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THE IMPORTANCE OF A PROPER AGAINST-MEDICAL-ADVICE (AMA) DISCHARGE: HOW SIGNING OUT AMA MAY CREATE SIGNIFICANT LIABILITY PROTECTION FOR PROVIDERS

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☐ **Abstract—Background: Every year, patients leave the Emergency Department against medical advice (AMA) and before an adequate evaluation can be performed. It is well known that many of these patients are at risk of subsequent complications. Objective: The goal of this article is to explain the potential legal protections that may be created from a proper AMA discharge. Discussion: In this article, the authors review the steps that need to be taken when performing an AMA discharge, including an assessment of capacity, proper documentation, and adequate disclosure. The authors then review the potential legal protections that can result from a properly documented and performed discharge. Among these protections are: proof that the provider's duty to the patient ended with discharge and that the patient assumed the risk of a subsequent complication. Conclusion: The authors conclude that a properly executed discharge can provide significant legal protection from liability risks.** © **2012 Elsevier Inc.**

☐ **Keywords—malpractice; liability; AMA; against medical advice; protections; capacity; disclosure; assumption of risk; negligence; duty**

INTRODUCTION

Against-medical-advice (AMA) discharges are a significant problem in emergency departments (EDs) across the United States. Approximately 1–2% of discharges at acute care hospitals in the United States are AMA; this figure goes up to 6% in disadvantaged inner-city populations (1,2). A study at a major academic medical center found that about 2.7% of patients left the ED AMA (3). This problem is not limited to the United States. A prior study in the United Kingdom found that .73% of ED patients left AMA and that 3% did not wait to be seen (4).

A number of empiric studies have demonstrated that patients who leave AMA have higher readmission rates and may have increased risks of adverse health effects (1,3,5). Risk of emergent hospitalization seems to be highest in the first 9 days after the AMA discharge (3). This short-term risk of hospital admission suggests that AMA discharges adversely impact patient safety. Whether this short-term admission rate is due to incomplete treatment during the initial ED visit or other reasons remains unclear.

Patients who present with high-risk clinical conditions may pose the greatest safety risk. Of note, concerning complaints such as non-specific chest pain and abdominal pain are often presenting problems among patients who eventually leave AMA (3). Table 1 illustrates some of the more common complaints and characteristics of patients who sign out AMA (2,3). The purpose of this article is to explore the legal requirements of the AMA process and to examine the legal protections that can be created by properly executed AMA discharges.

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Table 1. AMA Patient Risk Factors

Shared traits	Common Presentations	Reasons for Leaving AMA
Young age	Psychiatric conditions	Personal obligations
Male	Nausea and vomiting	Financial concerns
Low socioeconomic status	Abdominal pain	Dissatisfaction with care
No health insurance	Nonspecific chest pain	Subjective improvement in treatment
No primary care physician	Alcohol-related disorders	
Substance abuse	Headache	

AMA = against medical advice.

DISCUSSION

Proper AMA Discharge

Given the prevalence of AMA discharges and the serious problems that they present, emergency physicians should make every attempt to prevent a patient from leaving AMA (3). However, if it is unavoidable, three requirements should be met for the AMA process to confer optimal legal protection. First, a patient should be deemed to have the capacity to refuse care. Second, all potential risks should be disclosed. Third, the AMA consent should be properly documented in the chart.

1) Capacity. The law dictates that a patient has the right to refuse medical care and that treatment without consent may be considered battery (6,7). When a patient signs out AMA, he or she is exercising this right to refuse care. However, before a patient can do this, it must be determined that the patient has the capacity to make this decision. If a patient is not capable of making a decision, then a provider cannot ethically or legally allow a discharge that may imperil the patient's life or health. As noted above, a patient has a legal right to refuse care, but this right can only be exercised if a patient has decision-making capacity (6,7). An assessment of decision-making capacity focuses on a patient's ability to understand and communicate a rational decision (8). This determination centers around whether a patient can manipulate information regarding a specific task or procedure. It does not require that a patient be free of mental illness or delusions. The essential elements of this assessment are denoted in Table 2 (9).

