DISCHARGE AGAINST MEDICAL ADVICE (DAMA) – A STUDY

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ABSTRACT

Objective: To establish the cause of DAMA in paediatric practice and highlight safety issues that may arise from DAMA.

Methods: Children aged 0 to 18 years who presented over 3 years from January 2007 to December 2009 to the St Richard’s Hospital for admission with an acute illness. A list of patients was obtained from a search of electronic patient discharge records and a retrospective study of the clinical notes. Results were analysed by a simple tally mark analysis and presented as percentages.

Results: 39 paediatric patients were included in the study who were discharged by DAMA. Of the 39 cases, 27 were male. Thirty four cases had medical input of which 32 were seen in the first 2 hours from the initial presentation. 25 children were initially seen by the paediatric team. 22 cases had a DAMA form signed and there were 6 readmissions and all were under the age of 5 years. The main recorded reason for DAMA as seen in 8 cases was the parents’ perception that the child was healthy and didn’t need any further hospital care.

Conclusions: A DAMA causes increased workload to the acute paediatric services but care should be taken to obtain accurate documentation and safeguarding children should always be paramount. Legal advice may be needed in some difficult cases.

What is already known

1. DAMA occurs in paediatric practice

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2. DAMA may not have been taken in the children’s best interest

3. It may increase the workload for the medical and nursing team

4. Signing of DAMA form is followed in some UK hospitals as a safe practice

What this study adds

1. Demonstrates a pattern for DAMA in the paediatric practice

2. Highlights the vulnerability of the children from the process of DAMA

3. Highlights the legal issues associated with the DAMA

4. Provides general recommendations for best practice in DAMA

Keywords

1. Discharge against medical advice
2. Paediatrics
3. Guidelines
4. Ailments
5. Open access
6. Legal

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INTRODUCTION

‘Discharge against medical advice’ (DAMA) arises when a patient or their carer decides to leave the hospital before the treating physician recommends they do so. Children are vulnerable in this situation as they may neither comprehend nor contribute to the decision and it may be that DAMA is not in their best interest. Leaving the hospital against medical advice may expose the children to the risk of inadequate treatment and may result in readmission and prolonged morbidity. There may also be safeguarding issues. There is little evidence on the extent of the problem and the outcome amongst paediatric patients. This article is based on a retrospective case note review
followed by a review of the available literature and endeavours to provide some general recommendations which may help paediatricians when faced with this problem.

MATERIALS AND METHODS

A retrospective case note review was done on all patients aged 0 – 18 years who attended St Richard’s Hospital, Chichester with acute illness from 1st January 2007 to 31st December 2009. St Richard’s Hospital is a 430 bed District General Hospital with 24 paediatric beds, a dedicated children’s area in Accident and Emergency Department and a Maternity unit catering for 2600 deliveries per year. St Richard’s Hospital mainly caters for a semi-urban Caucasian population with some immigrant population. The acute paediatric services currently admits about 2,400 medical and surgical admissions each year. The children’s assessment unit (CAU) sees approximately 150 children each month. Of these two-thirds are discharged following and approximately one-third are admitted.

The Emergency Department sees approximately 12,000 children annually. A total of 47 patients fulfilling the inclusion criteria of DAMA were identified from a search of the electronic patient discharge system (Sema Helix). Children are referred to the paediatric services either from the Emergency Department or by the general practitioners to the CAU. However, any children under 2 years of age are seen by the paediatric team irrespective of the place where they initially presented. Eight cases were excluded as these were incorrectly coded as DAMA.

The data collection included the reason for initial presentation, age and sex of the patient, time of discharge, whether seen by a doctor, time between initial presentation and medical review, reasons cited by parents or patients for DAMA, whether parents signed a DAMA form, whether there was consultant involvement and further input for safeguarding issues.

RESULTS

39 patients or carers took DAMA over the 3 year study period. 3 patients had pre-existing health conditions (cystic fibrosis, type 1 diabetes and asthma).

