

Original Article

Discharge Against Medical Advice from a Mission Tertiary Hospital, South-West, Nigeria

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ABSTRACT

Background: The fiduciary duty of a managing physician makes paediatric discharges against medical advice (DAMA) particularly challenging as children lack the legal power or authority to make their health decisions. **Aim:** It is aimed in the present study to determine the prevalence of paediatric DAMA in a mission tertiary hospital. **Methods:** This was a prospective descriptive study carried out from June 2018 to May 2019 among paediatric inpatients at the Bowen University Teaching Hospital, Ogbomosho, Nigeria whose parent/ care giver signed DAMA, despite adequate counselling. Data was analysed using SPSS version 23. **Results:** The prevalence of DAMA in the study was of 4.1%, and the neonatal group accounted for the largest bulk of DAMA. Birth asphyxia was the commonest diagnosis among this group. There was a slight female predominance among the patients whose parents signed DAMA. Financial constraint was the commonest reason [13(30.2%)] given for DAMA and none of the children whose parents signed DAMA was enrolled on the National Health Insurance Scheme (NHIS). **Conclusion:** Rate of DAMA in a private mission tertiary hospital was lower than previously reported from government tertiary hospitals in the present-day Nigeria.

KEYWORDS: Discharge against medical advice, Mission hospital, pediatrics, tertiary

INTRODUCTION

Discharge against medical advice (DAMA) is defined as a patient choosing to leave the hospital against the advice of the managing physician.^[1] It is of negative health implication, as it can lead to complications and result in hospital readmission and death.^[1] Pediatric DAMA is particularly challenging because children lack autonomous power over their health and so the decision to DAMA is not made by them. The father is often the sole decision-maker.^[2,3] The physician, therefore, has to balance the duty of care to act in the patient's best interest and the respect for the parents' power over their children.^[4]

The rate of DAMA seems to be on the increase in Nigeria. Differing rates have been reported by various authors from different parts of the country and among different groups of patients. Fadare *et al.*^[5] reported a DAMA rate of 7.2% among patients on the adult medical ward in a tertiary hospital in the South-West Nigeria. Among the pediatric population, a little over

a decade ago, Onyiruka^[6] from Benin, South-West Nigeria and Ibekwe^[7] from South-East, Nigeria reported prevalences of 6.3% and 1.5%, respectively in Government tertiary hospitals. More recently and probably due to worsening economic situation in the country, Okechukwu^[8] from a public tertiary center in North-central Nigeria and Duru^[9] from another public tertiary hospital in the South-South area of Nigeria reported increasing DAMA rates of 7.4% and 7.5%, respectively. Rates between 1.7% and 11.1% have been reported amongst neonates in studies from the northern part of the country.^[10-12]

Several reasons have been adduced to DAMA; and include financial constraints on the part of the patient,


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deteriorating clinical condition of the patient, apparent improvement of the patient's condition, seeking alternative care (such as spiritual and traditional), poor communication between patient and the health care providers, among others.^[3,5,7]

Little is known about the prevalence and pattern of DAMA in mission hospitals in Nigeria. Spirituality is recognized as a factor that contributes to health in many people and the tripartite (spirit, soul, and body) nature of man requires complex support (which includes spiritual care) particularly in the vulnerable sick state. The mission hospital, as part of its mandate, seeks to provide wholistic (including spiritual) care for its patients; and since seeking spiritual/alternative care is one of the reasons previously adduced to DAMA, could the DAMA rate in a Mission hospital be different from what is obtained in other health institutions that do not provide spiritual care? The present study, therefore, aimed to determine the prevalence, pattern, and causes of DAMA among the pediatric patients seen at Bowen University Teaching Hospital (BUTH), Ogbomoso, Nigeria.

SUBJECTS AND METHODS

The study was conducted at the Bowen University Teaching Hospital (formerly Baptist Medical Centre) Ogbomoso, Oyo State over a period of 12 months; between 1st June 2018 and 31st May 2019. The institution is a mission hospital that offers tertiary care to her patients. There are specialists in different departments and facilities to train medical students and residents in family medicine. The Hospital also serves as a referral center to primary and secondary health care facilities in and around Ogbomoso, including neighboring states like Osun and Kwara.

The hospital has a chaplaincy unit that attends to the spiritual needs of patients, relatives, and staff. There is a chapel that is accessible for 24 hours each day; Christian worship services are conducted every morning and open to anyone (including patients, their relatives; hospital staff) who wish to join the worship service. The chaplaincy conducts a round every day providing counseling and prayers for patients as necessary.

The hospital has a vibrant medical social service unit, which deals with social issues relating to patients, such as sourcing for funds for indigent patients, among others.

