well (72). In determining the visit rates for the top ten diagnosis groups, the total number of patients utilized was 346 as 72 patients did not have an ICD-9-CM code attached to their visit in the EMR.

### ***Allocation of Responsibility***

The author accepts responsibility for the development of the research topic and protocol, creation of the screening tool, implementation of the screening tool, and manuscript composition. This author in conjunction with Lori Post, PhD performed the data analysis.

## Results

During the enrollment period, 82,353 patients presented to the adult emergency department and 80,879 were eligible to be included in the study as presented in Figure 1. After individual chart review, 418 patients were determined to have been discharged against medical advice resulting in a discharge against medical advice rate of 0.52%. Of those patients, 246 men and 172 women, ages 18 to 94 years (mean  $45.1 \pm \text{SD } 15.4$ ), were included in the study. The largest percentages of the discharge AMA patients were identified as White (47.1%) followed by Black (33.3%) and Spanish or Hispanic (15.1%). The rest of the 4.6% of the patients were classified as Asian, American Indian, or other race. The majority of the patients (96.4%) were recorded in the chart as speaking English as their primary language. An additional 2.9% of patients declared Spanish as their primary language. The majority of the patients (56.7%) were documented as having a primary care provider (PCP); however, even after chart review, it was unclear if 38.3% of the patients had a PCP as there was no documentation. After review of medical histories, 16.3% of patients were documented as having a past medical history significant for substance abuse.

The actual stay in the emergency department from triage to discharge against medical advice was on average five hours and 24 minutes ( $\pm \text{SD } 3 \text{ hours and } 38 \text{ minutes}$ ). The most commonly utilized primary insurance for the visit was private coverage (34.5%) followed by Medicaid (30.2%), Medicare (20.9%), and self-pay (14.4%). The top diagnoses for AMA patients are found in Table B and the additional diagnoses can be found in Appendix B. A total of 23 patients (5.5%) presented with a chief complaint related to substance use (either alcohol or other drugs).

**Table B. Top Ten AMA Diagnosis Groups**

<b>CCS Diagnosis Group</b>	<b>Patients</b>	<b>Rate</b>
1. Nonspecific chest pain	73	21.1%
2. Abdominal pain	31	9.0%
3. Headache including migraine	25	7.2%
4. Epilepsy or convulsions	17	4.9%
5. Syncope	16	4.6%
6. Other lower respiratory disease	15	4.3%
7. Asthma	11	3.2%
8. Spondylosis; intervertebral disc disorders; other back problems	9	2.6%
8. Alcohol-related disorders	9	2.6%
10. Other injuries and conditions due to external causes	8	2.3%
10. Malaise and fatigue	8	2.3%
10. Conditions associated with dizziness or giddiness	8	2.3%

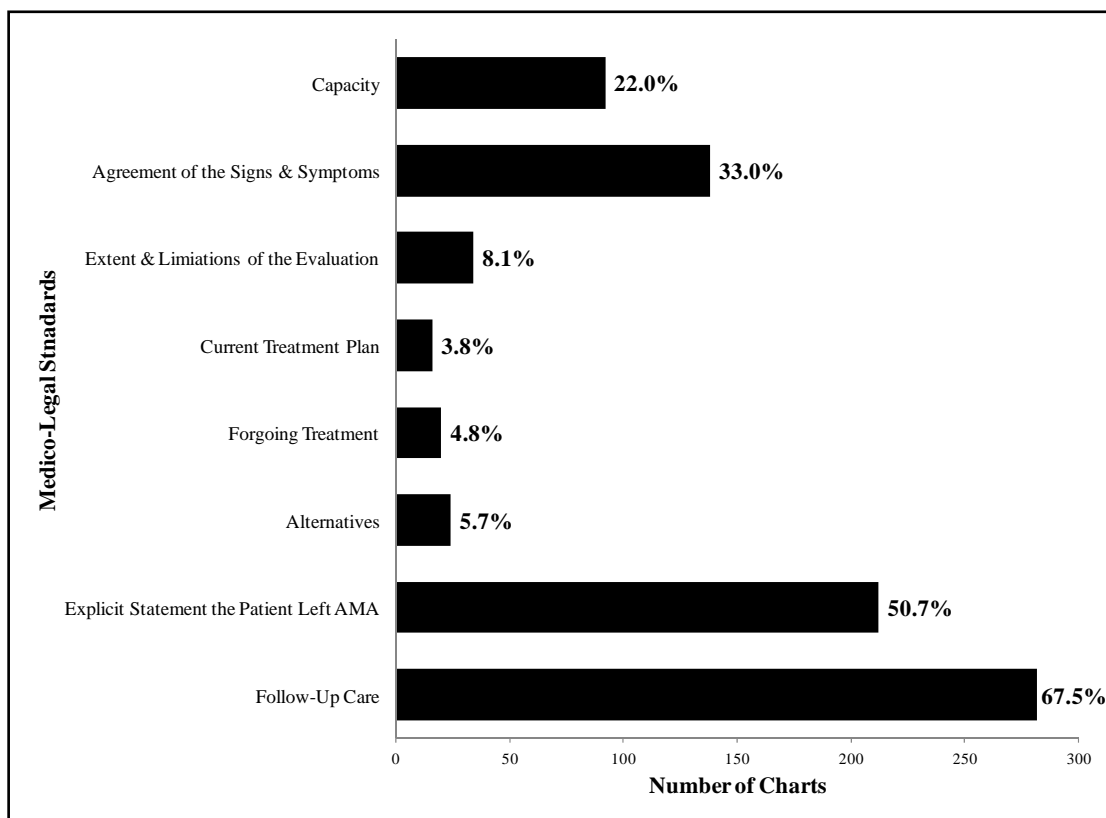
Healthcare providers utilized a hospital-provided translator 33.3% of the time for non-English speaking patients. Of the patients with a documented PCP, their physician was contacted 19.0% of the time regarding follow-up care or to inform the physician on the patient's decision to leave AMA.

The actual discharge against medical advice encounter was primarily documented by resident level physicians (54.5%) followed by physician assistants (21.3%), attending level physicians (17.7%), advanced practice registered nurse (17.7%), registered nurse

(1.9%), and medical or PA students (0.2%). In six instances (1.4%), there was no documentation of the AMA discharge besides the discharge disposition.

