Journal of Community Medicine and Primary Health Care. 25 (2) 53-58

JOURNAL OF
COMMUNITY MEDICINE
& PRIMARY HEALTH CARE

Incidence and reasons for Discharge Against Medical Advice in a tertiary health care facility in Port Harcourt, south-south Nigeria.

Ordinioha B
Community Medicine Department
University of Port Harcourt Teaching Hospital,Port Harcourt.
Email: ruralhealthforum@yahoo.com
+2348037075300

KEYWORDS

Healer shopping, Discharge Against Medical Advice, Non-communicable diseases, epidemiological transition, Port Harcourt, Nigeria

ABSTRACT

Background
Disease pattern in Nigeria is changing from communicable diseases to non-communicable diseases. However, the approach to patient care has not changed; neither has the expectations of the general public for quick recovery. These have resulted in poorer treatment outcome and patients' dissatisfaction that sometime result in discharge against medical advice. This study is to ascertain the reasons for the growing incidence of discharges against medical advice in the medical wards of the University of Port Harcourt Teaching Hospital, Port Harcourt, Nigeria.

Materials and Methods
A two year review of the records of all the patients discharged against medical advice in the medical wards of the hospital was carried out. Data collected included the number and socio-demographic characteristics of the patients, the main medical condition they were treated for, the duration of their stay in hospital, the stated principal reasons for the discharge and signatories to the discharge document.

Results
The proportion of patients discharged against medical advice during the study period was 5.4%. Out of the 118 patients whose records were available for analysis, 55.1% were males; they had an average age of 45.6 +/- 12.6 years, and half were within the middle socio-economic class. The patients spent an average of 12.9 +/- 7.6 days in the hospital before asking for the discharge; and most (75.4%) were managed for non-communicable diseases. The main reasons for asking for discharge included poor treatment outcome (42.4%), financial constraints (28.0%) and a desire to seek other treatment options (22.0%). The signatories for the discharge were mainly the relatives (22.0%), children (22.9%), spouse (25.4%), and others, including the friends and religious leaders of the patients (17.0%).

Conclusion
Discharge against medical advice is often due to poor treatment outcome. Serious efforts should be made to correct this, with the immediate adoption of the WHO's Innovative Care for Chronic Condition (ICCC) framework.

INTRODUCTION

Disease pattern is changing from communicable diseases to non-communicable diseases, in Nigeria and other developing countries. The WHO estimates that non-communicable diseases like heart disease, stroke, depression, and cancer will increase by 60% by 2020,[1] and are likely to triple in Nigeria and other sub-Saharan African countries in the next 50 years.[2] Studies indicate that the prevalence of hypertension in Nigeria has increased from 11.2% in the 1990s,[3] to 27.9% in 2010 in a rural community in the Niger delta,[4] and 22.6% in 2009 amongst a sub-urban Christian community in south-west Nigeria.[5]

This changing disease trend is already being reflected in the type of patients admitted in Nigerian hospitals. Studies carried out in various tertiary hospitals in Nigeria indicate that more than 60% of the patients admitted into the medical wards were treated for non-communicable diseases,[6] excluding the close to 25% with HIV/AIDS[7] that share most of the treatment modalities of the non-communicable diseases.[8]

However, the approach to patient care used in the hospitals has not changed;[8] neither has the expectations of the general public, who still expect patients treated in the hospitals to be speedily restored back to health, as is the case with most of the communicable diseases. Indeed, western medicine was largely seen as miraculous in most of the traditional communities, with the success

achieved with the surgical treatment for such stigmatizing surgical conditions as hydrocele, and the cure achieved for yaws, with a single injection of antibiotics.[9]

These have resulted in poorer treatment outcome for the prevalent non-communicable diseases. A study carried out in the Caribbean found that good blood glucose control could only be achieved for 50% of the diabetic patients;[10] a Nigerian clinic was able to achieve good hypertension control for just 24.2% of the patients seen;[11] and as much as 25.3% of all patients admitted to the medical ward of a Nigerian hospital died,[12] while about 45% of the patients admitted for hypertension-related illness in another Nigerian hospital died,[13]

These did not inspire any confidence in the patients, so much that some had to ask to be discharged against medical advice, to search for other treatment options, even from tertiary hospitals that were expected to provide the best care for patients with complicated health problems. This has been called healer shopping, a term derived from doctor shopping, and refers to "the use of a second healer without referral from the first, for a single episode of illness.".[14]

Healer shopping is believed to be a growing trend in Nigeria and other African countries, and linked to the growth in the publicity activities of traditional medicine practitioners and faith healers.[15,16] In several instances, patients already receiving orthodox treatment have been allured with the promise of miraculous cure, and encouraged to discharge themselves from the care of the orthodox physician.[15, 16] However, several Nigerian studies[17, 18] attributed the discharges to financial problems, while studies carried out in developed countries considered the discharges as the manifestation of an underlying psychiatric ailment, or drug abuse.[19]

A study on discharge against medical advice was recently carried out in the University of Port Harcourt Teaching Hospital, but was carried out on neonates discharged from the Special Care Baby Unit of hospital.[18] This study however is to ascertain the reasons for the growing incidence of discharges against medical advice, in the medical wards of the hospital, particularly the role played by the preponderance of patients with non-communicable diseases. It is hoped that the results of the study would help the hospital remodel its services to cope with the epidemiological transition, as it works to achieve its stated vision of becoming a world class hospital, with five star services.

