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Original Article

Evaluation of Administration of Discharge against Medical Advice: Ethico-legal Considerations

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Abstract

Background: Discharge against medical advice (DAMA) portends serious ethico-legal consequences for healthcare givers. Several studies have described its prevalence and pattern but hardly any to evaluate adherence to standards by medical staff while administering DAMA in developing countries.

Objectives: The objective of this study is to evaluate adherence of medical staff to standard protocols during the administration of DAMA in a public secondary hospital in Ondo State.

Methodology: In a descriptive, retrospective study we examined case files and DAMA forms of in-patients who obtained DAMA between April 2014 and September 2015 for design, signatories and completeness. Data were analysed by means of SPSS version 17.

Results: A total of 235 patients (male:female, 1.03:1) who obtained DAMA out of 7465 in-patients were studied. Their mean age was 40.5 ± 19.3 years (range, 17–110 years). The overall hospital DAMA prevalence was 3.2%. DAMA forms were inadequately designed, deficient and not protective against litigation. Improper processing of DAMA was high (66.7%). The only signatories in the DAMA forms were the nurses (8.5%) and patients' relatives (100%). There was no physician entry in the forms.

Conclusions: Adherence to standard DAMA protocol by medical staff was poor. Update courses on ethico-legal matters, adopting a discharge planning team, upgrading of DAMA forms and stressing global best practices will reduce or eliminate risk of litigations.

Key Words: *Discharge against medical advice, ethico-legal, litigation, Nigeria*

Introduction

Discharge against medical advice (DAMA) is a recognised phenomenon in hospitals with potential medico-legal implications on the hospital authority and medical staff as well as morbid and financial implications on the patients and their relatives alike.[1] Financial constraints, lack of health insurance, deteriorating the clinical condition of the patient, problematic doctor–patient relationship and substance abuse are among some of the common causes or contributing factors to DAMA in our setting.[2]

Prevalence rates for DAMA vary from centre to centre and among cultures and social backgrounds. In Nigeria, its prevalence ranges between 0.002% and 5.7%.[3,4] The Professionalism Charter, the ethics of professional conduct for medical practitioners and the law both recognise that patients are mature individuals who have the right to take a DAMA and consent to treatment, failing which the attending physician may be sued for an action in trespass under the law of torts if he opposes.[5] In the exercise of such rights by patients, medical staff must avoid deficiencies in compliance to the DAMA process as they may be held liable in the event of morbidity or mortality.[6]

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Lawsuits related to discharges seem more common among those discharged against medical advice. Quinlan and Majoros reported that 0.3% of DAMA cases led to litigation unlike 0.05% caused by regular discharges.[7] In recognition of this, hospitals have put up measures to ensure that the DAMA process is properly documented through the provision of proper forms. Well-executed DAMA forms have been found to protect physicians against litigation and indeed, will be a useful and compelling piece of evidence to help establish a defence for the physician from any liability in any civil suit which may be instituted against him.[8]

So far, the incidence of reporting against medical negligence by patients or their relatives in Nigeria is still considered low despite increasing awareness of the patient's bill of rights globally.[9,10] However, pockets of recent incidences of lawsuits

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indicate that medical staff in Nigeria need to pay more attention to standard procedures and documentation which include DAMA.[11]

While the DAMA form is designed to protect the hospital and the medical staff, it is not expected to be a mere signature exercise as is the practice in most of our hospitals. Inability to properly administer the DAMA form as part of the discharge process is equivalent to an act of negligence with legal consequences. How well this document is used by the medical staff in our setting is, however, unclear due to paucity of studies in this field. Our literature search showed only one study that described appropriateness of the DAMA process in Nigeria. They observed that the procedure adopted by medical staff in discharging patients against medical advice was found to fall below standard.[12] We, therefore, set out to conduct a practice audit of administration of DAMA in a public secondary hospital in Ondo State.

