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Reasons for discharges against medical advice: a qualitative study

Eberechukwu Onukwugha, PhD,

Pharmaceutical Health Services Research Department, University of Maryland School of Pharmacy

Elijah Saunders, MD,

Division of Cardiology, Department of Medicine, University of Maryland School of Medicine

C. Daniel Mullins, PhD,

Pharmaceutical Health Services Research Department, University of Maryland School of Pharmacy

Françoise G. Pradel, PhD,

Pharmaceutical Health Services Research Department, University of Maryland School of Pharmacy

Marni Zuckerman, MA, and

Pharmaceutical Health Services Research Department, University of Maryland School of Pharmacy

Matthew R. Weir, MD

Division of Nephrology, Department of Medicine, University of Maryland School of Medicine

Abstract

Background—There is limited information in the literature about reasons for discharges against medical advice (DAMA) as supplied by patients and providers. Information about the reasons for DAMA is necessary for identifying workable strategies to reduce the likelihood and health consequences of DAMA. The objective of this study is to identify the reasons for DAMA based on patient and multi-category provider focus group interviews (FGIs).

Methods—Patients who discharged against medical advice between 2006 and 2008 from a large, academic medical center along with hospital providers reporting contact with patients who left against medical advice were recruited. Three patient-only groups, one physician-only group, and one nurse/social worker group were held. Focus group interviews were transcribed and a thematic analysis was performed to identify themes within and across groups. Participants discussed the reasons for patient DAMA and identified potential solutions.

Corresponding author: Eberechukwu Onukwugha, PhD, Pharmaceutical Health Services Research Department, University of Maryland School of Pharmacy, 220 Arch Street, Baltimore, MD 21201, Voice: (410) 706-8981, Fax: (410) 706-5394, eonukwug@rx.umaryland.edu.

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None declared.

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Results—Eighteen patients, 5 physicians, 6 nurses and 4 social workers participated in the FGIs. Seven themes emerged across the separate patient, doctor, nurse/social worker group FGIs of reasons why patients leave against medical advice: 1) drug addiction, 2) pain management, 3) external obligations, 4) wait time, 5) doctor's bedside manner, 6) teaching hospital setting, and 7) communication. Solutions to tackle DAMA identified by participants revolve mainly around enhanced communication and provider education.

Conclusions—In a large, academic medical center we find some differences and many similarities across patients and providers in identifying the causes of and solutions to DAMA, many of which relate to communication.

Keywords

discharges; against medical advice; qualitative research

INTRODUCTION

Approximately one percent of inpatient discharges are against medical advice [1–3]. Discharges against medical advice (DAMA) are of interest because they are associated with higher patient morbidity and risk for hospital readmission.[3–12] Discharges against medical advice are also of interest because they can present ethical challenges for the physician.[13] Information from both providers and patients regarding the reasons for DAMA are necessary for identifying workable strategies to reduce DAMA. However, there has been no study to date comparing the reasons for DAMA from multiple perspectives.

Reasons for DAMA among patients diagnosed with psychiatric conditions or with a history of alcohol abuse have been identified in studies using a variety of methods including the retrospective review of patient medical records, interviews with patients or staff, and follow-up via telephone or mail.[14, 15] Reasons identified for DAMA from a detoxification/dual diagnosis unit at the Philadelphia Veterans Administration include family emergency obligations, financial obligations, and legal issues.[15] However, DAMA also occur in other disease settings. Awareness of this is reflected in the increasing number of studies of DAMA among patients admitted to a general (i.e. Medicine) service. A few studies have examined reasons for DAMA either from an inpatient setting [5] or from an emergency department setting [16–18]. In the study by Baptist et al. (2007), the reasons for DAMA were identified following a review of the medical records of asthma patients who left against medical advice and included: dissatisfaction with care; patient was feeling better and; family obligations.[5] Patient medical records provide a reliable source of information regarding the clinical condition of the patient and may contain limited notes reflecting communications between patients and their providers from the medical staff's point of view; however, these notes likely do not provide the complete picture from patients' perspectives. Direct patient interviews may provide additional information that would be missing from a medical record, due either to the provider's failure to inquire or to the patient's failure to provide complete information [16]. To our knowledge, reasons for DAMA based on direct patient and non-physician provider interviews in a general Medicine service have not been reported.

Given these, the current paper sought to explore the topic of DAMA using direct patient and multi-category provider interviews. The objective of this study was to identify the reasons for DAMA among patients admitted to the Medicine service at a large urban teaching hospital from a variety of perspectives. A secondary objective was to compare and contrast stated reasons for DAMA and the suggested solutions, as offered by patients, physicians, nurses, and social workers.

