

# The patient who threatens to self-discharge

Patients who take the hospital discharge decision into their own hands, leaving against medical advice, are familiar to all doctors. No data exist on precise numbers – but as most self-discharges are not logged on any hospital database, there is no way to know. From the author's personal experience, the vast majority of patients who self-discharge tend to be those seen acutely as emergencies and most of these patients only see doctors-in-training as opposed to a consultant. These patient episodes are often only witnessed by one doctor and a handful of agency nursing staff at night. Thus, no large studies have been published containing detailed clinical information to help doctors and hospital managers to determine the predictors of such discharge. Furthermore, as such data are lacking, the incidence of potentially dangerous outcomes is difficult to assess.

## Who self-discharges?

The medical literature on this subject hence remains sparse and confined to specific patient populations. Anis and colleagues (2002) addressed some of these issues in a retrospective cohort study of 981 patients admitted to hospital with a diagnosis of HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome). They reported that 125 (13%) of these patients left the hospital against medical advice. Furthermore, patients leaving against medical advice were readmitted more frequently than those who were formally discharged. The authors of this study found that age, sex, housing status and severity of illness were not significant independent predictors, although younger age, male sex, substance abuse and lack of a personal physician were.

The profile of a patient who self-discharges is not as predictable as many doctors may believe. They are not necessarily alcoholic, claiming social security benefits or possessing other such stigmatizing social attributes. In one audit, 50% of all cases

self-discharging from an emergency department were not under the influence of drugs or alcohol, and only a minority presented following an assault or minor trauma (Henson and Vickery, 2005). Furthermore, these patients are truly sick. The same audit found that 33% of these patients were assessed as either triage category 1 or 2.

## The attitude of doctors

The prevailing attitude of doctors to patients who self-discharge is a potentially dangerous one. There remains a perception in many doctors' minds that such patients are reckless with their health, do not appreciate the efforts of the health system and at worst are trouble-makers.

When the author was a preregistration house officer, his attitude and that of others around him was of contempt to those who left hospital against medical advice. It was very much a case of getting them to sign the self-discharge form as quickly as possible so that the hospital would not be sued. Unfortunately, this reflects the lack of humanity that exists in medical training, and the poor understanding many doctors have on how socioeconomic issues affect medicine. It may simply be that these patients have extenuating social circumstances. This is not understood by many doctors, who may feel that a patient who refuses their recommendations undermines their status as a figure of authority.

## Assessment of the patient who threatens self-discharge

These are patients at risk. Discharge against medical advice should concern doctors more not less, as these patients are leaving too soon and hence the risk of adverse events after discharge is higher. Patients are under no obligation to follow medical advice but they must be in a position to understand the implications of their decision.

Doctors must always try and assess the competence of the patient to make such

a decision. This is a difficult task for the busy emergency doctor, especially since mental incapacity is common enough in acutely ill medical inpatients, and not often recognized (Raymont et al, 2004). The high prevalence of this scenario is reflected in 'ability to self-discharge' being one of the most common referrals to the liaison psychiatry service in hospital settings (Ranjith and Hotopf, 2004).

## Why do patients threaten self-discharge?

There is little available in the medical literature on why patients choose to self-discharge. Identifying these reasons is essential to the design of any preventive intervention. Doctors must understand that patients have lives outside the hospital. Of course health is important, but a holistic view of these patients must be taken. Alcoholics do often run businesses, and patients on social security benefits may have sick relatives to look after. Furthermore, doctors should try and understand what patients go through when admitted to hospital – the noise of beeping intravenous pumps and ringing telephones coupled with inedible food may try the patience of even a saint (Brown, 2003).