Materials and Methods

Study design

This was a descriptive, retrospective study in which we reviewed case files and DAMA forms of patients who took DAMA over an 18-month period (April 2014 and September 2015).

Study location

The study was conducted at the State Specialist Hospital, Ondo City, Ondo State in Southwest Nigeria. It is a 98-bedded secondary public hospital with an average annual admission population of 5205. In-patient wards include the accident and emergency unit, medicine, surgery, antenatal, labour, postnatal and paediatric/neonatal wards. During the period of the survey, however, the paediatric ward was not in use due to on-going renovations. The patients' demographics, diagnosis and reasons for DAMA were obtained. The case notes and official DAMA forms were examined for signatories and completeness. The DAMA form used in this study was imprinted on the inner side of the back cover of every case note in our index hospital. It bears the following statement of intent in duplicate, 'I, (name of undertaker for DAMA) of (address of undertaker), undertake the responsibility to remove my (status of the patient as he/she is related to the undertaker) from the hospital against medical advice'. This statement is simply followed by a space for the name and signature of the undertaker and date. The form has no particular space for the signature of the medical personnel. A patient being discharged against medical advice is counselled and presented with the form if he or she (or the relatives) insists on DAMA.

Ethical approval

The study was conducted after due approval from the Research Ethics Committee.

Data analysis

Data were analysed by means of SPSS Statistics for Windows, Version 17.0. (Chicago: SPSS Inc. released 2008). Continuous variables were presented as frequency and percentages.

Results

A total of 235 patients who obtained DAMA were studied out of a total of 7465 patients admitted within this period. There were 119 males and 116 females (male:female, 1.03:1). Their mean age was 40.5 ± 19.3 years (range, 17–110 years). The mean length of hospital stay was 1.2 ± 0.5 days (range, 1–4 days). Their level of educational qualification was not documented in 86.9% of cases. Table 1 shows that 77 (32.8%) and 44 (14.9%) of the studied patients were entrepreneurs and farmers respectively while 56 (23.8%) were unemployed. Christianity (81.7%) was the predominant religion.

Table 2 shows the prevalence of DAMA according to departments; the overall hospital DAMA prevalence was 3.2% obtained from a total DAMA population of 235 out of a total admission of 7465 patients. The prevalence of DAMA ranged between 0.7% and 8.1% across the departments. Table 3 shows that DAMA forms were used in 94.9% of cases but in only 8.5% of cases was a healthcare provider involved. No medical officer (at any level) was involved. Financial constraint (23%) and lack of confidence in orthodox medicine (2.1%) were the highest factors causing requests for DAMA. The reason for DAMA was not documented in 169 (71.9%) cases.

Discussion

This study showed that among adults who obtained DAMA, the number of males was slightly higher than females. This is similar to findings from the previous studies.[12-14] A few of the medical staff administered DAMA by documenting in the case note or writing on its front cover similar to report by Fadare *et al*.[14] This is a cause for concern because it may leave room for culpability in matters of legality where a detailed DAMA audit is required.

Table 1: Sociodemographic characteristics of patients who obtained discharge against medical advice (*n*=235)

Sociodemographic parameters	Frequency	Percentage
Religion		
Christianity	192	81.7
Islam	35	14.9
Not stated	8	3.4
Marital status		
Single	58	24.6
Married	156	66.4
Widowed	6	2.6
Divorced	1	0.4
Un-specified	14	6.0
Occupation		
Public servants	14	6.0
Entrepreneurs	77	32.8
Artisans	35	14.9
Farming	44	18.7
Unemployed	56	23.8
Unspecified	9	3.8

Table 2: Admission and discharge against medical advice prevalence by departments

Departments	Total admissions, frequency (%)		Total DAMA#, frequency (%)		Percentage DAMA#
	Male	Female	Male	Female	
Medicine	793 (42.8)	1058 (57.2)	86 (57.3)	64 (42.7)	8.1
Surgery	607 (76.3)	189 (23.7)	33 (66)	17 (34)	6.3
Obstetrics and gynaecology	-	4818	-	35	0.7
Total	1400	6065	119	116	-