On chart review, the healthcare provider documented the medico-legal standards the following percentage of the time that are denoted in parentheses: (1) capacity (22.0%); (2) agreement of the signs and symptoms determined by documentation of the diagnosis (33.0%); (3) the extent (8.4%), limitations (34.7%), or both (8.1%) of the evaluation; (4) documentation of the current treatment plan (44.5%), risks (6.7%), and benefits (5.0%), or all of three (3.8%); (5) risks (66.7%), benefits (4.8%), or both (4.8%) of foregoing treatment; (6) alternatives to suggested treatment (5.7%); (7) an explicit statement the patient left AMA (97.8%) as well as explicitly stating what the patient was refusing (51.2%), or both (50.7%); and, (8) follow-up care (73.2%) including discharge instructions (68.9%), or both (67.5%). Additionally, 11.2% of patients were asked if they had any questions. A graphical summary of the results of the eight medico-legal standards is seen in Figure 2 and a full list of results can be found in Appendix C.

Notably, no single chart fulfilled all eight of the medico-legal standards suggested by the literature. Specifically looking at the minimum standards set by EMTALA, which means that the provider documented both the risks and benefits of the treatment as well as obtained a patient signature, only 17 (4.1%) charts fulfilled those requirements and only four other charts documented the risks and benefits of treatment without obtaining a signature. Also notable, any time a provider documented the benefits of either the current treatment plan or forgoing treatment, the provider also documented the risks of those scenarios.



**Figure 2. The proportion of charts that contained documentation of each of the defined medico-legal standards in the medical record of patients discharged AMA.**

Regarding capacity, of the 22.0% of healthcare providers that documented capacity, only 8.6% of the providers explicitly used the words “capacity” or “competence.” Of those providers, 77.8% used “capacity” and 22.2% used “competence.” The other documenters used phrases such as “clinically sober,” “no way compromised in making healthcare decisions,” “alert and oriented times three,” “full decisional making capacity,” and “not distracted” to assess the patient’s decisional making capabilities. Additionally, in assessing a patient’s capacity to make decisions, only 13.0% of the documenters commented that the patient did not have a specific deficit that would impede capacity (5.3%) or that there was a specific deficit (7.7%) such as



intoxication (including alcohol, PCP, heroin, cocaine), dementia, or other conditions that would cause an altered mental status. Psychiatry was utilized with five patients in order to determine capacity and two patients were documented to have a decision making conservator and in both of those occasions, the conservator was contacted. Finally, regarding capacity, one chart noted that the documenter did not “think patient has capacity to leave AMA.” However, patient left AMA without any further assessment of capacity.

Healthcare providers documented the AMA discussion in multiple places on the chart including on the formal emergency department AMA form, on the discharge instructions, and on multiple locations in the actual chart itself. The largest number of providers (34.9%) utilized both the AMA form and the chart for documentation, followed closely by employing the discharge instructions and the chart (31.1%). All three documentation locations were used by 18.7% of providers. There was no documentation whatsoever for two charts (0.5%). Of the incidents when an AMA form was used, there was a patient signature 94.7% of the time and a witness signature 82.0% of the time; however, the witness was the documenting healthcare provider 55.5% of the time as opposed to an outside individual. Likewise, when the AMA section on the discharge instructions was used, there was a patient signature 82.6% of the time and a witness signature 82.0%. As with the AMA form witness signature, the witness was the chief healthcare provider 62.4% of the time.

## Discussion

As relatively little is known about the current practice of transfer of information when a patient is discharged against medical advice, the purpose of this research was to both reevaluate the discharge AMA rate at an urban emergency department as well as to determine through chart documentation the current status of information transfers. A relatively low discharge AMA rate was calculated as well as a low percentage of healthcare provider documentation of defined medico-legal standards.

Though it was not the goal of this study to characterize the demographics of patients that leave AMA, the research presented here complies with some of the general trends published in the literature. Congruent with the literature, the majority of the patients leaving AMA were young, with an average age of 45 years, male, and only about half had a primary care physician (21). Additionally, seven of the top ten diagnoses of AMA patients as presented in this research are the same as those presented in previously published data (21). As there has only been one study conducted in the emergency department describing discharge AMA diagnoses to date, the differences in diagnoses are likely due to the variation in hospital coding practices at the study institutions as assigning ICD-9-CM codes is to some degree subjective. For example, in the Ding study, nausea and vomiting was the top diagnosis without any diagnosis of abdominal pain recorded; however, abdominal pain was this study's second top diagnosis and nausea and vomiting was only coded for one patient (21). This suggests that abdominal pain and nausea and vomiting were seemingly congruent, but each institution favored a certain code.

Though some research suggests that the likelihood of leaving AMA is independent of disease (11), patients with certain diagnoses may be at a higher risk of leaving for two reasons. First, as in the instance of chest pain, it is often clear to patients after certain studies such as an electrocardiogram and laboratory tests that they are not having a heart attack. Once they receive that affirmation, they do not wish to stay for long periods of observation or other tests and choose instead to leave. Second, in the cases of asthma and convulsions, patients in these scenarios generally have an underlying condition and have had multiple experiences with suffering asthma attacks and seizures. They, from their perspective and experience, know when they are out of trouble, per say, and once they feel better they are ready to leave. These reasons for leaving are postulation and further research is needed to affirm these conclusions.

The study, however, also showed some level of deviance from previous studies. The largest number of AMA patients carried private insurance as opposed to Medicaid, as has been the published trend for both inpatients and emergency department patients (7, 9, 11, 21). Also, unlike published trends, the largest percentage of patients was White as opposed to Black or Hispanic (9, 21, 44). It is first important to note that because the study conducted was not a cohort study, it is limited in claiming any statistical significance about the demographic information. If a cohort was performed, these trends may have appeared. The two demographic differences may also be explained by different hospital population. However, this is unlikely as Yale-New Haven Hospital is a large, urban academic center similar to the institutions in the studies published. It is also feasible that, as Franks suggested, independent of race, patients that leave AMA are from a lower socioeconomic status created by low income and public hospitalization (7).

Multiple inpatient studies suggest that patients that leave AMA are more likely to be admitted for alcohol use or abuse or have a history of alcohol abuse (7, 10). Though alcohol-related disorders were in the top ten diagnoses, only 5.5% of patients presented with an alcohol or drug issue and only 16.3% of patients after chart review had a past medical history significant for alcohol or drug abuse. This seemingly small value suggests that despite the importance of alcohol or drug history or admission in an inpatient setting, there may not be too much of a role for drugs and alcohol as a risk factor for emergency department AMA discharges. In the inpatient setting, it is a common belief that patients leave in order to seek drugs or alcohol; however, with the relatively short time spent in the emergency department, this is likely not as strong a risk factor (10). Additional studies along with a cohort comparison for this study's group are needed to clarify the effect of substances on patients' decisions to leave prematurely.