The Department of Pediatrics cares for children and adolescents up to 18 years. It consists of four units, (the children emergency unit, neonatal unit, children's outpatient unit, and pediatric ward) from which patients are seen as either outpatients or inpatients. Patients that require inpatient care are admitted straight into the

emergency room, neonatal ward, or the Pediatric ward. The children's ward is a 25-bedded unit that consists of an isolation room, an adolescent room, and a general ward while the children's emergency unit is a 6-bedded unit where emergency care is given to patients for the first 48 h of admission before they are transferred to the children's ward. The neonatal ward is a 30-bedded facility that provides level II care to new-born babies admitted via the outpatient unit, labor ward, or labor ward theatre. It consists of an inborn unit, out born unit, and specialized jaundice room for babies with neonatal jaundice. Verbal consent for hospital admission is sought from the parent/caregiver after adequate counseling and before all hospital admissions in the department. Assent is also sought from children older than 10 years.

Eligible children from birth to 18 years whose parents/guardians apply for DAMA were recruited for the study from the emergency, neonatal, or pediatric ward of the hospital; using a purposive sampling method.

Children between the ages of birth to 18 years as at their last birthday whose parents/guardian apply for DAMA and whose parents give consent were included in the study; whereas, children whose parents/guardian apply for DAMA but change their minds after counseling done by a member of the managing team and children whose parents declined participation in the study were excluded from the study.

Patients on admission received inpatient care based on the hospital's treatment guidelines for their disease condition. The parents or caregivers were adequately counseled by the managing physician about their ward's condition at admission and during ward rounds. Parents of patients who express the desire to DAMA were adequately counseled; having the implications of his decision thoroughly explained to him. If the child's condition permits, the physician tried to reach a compromise on the number of days of treatment; i.e., reduce the number of days of inpatient treatment instead of allowing a DAMA. The social workers and the chaplaincy were invited for social and spiritual support, according to the departmental protocol for DAMA. The Chaplaincy contacted the spiritual father of the parents/caregiver of the patient when necessary to resolve issues warranting the DAMA. If the parent or care-giver still insisted on leaving, he/she was required to sign the DAMA form and then the proforma document for the study was completed by the house officer on duty. An outpatient appointment was given. In the event that a parent changed his/her mind and brought his/her child back to the hospital after a DAMA, the child was readmitted and given the comprehensive care his condition required.

The study proforma was used to obtain relevant data such as the socio-demographic history, diagnosis, number of days spent on admission, and reason (s) for DAMA.

Data analysis

Data obtained was entered into a spreadsheet and analysis was done using Statistical Package for Social Sciences (SPSS)TM version 23.0 for windows.

Ethical considerations

Approval was obtained from the Bowen University Teaching Hospital Health Research Ethics Committee (HREC) with reference number NHREC/12/04/2012. Written informed consent was obtained from the parents of eligible children, in addition, assent was sought from children older than 7 years.

RESULTS

Of the 1043 pediatric patients admitted in the BUTH over the one-year review, 43 (4.1%) were discharged against medical advice. Of these, 20 (46.5%) were males and 23 (53.5%) were females, giving an M: F of 1:1. The neonatal group formed the bulk of the DAMA cases, constituting 60.5% of the total burden. Overall, children under five years of age were the highest contributors (79%) to DAMA. Most of the children that DAMA belonged to homes from the lower socioeconomic class as shown in Table 1. DAMA form was signed in all the cases and the father was the signatory on the DAMA form in 69.8% of cases. None of the patients who DAMA were enrolled in the NHIS. Other details are as shown in Table 2.