#Discharge against medical advice

Table 3: Data on discharge against medical advice processing

Parameters	Frequency	Percentage
Use of approved DAMA# form		
Yes	223	94.9
No	12	5.1
Alternatives to DAMA# form		
Written on front cover	3	25
Documented in case folder	8	66.7
No record	1	8.3
Signatories to DAMA#		
Patient's relative	215	91.5
Nurse and patient's relative	8	8.5
Reasons for DAMA#		
Finance	54	23
Lack of confidence	5	2.1
Religious belief in healing	1	0.4
Refusal of blood transfusion	1	0.4
Refusal of surgery	2	0.8
Refusal of referral	1	0.4
Social reasons	2	0.8
Not stated	169	71.9
Length of admission before DAMA# (weeks)		
<1	193	82.1
1-2	32	13.6
>2	10	4.3

#Discharge against medical advice

It is noteworthy that the reason for DAMA was not stated in 71.9% of cases that we studied. Nwokediuko and Arodiwe reported that in 85.2% of cases, the reason for DAMA was not stated.[12] This is evidence that health care workers probably paid little attention to the details in DAMA processing and probably are overtly reliant on the signature of the patients as a reason to be exonerated from legal penalty in the event of litigation. Indeed, on close scrutiny, we observed that the DAMA form in use at the hospital did not leave room for legal considerations and protection of the medical personnel on duty at the time of DAMA. It only bore a simple statement of intent by the undertaker which is grossly insufficient in a law court. There was no consideration for the identity and signature of the medical staff on the DAMA form even though current best practices show that DAMA is not just a 'signature event' but a painstaking process that entails filling in of multiple page documents that first puts into consideration the integrity of the patient's mental ability (where applicable) to request DAMA. This is followed by a separate formal request for DAMA by the patient (after education by the medical staff on the pros and cons of obtaining DAMA) before actual processing of the DAMA form. Post-discharge documentations which will include the physician's declarations, medication advice, home visits (where applicable) and declaration of the willingness of the hospital to receive back the patient should he/she choose to return complete this process.

There was incomplete documentation of some of the subjects' parameters with respect to their educational qualifications, religious affiliations, marital status and reasons for taking DAMA in this study. Similar incomplete documentation has been reported by previous authors in our setting.[14,15] Such omissions are ominous for the medical personnel as presentation of a duly executed DAMA form merely raises a rebuttable presumption of fact under the law of evidence that the preliminary steps to be followed prior to execution of such document were duly followed[16] and as such, the presumption can be duly rebutted if contradictory evidence can be given to show that the preliminary steps were not complied with and that the patient was not made to understand the import and consequences of his decision to seek DAMA. Under such circumstances, the DAMA form is unlikely to be relied on as conclusive evidence to exonerate the physician from liability.

The substantial deficiency of information on the educational status of our patients was of great concern to the authors because it may impact greatly on the capacity of the patient to understand the pros and cons of DAMA. In cases of possible litigation, it has capacity to expose the medical staff to legal scrutiny regarding the DAMA processing while a high knowledge base is not mandatory for comprehension of the possible outcomes of DAMA, a proper assessment of the patient's educational ability will enable the medical staff adopt approaches that will aid his/her comprehension of DAMA. This is particularly because the patient's right to health which is a basic fundamental human right has been widely interpreted to include the right to have access to all available information on one's health issues.[17]

