The Ramifications of At-Own-Risk Discharges in the Palliative Care Setting

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Received date: June 17, 2015**, Accepted date:** June 30, 2015**, Published date:** July 03, 2015

Abstract

Objective: The Principle of Respect for Autonomy is integral to the patient-physician relationship, yet within a society that prizes the value of life and remains defined by Confucian-inspired concepts of Beneficence, limits to respect for patient choice are increasingly apparent. This is particularly evident in the end-of-life setting and specifically in situations where terminally ill palliative care patients choose to leave health care institutions against medical advice potentially to the detriment of their health. Focusing on "discharges against medical advice" (DAMA), also known as "at own risk" (AOR) discharges within the palliative care inpatients setting, we highlight growing concerns on the AOR discharge process as it is practiced presently.

Methods: We used 3 patient case studies to highlight the various aspects of concern surrounding AOR discharges and its compromise of patient welfare, ostensibly as a result of compliance with the central tenets of the Principle of Autonomy and patient choice. To preserve the interests of the patient we propose the employment of Krishna, Lee and Watkinson's Welfare Model (WM) which offers a more clinically relevant and ethically sensitive means to decision-making at the end of life within societies still inspired by Confucian beliefs and the Principle of Beneficence.

Results: Based on the WM, AOR discharges in palliative care may be viable if decisions ki promise of pa deci V] hree d pcpere M empe end

The primacy of beneficence in the Singapore context

Singapore places a great emphasis on the value of life, as evidenced by e.g. (1) the outlawing of suicide [3], where the Penal Code Chapter 224, Chapter XVI Offences Affecting The Human Body states that whoever attempts to commit suicide, and does any act towards the commission of such offence, shall be punished with imprisonment for a term which may extend to one year, or with fine, or with both, and (2) the implementation of the policy of Advance Medical Directive (AMD) [4] which sets out to ensure that basic medical care is not routinely foregone ostensibly to hasten death. A welfare model backed by local socio-cultural beliefs and values thus validates the trumping of the Principle of Respect for Autonomy in favour of the Principle of Beneficence.

The practical assumptions underpinning utilisation of an AOR discharge

In the event of AOR discharge, a physician avoids the threat of professional negligence by meeting a number of basic obligations which include: (1) providing the patient appropriate information about his/her condition, (2) explaining current treatment options and (3) potential risks of treatment, (4) risks of non-compliance with medical advice, and (5) offering alternative treatment options.

Furthermore, the physician must try to ascertain that the patient has understood and cogitated upon this information, as well as clarified any areas of ambiguity in the information provided that may lead to gaps in comprehension. To facilitate this process, other medical staff may help to assess the patient's competence.

These discussions should be appropriately documented, and the patient should acknowledge these facts by signing the AOR discharge form. Levy et al. [5] suggest that in addition to the steps detailed above, "a properly executed" AOR discharge form is required to provide limited protection from future liability. The AOR discharge form proposed consists of information on: (1) the termination of the legal duty to treat a patient, (2) the creation of the affirmative defense of "assumption of risk", and (3) the creation of record evidence of the patient's refusal of care. To date, there are no relevant negligence cases on AOR discharges in Singapore or England.

However, the face of healthcare is evolving and rapidly embracing an integrated approach that sees all elements of medical care merging, to ensure safe and effective care transition between care settings. We

Medical team's responsibility to patient's family	No formal responsibility to the patient's family beyond the duty to maintaining the safety of the general public.	Part of the palliative care ethos is to provide care and support for the family, as well as bereavement support.
Levels of integration of the healthcare provision	In most cases, termination of the therapeutic relationship severs the responsibility of the unit towards the patient, since it is assumed that the patient would have refused transfer to the care of another physician or team.	An AOR in the palliative care setting may be difficult due to the integrated nature of services.
Methods used for appraisal of patient's competence	Appraisal of the patient's competence is carried out by 1 member of staff.	Appraisals are often carried out by more than one member of the multidisciplinary medical team.
The importance of cultural, religious, personal and social factors in the medical disciplines	Less emphasis is required on the patient's cultural, religious, personal and social factors, in the determination of capacity and the employ of an AOR discharge.	A holistic appraisal should be undertaken.
Time and resources available to discuss the patient's options	Limited opportunity to appraise the patient given time and resource constraints in emergency setting.	More time and resource in a palliative care setting to discuss patient's options.
Necessity of follow-up by medical teams	The patient may not be followed-up by the team after transfer to another discipline.	A follow-up by the home care team is usually done.
Availability of the option of home leave or terminal discharges	The option of home leave or terminal discharges is not available in an acute emergency setting.	The option of home leave or terminal discharges rather than an AOR is available, in order to preserve the therapeutic relationships in palliative care.

Case 3

Teng Chee was admitted to a palliative care hospice due to refractory acute myeloid leukaemia and bone marrow failure. Despite his bleeding diathesis, Teng Chee was adamant on pursuing Traditional Chinese Medical treatment (TCM), which included the use of cupping and acupuncture. When the medical team would not condone such treatment, Teng Chee opted for an AOR discharge. Teng Chee was motivated by his family not to 'give up' and continue to 'fight' through the use of TCM. For the family and Teng Chee who were told of the risks of cupping and acupuncture, TCM represented 'hope' when conventional Western options had failed. In addition, Teng Chee saw entering the hospice as 'giving up' and accepting his death, even though he was aware that he was bleeding spontaneously from his mouth, nose and rectum, and that the cupping which was applied to his back could result in severe pain, hematomas and potentially death.

