An Examination of Whether Discharging Patients Against Medical Advice Protects Physicians From Malpractice Charges

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Objective: **Many physicians believe that documenting a discharge as "against medical advice" protects them from legal actions for adverse consequences related to the discharge. The authors examined case law for evidence of such protection.** ***Methods:*** **MEDLINE and PsycINFO databases were searched for relevant articles. The medmal.base of Lexis and West Group was searched for annotated case law.** ***Results:*** **Four relevant cases were found in which medical authorities and physicians were sued for medical malpractice even though they discharged a patient against medical advice. In all cases the defendants prevailed. However, their success was not due to the fact that they used the procedure of discharging patients against medical advice. Rather, it was based on the plaintiffs' failure to prove negligence. The authors offer guidelines for physicians faced with the decision to discharge against medical advice. Physicians should perform a careful and well-documented examination. They should assess the severity of illness and the severity of the risk if the patient is discharged. They should engage in a constructive dialogue with the patient about grievances. They should ensure that the patient's withholding of consent for further hospitalization is informed with respect to risks, benefits, and alternatives. If the patient meets criteria for involuntary hospitalization, the patient should be committed.** ***Conclusions:*** **Good clinical practice and thorough documentation remain the best legal protection. Discharging a patient against medical advice may provide partial protection, but it is not a royal road to legal immunity. (*Psychiatric Services* 51:899–902, 2000)**

An estimated 6 to 35 percent of hospitalized psychiatric patients are discharged against medical advice (1). The literature shows that patients who discharge themselves against medical advice have a higher number of previous hospitalizations, shorter lengths of stay, higher rehospitalization rates, and more severe symptoms at the time of discharge, and they typically live alone (2). They tend to be young males and to have emergency admissions (3).

The prognoses of patients who leave emergency services against medical advice are not as serious as those of patients who consent to admission but are more serious than those for whom admission is not recommended (4). Common diagnoses are substance use disorders (2,5), personality disorders, and schizophrenia (3). Psychological factors involved in a patient's decision to leave against medical advice include anger, overwhelming fear, and psychotic reactions. The threat to leave may be an effort to communicate feelings (6). Schlauch and associates (7) suggested a subtle or not-so-subtle collusion between the patient and the medical staff, in which it is agreed that leaving against medical advice is an appropriate method of discharge, especially in cases that are not perceived as critical.

Implicit in the use of the term "against medical advice" is the physician's notion that it is some form of disclaimer that automatically exonerates the physician in the event of an adverse consequence. However, we could find no overt discussion of whether discharging a patient against medical advice is indeed protective in a legal challenge. Therefore, we studied case law to propose clear clinical guidelines with respect to the use of discharges against medical advice.

Methods

MEDLINE and PsycINFO databases were searched for relevant articles. The medmal.base of Lexis and West Group was searched for annotated case law.

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Results

Four relevant cases were found. They are reviewed below.

Kelly v. United States of America and John Doe et al.

In this 1987 case the plaintiff challenged the decision of a Veterans Administration medical center to release patient Arnold Shockley against medical advice (8). One day after Mr. Shockley's release, he stabbed a police officer.

The last of Mr. Shockley's several admissions to the VA medical center in Coatesville, Pennsylvania, was from November 1 through December 12, 1984. No evidence of violent or aggressive behavior or violent delusions was noted during the hospitalization, and records indicated that Mr. Shockley was not a management problem. He had unauthorized absences on several occasions while hospitalized, and he submitted multiple requests for discharge against medical advice, which were granted and later canceled when he returned to the hospital.

On admission, Mr. Shockley was noted to be disheveled and unkempt, with a strong body odor. He complained of hearing voices. During the initial examination, the clinician found that he did not have a present potential for suicide or injury to others. A diagnosis of chronic schizophrenia was made.

On December 10, 1984, Mr. Shockley signed a request to be released against medical advice. The nurse on duty noted that the patient was frustrated and angry about being hospitalized. Before his release, Mr. Shockley was seen by the psychiatrist on duty who reviewed his chart, conferred with nursing staff, and spoke with Mr. Shockley. The psychiatrist believed that the patient was not a clear and present danger to himself or others and made the medical determination that at the time of his release, Mr. Shockley could not have been committed involuntarily. Despite his efforts to convince Mr. Shockley to remain hospitalized, he was eventually discharged against medical advice and advised to seek follow-up at a clinic.