There were 27 male (69%) and 12 female (31%) patients in the study group. The age group of the patients are presented in fig 1.
Fever was the commonest reason \( n=6 \) for the initial presentation, followed by rash \( n=4 \), cough and wheeze\( n=3 \), self harm/overdose \( n=3 \) and head injury \( n=3 \). The Others group \( n=12 \) comprised of 1 patient each with vomiting, fever + rash, blood glucose monitoring in a diabetic, elective admission for antibiotics in a patient with cystic fibrosis, neck pain, alleged abuse, vomiting with fever, elective admission for sleep study, vomiting with rash, meconium observations, sore throat and swallowed foreign body. 34 of the 39 patients (87%) were seen by a doctor and 5 (13%) took DAMA prior to a medical review. 32 patients (94%) were had a medical review within 2 hours of the initial presentation. The other 2 (6%) were seen within 4 hours from the time of attending the hospital.
As evident from our clinical pathway the children were either seen by the casualty medical officer or the paediatric team but all of them had involvement from the paediatric team at some point. At the initial presentation 25 patients (73.5%) were seen by the paediatric doctors and 9 patients (26.5%) were seen by the casualty medical officer before being referred to the paediatric team. Fig. 2 highlights the clinical referral pathway of the patients who took DAMA.

22 (56.5%) out of 39 patients had signed a DAMA form. In the other 17 cases (43.5%) there was no form signed but it was documented either in the medical or nursing notes. No clear documentation about the possible complications and risks from the DAMA were documented. All the patients who took DAMA occurred within the first 24 hours from the presentation.

The time duration from the initial presentation to availing DAMA is presented in fig. 3

A number of different reasons were given by parents or carers for taking DAMA, highlighted in fig 4. Nine out of the 39 patients (23%) gave no reason (or it was not documented), 8 (20.5%) felt their child was now well so did not need to stay, 6 (15%) did not want to wait any longer for a further review or observation, 4 (10%) were unable to wait but didn’t cite any particular reason and a further 4 (10%) cited child care issues.

The remainder were a mixture of child or parents being unhappy and those who left without informing the staff.

4 parents who cited child care issues as the reason for DAMA. 2 of the children were around 1 year of age and 1 of them got readmitted within 24 hours of DAMA as the chesty symptoms worsened. The other 2 children were 7 years and 9 years respectively, none of them needed any further medical care in the hospital. It may be noted that the 8 children whose parents or carers felt that the child was healthy and didn’t needed any further inpatient care, 2 children were readmitted. Persistent fever was the main cause for the re-presentation to the paediatric services. They had blood investigations and
had a period of observation in the hospital. Fig. 5 highlights the initial presentation of this subgroup of patients.

Fig 4. Reasons cited for going home with DAMA

Fig.5 DAMA in patients where parents perceived that child was ok

The subsequent outcome following DAMA is recorded in fig 6. Most of the children (n=26, i.e.66%) stayed at home. 6 (15%) were readmitted within 48 hours to the children’s ward, however none were found to be so seriously ill as to cause significant morbidity or mortality. A review of the reasons for a
readmission to the hospital revealed fever and rash in 4 children (66%), vomiting in 1 child who had swallowed a foreign body and worsening of chesty symptoms in 1 children. All the children who got readmitted were under 5 years of age.

A further 6 (15%) children received input via the child safeguarding system (either through the liaison health visitor or needed social services input). 3 children (50%) needed involvement of the safeguarding system for overdose concerns, 1 child had alleged abuse issues, 1 had concerns about supervision having swallowed a foreign body and 1 child was already known as a child in need and needed further inpatient care. One (3%) patient was followed up over the telephone by the ward nurse.

![Fig 6. Final outcome of patients who went home with DAMA.](image)

A large proportion of children (n=30, 77%) were taken home with DAMA out of the normal working hours (17:00 – 09:00) when the consultant paediatricians were not physically present in the hospital, they remain on-call from their residence. A paediatric consultant was involved in 10 (25%) cases either because of availability (DAMA during the day), pre-existing health issues (e.g. – a known patient) or social concerns.

Open access were provided to 7 children (18%) and 2 out of the 7 had had long term open access because of their chronic health issues e.g. – Type 1 diabetes, cystic fibrosis. The open access system allows the patient to return to the discharging ward within a specific period of time so as to expedite the medical care.

As 8 out 47 patients were incorrectly coded as DAMA, it was highlighted as an issue for the staff working with the admission coding and further training issues has been highlighted so as to minimise such discrepancies in
the future. The staff were also made aware of the need to document the reasons clearly in the notes why DAMA was taken and the explanation and advice provided to the parents and carers.

