**Summary of our last Ethics for Lunch:**  
  
**Patient Requests to Leave Against Medical Advice: Ethical Boundaries and Clinical Realities**   
Presented November 19, 2019 / [Video available online](https://www.youtube.com/watch?v=NAO7Rb4AMS4)

Panelists: Cynda Rushton, Jackie Bradstock, Carrie Herzke,  
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Summary:    
  
Last month’s case highlights the complex challenges in caring for patients who, for a variety of reasons, decide they no longer wish to receive treatment and choose to sign themselves out of the hospital against medical advice.  While every patient situation is different, such cases may involve questions about decision making capacity and the boundaries of professional and institutional responsibility. For clinicians such cases may cause moral distress as they attempt to resolve the competing ethical tensions.  
   
Highlights of the panel:

1. When patients request to leave against medical advice, it is vital that clinicians assess their decision-making capacity over time, document the assessment and seek to remove any impediments to their decisional capacity.  Assessing understanding involves seeking to understand the patient’s perspective and to determine if they are able to appreciate the consequences of their decision.
2. In assessing patient’s understanding of the consequences of the decision clinicians should be mindful of how their concern about the patient’s decision is communicated and avoid statements such as “insurance will not cover treatment” or “you will need to find your own transportation”, etc.
3. Proactive identification and intervention of high-risk cases can assist in developing plans that avoid the need for requests to leave AMA. Reasons patients may request to leave AMA include personal or financial obligations, patient perception that they are “better”, substance use disorder, or psychiatric conditions that involve anxiety disorders, impulse control, disordered cognition, etc. Assistance in assessing the contribution of these factors is often necessary to avoid patterns of bias or stigma.
4. Participants in the session raised concerns about how to remain respectful and empathic when they disagree with the patient’s decision or behaviors. Engaging empathy involves attuning to the patient’s experience and imagining what their experience might be life (perspective taking).  Pausing to connect to the patient as a person can open opportunities for understanding. When clinicians are focused on convincing the patient that their decision is wrong or risky, the opportunity for empathy is diminished. Stepping back and clarifying the boundaries of clinician responsibility to inform, understand, advise and advocate for optimal treatment can assist in keeping boundaries clear and communication open.
5. Clinicians often struggle to determine whether their engagement in executing the patient’s plan to leave AMA constitutes enabling behavior or implies agreement with the patient’s decision.  The panel distinguished that offer routine resources and supports that are available to other patients does not imply agreement with the patient’s choice but rather a reflection of clinician’s commitment to provide respectful, equitable care to all patients.
6. Clinicians may also struggle to determine whether they have exerted sufficient effort to bring about the best outcome for the patient. While there is not a single standard to assess this, clinicians should exert reasonable efforts to engage resources that are available and honor the very real constraints that limit options for risk mitigation. Systemic barriers to being able to deliver the care that clinicians would choose cannot be overlooked and should be systemically addressed.
7. When a patient with decision making capacity chooses to leave AMA the panel proposed the following:
   1. Assure non-abandonment of the patient. Separate the decision from the inherent dignity of the person.
   2. Given the constraints of the situation, create a safe discharge plan—realizing that in some instances there are significant barriers to the ideal circumstances.
   3. Identify areas where it is possible to modify risks to the patient’s treatment plan (e.g. changing from IV to PO medications) and create a follow up plan.
   4. Involve family and others who can participate in the ongoing care of the patient along with available social and community resources.
   5. Document and complete the necessary discharge instructions and paperwork.
   6. If there are legal or ethical questions, request consultation.
8. When cases involving requests to leave AMA include behavioral patterns or outbursts that threaten staff physical or emotional safety, clinicians should follow hospital guidelines and involve the Behavioral Liaison Team (BLT), institute co-created behavioral management plan, and clarify the institutional norms of respectful patient/family and team interactions.
9. Clinicians caring for patients who request to leave AMA may experience moral distress as they attempt to preserve or restore their professional integrity.  Organizing inter-professional forums to discuss troubling cases, conduct patient care conferences that involve all services and disciplines, can create an important safety net.