Capacity is not the same thing as competence. Competence is determined by a court of law and uses issues of capacity in evaluating the legal ability to contract (9). Although courts have found that intoxication can impair a patient's competence and ability to refuse medical treatment, a patient who is intoxicated does not automatically lack the competence or capacity to make medical decisions (10). Similarly, as noted above, patients with psychiatric complaints can also be difficult to assess, but do not necessarily lack capacity or competence.

In general, the determination of capacity is relatively straightforward. However, patients presenting with intoxication or psychiatric disorders can make such determinations challenging. Moreover, it is inappropriate to assume that a patient with mental pathology, sedation, or cognitive deficit lacks decision-making capacity. A formal assessment of capacity is necessary.

If the capacity of the patient is unclear and the patient wishes to leave AMA, emergency physicians should consult Psychiatry whenever feasible. If, after consultation, the patient's capacity remains uncertain, the best course of action may be a period of prolonged observation. In cases of intoxication, a patient's mental capacity often returns as the effects of the ingested substance clear. In those cases where intoxication persists and hampers capacity, involuntary admission may be the only remaining course of action for a patient who wishes to leave AMA but lacks capacity.

2) Adequate Disclosure of Risks. First and foremost, it should be pointed out that the adequate disclosure of risks to a patient attempting to leave AMA is primarily an ethical obligation of all practitioners. It is only secondarily a risk-management requirement and tool. Further, the patient's signature on an AMA form, by itself, does not indicate informed consent. Before executing an AMA form, the emergency physician must conduct a thorough

Table 2. Elements of Capacity

1. Ability to express a choice: The patient must be able to express his or her choice and communicate that choice.
2. Ability to understand relevant information: The patient must be able to understand information about the purpose of treatment, remember the information, and show that he or she can be part of the decision-making process.
3. Ability to appreciate the significance of the information and its consequences: The patient must understand the consequences of treatment refusal and the risks and benefits of accepting or refusing treatment.
4. Ability to manipulate information: The patient must be able to engage in reasoning as it applies to making treatment decisions (e.g., use logical processes, weigh treatment decisions and manipulate information about treatment decisions) (Mufson) (9).

discussion with the patient about the risks and consequences of leaving AMA. This is because informed consent requires: 1) disclosure of information, 2) comprehension by the patient, and 3) voluntariness (11). The emergency physician should provide the patient with all information relevant to the decision in an understandable manner, including the patient's medical condition, therapeutic options, and the risks and benefits of accepting or refusing treatment. The patient should then be asked to confirm his or her understanding of this information and demonstrate a reasoned basis for deciding to leave AMA. Table 3 lists the key elements to include when signing out a patient AMA.

Failure to properly inform a patient about the specific risks of leaving AMA may create legal liability despite the patient's refusal of care. In *Battenfeld v. Gregory*, the plaintiff sued two emergency physicians for delay in removing her infected appendix (12). Although she had executed an AMA form, the physicians had failed to inform her of the risks of leaving the hospital in her condition. The jury returned a verdict for the plaintiff and found that the failure to explain the risks of leaving AMA was not excused by the patient's execution of an AMA form (12). This case illustrates the need for emergency physicians to adequately explain the risks of leaving AMA to be protected.

3) AMA Discharge Should Be Properly Documented. If the patient has capacity, has been adequately informed of the risks, and still insists on leaving the ED against medical advice, emergency physicians should document the discharge. Proper documentation may be done within the body of the patient's chart and should include elements such as the patient's decision-making capacity, the risks that were disclosed, the patient's understanding of the risks, the patient's decision, and both the patient's and provider's signatures. Of note, use of a comprehensive AMA form may increase proper documentation.