### ***Defining the AMA Rate***

The discharge AMA rate (0.52%) calculated by this research is lower than previous rates determined by other studies as well as by national statistical data (21, 25-27). The low AMA rate may simply be due to good practices at Yale-New Haven Hospital. As was noted earlier, the demographic composition compared to other published emergency department AMA patients was slightly different, and perhaps this indicates that the patients at high-risk for leaving AMA are identified by their demographics and providers are offering appropriate interventions. Alternatively, the decreased rate may be due to changes that have occurred in documentation processes as the only emergency department study of rate was determined five years ago (21).

However, as was discussed in the introduction, the discrepancy in rates is most likely due to an inconsistency in the reporting and coding of AMA patients as well as a discrepancy in the appropriate calculation of the AMA rate.

The definition of leaving against medical advice as presented in this research utilizes the idea that in order for a patient to leave against the medical advice of a healthcare provider he must be given the opportunity to have such medical advice supplied. This excluded all patients that were seen by a triage nurse, but left before their name was called; all patients that were brought back to an exam room and left before being seen by a provider; and all patients that were brought back and seen by a provider, but simply left without the knowledge of any staff member. Thus, the rates calculated that include any of these patients, such as the AHRQ rates, are automatically inflated (26). Likewise, the studies, such as the CDC rates and the Ding study that exclude most of the LWBS patients are much closer to the actual rate (21, 27). As can be seen by the appreciably lower rate of 0.52% from this research, there has historically been an overrepresentation in the definition of patients leaving AMA.

In determining the AMA discharge rate, the number of AMA patient visits was divided by the number of individual visits to the emergency department that were eligible for an AMA discharge. In determining the denominator, it was important to exclude all transfers and expirations as well as all patients that did not have an assigned disposition as these patients did not have the potential to leave AMA. The Ding study uses the exclusions in determining rate; however, the study uses individual patients as opposed to individual visits both in determining the number of AMA patients as well as the total number of AMA patients (21). Observationally, some patients in this research's chart

review left AMA from the emergency department on multiple occasions and it is well known that many patients visited the emergency department on multiple occasions throughout the year. However, if the goal of creating a rate is to determine how likely it is for each individual person who is seen by a provider to leave AMA, it is important to analyze individual visits versus individual patients. As is the nature of the emergency department, even if a person leaves AMA often, on each occasion it is likely that he will be assigned to a different provider creating an entirely different scenario and different transfer of information setting. It is also important to note that in national statistic reporting, statistics collect the number of individual visits as it would be extremely difficult for national institutions to separate out individual patients especially with privacy concerns (15, 26). In determining a universal definition, it is important to keep the limitations of national organizations in mind. If the Ding study used this definition of rate, the AMA rate would be closer to 1.6% as opposed to the published 2.7%. Also, the Ding study excluded patients that were seen by a triage nurse and left before being seen by a provider, but did include patients that left after being called back to the treatment area even though they may have been better identified as having LWBS.

As the variations in three studies indicate, in order to get an accurate rate of patients leaving AMA, a standardized definition of leaving AMA as well as a standardized rate calculation must be accepted. The definition utilized in this research assumes that all patients that eventually leave AMA have been seen by a health provider and have discussed with that provider their wish to leave. Even if the provider is only able to discuss the AMA in a sentence before the patient decides to leave, that provider did have the opportunity to have an encounter. This definition excludes patients that

simply leave during the middle of their treatment, as there would be no way to provide a transfer of information. By defining an AMA discharge as having the opportunity to transfer information from provider to patient and then by manually auditing the charts to determine conformation to that definition, this research records a rate that more closely exemplifies how many patients are leaving the emergency department.

If a national committee accepted the definition of AMA presented in this research to be the common definition, data collection practices in the emergency department, as well as in all assigning of discharges, would need to be altered. Most data collection in national surveys is taken from the disposition assigned in the medical record. However, from performing a thorough manual audit, it was obvious that the medical record disposition did not always match the actual activities that occurred. It is also notable that at this institution there was no disposition choice in the medical record for patients that LWBS. Along with ensuring that all institution have a choice for an “AMA” and “LWBS” discharge, it could even be argued that in both the emergency department and in inpatient units an additional disposition of simply “eloped” should be adopted to record the disposition of patients that leave unbeknownst to any medical personnel. Each group, LWBS, AMA, and eloped, carries different risks that would require different academic studies and systemic interventions. In order to truly compare institutions and understand the scope of how many patients are leaving AMA, a standard definition and rate calculation must first be agreed upon and it could likely be the one defined in this research.

### *Inadequate Documentation*

As was introduced earlier, patients that leave AMA are at an increased medical risk and the situation places healthcare providers and hospitals at a higher legal risk. Despite not having a comprehensive definition of an AMA patient, it is clear that patients need to be given all pertinent information about their choice in order to make an informed decision. As the medical record is the written documentation of all encounters, the record must contain evidence of every interaction and conversation, including the transfer of information regarding an AMA discharge. However, as was hypothesized, this research data supports that it is not the current practice of emergency medicine physicians, physician associates, and advanced practice nurse practitioners at Yale-New Haven Hospital to provide and properly transfer the appropriate quantity and quality of information in order to allow patients that wish to leave AMA to make a fully informed decision. Additionally, emergency healthcare providers do not document this encounter according to EMTALA regulations and best practices defined by the literature.

### *Medico-Legal Standards*

Though healthcare providers were generally good at explicitly stating when patients were leaving AMA (as was identified 98.0% of the time), suggesting that the lack of documentation is not due to a lack of definition, most other documentation standards were met less than half the time. Notably, not a single chart reviewed had contained all of the suggested medico-legal standards and only 4.1% of the charts contained all of the minimum requirements set by EMTALA. Of the criteria questions,



documentation of the risks of leaving before treatment was completed was the most frequently recorded standard.

The original version of EMTALA from 1986 only explicitly stated that providers needed to document “the risks and benefits to the individual of such examination and treatment” (48). This research suggests that providers more commonly document the risks of leaving the hospital (66.7%) and only rarely document the risks and benefits of the actual treatment option (6.7% and 5.0% respectively). It is unclear as to why providers most commonly document the risks of leaving and not the risks of the treatment and it may be due to misinformation that has passed down from generations of providers. The amended version of EMTALA additionally stipulated that along with risks, the documenter should provide a description of the treatment and examination. Only 4.1% of the charts obtained the minimal EMTALA requirements. Healthcare providers were better at recording a treatment description (44.5%) and recording the limitations of the examination (34.7%). However, it is clear that providers are not recording the minimum amount of required information as suggested by the law.

Documentation of the other medico-legal standards as seen in the results section of this paper was equally poor. In general, it seemed as though documenters neglected to include specific details about what care was provided as well as what the patient objected to during the treatment process. The lack of documentation likely is occurring due to a lack of knowledge of what to record and consequently a lack of consensus as to what to teach. As residents are the most likely providers in this teaching hospital to document AMA discharges, they must be taught how to appropriately discuss an AMA discharge

with a patient and subsequently document the encounter. However, with the current lack of consensus, it is difficult to know what to teach.

