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DISCHARGE AGAINST MEDICAL ADVICE IN THE EMERGENCY DEPARTMENT: A TERTIARY CARE CENTER ANALYSIS

Emergency Medicine

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ABSTRACT

Background: Patients leaving Against Medical Advice (AMA) from Emergency Departments (EDs) in tertiary care settings present with acute, life-threatening conditions. AMA is associated with increased morbidity, mortality, readmissions, and poor resource utilization, with many returning worsened. **Objectives:** To identify key demographic patterns and contributing factors (both patient-related and system-related) leading to patients leaving AMA from the Emergency Department. To quantify the magnitude of various factors including financial constraints, preference for alternative therapies, and other socioeconomic determinants influencing AMA decisions. **Methods:** This prospective observational study using simple random sampling was conducted over May-August 2024 in the Emergency Medicine Department . All patients leaving AMA from the ED during the study period were included (n=93). Demographic data and reasons for leaving AMA were collected through structured questionnaires administered to patients and their attendants via direct interview and telecommunication. Data were analyzed using descriptive statistics. **Results:** A total of 93 patients . Males constituted 64.5% (n=60) and females 35.4% (n=33). Pediatric patients (<16 years) comprised 18.27% (n=17) and elderly patients (>65 years) 16.12% (n=15). Financial constraints were the most common reason for leaving AMA (30.10%), followed by preference for alternative therapy (15.05%), and ignorance regarding medical attention (10.75%), transfer to corporate hospitals (9.6%), prolonged waiting time (7.5%), doubts about diagnosis and unclear explanation (6.45%), and dissatisfaction and second opinion (5.37%). Lower socioeconomic status was strongly associated (55.91%). Readmissions 10.8% with worsened symptoms. **Conclusion:** Leaving against medical advice in tertiary care emergency settings is predominantly driven by financial constraints and socioeconomic factors. Understanding these determinants is crucial for developing targeted interventions. Addressing financial barriers, improving patient education, enhancing communication strategies, and reducing waiting times can significantly reduce AMA rates and improve patient outcomes while optimizing ED resource utilization.

KEYWORDS

Against medical advice, LAMA, Emergency department, Tertiary care, Financial constraints, Patient discharge, Readmission

INTRODUCTION

Leaving against medical advice (LAMA) represents a significant challenge in emergency medicine, with global prevalence ranging from 0.07% to 20%[1]. Emergency physicians struggle daily with the responsibility and potential implications of patients leaving against medi cal advice (AMA)[2].

Patients leaving AMA account for approximately 1 in 50 hospital discharges[3] and are associated with higher health care costs[4,5] and face substantially higher risks including readmission rates up to four times higher[6,7] and elevated morbidity and mortality[8,9].

This population is characterized by vulnerability-patients with substance abuse, low income, and mental health problems are disproportionately represented[6,7,8]. Readmissions following AMA incur 50% higher costs[10]. Multiple factors drive AMA decisions: financial constraints, prolonged waiting times, family obligations, treatment dissatisfaction, and perceived improvement[8]. The American College of Emergency Physicians reports malpractice litigation risk of one lawsuit per 300 AMA cases[11,12].

In India, where tertiary care centers serve diverse socioeconomic populations, understanding AMA causes is vital. Financial burden, limited insurance, and preference for traditional medicine play prominent roles. This study identifies demographics and contributing factors of patients leaving AMA from a South Indian tertiary care ED.

MATERIALS AND METHODOLOGY:

Design: Prospective observational study approved by Institutional Ethics Committee with informed consent.

Sample Size – 93 patients.

Inclusion Criteria

- All ED patients, AIMS&RC, Devanahalli (May-August 2024)
- Left against medical advice from ED
- Provided informed consent

Exclusion Criteria

- Post-admission AMA from specialty departments
- Unwilling participants
- Absconded without notification

AIMS:

Primary Objective:

Identify demographics and key factors contributing to AMA from ED.

Secondary Objectives:

Quantify factors including financial constraints, alternative therapy preference, waiting time, and assess socioeconomic profile and readmission patterns

DATA COLLECTION:

After Institutional Ethics Committee approval and informed consent, Structured questionnaires administered via direct interview or telecommunication captured demographics, reasons for AMA, and readmission data.

Statistical Methods:

Data were entered into Microsoft Excel and analyzed using descriptive statistical methods. Categorical variables were expressed as frequencies and percentages.