In the Henson et al. study, it was shown that when providers used detailed AMA forms, physician documentation improved (13). In this study, the investigators compared the documentation of AMA discharges before and after use of a detailed template form, which included an assessment of the patient's capacity, medical risk, and outcomes (13). In contrast to this template, the previously used form employed at the test hospital had only a single boilerplate sentence indicating patient consent to discharge AMA (13). Of the 55 audited cases in which the older form was used, no assessment of capacity was documented on any of the forms. Also, this audit showed that only 58% of the AMA patients signed the discharge form before leaving, 25% of the patients were seen by a physician before leaving, and 31% of the patients left the department without the staff's knowledge (13). That is, there were no notes indicating that the patient left AMA in 31% of the cases. In comparison, of the 56 cases reviewed using the comprehensive form, capacity was documented in 80% of the cases, 80% of AMA patients signed the form, 41% of the patients were seen by doctors before leaving the department, and none of the patients left without the documented knowledge of a physician (13). Table 4 lists some desired elements of a comprehensive AMA form. These elements can also be documented in the chart. However, the use of a comprehensive form may improve documentation, as noted above.

Emergency physicians should assess the AMA form for adequacy and should hand-write in any of the above items if they are missing from the respective forms. If the patient refuses to sign the AMA form, the physician should read it aloud, document the refusal to sign, and document the fact that the patient was made aware of the risks of leaving.

Legal Protections Afforded by a Properly Executed AMA

Although AMA forms and procedures do not completely insulate emergency physicians from liability in a medical malpractice action, properly executed AMA forms and

Table 3. Elements of a Proper AMA Patient Conference

- Discuss the recommended course of treatment and available alternatives;
- Go over the specific risks of that patient refusing treatment;
- Ask the patient to explain their diagnosis;
- Have the patient describe the consequences to them of leaving AMA;
- Evaluate the patient's rationale for leaving AMA;
- Discuss follow-up care and the patient's option to return to the ED;
- Notify the patient's primary physician and their family or friend;
- Document the discussion in the medical record.

AMA = against medical advice; ED = emergency department.

Table 4. Required Components of a Comprehensive AMA Form and Discharge Instructions

Formalities:
Signature of physician and patient
Date and time of AMA discussion and form execution
Personalized to patient:
Medical condition(s)
Specific risks and benefits of proposed treatment and alternatives
Specific consequences of leaving AMA
Reports results of mental capacity assessment:
Patient understanding of proposed treatment
Patient understanding of consequences of refusing treatment
Patient's reason for refusal of admission or treatment
Lists follow-up instructions:
Self-care and when to seek medical attention
Arrangements with police, social services, relatives, etc.

AMA = against medical advice.

procedures can confer important legal protections. However, it must be understood that this is not a legal panacea and will not always provide total immunity from suit. In addition, the tort laws (liability laws) of the United States are dictated by state law and vary depending on the state jurisdiction. Some states are more amenable to these defenses than others. For example, in the state of New York, an AMA disclaimer that releases a physician from all future liability upon discharge may be considered against public policy (14,15). This being said, there are three significant ways that the use of a properly executed AMA form can create protection from future liability: 1) the termination of the legal duty to treat a patient; 2) creation of the affirmative defense of "assumption of risk"; and 3) the creation of record evidence of the patient's refusal of care.

1) Signing Out AMA May Terminate a Physician's Legal Duty to Treat. Adherence to AMA protocols may enable emergency physicians to raise a unique defense to a medical malpractice claim—the absence of a duty to treat a patient after the patient leaves AMA. The duty to treat is one of the four elements of negligence that a plaintiff must prove to prevail in a malpractice action. In addition to a duty to treat, a plaintiff must show that a physician breached this duty by failing to adhere to a standard of medical care when treating the patient. This breach must be shown to have caused the patient to suffer injury or damages (16). The plaintiff must prove each of these elements in order for a negligence case to proceed.

Contrary to most malpractice cases, which focus on the element of breach, the pivotal issue in an AMA case may be whether a duty to treat existed at the time of the patient's injury. The duty to treat arises with the formation of the physician-patient relationship. Absent that relationship, the physician has no duty toward the patient and, therefore, cannot be liable under a negligence theory. Duty is generally implied when the patient presents to the ED. In an AMA case, a critical inquiry may be whether the duty to treat has ended. Courts have found that a proper AMA discharge terminates the physician-patient relationship, and with it, the physician's duty to treat the patient. For example, in *Brumbalow v. Fritz*, the plaintiff fell in an ED hallway and fractured her hip after she had left AMA (17). The court found that the emergency physician had no duty towards the plaintiff at the time of her fall because her AMA had effectively ended the physician-patient relationship (17). Similarly, in *Griffith v. University Hospitals*, the court found that the decedent had terminated the physician-patient relationship when she left the ED AMA without informing hospital staff (18). Finally, in *Lyons v. Walker Regional Medical Center, Inc.*, the court affirmed a jury verdict for the hospital partially on the grounds that the patient's AMA discharge ended the physician-patient relationship (19). In each of these cases, the courts held that because the physician had no duty to treat, he/she could not be liable for injuries the patient suffered subsequent to the AMA discharge.