Though there are no national policy requirements that insist that providers set up follow-up care, multiple scholars and some of the case law as seen below, emphasize the importance of follow-up care (25, 50). With the caveat that offering follow-up care, including prescriptions and appointments, does not sway a patient's decision to leave AMA, providers, as Berger suggests, are ethically obligated to provide this care (3). This research shows that in the Yale-New Haven Emergency Department, patients receive information about follow-up care almost 75% of the time and discharge instructions, with information about returning to the emergency department, are received 68.9% of the time. The relatively high compliance rate of providing follow-up care is likely due to a pre-populated AMA discharge instructions form that emergency department providers can select in the computer system. It is impossible to determine if providers actually review this information with their patients; however, the information especially regarding follow-up care is written down. Providers, through the system, have the opportunity to add additional information about follow-up care, but not all choose to do so. More telling perhaps about the follow-up care conversation, only 11.2% of providers asked if patients had any follow-up questions.

Providers are often under the impression that providing the patient with follow-up resources will introduce them to greater legal liability; however, there is no evidence for that theory (3). Physicians should instead attempt to balance the risk of the disease, the efficacy of the treatment, and the risk of the treatment in determining whether to send the patient home with specific treatment protocols (3). It is the physician's duty to avoid

harming the patient by providing them with a high-risk medication such as warfarin; however, if a patient can benefit from a proton pump inhibitor, there is little harm in providing that medication. Beyond simple follow-up instructions in the emergency department, it has even been suggested that mandating follow-up via a phone call or a letter within a week of a patient signing out AMA would increase patient safety and provide information, much of which is covered during the emotionally charged discharge AMA process, about follow-up (73).

The results, taken generally, suggest that current healthcare providers are uninformed about what needs to be documented. Most telling, perhaps, is that no singular chart documented all of the medico-legal and EMTALA standards. There is a clear disconnect from what medical and legal scholars suggest needs to be documented and what is actually being recorded.

### *Capacity*

The research additionally took an in depth look at the documentation of capacity finding that capacity is mentioned only 22.0% of the time. In any sort of refusal of care situation, the patient has the ultimate decision on what to do as long as the patient has the capacity to make that decision (58). The same rules of informed consent that are required to allow a treatment, admission, or any other aspect of care are also applicable to refusing care. There is a delicate balance between the autonomy of the patient to make the decision versus the authority of the physician to provide the best care for the patient (3, 58, 74, 75). Patients can only make an informed decision if they are able to understand the caveats of their situation including their disease, treatment, risks, and benefits (58).

They must be able to process this information and understand the ramifications of their decision; otherwise, patients cannot, by definition, make an informed decision. Besides the importance of informed consent for the safety and autonomy of the patient, legally it is important to show that healthcare providers have truly informed their patients.

Protecting the autonomy of the patient, most courts have taken to accept a reasonable person standard, which entails that physicians provide enough information that a reasonable person would want or need to know in order to make a medical decision (76, 77). Conversely, a less stringent and older standard, the professional disclosure standard requires that physicians provide the same information that other physicians would, or should, provide (6, 58).

In the majority of situations, patients' capacity is not an issue in making decisions as capacity is often quite apparent (74, 78). However, when a patient makes a decision to leave against medical advice, it is a common myth that there may be a lack of capacity to make decisions (74). Due to a growing debate over a patient's right to refuse care, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, a predecessor to the current Presidential Bioethics Commission, was asked in 1982 to assess the controversy over patient's autonomy versus physician authority (79, 80). The Commission suggested that when attempting to assess a patient's capacity, that the patient must possess the following three elements: a set of values and goals of care; ability to understand and communicate information; and ability to reason and deliberate about the choice of the patient (79). The Commission also attempted to define the gray area where a person meets some, but not all of the criteria required to make a decision. They suggested utilizing the balance between "well-being

and self-determination” in that if the decision has minor medical implications and potential outcomes that there is more leniency in determining that a patient is competent (79). If the potential outcomes of refusing care are more severe, then there is a lower threshold of deeming a patient incompetent. There is, as Drane terms it, a sliding standard of capacity (64). Additionally, the Commission made it clear that healthcare providers do not have the right to make decisions based on what is objectively correct in the course of medical treatment.

With that general description of capacity and the ability to make an informed decision, how is capacity actually assessed especially in the busy setting of the emergency department? Using the standards established by the Commission, Appelbaum and Grisso in 1998 established a series of criteria, patient tasks, and clinical assessment questions to provide a determination of capacity (59, 81). For example, they suggest that in assessing a patient’s goals, the patient would have to be able to clearly communicate a choice. The provider may ask a question such as “can you tell me what the decision is” or “what is making it hard for you to decide” and the provider uses both the patient’s actual answers as well as the pattern of answers, such as if the patient is frequently changing his preferences, to determine if the patient really does have a solid set of goals (59). Appelbaum and Grisso’s questionnaire, as seen in Table C, has been widely accepted as a way to practically assess capacity to make an informed refusal (58, 74, 78). Comparing their criteria with the medico-legal standards assessed by this research, addressing each of the criteria will allow a practitioner to both assess capacity to make decisions as well as provide the appropriate level of discharge AMA information transfer.

**Table C. Legally Relevant Criteria for Decision making Capacity and Approaches to Assessment of the Patient (59)**

<b>Criterion</b>	<b>Patient Task</b>	<b>Physician's Assessment Approach</b>	<b>Questions for Clinical Assessment*</b>	<b>Comments</b>
Communicate a choice	Clearly indicate preferred treatment option	Ask patient to indicate a treatment choice	Have you decided whether to follow your doctor's [or my] recommendation for treatment? Can you tell me what that decision is? [If no decision] What is making it hard for you to decide?	Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity
Understand the relevant information	Grasp the fundamental meaning of information communicated by physician?	Encourage patient to paraphrase disclosed information regarding medical condition and treatment	Please tell me in your own words what your doctor [or I] told you about The problem with your health now The commended treatment The possible benefits and risks (or discomforts) of the treatment Any alternative treatments and their risks and benefits The risks and benefits of treatment	Information to be understood includes nature of patient's condition, nature and purpose of proposed treatment, possible benefits and risks of that treatment, and alternative approaches (including no treatment) and their benefits and risks
Appreciate the situation and its consequences	Acknowledge medical condition and likely consequences of treatment options	Ask patient to describe views of medical condition, proposed treatment, and likely outcomes	What do you believe is wrong with your health now? Do you believe that you need some kind of treatment? What is treatment likely to do for you? What makes you believe it will have that effect? What do you believe will happen if you are not treated? Why do you think your doctor had [or I have] recommended this treatment?	Courts have recognized that patients who do not acknowledge their illnesses (often referred to as "lack of insight") cannot make valid decision about treatment Delusions or pathologic levels of distortion or denial are the most common causes of impairment
Reason about treatment options	Engage in a ration process of manipulating the relevant information	Ask patient to compare treatment options and consequences and to offer reasons for selection of option	How did you decide to accept or reject the recommended treatment? What makes [chosen option] better than [alternative option]?	This criterion focuses on the process by which a decision is reached, not the outcome of the patient's choice since patients have the right to make "unreasonable" choices

\*Questions are adapted from Grisso and Appelbaum (81). Patients' responses to these questions need not be verbal.