METHODS

Participants

Healthcare providers and patients were recruited to participate in focus group interviews (FGIs) to discuss why patients admitted to the Medicine service at a large teaching hospital leave against medical advice. A total of five FGIs were held: three patient-only groups, one physician-only group, and one nurse/social worker group. All FGIs took place in October 2008 in Maryland. Patient and provider groups were held separately in order to minimize incentives to withhold information about the reasons for DAMA. The study was marked as exempt by the University of Maryland Baltimore Institutional Review Board (H30288).

Potential participants for the patient-only FGIs were identified from hospital discharge data. Discharges against medical advice constitute a standard category of discharge disposition as noted in the hospital discharge record. Hospital discharge data available for analysis were limited to patients aged 18 years or older who left against medical advice between July 1, 2006 and June 30, 2008. To reduce the likelihood that patients required detoxification or psychiatric services, patients with a primary admitting diagnosis of alcohol abuse, drug abuse, or psychoses were excluded (See Appendix A for ICD-9 codes). Participant recruitment to the patient FGI was based on an initial invitation letter sent via mail. A follow-up telephone call was made after one week of non-response to the initial invitation letter. General announcement posters were placed in common areas throughout the hospital inviting providers to participate in the FGI. A \$50 honorarium for each participant was set using the wage-payment model.[19]

Conducting the focus groups

The methodological framework to develop a topic guide was based on the cognitive constructs (perceived susceptibility to health consequences due to DAMA, perceived severity of health consequences due to DAMA, benefits and costs of DAMA) of the Health Belief Model (HBM).[20] This topic guide was reviewed by clinicians (E.S. and M.R.W.), a hospital administrator, and a health services researcher trained in qualitative analysis (F.G.P.), and was modified as needed to direct the conversation.

Each FGI lasted approximately one hour. The provider groups were held in a convenient hospital location and the patient FGIs were held in a university facility to minimize patient discomfort, given the interview topic. The same moderator (E.O.) guided all five FGIs. Two research assistants attended the FGIs as observers. All participants were informed that the discussion would be audio-recorded and that the transcriptions would be verbatim, anonymous, and confidential. Each participant verbally agreed to these conditions.

Analysis

The recordings were manually transcribed by E.O. and M.Z. Each transcription was subject to an additional review for accuracy by someone other than the original transcriber and then the associated audiotapes were destroyed. The researchers independently analyzed each transcript and identified themes. A thematic analysis was used to identify themes within the text of all five FGI transcripts.[21] Themes were identified separately for the patient group, the physician group, and the combined nurses and social workers group, for a total of 3 groups.

RESULTS

A total of 276 patients meeting the inclusion criteria were contacted by letter. Sixty-two envelopes were returned by the post office, labeled with “wrong address/undeliverable”.

One hundred and seventy-one patients did not respond to the letter. There was a 20% [(43/(276–62))*100] response rate for the patient FGIs: 20 used the response card method, and 23 were contacted via telephone call. Ten of these 43 patients did not respond to a follow-up telephone call, and therefore were not scheduled for a FGI. Thirty-three respondents were placed in a scheduled FGI, with a final participation count of 18 patients due to no-shows. Patient demographic information was collected from discharge data, however minimal demographic information for providers was collected, consistent with the IRB-approved protocol. The average age of patient participants was 45 (range= 25 to 63), 61% were male, 73% were African American. Five physicians (2 males) participated in the physician-only FGI and 10 females (60% nurses) participated in the nurse/social worker group interview.

Reasons for discharges against medical advice

Seven themes emerged across the patient, doctor, nurse/social worker FGIs of reasons for DAMA: 1) drug seeking patients, 2) pain management, 3) other obligations, 4) wait time, 5) doctor's bedside manner, 6) teaching-hospital setting, and 7) communication. Patients' and Providers' comments illustrate these themes (See Table 1). First, drug seeking patients are likely to leave the hospital against medical advice to acquire their drug of choice (i.e. alcohol, cocaine, heroin). Second, while some patients may leave against medical advice to seek their drug of choice, other patients indicated that they are prejudged by providers who assume that they are drug seeking when rather, they truly are in pain. Some providers echoed this sentiment, reporting that sometimes they assume patients are drug seeking, when in fact they truly are in pain.