Clinical Definitions

- **Against Medical Advice (AMA):** A patient's decision to leave the emergency department before the treating physician recommends discharge, despite being informed of potential risks and consequences[13].
- **Leave Against Medical Advice (LAMA):** Synonymous with AMA; patient-initiated premature departure from ongoing medical care[14].

RESULTS:

Table – 1: Patient Demographics

Variable	Number (N=93)	Percentage
1. Gender Distribution		

Male	60	64.5%
Female	33	35.4%
2. Age Group Distribution		
Pediatric (<16 years)	17	18.27%
Adult (16-65 years)	61	65.59%
Elderly (>65 years)	15	16.12%
3. Socioeconomic Status		
Lower class	52	55.91%
Middle class	21	22.58%
Upper class	20	21.51%

Table 2: Reasons For Leaving Against Medical Advice

Reason for Leaving AMA	Number (N=93)	Percentage
Financial constraints	28	30.10%
Preference for alternative therapy	14	15.05%
Ignorance regarding medical attention	10	10.75%
Transfer to corporate hospital	9	9.68%
Prolonged waiting time	7	7.53%
Doubt about diagnosis/unclear explanation	6	6.45%
Dissatisfaction with treatment/second opinion	5	5.38%
Other reasons	14	15.05%

Table 3: : Readmission Status Following AMA

Outcome Parameter	Number	Percentage
Readmission with worsened symptoms	10	10.75%
No documented readmission	83	89.25%

Among 93 patients, males predominated (64.5%) versus females (35.4%). Adults comprised 65.59%, pediatric patients 18.27%, and elderly 16.12%. Lower socioeconomic class represented 55.91%, middle class 22.58%, and upper class 21.51%.

Financial constraints were the predominant reason (30.10%), followed by alternative therapy preference (15.05%) and ignorance regarding medical attention (10.75%). System factors included corporate hospital transfer (9.68%), prolonged waiting (7.53%), unclear explanations (6.45%), and treatment dissatisfaction (5.38%). Ten patients (10.75%) were readmitted with worsened symptoms.

DISCUSSION:

This study reveals critical insights into AMA patterns from a South Indian tertiary ED. Male predominance (64.5%) aligns with international findings[14,15]. Over 55% from lower socioeconomic class underscores financial barriers' critical role in Indian healthcare access. Financial constraints (30.10%) represent the primary driver, reflecting limited universal coverage and high out-of-pocket costs. This profoundly impacts treatment completion in economically vulnerable populations[4,5]. Alternative therapy preference (15.05%) reflects cultural healthcare-seeking patterns where Ayurveda and Unani maintain credibility, driven by cultural beliefs, perceived safety, and lower costs.

System factors-waiting times (7.53%), unclear explanations (6.45%), dissatisfaction (5.38%)-collectively represent 20% of cases and offer quality improvement opportunities. The 10.75% readmission rate with worsened symptoms demonstrates clinical consequences, consistent with literature showing quadrupled readmission rates[6,7] and increased costs[8,9].

Strategies to Reduce AMA:

Patient-centered communication exploring underlying concerns rather than immediate documentation[15]; financial counseling integrating government schemes and payment alternatives; alternative discharge planning using harm reduction approaches with abbreviated plans and outpatient follow-up[15]; efficient triage reducing waiting times; clear explanations in understandable language; cultural sensitivity acknowledging traditional medicine beliefs; avoiding stigmatizing "AMA" labels while ensuring informed refusal[15].

Limitations:

- Single-center design limits generalizability
- Sample size may limit subgroup comparisons
- Questionnaire data subject to recall and social desirability bias
- Readmission follow-up limited to same institution

CONCLUSION:

AMA from tertiary EDs is predominantly driven by financial constraints and socioeconomic vulnerabilities, with contributions from alternative therapy preferences, system factors, and communication gaps. Males and lower socioeconomic patients are disproportionately represented.

Reducing AMA requires multifaceted approaches: financial counseling and support, enhanced physician-patient communication, reduced waiting times, and culturally sensitive care. Patient-centered discharge protocols prioritizing harm reduction minimize adverse consequences. Healthcare policy expanding financial protection and ED operational improvements targeting modifiable factors are crucial for reducing LAMA rates and improving emergency care quality and safety.

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