Commentary

Discharge against medical advice (DAMA) in paediatrics: An approach to promote safety and ethics

Aifric Kavanagh BA¹, Olivia Ostrow MD FAAP^{2,3}, Randi Zlotnik Shaul JD LLM PhD^{1,3}

¹Department of Bioethics, The Hospital for Sick Children, Toronto, Ontario; ²Division of Pediatric Emergency Medicine, The Hospital for Sick Children, Toronto, Ontario; ³Department of Paediatrics, University of Toronto, Toronto, Ontario

Correspondence: Olivia Ostrow, Department of Paediatrics, The Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, M5G 1X8. Telephone 416-813-2197, fax 416-813-5047, e-mail olivia.ostrow@sickkids.ca

Abstract

Requests for discharge against medical advice are often challenging for clinicians to navigate, especially when the patient is a child. An informed, standardized approach to managing situations where children and their families are requesting to leave against medical advice is essential to maximizing safety and ethics for patients and staff, yet such situations are often not handled this way. Paediatric discharge against medical advice (DAMA) requests are best managed when clinicians ensure the patient's best interests are met, understand and act upon their professional obligations, and engage in guided discussion with patients and families that involves both shared and informed decision-making strategies. A process map can capture these criteria and readily provide clinicians with a bedside reference tool when managing paediatric DAMA requests.

Keywords: *Best interests; Bioethics; Capacity; Decision making; Discharge; DAMA; Patient safety*

Discharge against medical advice (DAMA) refers to instances in which patients are discharged from a health care setting against the recommendation(s) of their clinician. This may be at their insistence or at the wishes of their substitute decision maker (SDM). DAMA can present risk of harms to patients (1,2) (e.g., readmissions, prolonged subsequent hospital stays, worse outcomes), as well as significant stress to clinicians and resource strain (2). While instances of DAMA in paediatrics are less common, clinicians often feel ill prepared to manage their complexity when they do occur, especially as they can arise anytime, escalate rapidly, and require swift decision making in a high-pressure environment where often there is no time to consult an expert source. Definitions and consequences of DAMA are well documented, but the literature concerning paediatric DAMA is lacking (3,4). In the paediatric setting, DAMA is particularly challenging: clinicians must be respectful of the autonomous health care decisions of capable patients, be respectful of SDMs while meeting their legal obligation to act in the best interests of their incapable patients (3).

Consent law provides clinicians with guidance regarding what it means to act in a child's best interests, as well as when a child being denied recommended treatment may warrant engaging child protection services. While DAMA may not be the preferred option from the physician's perspective, it can be acceptable if still felt to be consistent with the child's best interests.

DEVELOPING THE APPROACH

Given the associated potential risks of DAMA, it is important that hospitals adopt evidence-based policies, as well as other clinical tools, to help guide their clinicians and patients in these instances. The Hospital for Sick Children in Toronto, Ontario, Canada sought to address this gap of paediatric-specific guidance regarding DAMA through the development of a standardized approach to DAMA that is ethically sound, and ensures safety for patients, families, and staff. Development of the approach was led primarily by representatives from the

Division of Pediatric Emergency Medicine and the Department of Bioethics, who established an interdisciplinary working group, which included health lawyers, interprofessional clinicians, and bioethicists to better understand the current literature and the clinical experiences with DAMA. The objective was to develop a standardized approach to the full range of DAMA situations that meets ethical and safety standards, has real-world utility, and that could be utilized hospital-wide. The following approach and tools were vetted in several hospital rounds and enriched through the vantage points of multiple specialties, families, and administrative roles.