Third, often patients have other obligations to attend to outside of the hospital such as childcare, paying rent, attending a court hearing, or attending work. Fourth, patients, doctors, nurses, and social workers reported that patients left against medical advice because they did not expect an extended hospital stay, the test results were not coming back soon enough, or the doctor was taking too long to conference with the patient. Fifth, patients reported that doctors do not always have proper bedside manner, and both groups of providers admitted that doctors can be rude to patients at times, leading patients to leave against medical advice. Sixth, the teaching hospital setting was described as confusing and frustrating to some patients, causing them to leave against medical advice.

Finally, two types of communication problems were identified as responsible for DAMA. The first communication difficulty is between providers. For example, patients and providers report that patients become frustrated by inconsistent messages from doctors and nurses. Doctors report that they sometimes have to ask the patient about the treatment plan that a previous doctor had established. Nurses and social workers are also aware that there is poor communication between providers, which frustrates the patients. The second communication difficulty is between providers and patients. For example, providers report that patients do not understand the severity of their illness when making the decision to leave against medical advice, while patients report that providers use words that are hard to understand. Reasons for DAMA mentioned during the patient FGIs that did not emerge as a theme include: 1) patients leaving because they want a second opinion from another doctor; 2) the patient feels better; 3) lack of health insurance coverage and; 4) the hospital room was dirty.

Solutions

Patients' Solutions—First, patients would like providers to communicate what they know about the consequences of leaving against medical advice. Second, patients feel that the providers should spend more time convincing patients not to leave.

Nurses' and Social Workers' Solutions—Nurses suggest improved communication between *doctors and nurses* regarding patient discharge orders and lab tests ordered. Nurses and social workers suggest improved communication between *nurses and patients* in what concerns sharing information about the general hospital setting, the functioning of a teaching hospital (e.g. schedule for morning rounds), and the discharge process as distinct from the discharge event. In addition, nurses and social workers suggest better management of patients' expectations as described in Figure 1.

Alterations to the hospital system suggested by nurses to prevent DAMA include nurses attending patient-doctor consultations as a way to stay abreast of patient management. Nurses suggest implementing a system that rewards professional behavior and outlines consequences for providers who fall short. Also, nurses and social workers identified a need to modify the perception that everyone who asks for pain medication is a drug abuser.

Physicians' Solutions—Similar to the nurses' and social workers' solution, doctors indicate that improved communication between provider team members and with patients would help reduce DAMA. However, physicians feel that nurses need to be more responsive to patient phone calls and provide more current information to patients. Other solutions offered include: 1) communicating with the patient's primary care provider; 2) physician education (see Figure 2); 3) Patient Advocate as a resource for patients.

DISCUSSION

There is no information available in the published literature that compares and contrasts the predictors of a discharge against medical advice in a general inpatient population from patients' and providers' viewpoints. We used the focus group methodology to identify reasons for DAMA from these perspectives. The use of focus groups is advantageous when collecting the desired information on a large scale is cost-prohibitive, the overall topic of interest is a sensitive one, or the intent is to identify underlying reasons for observed behavior.[22, 23] Both patients and providers identified similar reasons for DAMA from a Medicine service as identified in Table 1. Thus, the current study provides new evidence to support the limited literature[24] on patient-reported reasons for DAMA in any disease setting.

The degree of consonance between patients and providers suggests that there is sufficient common ground to support a coordinated intervention effort to reduce the frequency of avoidable DAMA. The need for an intervention effort as the next step towards reducing the number of DAMA has been identified previously.[16] A refinement suggested by the combination of patient and provider FGI data from the present study relates to the idea of a *coordinated* intervention effort. A coordinated intervention effort recognizes the joint role of patients and providers in the series of events leading up to a discharge against medical advice and actively seeks both patient and provider input in designing the intervention, defining the scope of action, and identifying success metrics. A coordinated effort also builds on the themes and lessons from patient stories regarding both actual and averted DAMA, identifies and addresses disagreements within provider groups regarding which group of providers is most responsible for effectuating change, and leverages the common desire for better outcomes shared by patients and providers.

Despite the consonance in reasons, there were subtle indications of dissonance within providers regarding the party responsible for effectuating change. There was a feeling among some doctors interviewed that nurses are responsible for the breakdown in communication with patients and thus bear a larger share of the burden of improving communication with the patient; the opposite viewpoint was expressed in the nurse/social

worker groups. For example, a few doctors noted that by the time they are called to speak with the patient, the situation already has progressed to a point beyond which they are able to exert a positive influence. On the other hand, participants in the nurse/social worker group would note that the long time interval between the patient's admission and consultation with the attending physician often contributes to the patient deciding to leave against medical advice. The correlation between perceptions and reality justifies further examination into the extent to which the stated provider viewpoints are generalizable and/or may be strong enough to torpedo interventions designed to reduce DAMA.

