Discharge against Medical Advice in Orthopedic Trauma Surgery: Ethical Considerations and Practical Tips

A 9-year-old male presented to the emergency room (ER) with an open fracture of the left tibia after he was hit by a car. After stabilizing the patient and completing the workup, the ER physician discussed the next step and the cost of management with the parents. The father was frustrated and refused the admission and surgery idea and insisted on an outpatient treatment.

During day-to-day practice, we encounter patients who opt to refuse certain treatment options or reject certain procedures offered by the treating physician. This may end with them leaving the hospital without treatment. These cases account for around 1%–2% of all hospital discharges,[1] but in trauma and orthopedics, it varies widely from one region to the other. It can be as low as 0.26% in developed countries and as high as 13.9% in developing countries.[2-4] The refusal of treatment is much more in HIV, substance or alcohol abuse, and psychiatric patients (10%–30%). Other studies showed that it is more common in ethnic minorities, low-income groups, males, younger age, and could be related to the type or availability of insurance.[5,6] These patients have a higher rate of readmission, and when readmitted, they are more likely to stay longer (which means more health-care cost). They will have a less favorable outcome, and in the orthopedic practice, this is mostly due to complications of alternate medicine management.[1-3]

These patients can leave using one of three different ways:

- Discharge against medical advice (DAMA), this is when a patient requests to leave the hospital before completing the planned treatment, against the proposal of the treating physician[7]
- Then, there is leaving against medical advice (LAMA), which may hold the same meaning as DAMA, as well as, meaning that the patient has absconded or left without informing the medical team in charge of the treatment
- Finally, there is discharge on patient's request but with the consent of the treating physician. The patient and physician have reached an agreement for discharge.

DAMA has been studied widely in psychiatry practice, whereas studies on the surgical practice in general and orthopedics, in particular, are scarce.[2] Trauma accounts for the majority of surgical cases of DAMA in developing countries, and in Africa, it ranges from 64% to 97% of the surgical DAMA cases, with many of these patients preferring traditional bone setters to hospital management.[2,3] This is may be due to financial issues, family pressure, superstitious beliefs, and ignorance. An added claimed advantage they get is a quicker and cheaper service.[3]

The critical question the physician has to ask himself before processing the DAMA papers is why the patient is refusing the offered management plan? Did the patient understand the seriousness of his condition and the possible complications? Did he understand the different options of management he has? Did the patient have a compelling reason for the DAMA? Is it a finance issue (cost of treatment in an uninsured patient in private facilities)? Is it a family obligation or commitment? Is it a personal issue with the treating physician (communication issue) or trust issue in the physician or the hospital, which is a very common and important variable (more with private versus government hospitals)? Does the patient want a second opinion? Is it a legal problem such as when the law enforcement is informed in cases of suspected child abuse? Was he seen by the next step treating specialist or only by the ER physician? Were the social workers involved? Was there external pressure work or family. Is there a chance that the patient may be an illegal worker, a victim of trafficking, or are there safeguarding issues due to mental health, dementia, incapacity, or domestic abuse? Knowing the causes of DAMA can explain the process of identifying practical approaches to reduce the DAMA probability. There is limited literature on patient-reported reasons for DAMA in any disease setting.[8]

When should one question the decision-making capacity of the patient making the decision that may be dangerous? Physicians have an obligation to ensure that patients with adequate capacity can make their own decisions, and these decisions need to be informed decisions.[9] An informed decision means that the patient has reached to the decision after discussion with his treating physician without being exposed to pressure and with a full understanding and appreciation of the risks, benefits, and all options of the decision. It has been advocated to use a "sliding scale" of capacity assessment, which is, the greater the risk from the patient's rejection, the more confident the physician should be that the patient has decisional capacity.[10] Once the patients' decision-making capacity is established and he is sufficiently informed, the treating physician must respect the patient's decision if it is not going to endanger others, like, for example, an active patient with a highly infectious disease like COVID-19.