KEY CONCEPTS

Capacity

While consent frameworks vary among jurisdictions, this approach focuses on the context produced by Ontario's consent legislation, wherein people of any age may be considered capable of making their own health care decisions so long as they can "understand relevant information and ... appreciate the reasonably foreseeable consequences of accepting or refusing the treatment in question" (5,6). When paediatric patients do not have this capacity, their parent(s) or guardian assumes the role of SDM and makes health care decisions for them. Regardless of who is making health care decisions, clinicians should engage in shared decision making, to ensure that the treatment agreed upon is "consistent with (the patient/SDM's) preferences and values" (7). This approach enables patients/SDMs to make as informed, preferred, and self-determined decisions as they can, and is accomplished by involving patients/SDMs throughout the decision-making process (7,8). Engaging the patients/SDMs allows them to "communicate their preferences and help select the best course of action for them" (9).

Sharing decision making

According to the described approach, in cases where DAMA is being considered, clinicians should inform the patient/SDM that the goal is to devise a plan that meets their needs and is in the patient's best interests. To develop such a plan, it is recommended that clinicians understand: why the patient/SDM wants to leave; their concerns; their understanding of the medical status and the proposed treatment; and, whether they appreciate the risks of leaving. Clinicians should also discuss any reasonable alternative options. The importance of shared decision making is reflected by The Hospital for Sick Children's model of child and family-centred care, an approach that acknowledges: "that the family is central in the child's life and therefore central to our care processes" (10); however, SDMs do not have total freedom.

Best interests

SDMs' decision making is limited insofar as they are "legally obligated to make ... decision[s] solely in the best interest of the child",

or in accordance with previously expressed wishes made when the child was capable and over the age of 16 (5,11). It can sometimes be difficult to reach agreement as to what is in a child's best interests; patients/SDMs can disagree with one another or with clinicians, or clinicians can disagree among themselves. Ultimately, guidance from the law calls for the primary considerations to be the child's "health ... well-being ... [and] quality of life" (11). If the clinician believes that without remaining in hospital, the child's best interests cannot be met and harm to the child may result, the clinician is legally obliged to contact a child protection authority (12). However, if the clinician believes that the child's best interests have been met—even if it is not the action the clinician would have recommended most—they must respect the right of the capable patient/SDM to decline the recommendation and they may proceed with DAMA (13). In all cases in which DAMA is being considered, clinicians are obliged to explain its possible consequences, "most specifically about clinical signs and symptoms that may indicate the need for immediate treatment" (14). Finally, it is important for clinicians communicate with patients/SDMs in a collaborative manner, considering the higher likelihood of hospital readmission—these patients/SDMs may have a "fear of being refused by the [hospital]" (15).

A standardized process

As depicted in the process map (Figure 1), when a situation begins to escalate and/or a desire for DAMA is indicated, clinicians should: notify the most responsible physician; refer to their institution's local resources and policies; utilize shared decision-making strategies; and engage additional staff and family members for support. If despite these measures, DAMA is still pursued, capacity must be assessed. If the patient is deemed to be capable, then the clinician must evaluate whether they pose a serious risk to themselves or others. If so, possible routes would be a report to child protection, detaining the patient under mental health allowances where there is risk to self or others, or under consent legislation of restabilization (i.e., in Ontario - CAS/PGT (Children's Aid Society/Public Guardian and Trustee) and/or FORM 1 & Medical Stabilization Consent to Treatment Policy). If deemed to not be a risk to themselves or others, the following steps are recommended:

1. Have another clinician witness and document conversation with patient/SDM
2. Request patient/SDM signature
3. Complete discharge papers with pertinent prescriptions and outline reasons to return to care
4. Organize a specific follow-up plan (provide appropriate materials such as contact information, appointments, referrals, etc.)
5. File a safety report in institutional safety reporting system or complete other means to ensure DAMA events are tracked and reviewed.

Discharge Against Medical Advice (DAMA) Process Map

This guided algorithm aims to support clinicians with a skilled approach to minimizing situations of discharging patients AMA.

Note: documentation should detail entire DAMA process, as per policy.