## Dealing with self-discharges

What must be offered to these patients is not only the full nature and prognosis of their condition and the implications of inadequate management, but also a safety net by which they can be brought back into the health-care system. Thus when confronted with a patient threatening self-discharge, a doctor must demonstrate a non-judgmental attitude as well as providing adequate information given in clear, simple, non-blaming language. It is known that patient information at discharge renders them with more confidence and this is possible even in patients who may be perceived to be less amenable to information such as the elderly (Fagermoen and Hamilton, 2006). Patient knowledge empowers them to self-care (Kerzman et al, 2005).

Behavioural interventions have proven effective in other settings aside from self-discharge – for example, patients have been found to accept referral to treatment or adhere to medication more readily through techniques based on stages of readiness to change and the principles of motivational interviewing – these studies included those patients with one of the key risk factors for discharge against medical advice, addiction (Welte et al, 1998; Moyer et al, 2002). Doctors should also be aware that, in extreme circumstances, common law allows a single doctor to recommend the detention of patients incapable of consenting to treatment if it is in their best interest.

In a 1999 article, self discharge is listed as one of the 'case scenarios in which to phone the general practitioner' alongside such situations as an unstable condition or complex medication needs (Rosenthal and Singh, 1999). Good communication with primary care, the hospital site manager and senior doctors is essential. Five minutes of good doctor-patient communication may be all that is required and assessment of patient competence may not even be required if a simple, thorough explanation is provided. Nowadays, doctors are trained in medical school in the art of revealing a diagnosis of cancer to a patient – so why are they all not trained to assess and document the capacity of these patients to understand why not to self-discharge?

More importantly, standard hospital self-discharge forms are more about apportioning blame to the patient and fending off

lawyers. In place, doctors should provide a formal discharge summary to the patient, a copy to their GP if they have one and options on how to re-present to the health-care system both orally and in writing. Having such protocols in place would in fact protect health-care institutions and their staff from potential litigation.

## Conclusions

There is little national awareness about patients who self-discharge. These patients should be given more of our time, not less, as they represent a high-risk category. Without a change in attitudes and medical practice, the outcomes for these patients may be less than desirable. **BJHM**

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Anis AH, Sun H, Guh DP, Palepu A, Schechter MT, O'Shaughnessy MV (2002) Leaving

hospital against medical advice among HIV-positive patients. *CMAJ* **167**: 633–7  
Brown AS (2003) The drivers of self-discharge. *CMAJ* **169**: 279  
Fagermoen MS, Hamilton G (2006) Patient information at discharge-A study of a combined approach. *Patient Educ Couns* Jan 17 [Epub ahead of print]  
Henson VL, Vickery DS (2005) Patient self discharge from the emergency department: who is at risk? *Emerg Med J* **22**: 499–501  
Kerzman H, Baron-Epel O, Toren O (2005) What do discharged patients know about their medication? *Patient Educ Couns* **56**: 276–82  
Moyer A, Finney JW, Swearingen CE, Vergun P (2002) Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. *Addiction* **97**: 279–92  
Ranjith G, Hotopf M (2004) 'Refusing treatment-please see': an analysis of capacity assessments carried out by a liaison psychiatry service. *J R Soc Med* **97**: 480–2  
Raymont V, Bingley W, Buchanan A, David AS, Hayward P, Wessely S, Hotopf M (2004) Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. *Lancet* **364**: 1421–7  
Rosenthal J, Singh S (1999) Communication: not just doctors talking to patients. *student BMJ* **7 Sept** (<http://www.studentbmj.com/issues/99/09/education/319.php>)  
Welte JW, Perry P, Longabaugh R, Clifford PR (1998) An outcome evaluation of a hospital-based early intervention program. *Addiction* **93**: 573–81

## KEY POINTS

- Patients who self-discharge are at high risk of adverse outcomes yet no data exist on precise numbers.
- The patient who self-discharges may have accentuating social circumstances and doctors need to change their attitudes towards them and understand better how socioeconomic issues affect medicine.
- Discharge policies need revising to minimize the potential harm associated with unplanned leave from hospital and adequate information on the condition and how to re-present to the health-care system must be provided to the patient in clear, simple, non-blaming language.