Not much is written on what should happen next, once the patient is discharged. In many places, there is a negative attitude toward patients opting for DAMA. Some even going as far as refusing to provide any sort of treatment and imaging related to their condition or even future appointments for those who prefer DAMA versus undergoing the offered treatment. Some think that if we provide partial care to patients, this would leave them with some sort of relief or give them the idea that the rest of the treatment is not as necessary. This, in

turn, might risk their lives, their limbs, or function, such as in cases of refusing operative management for open fractures; would it be right for the treating physician to do some local debridement in ER, apply a cast and prescribe oral antibiotics or just write a DAMA form, ask the patient to sign, deny the patient any form of treatment and discharge?

The question here, ethically, what is the right approach in these cases? It is clear in the cases of LAMA when they do not inform the treating physician and leave. The treating physician cannot do anything, but in cases of DAMA when you still have the patient in front of you, would you discuss his thoughts about his condition with him? What is his next destination? Is he going to another health facility (government versus private, or less expensive facility), or a local bonesetter in fracture cases? Is he going home?

Does the treating physician have an obligation to facilitate aftercare when discharging a DAMA patient, even to patients who have a history of frequent DAMA and not using the aftercare provided? There is a wealth of literature on patients' rights, but there is a scarcity of literature on patients' duties and responsibilities.[1] The physician's duty is to guarantee that the discharge is as safe and appropriate as possible under the circumstances, which includes facilitating aftercare.

While others worry about the potential sequelae of partial treatment, it is understandable that many physicians would worry about the possible liability that is incurred by giving patients partial treatment. Many of the DAMA patients who get adverse outcomes complain against the treating physician who gave them partial treatment based on their own request.

Is it really enough to warrant such a negative attitude toward one of the patient's most basic rights, which is the right to choose what treatment they receive, how they receive it, and from whom? Are we essentially denying them their rights to protect ourselves? It is understandable with the widespread of all the malpractice lawsuits, and how one's reputation is questioned and said reputation is the source of livelihood for them and their families. However, we must consider what is truly at risk when physicians are so fearful over their own occupation that they would put it over their patient's rights.

I believe that in its current state, the medicolegal system is creating a gap between doctors and patients putting both at greater risk, because by allowing the physicians to be so heavily persecuted and by patients abusing their rights in suing them in the hopes of getting financial compensation, medical practice is losing its essence rather than pushing the furthest to help patients. Physicians are now opting to practice defensive medicine to do as much for the patient as is needed while maintaining a low probability for malpractice suits.

Since it is necessary to protect both patients and physicians, and for the physician to be a patient advocate (which is part of his job), I believe it might be crucial to implement a system, a protocol or "a sliding scale" that divides the grade of intervention based on the risk on the patient, like the ones already implemented in the ERs. Where for example if a patient is a low risk, it might be enough to give some verbal instructions with a follow-up appointment (plus medication or imaging depending on the case at hand), or if it is an intermediate risk, we might add that the patient must talk to a senior and/or social worker before being given the DAMA papers. However, in a high-risk patient where his limb or life is at risk, one might be prompted to judge the patient's capacity, and if the patient may be detained against their will for treatment. The last group is those who are a risk to others like patients threatening to harm themselves or others or those who are infectious to others. Those might need forced admission with the help of the security even without capacity assessment. Local legislation (this is different from one country to the other) will dictate what can be accomplished in such cases when the patient needs protection.

Perhaps, every major health-care facility should have a specialized DAMA/LAMA coordinator who should be involved in all cases of intermediate to high-risk patients. It might be a good idea to video record the conversation for ethical and legal purposes. Furthermore, the coordinator may need to call all DAMA/LAMA patients to ascertain the reason(s) why they left and use that information for audit of the hospital DAMA and LAMA cases. This practice will highlight modifiable reasons with possible remedies, which potentially could reduce the number of such patients leaving prematurely the health-care facilities.

Educating medical students and residents during the communication skills and patients' rights and responsibilities sessions about DAMA and LAMA's potential causes and how to handle these cases is another strategy to reduce the occurrence.

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