DISCUSSION

Parents or carers bring the children voluntarily to the hospital for a medical opinion, a DAMA is merely a withdrawal of the original consent.\(^1,4\) The study of DAMA highlighted a few potential issues for children and staff. Although only 39 children were taken home by DAMA over a 3 year period, this still represents a significant problem. The staff may be taken away from more significant clinical situations to deal with parents who are taking their children home by DAMA to advise on clinical needs for further observations in the hospital and what to look out for while they are in the home to keep the child safe after DAMA.

In some cases, DAMA may have been avoided if a consultant paediatrician were on site either by sharing the workload if the DAMA was due to delay in being seen or by providing a more specialist opinion, or indeed by diffusing the situation having had more experience to deal with difficult consultations.

Parents perspectives of other home or social commitment were contributory to DAMA. Most of the children had a medical review within 2 hours from the initial presentation, However, an appropriate waiting time as perceived by parents and staff may differ in their views and there is no national consensus on how long it is acceptable to wait. Signing a DAMA form has no special properties and does not waive the physician or the hospital of the duty of care to the patient. The UK legal system does not clearly specify issues surrounding DAMA, however, even in the presence of a signed form, a patient who later came to harm could recover damages if he/she had not been warned of a risk which later materialized and the patient proved that if he/she had been told of that risk he/she would not have left the hospital.\(^5,8\)

Six readmissions were in children under the 5 years of age with 4 of them being under one year of age. Even though parents are generally considered to be acting in the best interest of their child, circumstances may arise when the attending physician, in liaison with other healthcare professionals, may need to reconsider the best interests of the child for whom DAMA is requested.\(^9\) This issue about DAMA, where parents may not be acting in the best interests of their child, is highlighted in other studies.\(^2,3\)

A proportion of the adolescent population with drug over-dosages, self harm or social issues took DAMA or absconded leading to a significant workload to the out-of-hours paediatric team to ensure their safety. This was because parents, carers, police and the social services needed to be contacted to trace them, and to make sure they remain safe after a DAMA.\(^10\) Similar issues are highlighted in different studies with young people from difficult
social background who have problems with drugs, self harm and psychological issues.\textsuperscript{5,6}

It is important that prior to DAMA that parents or patients are provided with full information about the medical condition, and that you are sure parents or adolescents possess the mental competency to understand their action and that they are not putting the children at risk. It is essential that it is made clear that the child should be brought back to medical attention at the earliest opportunity if the condition deteriorates or parents become concerned after DAMA, and to have a non-judgemental approach. It is also important that appropriate medications are provided for the ongoing care of such children and that the parents’ decision for DAMA should not compromise the medical care\textsuperscript{5}.

If it is felt at any stage that children may come to harm from DAMA, the consultant paediatrician should assess the case and, if needed, legal advice may need to be obtained to obtain a court protection order. Clear documentation and involvement of appropriate personnel is paramount especially if safeguarding concerns are found. The advice provided to the parents or carers and the discussion about pros and cons of the medical condition should form part of the medical and nursing documentation.\textsuperscript{4,5,8}

We feel the following recommendations would be helpful in cases where DAMA is being taken by carers or the patient.\textsuperscript{4,7,8,9,10}

1. Clear documentation about the situation leading towards DAMA to be recorded and also the discussion about the pros and cons that may arise from the DAMA.

2. A DAMA form may need to be signed by the carers or patients depending on the Trust policy. It may however be noted that the legal system in the UK has got no clear guidelines and the law varies depending on where the DAMA is noted e.g. England, Wales, etc.

3. They should be assessed in general to make sure that they have a sound understanding of the process and should not be under the influence of alcohol or any drugs that can have an effect on the mental capacity.

4. A brief documentation about the salient points from the discussion with the parents about the illness and its consequences must be made.

5. Further follow up plans should be clearly made and explained to the carers.
6. Open access should be offered to all the parents or carers taking DAMA and clearly documented in the notes.

7. The consultant responsible should be made aware of the potential DAMA and if felt appropriate they should be requested to review the case personally prior to DAMA.

8. A telephone follow up may be appropriate in the next 24 hours to make sure the child remains safe at home.

9. Police or social services input should be requested if any child safeguarding issues arise.

CONCLUSION

This study provides an overview of a situation which any clinician may face in their practice of hospital paediatrics. In most cases there will be a clear and appropriate reason for DAMA and the children can be safely managed at home with clear guidance given to the parents. The best interests of the child should always be paramount and legal guidance may be needed in some circumstances. We hope this study leaves the clinician with an heightened awareness of the issues involved in DAMA and helps in better management of cases of DAMA in the paediatric patients.

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