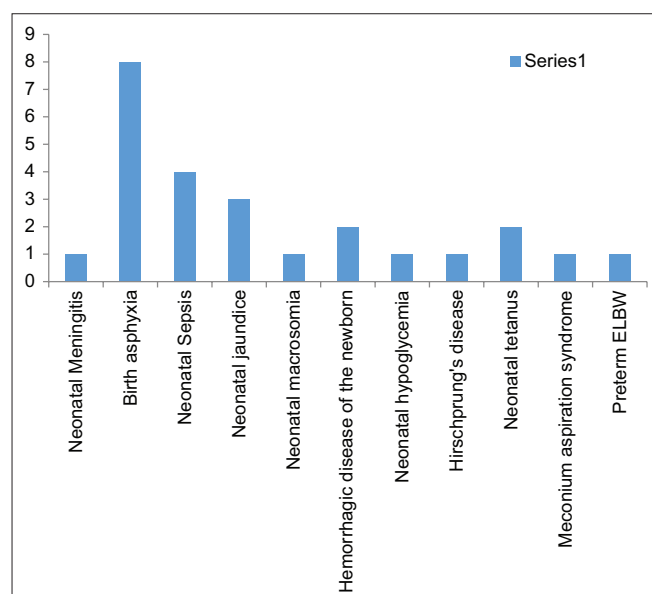


Figure 1: Diagnoses among neonates that DAMA

Table 1: Socio-demographic characteristics of patients that DAMA

Variables	Frequency	Percent	
Gender	Male	20	46.5
	Female	23	53.5
Age group	0-30 Days	26	60.4
	2-12 Months	3	6.9
	1-2 Years	4	9.3
	3-5 Years	2	4.7
	6-9 Years	2	4.7
	10-18 years	6	14.0
Educational status Father	None	0	0.0
	Primary	13	30.3
	Secondary	21	48.8
Educational status Mother	Post-secondary	9	20.9
	None	4	9.3
	Primary	13	30.2
Social Class*	Secondary	15	34.9
	Post-secondary	11	25.6
	Upper	11	25.6
	Middle	15	34.9
	Lower	17	39.5

*Oyediji social class 1 and 2: Upper class, class 3: Middle class; classes 4 and 5 lower class

Table 2: Response to content of DAMA Proforma

Questions	Frequency	Percent	
Who signed the DAMA form?	Father	31	72.1
	Mother	11	25.6
	Grandparent	1	2.3
When was the DAMA form signed?	Week day	36	83.7
	Week end	7	16.3
Is the child enrolled on NHIS?	No	43	100.0
	Yes	0	0

Table 3: Diagnoses among children that DAMA

Diagnosis	Frequency	Percent
Neonatal Conditions	26	60.5
Severe malaria	3	7.0
Meningitis	2	4.7
Febrile convulsion	2	4.7
Corneal laceration	2	4.7
Protein energy malnutrition	1	2.3
Chronic kidney disease	1	2.3
Sickle cell crises	1	2.3
Congestive cardiac failure	1	2.3
Corrosive esophagitis	1	2.3
Acute diarrhea disease	1	2.3
Sepsis/Septicemia	1	2.3
Dilated cardiomyopathy	1	2.3
Total	43	100.0

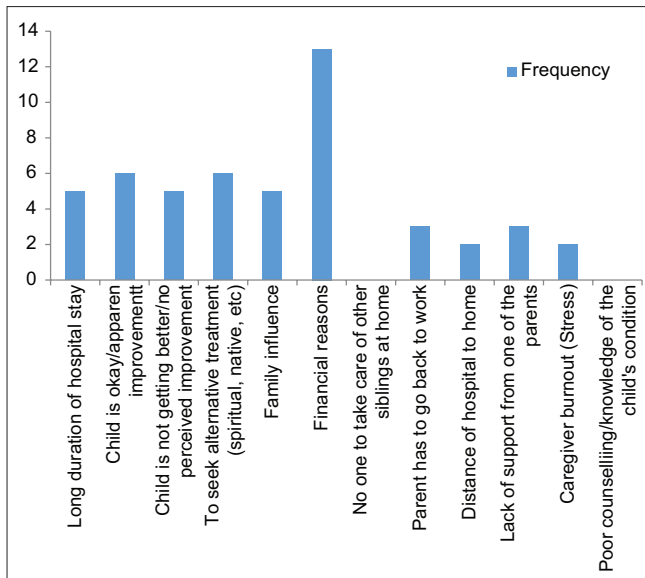


Figure 2: Reasons for DAMA

Table 4: Number of days spent on Admission, Condition of patients at discharge, and Outcome within one month

Variables	Frequency	Percent
Admission Duration (Days)		
1-5	28	65.1
6-10	8	18.6
11-25	7	16.3
Condition at discharge		
Improved	18	41.9
Same/No improvement	6	14.0
Danger signs still present (Palor, loss of consciousness, severe dehydration, fever)	19	44.1
Outcome		
Readmitted	1	2.3
Died	2	4.7
Lost to follow-up	33	76.7
Returned for follow-up	7	16.3

Table 3 shows the spread of the diagnoses in children who were discharged against medical advice. Neonatal conditions contributed the highest to DAMA; and of these, birth asphyxia was the commonest as shown in Figure 1.

The commonest reason for DAMA was financial constraint, other reasons were apparent improvement in the child’s condition, and seeking of alternative therapy such as traditional and spiritual as shown in Figure 2.

The mean duration of hospital stay was 5 days. Most of the patients, however, DAMA between the 1st and 5th day of admission. Almost half (44%) of the patients that DAMA still had illness danger signs such as palour, dehydration, and fever at the time of DAMA, however, only 1 (2.3%) was readmitted, 2 (4.7%) were reported dead by phone calls made to the ward sisters by the

parents; and 21 (48.8%) were lost to follow-up within a month after signing DAMA. Other details are as shown in Table 4.