In addition to the above, the physician has a duty to provide relevant information on the benefits, risks, costs and consequences associated with decisions and treatment options taken by patients as codified in the National Health Act. This must be explained in a language understood by the patient, and the physician is obliged to take the patient's level of literacy into account.[18] It is thus required of physicians to

pay attention to the relative health literacy of patients being discharged against medical advice as this has been shown to have an effect on patients who obtain health care.[19,20] Failure to comply with the above provisions amounts to a breach of the extant laws for regulation, development and management of the health sector in Nigeria. Okoromah and Egri-Qkwaji found that for paediatric patients, well-informed caregivers are more likely to take rational health decisions concerning their sick children.[4] This will be considered to be in the best interest of the child and in line with international conventions on the fundamental human rights of children particularly since paediatric patients are considered to be minors.[21]

Adherence to the use of a formal document for DAMA was high in this study (94.9%). This is a positive trend as previous studies reported lower adherence rates.[14,22] Henson and Vickery reported that when providers used detailed DAMA forms, physician documentation was found to improve.[23] This study, however, revealed that it was only the nurses that were involved as signatories in the DAMA processing form. In standard settings, DAMA should be administered by the attending physician.[23] Indeed, if possible, because of the sensitive nature of the process, the most senior doctor should administer the document to minimise errors. In some cases, where the patient or the family feels the closeness and empathy of the experienced physician, the decision to DAMA may be reversed. The physician is expected to assess the DAMA form for adequacy and proper filling.[24] In situations where the patient refuses to sign the DAMA form, the content should be read out aloud and patient's refusal to sign documented; the fact that the patient was made aware of the risks of leaving should also be documented in line with the provisions of the National Health Act.[18,24]

This study also revealed that none of the patients personally signed the forms. It was their relatives who signed for them. This is completely at variance to findings from other studies where the rate of the signing of DAMA by the patient has been put at 25.3%, 21.6% and 40.7% by Nwokediuko and Arodiwe Fadare *et al*. and Eze *et al*. respectively.[3,12,14] There are recognised conditions such as psychiatric cases, unconscious patients and minors that may warrant patients' relatives signing the DAMA form. However, most times in our environment, when relatives sign for patients, it is an indication that the family system is still largely influential in matters of access to healthcare, financial support and discharge of the sick in our setting. This notion is further strengthened by the report of Ndukwu *et al*. that in 81.3% of cases, families even went ahead to sign DAMA for single adult patients who were <29 years of age.[13] The ideal situation to minimise controversies, however, is to have the individual sign except in cases where it can be established that the patient is not in a position to do so; the patient is considered to be a minor, or the patient is of unsound mind. Even in all these exceptions, the only person legally qualified to sign on the patient's behalf is the next of kin or guardian and not just any random family member.[25]

The preliminary but nonetheless important steps discussed above should be given priority above the signature stage, and physicians should ensure that it is well-documented especially if the patient eventually insists on DAMA. Indeed, the need for the patient to be well informed before signing the form cannot be over-emphasised and thus, the signing of the DAMA form should only be a confirmation that a detailed conversation which had helped the patient come to the decision to seek DAMA has taken place between the patient and the physician.[26] Until that is done, the patient cannot be said to have enjoyed his full autonomy and the medical personnel may be culpable in a law court for infringement of the patient's fundamental human rights and more specifically, the patient's right to the highest attainable standard of health and his right to privacy.[27]

Conclusions

From the foregoing, it is clear that medical staff in Nigerian hospitals may be practicing contrary to extant legal provisions and rules of professional ethics relating to DAMA. This is probably due to inadequate knowledge of the process admixed with a low drive for ensuring standards by the hospital authorities thereby exposing the system to potential litigations.

Recommendations

It is necessary to redesign the current DAMA forms to meet up with current global standards and emphasise its use by medical staff. It should include a separate informed consent document to be filled in by the patient before proceeding to sign the DAMA form. We suggest the constitution of a discharge planning team which is to include the physician, a nurse and a hospital social worker in our hospitals. This way, errors associated with administering DAMA will be curbed. Finally, regular continuing medical education on patients such as current best practices for DAMA and its legal implications should be conducted for all medical staff and hospital administrators involved in the administration of DAMA.

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Conflicts of interest

There are no conflicts of interest.

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