Additionally, by meeting the criteria, the practitioner will address with the patient the information required by a “reasonable medical practitioner.”

It is almost universally agreed upon, as has been mentioned earlier, that when documenting a patient leaving against medical advice, the capacity of the patient should be documented (25, 56-58). This research shows that physicians directly cite a patient’s “capacity” or “competence,” which are used interchangeably by documenting physicians, only 22.0% of the time. The potential reasons for the relative lack of documentation are twofold. First, like with all the other documentation criteria, providers may not realize that they should be documenting capacity, especially since it is often quite apparent that the patient has full capacity to make decisions. Secondly, providers may not know how to document capacity. There is a common myth that only psychiatrists or other mental health experts can assess a patient’s ability to make decisions (74). However, despite the ease of access in this study to psychiatrists, only three providers chose to have the on-call psychiatry team assess the capacity level of the patient. Additionally, in the emergency department there is such limited time that emergency providers perceive that they do not have the time to formally assess their patients. However, as Appelbaum and Grisso’s criteria suggest, if a health care provider is able to have a complete discharge AMA discussion with the patient utilizing this research’s eight-point test, the provider will be able to have a good quality bedside assessment of capacity.

Using Appelbaum and Grisso’s criteria, this research may underestimate the number of providers that are documenting capacity. Additionally, providers, especially at the attending level of training, may be assessing capacity without documenting their thought process. However, it is clear that as documentation is the direct record of what

happens in the course of an emergency department stay, providers are insufficiently documenting capacity.

Finally, there are two more important caveats to assessing a patient's capacity. First, the healthcare provider must ensure that the patient understands the physician and is able to communicate his preferences. This requires that providers use terminology and language that the patient can understand. This research showed that only fifteen patients did not speak English as their primary language. However, the data, though recorded directly from the database, likely has some underrepresentation of the Spanish-speaking population and overrepresentation of the English-speaking population. The "primary language" is recorded by the business associate (BA) in the emergency department during admission. It is likely that if the person is speaking English to the BA, then "English" is recorded as the patient's primary language despite the patient's actual primary language or ability level. Despite having a live translator stationed in the emergency department during the day, a translator was utilized with only 33.3% of non-English speaking patients suggesting that this service is either under-utilized or under-recorded. With a language barrier there is also a cultural barrier that a translator can help transcend in order for the patient and provider to have the ideal interaction and transfer of information.

Secondly, it is important for the provider to know and for the documenter to record if there are any mental or physical alterations, either temporary or permanent, which would alter the capacity level of the patient. In this study, of the 418 patients only 54 charts included documentation that there was or was not a condition that would impede capacity. Of those charts, 32 documented a specific deficit, either drug induced or due to an organic condition. Considering that 60 patients received some agent in the



emergency department including alprazolam, diazepam, haldol, hydromorphone, lorazepam, morphine, naloxone, and oxycodone that could, in some dosage be distracting to the decision making process, there were likely instances when a patient had at least temporarily lost decision making capacity that were not documented. Regarding organic conditions such as dementia, Alzheimer's, strokes, or schizophrenia, it is important to both remember and to provide education that there is a range of severity associated with most disorders (59). Simply carrying a diagnosis does not make a patient incapable to make a decision. It is important in going forward with any changes to the discharge AMA procedure to make sure that providers take into account both language and temporary or permanent deficits, whether drug-induced or organic, when assessing patients for capacity.

### *Signatures and Forms*

Beyond the medico-legal standards that were assessed in this research, EMTALA, both the original version and the amended version, contain language that "the hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment" (48). On the computer generated discharge AMA form and on the computer generated discharge instructions that contain a discharge AMA section, there are signature blocks that request the patient's, as well as a witness's signature. Whichever form was utilized, a patient and witness signature was obtained the majority of the time. The high compliance rate here suggests that this specific part of EMTALA has become widely understood and known to providers. Unlike the other standards written in to EMTALA, the necessity for a signature and a

witness has been incorporated into hospital forms, which perhaps has also increased providers' knowledge of obtaining signatures. Despite being well understood, as was discussed in the introduction, forms and signatures are not as important or binding as the actual transfer of information.

### *Study Limitations*

In conducting this study, there were limitations and biases that were unable to be completely eliminated from the study. In collecting the data, a single researcher enrolled patients according to the definitions provided in the study and audited all of the charts in order to eliminate the greatest possible bias in collecting and coding data. The researcher attempted to compile the most complete representation of the patient being reviewed. For example, if the patient did not have a PCP listed in the electronic medical record, but the name of their PCP was written on the triage intake form, the physician documentation in the chart, or the discharge instructions, the patient was noted to have a PCP. In reviewing the medico-legal standards, the researcher utilized the research tool in Appendix A along with a standardized abstraction form. At the conclusion of the data collection, the first ten patients were reviewed again in order to check for consistency of data collection. As in all studies that utilize manual chart review, there likely may have been some human error in transferring data from the chart audit to the study's database.

The study attempted to review the current transfer of information from healthcare provider to patient; however, the study was limited to auditing what was included in the chart. It is quite likely that physicians, especially at the attending level, reviewed much more with their patients than that which was recorded in the actual chart. However, as

has been reviewed especially in discussing case law, it is equally important to know what has been written down versus orally discussed for litigation purposes.

The study, despite biases in researcher data collection, depended on the integrity of the medical record. Manual data collection by the researcher eliminated some biases that were seemingly inherent to general patient data collection in the emergency department. For example, if the PCP was not entered into the medical record, the researcher could find the name of the PCP elsewhere and add it to the database. Additionally, multiple business associates (BA) in the emergency department added patient demographic data into the two electronic medical records utilized in this study. Beyond simple keystroke and data entry errors, some demographic information such as language, as mentioned previously, and name of PCPs was not consistently completed on the triage intake form. Additionally, the BA would often record the primary language of the patient as the language the patient was currently speaking, despite the patient's level of competency in that language. Similarly, patients and BAs are often unclear about who constitutes as the patient's primary care physician. In the medical record, specialists are often listed as primary care providers consequently over representing the number of patients with PCPs. Patients may have also chosen to not report the name of their PCP thus under representing the number of patients with PCPs.