2) AMA May Create an Assumption-of-Risk Defense. A properly performed AMA discharge may also entitle the provider to the additional defense of assumption of risk. Unlike the argument in which the defense asserts that signing out AMA terminates the duty to treat, assumption of risk is an affirmative defense. An affirmative defense is an excuse, or justification, that allows the defendant to avoid liability regardless of his or her conduct. That is, even if the case of negligence is proven, an affirmative defense is an excuse that prevents a finding of liability. In the context of an AMA case, the assumption of risk defense asserts that a patient who chooses to leave AMA has voluntarily assumed the risk of his or her subsequent injury. The assumption of risk defense is not applicable in all jurisdictions. However, if appropriate, this defense requires three legal elements: 1) a patient's knowledge of the existence of a dangerous condition; 2) understanding of this danger; and 3) failure to exercise care to avoid the danger (19). These legal elements become clinically relevant when the provider informs the patient that he or she may be sick, the patient understands the risk of an AMA discharge, and he or she still refuses care despite this knowledge. Appropriate disclosure of potential risks and documentation of such discussions with the patient can support this defense. If proven, the assumption of risk defense can completely avoid a finding of negligence.

The assumption of risk defense has been previously used in cases where patients have signed out of the ED against medical advice. In *Lyons v. Walker Regional Medical Center, Inc.*, the Supreme Court of Alabama found that an assumption of risk defense was appropriate when a patient signed out from the ED against medical advice after being told that "[he] could die" without proper treatment (19). After discharge, a laboratory value for this patient indicated that he was in diabetic ketoacidosis. Subsequently, the patient died (19). The Court determined that it was appropriate for the defendant to claim that the patient had made an informed decision to leave and thus, assumed the risk (19).

3) Evidence of the Patient's Refusal of Care and Assumption of Risk in the Medical Record. AMA procedures also function as a practical legal tool by providing emergency physicians with potential evidentiary support for the above defenses. When a lawsuit is filed and negligence is asserted against a physician, the medical record for the relevant admission or visit typically is considered

evidence of the case. With respect to such evidence, the AMA form is an essential statement by the plaintiff. If properly executed and documented, this form contains the patient's signed refusal of care and an acknowledgement of the risks posed by discharge. Having this contemporaneous document signed by the patient removes any attempt by the plaintiff to later claim that he or she was never explained the risks of leaving against medical advice or of denying that he or she actually signed the form.

Of note, an AMA form is not required for proper documentation. Memorializing the AMA discharge, the discussed risks, and the patient's refusal in the medical record preserves this information. Because this evidence is vital to prove the above defenses, the importance of good documentation cannot be underscored enough. This being said, a well-documented AMA consent form (specifying the risks of discharge) is a good method of documentation. Either the form or a well-documented record can potentially refute allegations that the discharge itself was done negligently or without proper disclosure of potential risks.

CONCLUSION

A properly executed and documented AMA form can provide significant protection from liability risk. If a patient is deemed to have capacity, is disclosed and understands the risks of leaving and still refuses care, emergency physicians may be protected from potential liability from adverse outcomes. Specifically, case precedent shows that emergency physicians may be able to claim that the legal duty to treat was terminated when the patient signed out AMA. In addition, emergency physicians may be able to rely on a defense that the patient "assumed" the risk of his or her actions upon discharge. Finally, the AMA form and documentation in the chart may provide vital evidence for any ensuing litigation. Providers would be well advised to take the additional time required to execute an AMA discharge so as to avail themselves of these added legal protections.

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