Results

Analyses of the cases

In all 3 cases, an AOR discharge was granted. However, it is important to understand the (1) various psychosocial¡gî ld baíd a#T

there is acceptance of the role of the palliative care team in caring of the patient's loved ones during the patient's illness as well as in providing bereavement care later.

When the patient realizes these long-term goals, a break in the therapeutic physician-patient relationship may be prevented. Furthermore, palliative care as a whole attempts to convey a more holistic and humanistic approach to care provision. In light of this view, an AOR discharge is much less desirable in comparison to a consensus about treatment from the physician, patient and other stakeholders after careful and in-depth discussion.

Efforts must be made to prevent deterioration in the relationship to the point when an AOR becomes necessary. To make compromises that are acceptable for the patient, the patient's family and the medical team should have regular meetings and understand one another's point of view, which would culminate in a much more desirable outcome than an AOR discharge. Here, flexibility is important as one may then arrange for medically-sanctioned discharges home, where the patient care is facilitated. Notably, shared decision making has a role in achieving more patient-centred care in decisions related to discharge against medical advice [37]. Hastily arranged medically-sanctioned discharges home that accept the realities of inevitable compromises in patient care are facilitated, often with home hospice care input, in order to preserve the therapeutic relationship.

Careful consideration of Mark's (Case 1) situation on his wish to continue to smoke and his concepts of preserving his sense of dignity at the end of life, would have culminated in a better resolution instead of his subsequent experience, which was a re-admission to hospital some days later following a fall. On the other hand, closer inspection of Nia's (Case 2) predicaments would have revealed that beyond the concerns about costs, was the pressure on the family to not 'abandon' the patient to a hospice, but to care for her at home. Facilitating the practical and personal needs of the family members, as they prepared to take 'no pay leave' to care for her, would have led to a more palatable solution. Tee Cheng's (Case 3) family members were under significant pressure to fulfil their filial obligations to continue to care for him and Tee Cheng himself felt obliged to let them try, simply to prevent his children from being seen as abandoning him to his fate and subsequently enduring a 'loss of face', i.e. suffering humiliation from others.

Decisions made based on patient's context

Balance between a paternalistic approach and absolute patient autonomy is sought through careful and active listening to the patients concerns, wishes and views, while also assessing the viable options that least compromises their care [38]. This process of assessment also serves to correct misunderstandings and address shortfalls in patient care, thus providing a better understanding of the psychodynamics of the patient's and their carer's social, emotional, physical, financial, spiritual and cultural considerations. Such a process will improve the understanding of the positions of various parties' involvement in the deliberative process, build trust between patients, their caregivers and health care professionals, allow appraisal of the way in which decisions are made, and lower the prevailing tensions during the deliberative process. It will also provide insights into the reasons for acting against medical advice and potentially identify more acceptable alternatives for effective and practical delivery of patient-centred care [30-32,38]. This is evident from the later evaluations of the three cases presented.

Having a multidisciplinary medical team to obtain a 'balanced' viewpoint

In Singapore, a multidisciplinary medical team approach employs a group of people of different healthcare disciplines, which meets together at a given time (whether physically in one place, or by video or teleconferencing) to discuss a given patient [39]. The multidisciplinary team is seen as a source of 'balance' to various ideas, opinions and perspectives of all involved in a patient's care, in order to provide a holistic viewpoint of the situation. This ensures that all decisions made are well-considered, equitable, effective, and accountable and focused on providing the patient and their families with the best and most appropriate care as determined by the specifics of their individual circumstances. Through careful consideration of both clinical and psychosocial issues, in addition to the values, cultural and spiritual matters relevant to the patient, decisions made on care provision will be beyond a purely clinically-orientated approach. Therefore, there are times when the input of the physician is not the most important. Instead, the medical social worker's perspectives become the pivotal factor when significant psychosocial considerations are involved, as was the case with Nia (Case 2) or the physiotherapist and the occupational therapists in Mark's (Case 1) circumstances and the nurse's understanding of Teng Chee's (Case 3) sociocultural pressures.

Given the breadth and variability of individual factors to each specific aspect, it is logical that a multidisciplinary team, rather than a single individual member of the health profession, ³M s event at`

minimize disruption to patient care [30,31]. Such actions ensure accountability, transparency and true understanding of the patient's progress, in the process of discussing the patient's options.

Conclusion

It is clear that using an AOR discharge within the local health care setting is fraught with problems, as a result of the wider considerations of palliative care patients and the overarching goals of a palliative care approach. Indeed, we hope that discussions thus far emphasize the importance of maintaining the therapeutic relationships in patient care, and provide greater impetus to curtailing the need for AOR discharges wherever possible, among inpatients of palliative care or other medical disciplines. We hope that using the multidimensional approach adopted within Krishna, Lee and Watkinson's Welfare Model [41] to assess the situation will help in these efforts.

However, we also hope that should these efforts fail and an AOR discharge does arise, Krishna, Lee and Watkinson's Welfare Model [41] will pave the way to decisions which extend beyond simple respect for patient autonomy, and aspire towards broader considerations of the patient's welfare based on the far-reaching goals of a holistic palliative care approach.

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