In reviewing patients with the disposition "eloped," a few patients were found to have been actually discharged home with completed discharge instructions, while others were found to have been actually admitted to the hospital. It can be inferred that likewise patients with alternative dispositions besides "eloped" may have actually left the emergency department against medical advice.

Finally, it is important to note that, as obtaining the demographic makeup of the AMA population was not the goal of this study and has already been well-reviewed, the demographics obtained in this study were not compared to a cohort of other emergency department patients and no significance was able to be placed on the observational data. Previous studies have compared AMA patient demographic information to cohorts of LWBS, admitted, and discharged patients in order to determine statistical significance of certain factors (21). General trends obtained in this study are similar to the published data.

### ***Conclusions and Future Directions***

It is clear from both this study and those previously published that when patients leave against medical advice, patients and healthcare providers are at an increased medical and legal risk, respectively, and healthcare providers are unclear as to what constitutes and how to provide appropriate healthcare information in order to allow patients to make informed decisions. Since the 1980s, multiple medical, legal, and ethical scholars have discussed what should be included in an discharge AMA transfer of information; however, as this study indicates, current knowledge and actual documentation practices of discharging a patient AMA have not changed since Dubow published his study in 1991 (34). In fact, in comparing his results, this study's providers were only better at documenting the diagnosis and alternative treatments and were far less likely to document capacity. Documentation of the proposed treatment and clinical consequences of refusal were approximately the same in both studies. Comparatively, the data between Dubow and this study suggest that there have not been any real

progression of information transfer despite a number of published articles and opinions on what should be included. What can be done to ensure that changes are implemented to improve the quality of the information transfer in order to improve patient safety?

First, as more of an academic purpose to monitor the problem and subsequent interventions, a common definition accepted by a national level medical organization should be agreed upon and implemented. As mentioned previously, there is a need to clarify the difference between patients that LWBS, leave AMA, and simply elope without notifying medical personnel. Considering that two major national organizations, the AHRQ and the CDC, collect the same statistic with different definitions, it indicates a need for standardization. There will be no way to determine if interventions improve the situation without first defining the study group.

Secondly, standardized creative interventions should be actively implemented with the goal of decreasing the rate of patients leaving AMA and of increasing the number of medico-legal standards discussed. There are many different interventions that could be employed from simply educating providers on the eight medico-legal standards suggested here to creating a universal discharge AMA procedure created by a national organization. In determining the appropriate type of standardized intervention, research will have to weigh the effectiveness of an intervention measured by outcomes versus the ease of ability to actually implement the intervention in independent, autonomous hospitals. It is important to note that any trial intervention should be conducted with groups, such as the one presented in this research, which have been previously studied and audited in order to monitor if changes actually occur in the rate of standard documentation.

One type of intervention that may be effective providing both good outcomes and ease of use is a detailed, universal AMA form. Despite the worry that using forms with checkboxes and other pre-populating material leads to poor care and incorrect documentation (55, 60, 61), forms may be a way to help healthcare providers guide the AMA conversation. One study in the United Kingdom showed that after implementing a more comprehensive AMA form, the amount of providers assessing capacity of the patient leaving AMA increased from 0% to 80% (82). The study first audited the AMA form looking for a capacity assessment. The study's initial AMA form was similar to the one currently implemented in the Yale-New Haven Emergency Department as seen in Appendix D. It only included room for signatures of the patient or the patient's conservator as well as a space for a witness's signature. Similarly, the Yale form contains a signature block along with a large empty white space where AMA discharge documentation is inferred to be reported. However, as this research observationally indicates, the white space is rarely used.

In the Henson study, the second audit occurred after implementation of a comprehensive AMA form. Unlike a simple checkbox form, the form also included lines for the documenter to elaborate on items such as reasons for refusal for treat as well as for follow-up arrangements. The sample form is seen in Figure 3. Important to note on the form is that the assessment of capacity is not simply posed as a yes or no question. It contains three separate criteria that each must be fulfilled in order for the patient to be capable to make decisions. In a form for Yale-New Haven Hospital, a capacity assessment would best be compiled using the criteria outlined by Appelbaum and Grisso and seen in Table C, which has been widely accepted as a standard for capacity

<u><b>Self Discharge and Refusal of Treatment</b></u>	
<b><u>Assessment of the Patient's Ability to Refuse their Consent</u></b>	
(all 3 criteria must be fulfilled for them to be deemed capable)	
1. <b>Does the patient understand the medical treatment?</b> Its purpose, justification, benefits, risks and alternatives	<input type="checkbox"/>
2. <b>Does the patient understand the consequences of not receiving the treatment</b>	<input type="checkbox"/>
3. <b>Is the patient able to retain the information for long enough to make an effective decision and make a free choice without duress?</b>	<input type="checkbox"/>
<b><u>Assessment of the Patient's Medical Risk</u></b>	
Indicate below the working diagnosis or presenting complaint .....	
.....	
Record below any abnormal examination or investigation findings	
.....	
<b><u>Outcome</u></b>	
• Advised of important features to be aware of and when to seek medical attention	<input type="checkbox"/>
• Advised they can return at any time for reassessment	<input type="checkbox"/>
• Self management advice/advice sheet given	<input type="checkbox"/>
• Reason for refusal of admission or treatment? .....	.....
.....	.....
• Follow up arrangements and other agencies informed (police, social services, GP, relatives)	.....
.....	.....
I the undersigned am taking my discharge from the Emergency Department of Gloucestershire Royal Hospital against medical advice.	
<b>Patient's Signature</b> .....	<b>Doctor's/Nurse's Signature</b> .....
Name .....	Name .....
Address .....	Title .....
.....	Date .....
NB If concerned regarding an individual's capacity or risk, discuss with senior staff and refer to guidelines book.	

**Figure 3. Example of the discharge AMA form used by Henson in his study (84).**

assessment in the United States (58, 59, 74, 78). Additionally, the form would contain dedicated space for the provider to note the clinical course as well as his clinical

reasoning, including a differential diagnosis. Finally, it would be important for the form to include each of the medico-legal standards presented as either a checklist to guide the conversation or as a place to note each aspect of the conversation.