Under the Pennsylvania Mental Health Procedures Act, mentally ill patients are entitled to the "least restrictions consistent with adequate treatment." A person is subject to involuntary treatment and examination only when, as a result of mental illness, the person poses "a clear and present danger of harm to others or himself" as shown by conduct within the past 30 days. Under the act, clear and present danger to others must be shown by establishing that within the past 30 days, the person has inflicted or attempted to inflict serious bodily harm on another and that a reasonable probability exists that such conduct will be repeated. A clear and present danger to self must be shown by establishing that within the past 30 days the person's actions provide evidence that the person is not able to care for him- or herself and a reasonable probability exists that death, serious bodily injury, or serious physical debilitation would ensue within 30 days; the person has attempted suicide; or the person has substantially mutilated him- or herself or attempted to do so. The statute further provides that a doctor may be held liable for a decision to authorize release against medical advice only if a plaintiff can prove that the doctor acted with gross negligence or willful misconduct.

In *Kelly v. United States,* no witness testified, nor did any hospital record indicate that Mr. Shockley committed any acts of violence before his release against medical advice on December 10, 1984. The record of his hospitalization and conduct for the 30 days before his release could not support a prediction of violence the following day.

Mr. Shockley, who was 30 years old at the time of the stabbing, had several psychiatric admissions at Albert Einstein Medical Center before entering the Army in 1972. He was discharged as unfit for military duty in 1974 while serving in Korea and was hospitalized after he began to hear voices. He was then transferred to the VA medical system in Philadelphia, where he had numerous admissions. On one occasion he was brought by the police to the emergency room of a university hospital when he was found running nude in the streets, clutching a Bible shouting, "Satan ain't shit," "Get away from me, Satan," and "The Lord is my shepherd, I shall not want." Most of his many admissions were voluntary, and many of them ended with discharge against medical advice.

The court found that, under the criteria of the Pennsylvania Mental Procedures Act, the doctor exercised reasonable judgment in determining that Mr. Shockley was not a present danger to himself or others. The court held that no reasonable grounds existed for the doctor to seek involuntary commitment procedures against Mr. Shockley just before the stabbing. Although the doctor involved could not document that he conducted a complete mental status examination of Mr. Shockley on the day of discharge, it is clear that he knew the patient's medical history and present medical condition at the time of discharge. Because of these factors and because the Pennsylvania Mental Procedures Act requires that gross negligence or willful misconduct be shown, the court decided in favor of the defendants and against the plaintiff.

Solbrig v. United States of America

On January 3, 1990, Terrence "Mike" Solbrig committed suicide by ingesting a lethal quantity of pills. For 22 years before his death, he had suffered from posttraumatic stress disorder and bipolar disorder, which frequently left him depressed, listless, and thinking of suicide. Mr. Solbrig's mental illness developed after combat service in Vietnam. After his death, his wife brought an action against the United States alleging that the VA hospital in Milwaukee and two of its employees should not have released Mr. Solbrig, as he was at clear risk of suicide (9). He stayed at the facility on January 2 and 3, 1990, and died within hours of his release, which was against medical advice.

Mrs. Solbrig claimed that the hospital was negligent in entrusting Mr. Solbrig's care to two doctors who were unqualified either to diagnose or to treat him and that the doctors were negligent because they failed to recognize the substantial risk that he was suicidal when he was discharged. She contended that given Mr. Solbrig's condition, he should have been involuntarily committed under Wisconsin law rather than released against medical advice. The principal issue in the case was whether the VA breached its duty of care.

Mr. Solbrig was admitted to the VA hospital in the late afternoon of January 2, 1990, complaining of inability to

sleep, depression, and thoughts of suicide. The admitting doctor found no present intent or plan to commit suicide and noted that Mr. Solbrig's judgment was adequate and his understanding intact. An admission nurse on the psychiatric unit observed signs of hopelessness and suicidal thoughts but no present plan to commit suicide. Mr. Solbrig denied experiencing hallucinations or delusions. He was restricted to the ward. Some blood tests were done, and a sleeping medication was prescribed.