Lastly, we examined whether the consonance in identifying potential causes translated into consonance in identifying potential solutions. Improved communication was a common solution identified across the focus groups and in previous literature[24] but this consonance masks differences in conceptualization and implementation that have not been highlighted to date. Even when participants stated a common definition of "improved communication", each group placed the responsibility for improving communication with others: patients looked to doctors; doctors looked to patients and to nurses; nurses looked to doctors (see Figure 1). For example, patients and providers expressed a need for more honesty in communication but did not agree on the responsible group.

Actionable solutions included: communicating with the patient in an empathetic tone and using lay English terms, nurses attending the patient-doctor consultation, educating physicians about the results from research on DAMA, providing physician education about strategies for communicating with patients likely to leave against medical advice, physician education about the consequences of leaving against medical advice, informing the patient about the patient advocate service. The solutions are directly relevant to discussions in the literature about ensuring fully informed decision making[24] in the case of a patient who seeks to leave against medical advice. The need for communicating with the patient about the consequences of DAMA has been noted previously[16, 24] and the current study provides new information suggesting that, in some situations, lack of knowledge of DAMA consequences on the part of the physicians may mean that the patient is less able to make a fully informed decision about whether or not to leave against medical advice.

Some limitations to the qualitative study apply. The FGIs were conducted in a large, teaching hospital setting and the results may not generalize to community or smaller hospitals. Individuals in the patient groups may have withheld relevant information concerning the reasons for DAMA. The moderator involved all participants using direct questions; however their involvement does not guarantee that all concerns related to DAMA held by the participant were voiced. Non-response bias is a concern for this study due to the low patient participation rate. Despite the promises of anonymity in responses, the nature of the subject matter may have discouraged patients who feel embarrassed about their unauthorized discharge from responding to the request to participate in the study.

CONCLUSION

Knowledge of the reasons for discharges against medical advice in a large, academic medical center can demystify the process of identifying workable strategies to reduce the likelihood of discharges against medical advice. In this study we identified several reasons, largely related to communication, for discharges against medical advice. Areas of consonance and dissonance related to the definition and implementation of improved communication between patients and (among) providers. The general consonance across patient and provider focus group interview groups, coupled with the actionable solutions identified by the participants, suggests that effective strategies to reduce discharges against medical advice are possible and would be welcomed.

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Appendix A: ICD-9 Codes used for Inclusion and Exclusion Criteria

Patients with a primary admitting diagnosis of alcohol abuse

- ICD9: 265.2, 291.1–291.3, 291.5–291.9, 303.0, 303.9, 357.5, 425.5, 535.3, 571.0–571.1, 980.x, V11.3