Figure 1. Discharge against medical advice (DAMA) process map

DISCUSSION

DAMA in the paediatric setting is uniquely complex due to the triad of patient, SDM, and clinician. Knowledge of a broad spectrum of literature (e.g., consent and child protection legislation, professional statements, legal decisions, ethics and shared decision making, patient safety tools) is essential to creating a framework to managing these situations. While developing a plan that the patient/SDM will find acceptable, the clinician must remain mindful of paediatric health care organizations' commitments to family-centered care while not losing sight of the ultimate consideration—the best interests of the incapable child. This is a challenging, but not impossible, task, and will not always meet the threshold of involving child protection services. When a child is capable, the approaches to DAMA would be informed by the values and laws that apply to any capable patient.

CONCLUSION

We provide the framework for a policy and process map to manage instances of DAMA that other health care organizations and professionals will find to be safe, ethical, and practical. While further research into paediatric-specific DAMA is required, our institutional approach establishes that DAMA requests are best managed when clinicians ensure the patient's best interests are met, understand and act upon their professional obligations, and engage in guided discussion, as well as shared and informed decision making. This approach is grounded in values underpinning paediatric health care and is captured clearly in a process map that clinicians can utilize at the bedside for navigating instances of DAMA.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the DAMA working group members for their support in developing the SickKids DAMA policy and process map: Megan Evans, Christina Bartha, Lee Ann Chapman,

Michael Weinstein, Emma Cory, Karima Karmali, Kate Langrish, David Lubert, Tara Tyson, and Miranda Vermeer.

Funding Information: There are no funders to report for this submission.
Financial Disclosure: None.

Potential Conflicts of Interest: All authors: No reported conflicts of interest. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

References

1. Clark MA, Abbott JT, Adyanthaya T. Ethics seminars: A best-practice approach to navigating the against-medical-advice discharge. *Acad Emerg Med* 2014;21(9):1050–7.
2. Berger JT. Discharge against medical advice: Ethical considerations and professional obligations. *J Hosp Med* 2008;3(5):403–8.
3. Macrohon BC. Pediatrician's perspectives on discharge against medical advice (DAMA) among pediatric patients: A qualitative study. *BMC Pediatr* 2012;12:75.
4. Reinke DA, Boslaugh S. Predictors of pediatric emergency patients discharged against medical advice. *Clin Pediatr* 2009;48:263–70.
5. Government of Ontario [Internet]. Health Care Consent Act: Capacity. 1996. <<https://www.ontario.ca/laws/statute/96h02#BK4>> (Accessed December 13, 2018).
6. Geist R, Opler SE. A guide for health care practitioners in the assessment of young people's capacity to consent to treatment. *Clin Pediatr (Phila)* 2010;49(9):834–9.
7. Barry MJ, Edgman-Levitan S. Shared decision making—pinnacle of patient-centered care. *N Engl J Med* 2012;366(9):780–1.
8. Elwyn G, Frosch D, Thomson R, et al. Shared decision making: A model for clinical practice. *J Gen Intern Med* 2012;27(10):1361–7.
9. Elwyn G, Laitner S, Coulter A, Walker E, Watson P, Thomson R. Implementing shared decision making in the NHS. *BMJ* 2010;341:c5146.
10. The Hospital for Sick Children [Internet]. Child and Family-Centred Care. 2014 <<http://www.sickkids.ca/patient-family-resources/child-family-centred-care/index.html>> (Accessed December 13, 2018).
11. The Hospital for Sick Children. 2017. Making Medical Decisions for Your Child [Pamphlet]. Toronto, ON.
12. Government of Ontario [Internet]. Child, Youth and Family Services Act. 2017. <<https://www.ontario.ca/laws/statute/17c14>> (Accessed December 13, 2018).
13. The Canadian Medical Protective Association [Internet]. Informed Refusal. 2016. <<https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians#Informed%20refusal>> (Accessed December 13, 2018).
14. The Canadian Medical Protective Association [Internet]. Informed Discharge. 2016. <<https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physicians#discharge>> (Accessed December 13, 2018).
15. Alireza NN, Hamid P, Jamalodin B. The process of parents' decision-making to discharge their child against medical advice (DAMA): A grounded theory study. *IJMRHS* 2016;5:335–43.