The next morning, after an apparently good night's sleep, Mr. Solbrig met with the two doctors, neither of whom was a psychiatrist. However, both had been granted privileges in the psychiatry clinic, which permitted them to take histories, perform physical examinations, and order investigations and treatment. Relying on the government's expert witness, the court concluded that the doctors were qualified to conduct the interview of Mr. Solbrig on January 3 and were qualified to make the decision to release him against medical advice. The expert testified that only a tiny percentage of doctors were psychiatrists and that it was common and acceptable practice for hospitals to assign doctors who were not psychiatrists to work in psychiatric clinics. The two doctors were competent to treat depressed people and make appropriate decisions about medication and treatment, according to the expert witness. The doctors were expected to handle patients whose illness had already been diagnosed by a psychiatrist.

On the morning of January 3, Mr. Solbrig was noted to be alert and completely oriented. He had normal speech and clearly communicated what he wanted to do. He explained to the doctors that he was no longer thinking of suicide and that he wanted to return to Chicago to a private hospital. The doctors felt he should not leave and advised him to stay, but he insisted. The doctors explained that if he left, it would be against medical advice. Mr. Solbrig said he understood but wanted to go.

In court the government expert explained that suicide risk was a continuum, beginning with thoughts and progressing to a plan and then to an intent to act. Suicidal thoughts are at the low end of the scale and are somewhat common among depressed patients. Suicidal thoughts do not create a meaningful risk of imminent suicide. At no time during his stay of less than 24 hours in the VA hospital did Mr. Solbrig ever express a suicide plan or, more important, the intent to act out a plan.

Thus the VA doctors had only two options. They could permit Mr. Solbrig to leave against medical advice, or they could seek involuntary commitment under Wisconsin law. The law permits such a petition when the patient is mentally ill and dangerous because of a substantial probability of self-harm "as manifested by evidence of recent threats of or attempts at suicide." Mr. Solbrig had often thought of suicide in the past 22 years, but he had acted on these thoughts only once, 22 years before. The government expert testified that it was a reasonable exercise of medical judgment not to seek involuntary commitment for Mr. Solbrig, who showed no signs of being a meaningful suicidal risk on the morning of his discharge.

The plaintiff claimed that the discharge of Mr. Solbrig could not be examined in a vacuum and that account had to be taken of his activities in the four or five weeks before his death, when he had repeatedly sought medical help for his severe depression and suicidal impulses. The plaintiff argued that the hospital and the doctors were negligent in not obtaining the records of two recent admissions in November and December 1989, when he was involuntarily committed because he indicated that he had suicidal thoughts and a plan to kill himself by overdosing on his medication.

The court rejected the plaintiff's argument on the basis that the doctors would have had "incredible difficulty getting these records that morning even if they knew where to request them." The court noted that even if the doctors had had the records, "at most, they show a mentally ill individual suffering continually from depression and thoughts of suicide. That is the nature of Mr. Solbrig's illness. None of the records show present or future intent to commit suicide. Only one record shows the existence of a possible plan."

Dedely v. Kings Highway Hospital Center

In this 1994 case, the supreme court of New York, Kings County, ruled that a hospital may not require a patient to sign a release form purporting to release the hospital from liability for malpractice claims as a condition of allowing the patient to leave against medical advice (10). The defendants had requested to amend their answer to assert the affirmative defense of release from liability. Kathleen Dedely, on behalf of her infant son Robert Dedely, sued for medical malpractice, alleging that Robert had suffered injuries as a result of physicians' failure to diagnose and treat an intestinal perforation.

The infant was admitted to Kings Highway Hospital on August 5, 1985, with abdominal pain. On August 8, Kathleen Dedely demanded the release of her son. She was required to sign a form, by which she assumed "all risks, responsibilities and liabilities, whatsoever" and released "Kings Highway Hospital Center, Inc., its physicians, surgeons, authorities and employees from all risks, claims, responsibilities whatsoever." The court found such a form to be contrary to public policy and a nullity. It also observed that "a hospital's failure to release a patient unless it sought judicial relief would, undoubtedly, subject the hospital to an actionable tort."

Weinstock v. Ott

A jury found for the estate of Norma Ott in a medical malpractice action against Adolph Weinstock, M.D. The suit alleged that Dr. Weinstock had breached his duty to refer Ms. Ott for diagnostic consultation when he was unable to discover the cause of her disorder. Dr. Weinstock, a general practitioner in Rolling Prairie, Indiana, about a one and a half hour drive from Chicago, had been Ms. Ott's family physician since 1956. She first consulted him for abdominal pains in October 1972. Despite various tests and the removal of four feet of gangrenous bowel at the local hospital in November of 1972, Ms. Ott continued to complain of abdominal pain.

