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The Sufficiency of Emergency Medicine Physician Documentation of Against Medical Advice Encounters

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A great deal of ambiguity exists among emergency medicine (EM) physicians regarding how to document against medical advice (AMA) encounters in the emergency department (ED) setting. In our own institution this ambiguity surfaces as inconsistent and eclectic documentation of patients terminating their evaluation and/or treatment prematurely. This ambiguity suggests (EM) residency programs fail to educate EM physicians-in-training in the area of AMA encounters and the importance of this emergency patient population in the context of the extant EM climate. The Open Access Initiative provides an ideal venue to distribute information and supports efforts to establish uniformity in the provision of certain aspects of EM care, such as documentation of AMA encounters.

Emergency department overcrowding, healthcare manpower shortages, and lack of healthcare access have created novel quality and safety challenges not previously examined in US healthcare systems. Patients who leave before the conclusion of diagnostic and treatment modalities represent a failure of emergency healthcare [1]. These visits are used as a marker of ED crowding and have indirectly been linked to delays in treatment, [2-4] higher complication rates, [5] and increased mortality [6]. As such, the proportion of these visits has been proposed by the Joint Commission and Centers for Medicare and Medicaid Services (CMS) as hospital quality indicators [7]. Patients who leave the EM AMA represent a subset of this population and carry the same increased risk of morbidity and mortality [8,9].

In 2003, CMS mandated that the documentation of refusal to treat should include proof that patients had "been informed of the risks and benefits of the examination or treatment, or of both" [10]. The extent to which emergency physicians are aware of documentation requirements memorializing AMA encounters has never been formally addressed in the EM literature. Heretofore, the AMA literature focused on the identification of at-risk populations and demonstrated that middle-age, impoverished, poorly–insured, males make up the lion share of this population.

A retrospective, year-long audit of ED AMA-encounters was conducted at our own institution between January 1 and December 31, 2010. During that time, four-hundred-and-eighteen patients left the ED AMA. The audit revealed 22.0% of EM-physicians documented patient capacity; (b) 34.9% documented extent or limitations of the evaluation; (c) 34.4% documented patient understanding of the diagnosis; (d) 43.1% documented physician concerns; (e) 66.7% documented the risks and benefits of leaving prematurely; (f) 5.8% documented alternative treatment or diagnostic options; (g) 97.8% explicitly documented that the patient left AMA; (h) 11.2% documented an opportunity to ask questions, 73.2% documented a follow-up care plan, and 68.9% documented that discharge instructions were received. In summary, we found that EM physicians sufficiently documented that patients left the ED AMA, but faired poorly in documenting other aspects of the encounter.

Critiques may argue that clinical demands prevent achieving the level of documentation suggested in our audit or that documentation advice aligns itself more closely with legal manoeuvres than with medical practice. However, these assertions, historically, do not tip scales in their favour when compared to the weight of federal mandates, standard of care requirements or professional liability threats. It remains unclear whether electronic medical records will facilitate AMA documentation compliance or further complicate the issue.

An effective and efficient standardization of the ED AMA encounter needs to be established to comport with federal and national documentation requirement. Future efforts in this area will include educating providers on AMA encounters, quality and safety risks, measuring the sufficiency of information received after this education, and comparing patient outcomes before and after these interventions.

Further multi-center studies are required to determine the extent of the problem, ascertain regional variations and attempt to uncover commonalities. If our audit forecasts the nature of AMA documentation in the U.S., these results demonstrate that physicians are not conducting AMA encounters according to quality and safety domains set forth by oversight institutions. Without appropriate documentation, it may be assumed that patients are ill-informed when deciding to leave the ED AMA.

Healthcare institutions should be cognisant of disparities between AMA documentation requirements enforced by oversight agencies and the documentation practices of EM physicians in their institution. Conformation to these requirements begins with the threshold determination of the sufficiency of extant documentation practices.

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