Patients with primary admitting diagnosis of drug abuse

- ICD9: 292.x, 304.x, 305.2–305.9, V65.42

Patients with Primary admitting diagnosis of psychoses

- ICD9: 293.8, 295.x, 296.04, 296.44, 296.54, 297.x, 298.x

Figure 1.
Nurses' and Social Workers' Solutions: Communication

Figure 2.
Physicians' Solutions: Provider Education

Table 1

Patient and Provider Quotes from Focus Group Interviews

Theme	Quote
Drug-seeking patients[7]	PT: "The time I left before, I was in active addiction, and somebody ... left me some money, and I went to go grab that money and to go get high, so I left the hospital." MD: "Sometimes they'll say 'morphine's not working, I need to go get a hit.' Some of them are honest about it." RN/SW: "We have had some patients also that want to leave that are having withdrawal symptoms from drugs or alcohol and they feel they need to leave so that they can go out and get something that helps them because [we are not managing their pain symptoms]."
Pain management	PT: "I feel like [the teaching hospital] is very prejudice against drug addicts...whether you White or Black...if you tell them that drugs is in your story, it just doesn't matter, they just tend to treat you differently and I'm trying to explain to them, my pain, the level of pain that I'm experience, and none of that really was important to them, so I left." MD: "...we kind of have certain things we think about in terms of a patient feeling well enough to go out. For them, it might be well enough to go use drugs, as opposed to well enough to let's say, have some chronic condition...more adequately managed." RN/SW: "Not getting adequate pain control [is a reason why patients leave against medical advice]"
Other obligations[5]	PT: "I also left because I got a five year old daughter that I got sole custody of, and sometimes things don't work with babysitters, they give me a call and I gotta turn around and leave and go get my daughter." MD: "...they have something important they need to do, which is a common reason they cite. Whether it's actually something important like paying rent, making sure someone's out doing their stuff, having to go to a court date, OR they need to get out and get a drink of alcohol or shoot heroin, and that's something that they can't tell you, but it's the important thing they need to do." RN/SW: "I have been presented with patients who really had situations outside of the hospital as reasons why they want to go. With their housing, with their income, and these are things that are very important to them even though we are looking at it from the medical standpoint ..."
Wait time [16]	PT: "...they left me in the room for over three hours and no one came to talk to me after that, right. And I got very agitated about that right there ...I'm here and this is the way ya'll treating me? It automatically makes you want to get up and leave." MD: Unfortunately, we're at a loss too because we don't know exactly when the procedure is going to happen either. So often we're going into the patient's room saying, 'Once we find out we'll tell you.' But hours have passed, and I don't underestimate the frustration of hunger. For some patients, you know, it's enough to make them want to jump out of a window. ...And so um it's tough because we'd like to be able to tell them um a quick answer, but sometimes we're actually the last to know." RN/SW: "Also, I have seen... a delay in procedures and somebody is kept NPO *, ... with nothing by mouth the night before. 'You're gonna have your biopsy tomorrow and after that you can leave', and then for whatever reason the biopsy doesn't happen the next day ..., somebody bumps them, an emergency or whatever, and it happens like day after day after day and they're like, I cannot stay here anymore."
Doctor's bedside manner [16]	PT: "...He [the doctor] telling me that since the medicine ain't working it's because I'm outside getting high. So if a doctor...telling you that you get high, and you know you don't get high, that kind of hurts your feelings...I left!" MD: "An interesting experience I had was a patient who cited that they had things to do, and they left. And I actually ran into them in a store, just later on, they didn't know that I was the physician in the group. And I said, 'Hey, what happened?' And they said to me that, um, one of the medical students made a very derogatory comment towards them, and because it was a teaching hospital, they didn't really think they had the recourse to say anything to anyone, so they left, to seek care elsewhere." RN/SW: "...I hear some of the addicts and such, say 'we've got substance abuse issues' and then they wait for their consult and the doctors come in and talk to them like dirt. And [they say] 'I cannot believe how they just talked to me, I want to go, I will not stay here.' They have the ability to know when someone is being disrespectful at least. So the intimidation comes from the doctors, I mean, most of the time. I mean sometimes, er, nurses kind of, y'know they don't want to give them pain medication and stuff like that because [we] know they are abusers but the doctors sometimes belittle people."
Teaching hospital setting	PT: "I'm hurting in pain, and I have to be explored by a bunch of students first, before I actually get medical treatment... I can understand that's a teaching program, but do that somewhere else...don't prolong that patient's pain and agony...that patient is paying good money to come in there and get help, but instead... they paying for that student's training program... and that's not right!" MD: "Unfortunately, in a teaching institution, uh, many levels of education are speaking to the patient and giving them different [opinions]...one person says, 'this is bad,' and one is saying 'this is not really that important' ". RN/SW: "Sub-I's... can't write orders, they can't really make decisions for the patient so they will have to get, or I'll have to bring somebody else. So sometimes the patients don't like that, having the med students, sub-Is."
Communication[16]	PT: "I mean you're told one thing by one person, and then next thing you know, you got half a dozen other people coming in telling you something different. You know, what are you supposed to believe, ...and how are you supposed to have confidence in somebody that's supposed to be trying to help your health to get better if you're being contradicted all the way up and down the line." MD: "some patients say that as the reason why they are going to leave. They say, 'Ahh, you guys don't communicate with each other, I've seen fifty people in my room.' "

Theme	Quote
	RN/SW: "...sometimes some providers don't communicate with each other so you might have multiple providers going in to see the patient and they are telling different stories, and then the patients get confused and frustrated. I have seen patients get y'know to the point that they just want to leave because they don't think that they are getting adequate care because '... one hand doesn't know what the other hand is doing, am I able to have faith in this place?' "
Other	PT: "If they indicate there's no more that I can do, then I understand it's time to go and get some second opinion elsewhere." PT: "I was feeling a little better, and I was suffering from the disease of addiction, and the disease of addiction said it was time to go... That's why I left." PT: "...the main reasons that I would leave the hospital was I had no medical insurance... I would go to the hospital to get treatment...and once I had all my medication, I would leave because I knew they wanted to keep me for at least three or four days." PT: "It was enough to make me leave. You know, because anytime ... the sanitation of that area be as bad as it was, that's letting you know something about what they goin' to do with you."

Table Key: PT: patient; MD: physician; RN: nurse; SW: social worker;

* NPO: *Nil per os*