In July 1976 Dr. Weinstock transferred her to Billings Hospital at the University of Chicago where she underwent numerous diagnostic tests for

approximately four weeks. A diagnosis of ischemic bowel disease was made. At the beginning of the fifth week, her condition greatly worsened. Because of this, she discharged herself from the Billings Hospital against medical advice and returned home. A few days later, on August 31, 1976, she saw Dr. Weinstock in his office, and the next day he admitted her to the local hospital. Her husband, however, was dissatisfied with the care she was receiving and took her back to Billings Hospital on September 29, 1976. She had further surgery in October, and she died soon afterward.

Dr. Weinstock appealed the decision of the jury on a number of grounds, including that Ms. Ott was contributorily negligent in discharging herself against medical advice from the Billings Hospital. The general rule on a patient's contributory negligence states that the patient must exercise that degree of care that an ordinary reasonable person under the same disabilities and infirmities in like circumstances would exercise.

The appeals court found that whether Ms. Ott acted unreasonably in discharging herself against medical advice was a question of fact for the jury. The jury acted reasonably when it found that Ms. Ott was justified in discharging herself from the hospital, considering that she had been ill for four years, had been in and out of hospitals, had undergone a frustrating plethora of tests, and was in extremely poor health. The jury's findings of no contributory negligence was upheld.

Discussion and conclusions

In the event of an adverse consequence after discharge against medical advice, legal action is certainly possible— and in recent years probable. The cases described here illustrate that medical authorities who comply with patients' requests to leave by discharging them against medical advice may not be sufficiently protecting themselves from legal action. Liability may still exist for malpractice and also for failure to provide the patient with sufficient information to ensure an informed withholding of consent to hospitalization. The hospital and the doctor have a clear duty to evaluate whether the patient meets involuntary commitment criteria.

On the basis of the cases described here, we formulated guidelines for physicians faced with the decision to discharge a patient against medical advice.

♦ A careful, thorough, and well-documented examination is the best defense.

♦ The severity of the illness should be assessed as well as the severity of the risk if the patient is discharged.

♦ When a high degree of risk is involved, the physician should engage in a constructive dialogue with the patient about grievances. Often, this opportunity for communication will be sufficient, and the patient can be persuaded to remain in the hospital.

♦ In a lower-risk case, it is still good practice for the physician to explore the patient's thinking about the discharge. Maintenance of a patient-physician alliance is still important for follow-up care. The physician should ask, "Why now, and why is this request made for this patient?"

♦ Before discharging a patient against medical advice, the physician should ensure that the patient's withholding of consent for further hospitalization is informed with respect to risks, benefits, and alternatives.

♦ If the patient meets criteria for involuntary hospitalization under the prevailing mental hygiene laws, the patient should be committed.

Hospital authorities should recognize that forms signed by a patient who is leaving against medical advice that purport to exonerate the hospital in the event of an untoward consequence are meaningless and have no legal protective value. The danger in such forms is that a physician may be tempted to rely on them instead of good clinical judgment and adherence to the guidelines presented here.

In *Kelly v. United States* and *Solbrig v. United States* the defendants prevailed. However, their success in court was due to the failure of the plaintiff to prove medical negligence. It was not due to the fact that the physicians used the procedure of discharge against medical advice.

Patients leaving the hospital against medical advice also bear some responsibility for the consequences of their actions. In a court action in which the physician is found to be professionally negligent, the patient-plaintiff may also be found to have contributed to the degree of damage suffered if the patient behaved negligently. Contributory negligence is defined as the plaintiff's failure to exercise that degree of care that an ordinary reasonable person with the same disabilities and infirmities in like circumstances would exercise. A finding of contributory negligence may result in a reduction in damages awarded by the court. Therefore, a patient leaving against medical advice bears some responsibility for subsequent damage, but only for the damage related to the unreasonable part of the behavior.

The legal standard for protection from lawsuits continues to be good clinical practice with thorough documentation. Use of discharge against medical advice is not a royal road to legal immunity. ♦

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