Medical Ethics

By Jonathan Evans, MD, MPH, CMD

Against Medical Advice, Whatever That Is

The Case

A 42-year-old man with a 25-year history of brittle insulin-dependent diabetes was admitted to a skilled nursing facility for intravenous antibiotic therapy. He was originally hospitalized 5 weeks earlier with cellulitis of the foot.

During that hospitalization, however, he became upset with the hospital physician, and vice versa. He was discharged from the hospital to home "against medical advice" (AMA). The hospital physician refused to provide prescriptions for medications, including antibiotics.

This discharge was not unlike those stemming from at least 15 other hospitalizations the patient had experienced over the past 10 years, primarily for diabetic ketoacidosis associated with acute infection. In almost every instance, he was discharged home from the hospital AMA.

Two weeks after his discharge home, he was readmitted to the hospital with diabetic ketoacidosis and osteomyelitis of the previously infected foot, which had received no treatment outside the hospital. Once readmitted, he received intravenous antibiotics. He developed acute renal failure (that later improved). After 2 weeks in the hospital, the patient asked to be discharged home for IV therapy there. Instead, he was transferred to a skilled nursing facility for the IV antibiotics.

Soon after arriving at the nursing facility, he told the social worker that he did not want to be in "an old folks' home." He asserted that he had not wanted to come to the facility at all but that the hospital sent him against his will. He insisted on going home. The attending physician at the nursing facility, contacted by phone, instructed nursing staff that the patient should "sign himself out AMA." Several nurses and other facility staff (some of whom knew him from the community) convinced the patient to stay at the nursing facility "for a while," but he reiterated his intention to return home soon.

On day 4 of his stay at the facility, he was transported back to the hospital for a previously scheduled appointment. The patient had not been informed of the nature of the appointment, which was neuropsychiatric testing, but agreed to go anyway. The results were normal.

Over the course of several weeks, the patient received antibiotic therapy as well as physical and occupational therapy. He left the facility for hours at a time most days, between doses, to socialize with friends or to visit his home.

In the facility, he had several episodes of hypoglycemia and hyperglycemia. His dietary intake was variable. Hypoglycemia typically occurred after he declined to eat breakfast.

However, in general, he did well. Within 5 minutes of receiving his last dose of intravenous antibiotics to complete a 6-week course, he was discharged home from the facility. He was offered home health care but declined. A follow-up appointment with his primary care physician was scheduled.

Discussion

The case is that of a mentally competent man who frequently had been discharged from the hospital AMA, with adverse consequences as a result. Subsequently, he was discharged to a nursing facility against his will (he said). Soon after arriving at the nursing facility, his attending physician there recommended that if the patient insisted on leaving, he should again be discharged AMA. But the patient was persuaded to stay.

Questions about his decision-making capacity while in the hospital prompted referral for neuropsychiatric testing, but not before he was discharged elsewhere. The patient asserted several times that his wishes were being disregarded. It appears that he was discharged to a nursing facility without his consent.

The right to refuse treatment is a constitutionally protected right that has been affirmed through several decades of case law, including U.S. Supreme Court decisions, and was later codified in the federal Patient Self Determination Act of 1990. A physician must evaluate a patient's mental capacity to be sure that the person is of "sufficient mind to reasonably understand the condition, the nature and effect of the proposed treatment, and the attendant risks in pursuing the treatment and not pursuing the treatment," as one court put it.

It should be emphasized that only mentally competent patients have the right to refuse treatment, however, and only competent patients may be discharged AMA. This patient's competence was never questioned (nor specifically assessed) in each of the many instances that he was discharged AMA over a decade.

Competent patients have the right to make all of their own decisions. This right is not restricted to making only good decisions, or only decisions that doctors and nurses recommend or agree with. We have an ethical and legal obligation to promote autonomy, provide adequate information to permit patients to make medical decisions (i.e., informed consent), and explain the basis for any recommendation we make. We have an obligation to do no harm through both our actions and inactions, and we have an obligation not to abandon our patients. Each health care provider has a legal duty to develop a safe discharge plan for a patient, regardless of the circumstances.

Autonomy, Control, Fear

Patients have the right to autonomy, but autonomy without power is meaningless. This patient was treated in a paternalistic manner and sent to "an old folks' home." More and more young adults are receiving care in nursing facilities. While the need for power and control over one's life is not limited to younger patients, the stigma of nursing home placement may be felt more acutely by younger, mentally competent patients.

This was a young man who had a strong need to feel in control in situations that seemed out of control. He reacted by trying to assert himself in ways that other, more powerful people disagreed with. An adversarial situation was created as a result. This patient, who nearly signed out of the nursing facility AMA, was persuaded to stay. Was he coerced? He was allowed to feel that it was his decision – that he was in charge. The staff tried to help him feel a sense of freedom, not captivity. No one made him stay and no one made him leave.

The motivation of practitioners and providers to have patients sign out AMA is based on fear, perhaps of a lawsuit or some sanction. All of us in medicine and health care have been trained to fear. But to fear what? At the heart of such an ostensibly defensive act as making a patient sign out AMA is fear of the patient. For there to be a lawsuit or some other action, the patient first must be very angry with us, so we fear him or her.

In practice, signing patients out AMA is not effective as an ethical defense, in large part because it is offensive toward patients. It makes them feel wrong and wronged, and they may suffer negative consequences. Providers securing AMA documentation often fail to offer or even arrange follow-up or other necessary care outside the provider's setting.

Indefensible

Defensive medicine is not good medicine. It wastes time, effort, energy, and resources and often has unintended negative consequences for patients as well as providers. "Defense" implies an attacking enemy, and if we begin to see patients as our enemies, we become their enemies. Instead, we should be doing everything we can to support and empower our patients.

From an ethical standpoint, defensive medicine represents a potential conflict of interest between our interests and those of our patients. In addition, it undermines our ethical obligations to do good for our patients and to promote autonomy. Defensive medicine, including discharging patients AMA, is the opposite of patient-centered care. It is insulting to patients.

Laws over the past 30 years have made obsolete the very premise of signing patients out against medical advice. There is no advantage for doctors or nurses to make patients sign out AMA, as long as the practitioner has documented the recommended course of action and the competent patient's decision to do otherwise (i.e., refusal).

There are a number of distinct disadvantages, however. An AMA discharge antagonizes the patient, who then is more likely to complain to a lawyer, a state or federal agency, or a professional regulatory board. Presenting an AMA document that the patient refuses to sign could be even worse. Is the facility to hold the person captive until he or she signs? What protection does such an unsigned form afford?

Regardless of our training or discipline, probably none of us chose health care as a profession in order to become the adversary of our patients. On the contrary, we all chose long-term care in particular because of a desire to care for others, to make a difference, and to have meaningful, mutually satisfying relationships with people we care about. All of that is undermined by fear, however.

No doubt there is much to be feared in this world, but the basis of care and caring is not fear but love and trust. We have to have faith that if we care about the people we care for, they will care about us as well. In the parlance of long-term care regulations, the resident has the right to achieve and maintain the highest level of function and well-being possible. In the words of Goethe, "Treat people as if they were what they ought to be, and you help them to become what they are capable of being."

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