

# MISSOURI HOSPITALIST

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## Hospitalist Update

### Predicting, Preventing and Managing AMA Discharges

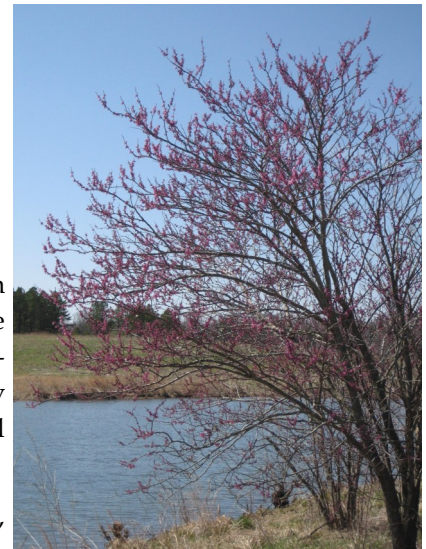
Dilip Bearely MD

Discharge against medical advice (AMA), in which the patient chooses to leave the hospital before the treating physician recommends discharge, continues to be a common and vexing problem, especially for hospitalists. Between 1% and 2% of all medical admissions end in an AMA discharge.

It is also known that patients discharged AMA, taken as a whole, are an at-risk group for both morbidity and mortality. Patients with asthma who are discharged AMA have a 4 fold higher risk of readmission to an E.R. within 30 days (21.7% vs. 5.4%) and an almost 3 fold incidence of hospitalization within that period (8.5% vs. 3.2%) In a study of general medicine patients, those who left AMA were 7 times as likely to be readmitted within 15 days (21% vs. 3%), almost all for the same diagnosis. In a large retrospective study of almost 100,000 patients with acute myocardial infarction, those who left AMA (n= 1079) underwent fewer revascularization procedures and had shorter lengths of stay; however, this AMA group had a 40% higher risk of death or readmission for acute MI/unstable angina during the following two years

#### PREDICTORS OF AMA DISCHARGE

Most of the published data are from retrospective analyses and case-controlled studies at single urban institutions, limiting our ability to define a clear casual relationship. Understanding why patients choose to leave AMA has obvious importance in the prevention of excess morbidity, mortality and health care costs. In most retrospective studies, the presence of drug or alcohol dependence has been shown to have a close relationship to AMA discharge requests; this may reflect underlying addictive behaviors and the desire to return to the use of these agents. Other factors that demonstrate an association with AMA discharge include a history of HIV, lack of a primary care physician and patient reports of financial problems or sickness within the family. For patient's with a known history of substance abuse, efforts to reduce AMA discharges have consisted of early identification, communication and counseling.



## STRATEGIES FOR PREVENTING AMA DISCHARGES

The following strategies are important in an effort to reduce the occurrence of AMA discharges:

1. Address substance abuse issues and initiate treatment for withdrawal symptoms
2. Recognize psychological factors and address them. Two articles have described the association of patient anxiety, depression and anger (perhaps masking feelings of helplessness) with AMA discharge; the latter may permit expression of these feelings in the context of personal control.
3. Avoid anger when dealing with difficult patients; such behavior by nurses and physicians may precipitate an AMA discharge. Whenever possible, the discussion should be focused on the patient's needs and on the importance of continuing inpatient care. Psychiatric consultants may be helpful in this regard. A dispassionate, empathetic and nonjudgmental approach to patients is challenging, takes time and requires continual practice and perseverance.
4. Consider a motivational interview.

## MANAGING AMA DISCHARGES

Informed consent is an important step in AMA discharges; an informed decision means that the patient has arrived at the decision in consultation with his or her physician without being subjected to coercion and with full understanding and appreciation of the risks, benefits and alternatives. The first step in this process is to evaluate the decision making capacity of the patient; distinct from mental competence, this evaluation does not require a psychiatric consultation though the psychiatrist may be helpful in assessing the extent of impairment caused by a psychiatric disorder.

The second step is to evaluate the patient's understanding of his/her current medical situation. Does the patient understand the admitting diagnosis, its prognosis and the likelihood of risks associated with leaving the hospital? Is the patient aware of alternatives to treatment in the hospital and of risks/benefits associated with them? Can the patient make and communicate a choice? Can the patient articulate a reason for refusing further inpatient care that is consistent with his/her values? Your discussion with the patient, covering these issues, must be clearly documented in the medical record. When answers are ambiguous or when the patient's decision imposes excessive risk to his/her health, decision making capacity may be questioned and other resources (family involvement, ethics consultation, hospital risk management) should be utilized. Finally, the patient's health literacy must be determined; this is defined as "the degree to which the individual has the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."

Once a patient has been fully evaluated in the above manner and after careful documentation of all discussions and recommendations has occurred, he/she may still choose to leave AMA. If so, it is the physician's responsibility to ensure that the discharge is as safe as possible, including written instructions regarding his/her diagnoses, medications, follow up arrangements, clinical signs of concern and how to seek medical attention if they

(continued) their mind or if symptoms worsen. The best possible alternative therapy must be provided. In effect, patients who choose to leave AMA should be offered as much continuing therapy, social support and follow up assistance as we would arrange for all other patients.

**References:**

Taqueti, VR, Leaving Against Medical Advice, NEJM 2007; 357(3): 213-215

**CARE OF THE HOSPITALIZED PATIENT 2009**  
**SATURDAY, MAY 2, WASHINGTON UNIVERSITY**  
**SEE CALENDAR FOR DETAILS**

**CASE OF THE MONTH ABIGAIL EMERSON, MD & ROBERT LANCEY, MD**

A 33 year old African American male was admitted to the University of Missouri I.M. Service, referred from a community hospital for uncontrolled hypertension. He was initially diagnosed with hypertension approximately ten years ago; the condition had been worsening over the past 2-3 months despite escalating doses of antihypertensive agents. In the office on the day of admission, his blood pressure was 210/110 and he was "not feeling good."

The patient was transported to the stepdown unit where more information was obtained. He complained of increasing fatigue, occasional headaches with blurred vision and chest pressure, worse in the morning. He reported increasing periorbital puffiness but was unable to specify a time period; he had lost 55 lbs over the past 8 months via a diet modification program. He had been diagnosed with diabetes 3 months ago and was controlling his glucose with diet and Metformin. Daily glucose checks range from the 130s-140s. He also reported that he had been treated for hypokalemia over the past 2 months and was currently taking K-Dur 60 mEq twice daily.

His past history was remarkable for essential hypertension, diabetes mellitus, GERD and obesity. His current medications included lisinopril, amlodipine, triamterene/HCTZ, Metformin, K-Dur, metoprolol, omeprazole and cyclobenzaprine (as needed). He had no medical allergies. The patient reported a 40 pack-year history of tobacco use (and was still smoking) but denied excessive use of alcohol. He works as a machine operator and is engaged to be married. Family history was remarkable for hypertension and diabetes.

Physical examination revealed a blood pressure of 174/122, T 36.2 C, P 78, R 16 and O2 sat 96% (RA). Significant findings included mild periorbital edema, acanthosis nigricans at the nape of the neck and striae over the trunk and antecubital fossae. There was no JVD, chest was clear to auscultation and no murmur, rubs or gallops were noted. He was fully alert and oriented with clear, fluent speech and no focal neurologic deficits.