DISCUSSION

The DAMA rate of 4.1% is much lower than reported among the pediatric population in previous Nigerian studies carried out in Government hospitals.^[8,9] The rate was, however, much higher than the 0.32% reported among the pediatric population in Oman. This may be due to the fact that payment for health care services in this study was out of pocket while the Omani children have access to free health care.^[13]

The neonatal group formed the bulk of the DAMA cases, and this was in tandem with other studies.^[6,7,13] Of the neonatal group, patients with severe perinatal asphyxia were the highest contributors to DAMA. The reason might be because the nature of their illness requires a prolonged hospital stay. It is also possible that the higher frequency of DAMA among this group of neonates could be an undesirable effect of the routine and extensive counseling sessions held in the newborn unit for the parents and caregivers of the patients with severe birth asphyxia and the consequent feeling of hopelessness on their children’s condition at the backdrop of extreme poverty.

The DAMA form was signed in all cases in this study. This was contrary to findings in other studies.^[3,5] The fact that the father was the signatory in most cases of DAMA seen in this study buttresses the fact that in the African setting, the father doubles as the cultural and the financial head of the home; and the bulk of the decision making lies with him. There is none doubting the role of female empowerment and female education as an important pillar in childhood survival. An educated female is empowered and contributes to finances in the home and should consequently contribute to decision making in matters that pertain to her children. Other signatories to DAMA in the present study included other family members such as the grandparents. This has been reported in another Nigerian study,^[5] and it portrays the strong communal influence of the family on health decision making in our society. This can be harnessed to positive influences like counseling of senior members of the larger family to prevent DAMA in some cases. Senior members of the family can also be asked to counsel the parents against DAMA if need be.

None of the patients in this study were enrolled in the National Health Insurance Scheme (NHIS). This is in agreement with the study in Enugu, in which 98% of the study participants were not on the NHIS.^[3] The need to pay for health service out of pocket poses a huge burden

on family resources (which are meager in most cases), the consequent financial frustration on parents leaves them with no other option than to opt for a DAMA.

The top three reasons for DAMA (financial constraints, apparent improvement of child, and to seek alternative therapy) are similar to findings in other studies,^[3,6,8] with as many as 30% signing DAMA due to financial constraints. This is probably due to the fact all the study participants had to pay their hospital bills out of pocket as none of them was enrolled on the NHIS. Furthermore, most of them were from the low socio-economic class, who live below the poverty line. The underlying reason for DAMA in the group that quoted apparent improvement in child's condition may in fact be financial, signing DAMA once the child showed the slightest improvement in health condition, in order to prevent the accumulation of hospital bills.

Of note is the proportion of parents that signed DAMA in order to seek alternative therapy in this present study was much less than the 20%, and 25% reported from Government tertiary hospitals in Southeast Nigeria and the Federal Capital Territory (FCT).^[7,8] The disparity might be due to the fact that the present study site is a mission hospital and provides some form of spiritual solace to patients who seek care in the hospital. Reliance on spiritual powers has been shown to yield positive coping mechanisms and consequently reduce anxiety among patients and their families.^[14,15] This helps them to easily accept and manage their health disorders. The involvement of the chaplaincy as part of the multi-disciplinary team in our hospital might have helped caregivers cope more with their children's illnesses and consequently reduced the rate of DAMA in our study. One other reason for signing DAMA noted in this study was because parents had to resume work. This has previously been documented in Nigeria decades ago by Oyedele.^[16] This precludes the much desired family-centered care and parental participation and contribution in the care of pediatric inpatients.^[17]

The fact that most of the children that DAMA still had danger signs present at the time of leaving the hospital portrays perhaps the hopelessness of the situation that most parents find themselves, leaving them only the option of DAMA. About half of the children that DAMA in this study were lost to follow-up, as reported in a previous study.^[18] Care should be taken on the part of the managing team to arrange as much as feasible a close outpatient follow-up visit after a DAMA. This will prevent more cases of lost-to-follow-up and mortality that follow DAMA.

CONCLUSION

The rate of DAMA in the mission hospital (4.1%) was lower than previously reported in government hospitals in present-day Nigeria. It was common among neonates, children of mothers with secondary education, and those from the lower social class. Financial constraint was the commonest reason for DAMA in our study.

A tripartite model of care, which includes spiritual/pastoral care should be adopted as a core value in health care delivery. Spiritual help like worship place should be provided in hospitals; in order to provide solace to parents with sick children. The coverage of the NHIS should be made to accommodate more children, including the newborns. Just as pregnant mothers are given maternity leaves to allow them to cater their newborns, Government policies should be made to excuse mothers who are required to stay with their sick children from work. Finally, the scope of counseling mothers and their surrogate helpers by the health team should be reviewed and be tailored to suit different family needs and where needed, directed at the older members of the family such as the grandparents in order to prevent DAMA.

Limitations

This is a single-center study and results may not be generalizable beyond the region, as DAMA has been reported to vary with culture and environment.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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