The ideal form would be connected to the electronic medical record (EMR) and would utilize pre-populated data to make “decisions.” For example, if the patient’s primary language in their demographic information were Spanish, the EMR would pop up a warning box that inquires if a translator should be utilized. Likewise, if an order for lorazepam was entered and time stamped for only one hour previous to discharge, the EMR would prompt the provider to ensure that the patient has capacity. When the provider attempts to print the AMA form to obtain signatures, the provider will be additionally prompted to print prescriptions and discharge instructions. If the patient insists on leaving before the AMA paperwork can be completed, the physician could be guided via a set of prompts to print discharge instructions and prescriptions and return to processing the AMA paperwork after the patient leaves. Once the patient leaves, the provider could continue to write the note and indicate the events that transpired as well as the patient’s refusal to wait and sign the AMA form. The EMR continues to place the nidus of decision making on the provider, but it guides the provider to consider the important components of the AMA conversation.

The utilization of prompts has been found to improve adherence to evidence based guidelines (83, 84). A meta-analysis study noted that with the exception of making a diagnosis, computer-based decision support systems perform significantly well for drug-dosing, preventative care, and other aspects of medical care and hospital management (83). The article also took care to mention that with any computer-based



system, the pre-implementation and post-implementation rates of compliance should be carefully assessed to determine if there were any significant differences.

Obviously, using a checklist type of form allows for the provider to check something off even if it was not necessarily completed. However, the checklist, whether on a printed form or located in the EMR would be an outline for the ideal discharge AMA conversation. Providers would have a cheat sheet, per say, of what they are supposed to review in the AMA conversation. In an era of medicine where there is so much information and divisions into so many subspecialties, providers have fallen into ineptitude where the knowledge exists, yet it is failed to be applied correctly (85). Simply providing a reminder of what to review with the patient would inherently increase the level of quality of the discharge conversation. With a plan in place, providers would not be flustered when a patient expresses his desire to leave.

Like the Henson study, the charts could be reviewed after utilizing the intervention and assessed for improvement in compliance. Once a definition is standardized, the discharge AMA rate can also be calculated and tracked. It is important to remember that patients wish to leave AMA for a variety of reasons many of which are outside of the control of the medical staff. There will always be patients that leave AMA and a goal of having no AMA discharges is not reasonable. However, it is logical, and as seen earlier in the legal examples presented, that patients would have chosen to remain in the hospital if they knew more information about their potential outcomes and risks. It can initially be hypothesized that with a higher quality informed consent patients may be more inclined to stay if they truly understood the risks and benefits. Consequently, the morbidity and mortality of AMA patients would likely decrease.

Finally, as an effective ideal standardized encounter process is being created, providers of all levels of training need to be educated about the AMA discharge procedure. As no set standard has existed in the past, there are a variety of myths and preconceptions about what needs to be included both in the discharge conversation and on the form that must first be overturned (74). Both anecdotally and in the literature, many physicians at both the resident and attending level believe that providing prescriptions is malpractice despite the widespread evidence that it in fact bodes in favor for the healthcare provider (3, 45). These myths must first be debunked through education and standardization of the procedure starting in medical, physician associate, and nursing schools. That being said, education efforts will also need to keep in mind that despite guideline development and standardization by a national organization, many practitioners, especially those in practice for multiple years, will still choose to ignore the guidelines (86-88).

Utilization of the EMR will aid in education efforts, especially of providers currently in practice, by allowing computer prompts to encourage documentation instruction and compliance. However, greater adherence obtained by using EMR prompts as to what should be included in the discharge AMA conversation and subsequent documentation does not necessarily equate to knowledge and understanding as to why the guidelines are in place (60). It will be important to include an educational component to discharge AMA training so residents and students continue to understand why and how the guidelines were created and they do not just go through the motions, per say. Medical, physician associate, and nursing students will need to be taught the standardized process within their educational curriculum. Employing actual case law in

the process of educating, such as was presented in this discussion, will also help providers understand the legal as well as the medical implications of properly discharging a patient AMA. Additionally, courtroom examples will help providers realize that the potential for extra paperwork and time is in both the patient's and their best interest.

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The research performed in this paper takes an in depth look at the current practices of information transfers that occur during the AMA discharge conversation. Despite federal requirements, there is an inconsistency and lack of physician documentation. Conformation to these requirements first begins with the threshold determination of the sufficiency of extant documentation practices, as provided by this research, in order to become cognizant of disparities between the quality and safety requirements and actual provider documentation. These results show that physicians are not conducting AMA encounters according to quality and safety domains set forth by oversight institutions. Without appropriate documentation, it is assumed that patients are not informed regarding their choice to leave AMA. In order to move forward in improving quality healthcare, the following final recommendations are suggested:

1. An effective and efficient standardization of the patient-physician AMA encounter needs to be established to provide better quality of care and increase patient safety.
2. Future research efforts, beyond standardization of a definition of AMA, in this area will need to include educating providers on AMA encounter quality and safety risks, and then subsequently measuring the sufficiency of information

received after this education, and comparing patient outcomes before and after these interventions.

Though it is ultimately the patient's decision to leave the hospital against medical advice, it is the ethical and professional responsibility of all healthcare providers to impart patients with the information necessary to help make, or not make, that choice.

## **Appendix A—Healthcare Provider Documentation Screening Tool**

The following screening tool was utilized to assess the inclusion of the following eight major medico-legal standards of documentation of discharges against medical advice: (1) capacity; (2) agreement of the signs and symptoms determined by documentation of the diagnosis; (3) the extent and limitation of the evaluation; (4) documentation of the current treatment plan, risks, and benefits; (5) risks and benefits of foregoing treatment; (6) alternatives to suggested treatment; (7) an explicit statement the patient left AMA as well as explicitly stating what the patient was refusing; and, (8) follow-up care including discharge instructions. The medico-legal standards are numbered and bolded with the criteria questions for each standard listed underneath. Each criteria question was answered either “yes” or “no.” An additional standardized abstraction form, which is not included in this thesis, was also utilized.

### **1. Capacity**

Did the healthcare provider document “capacity,” “competence,” or the equivalent?

### **2. Agreement of the signs and symptoms**

Did the healthcare provider document the diagnosis?

Did the healthcare provider document that the patient understood the diagnosis?

Did the healthcare provider document both the diagnosis and that the patient understood?

### **3. Extent and Limitations of the Evaluation**

Did the healthcare provider document only the extent of the evaluation?

Did the healthcare provider document only the limitations of the evaluation?

Did the healthcare provider document both the extent and limitations of the evaluation?

#### **4. Current treatment plan**

Did the healthcare provider document the details of the current treatment plan?

Did the healthcare provider document the risks of the current treatment plan?

Did the healthcare provider document the benefits of the current treatment plan?

Did the healthcare provider document both the risks and benefits of the current treatment plan?

Did the healthcare provider document the details of the current plan and the risks and benefits?

#### **5. Forgoing Treatment**

Did the healthcare provider document the risks of forgoing treatment?

Did the healthcare provider document the benefits of forgoing treatment?

Did the healthcare provider document both the risks and benefits of forgoing treatment?

#### **6. Alternatives**

Did the healthcare provider document any alternative treatment options?

#### **7. Explicit statement the patient left AMA**

Did the healthcare provider document explicitly that the patient "left AMA"?

Did the healthcare provider document explicitly the care and treatment that was refused?

Did the healthcare provider document both that the patient "left AMA" and what he refused?

**8. Follow-up care**

Did the healthcare provider document a follow-up plan on the chart?

Did the healthcare provider document discharge instructions?

Did the healthcare provider document both a follow-up plan and discharge instructions?

## Appendix B—Additional Diagnoses

Table D shows the complete list of diagnostic clusters for the 418 patients in the study group using the CCS grouping system as well as indicating the number of patient in that grouping.

**Table D. AMA Diagnosis Groups**

<b>CCS Diagnosis Group</b>	<b>Patients</b>
Abdominal Hernia	1
Abdominal Pain	31
Acute Bronchitis	1
Alcohol-Related Disorders	9
Allergic Reactions	1
Anxiety Disorders	2
Asthma	11
Blindness and Vision Defect	1
Cardiac Dysrhythmia	7
Chronic Obstructive Pulmonary Disease and Bronchiectasis	2
Complications of Device, Implant, or Graft	1
Conditions Associated with Dizziness or Giddiness	8
Coronary Atherosclerosis and Other Heart Disease	1
Diabetes Mellitus With Complications	4
Diabetes Mellitus Without Complications	5



<b>CCS Diagnosis Group</b>	<b>Patients</b>
Diverticulosis and Diverticulitis	1
Ectopic Pregnancy	1
Epilepsy; Convulsions	17
Esophageal Disorders	1
Fever of Unknown Origin	1
Fluid and Electrolyte Disorders	1
Fracture of Upper Limb	2
Gastritis and Duodenitis	1
Gastrointestinal Hemorrhage	2
Headache including Migraine	25
Infective Arthritis and Osteomyelitis (Except that Caused by Tuberculosis or Sexually Transmitted Disease)	1
Intercranial Injury	1
Malaise and Fatigue	8
Medical Examination/Evaluation	1
Miscellaneous Disorders	1
Mood Disorders	1
No Code Provided	72
Nausea and Vomiting	1
Noninfectious Gastroenteritis	1
Nonspecific Chest Pain	73
Open Wounds of the Extremities	1

<b>CCS Diagnosis Group</b>	<b>Patients</b>
Open Wounds of the Head; Neck; and Trunk	3
Other Aftercare	2
Other Bone Disease and Musculoskeletal Deformities	1
Other Complications of Pregnancy	5
Other Connective Tissue Disease	3
Other Ear or Sense Organ Disorders	1
Other Endocrine Disorders	1
Other Eye Disorders	3
Other Female Genital Disorders	1
Other Fractures	4
Other Gastrointestinal Disorders	2
Other Injuries and Conditions Due to External Causes	8
Other Liver Diseases	1
Other Lower Respiratory Disease	15
Other Male Genital Disorders	1
Other Nervous System Disorders	5
Other Non-Traumatic Joint Disorder	4
Other Open Wounds of Extremities	1
Other Screening for Suspected Conditions (Not Mental Disorders or Infectious Disease)	1
Other Skin Disorders	1
Other Upper Respiratory Disease	1

<b>CCS Diagnosis Group</b>	<b>Patients</b>
Phlebitis; Thrombophlebitis and Thromboembolism	1
Pleurisy; Pneumothorax; Pulmonary Collapse	1
Poisoning by Nonmedicinal Substances	1
Poisoning by Other Medication or Drugs	1
Poisoning by Psychotropic Agents	1
Pulmonary Heart Disease	1
Residual Codes Unclassified	2
Septicemia (Except in Labor)	1
Skin and Subcutaneous Tissue Infections	5
Spinal Cord Injury	1
Spondylosis; intervertebral disc disorders; other back problems	9
Sprains and Strains	3
Substance Related Disorders	4
Superficial Injury; Contusion	6
Syncope	16
Transient Cerebral Ischemia	1
Urinary Tract Infections	1
<b>Total</b>	<b>418</b>

## Appendix C—Complete Documentation Compliance Results

Medico-Legal Standard	Number of Compliant Charts, <i>n</i>	Compliance Rate, %	Standard Compliance Rate, %
Did the healthcare provider document...			
<b>1. Capacity</b>			<b>22.01</b>
...“capacity,” “competence,” or the equivalent?	92	22.01	
<b>2. Agreement of the signs and symptoms</b>			<b>33.01</b>
...the diagnosis?	174	41.63	
...that the patient understood the diagnosis?	144	34.45	
...both the diagnosis and that the patient understood?	138	33.01	
<b>3. Extent and Limitations of the Evaluation</b>			<b>8.13</b>
...the extent of the evaluation?	35	8.37	
...the limitations of the evaluation?	145	34.69	
...both the extent and limitations of the evaluation?	34	8.13	
<b>4. Current treatment plan</b>			<b>3.83</b>
...the details of the current treatment plan?	186	44.50	
...the risks of the current treatment plan?	28	6.70	
...the benefits of the current treatment plan?	21	5.02	
...both the risks and benefits of the current plan?	21	5.02	
...the details of the plan and the risks and benefits?	16	3.83	
<b>5. Forgoing Treatment</b>			<b>4.78</b>
...the risks of forgoing treatment?	279	66.75	
...the benefits of forgoing treatment?	20	4.78	
...both the risks and benefits of forgoing treatment?	20	4.78	
<b>6. Alternatives</b>			<b>5.74</b>
...any alternative treatment options?	24	5.74	
<b>7. Explicit statement the patient left AMA</b>			<b>50.72</b>
...explicitly that the patient "left AMA"?	410	98.10	
...explicitly the care and treatment that was refused?	214	51.2	
...both that the patient “left AMA” and what he refused?	212	50.72	
<b>8. Follow-up care</b>			<b>67.46</b>
...a follow-up plan on the chart?	306	73.21	
...discharge instructions?	288	68.90	
...both a follow-up plan and discharge instructions?	282	67.46	

## Appendix D—Yale-New Haven Discharge Against Medical Advice Form

DISCHARGE AGAINST ADVICE	
Date: _____ 20__	Time _____ A.M. P.M.
<input type="checkbox"/> am voluntarily leaving and signing out <input type="checkbox"/> am voluntarily leaving and signing out unaccompanied	
I _____ (Name of Person Signing)	<input type="checkbox"/> am taking _____ (Name of Person Being Taken)
from the Hospital against the advice of Dr. _____ and release him and the Yale-New Haven Hospital from any and all liability in connection herewith.	
Witness: _____	Signed _____ (Patient or person authorized to consent for patient)

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