MATERIALS AND METHODS

This study was carried out in the University of Port Harcourt Teaching Hospital, one of the two tertiary health care institutions in Port Harcourt, the capital of Rivers State. Although located in Port Harcourt, the hospital constantly draws patients from the neighboring States of the Niger delta region; a catchment population that can be conservatively put at ten million people. The hospital is a 657 bed multi-specialist teaching hospital that offers not only tertiary health care services, but also secondary and primary health care, due to the near collapse of the other facilities in the State and region. It has a 78 bed medical ward that has average bed occupancy of 90%, with most of the patients being treated for non-communicable diseases.[6]

A two year (2009 – 2010) review of all patients discharged against medical advice in the medical wards of the teaching hospital was carried out. The medical wards were chosen for the study because they represent the clearest demonstration of the epidemiological transition.[6]

Patients that were discharged against medical advice within the study period were identified using the nurses' records, and their folders retrieved from the medical records department. Data collected include the number and socio-demographic characteristics of the patients, the main medical condition they were treated for, the duration of their stay in hospital, the stated principal reasons for the discharge and signatories to the discharge document. The data were collected using a data

sheet, and manually checked for consistency and completeness before being analyzed, using a pocket calculator. Summary measures were calculated for each outcome of interest.

RESULTS

A total of 131 patients were identified from the nurses' records to have been discharged against medical advice, out of a total of 2446 patients that were admitted into the medical wards during the study period. This puts the proportion of patients discharged against medical advice at 5.36%.

Out of 131 patients that were discharged against medical advice during the study period, only the records of 118 (90.08%) could be retrieved from the medical records department. Out of the 118 patients, 65 (55.08%) were males, while 53 (44.92%) were females. The average age of the patients was 45.64 +/- 12.56 years, and most (76.20%) were below the age of 60 years. Only 7 (5.93%) of the patients could be classified as being of high socio-economic class, 59 (50.0%) were of middle socio-economic class, while 52 (44.07%) were of low socio-economic class.

Most 89 (75.42%) of the patients were managed for non-communicable diseases like hypertension, cardiovascular accidents, diabetes, congestive cardiac failure and chronic renal failure; 17 (14.41%) were treated for HIV/AIDS-related illnesses, while 12 (10.17%) were managed for other communicable diseases like tuberculosis and hepatitis.

The patients spent an average of 12.91 +/- 7.60 days in the hospital before asking for the discharge, with 78 (66.10%) spending between one and four weeks. Table I shows the reasons given by the patients, or their relations for asking to be discharged. Most of the reasons were related to poor treatment outcome (42.37%), expressed as no improvement, long hospital stay, protracted illness and dissatisfaction with treatment; 27.97% of the patients cited financial reasons, while a desire to seek other treatment options was the reason given by 22.03% of the patients, and was expressed as desire to try traditional medicine or faith healing, disagreement with treatment plan, and nature of the ailment.

The signatories for the discharge were the relatives 26 (22.03%), children 27 (22.88%), spouse 30 (25.42%), parents of the patient 23 (19.49%) and others, including the friends and religious leaders of the patients 20 (16.95%), while 2 (1.69%) of the patients signed for their own discharge. The health outcome of 113 (95.76%) patients were unknown, while 5(4.24%) were recorded to have died from their ailment.

Table I: Principal reasons given for asking for discharged against medical advice

Reasons	**Frequency (N = 118)**	**Percentages**
Lack of funds	33	30.0
Poor treatment outcome	50	42.4
Desire to seek for other treatment options	26	22.0
Falsely perceived improvement	7	5.9
Distance from home	1	0.9
No stated reason	1	0.9

DISCUSSION

The study found that as much as 5.36% of the patients admitted into the medical wards of the study hospital asked to be discharged against medical advice. This is much higher than the 0.002% observed in Enugu,[20] and the 2.8% found in Sagamu.[21] The highest in developed countries was 2%.[19] The main reason for the difference is probably because the patients in our study were mainly being treated for non-communicable diseases, which are known to have poor treatment outcome.[10, 13] This is supported by the finding in our study that as much as 42.4% of the patients asked for the discharge, because of poor treatment outcome; which is much higher than the 8.6% recorded in Benin City[17] for paediatric patients, and the 12.1% recorded in Port Harcourt, for neonatal patients,[18] who were mainly being treated for communicable diseases and their complications that typically have better cure rate in hospitals.

The poor treatment outcome for noncommunicable diseases is recognized globally, and has prompted the WHO to propose a radical change to the present method of health care delivery, through the Innovative Care for Chronic Condition (ICCC) framework.[22] This framework consists of measures taken at the level of the patient, health system and policy formulation, aimed at ensuring the productive interaction of "informed, motivated, and prepared" patients with proactive practice teams. To ensure that patients are informed, motivated, and prepared, the framework recommends the empowerment of patients and families with the skills necessary to manage chronic conditions. The framework also called for the formation of "organized and well equipped" healthcare teams, (not just doctors and nurses) that are guided by evidence based decision support tools, and empowered with essential supplies and technologies that are able to provide continuous and coordinated services. This framework has been implemented in several countries with remarkable success,[8] and should therefore be adopted immediately in Nigeria.

The explicit desire to seek for other treatment options was the reason given by 22.03% of the patients in our study. This is much higher than the 4.4% recorded in Enugu,[20] and the 8.6% and 3.4% recorded amongst paediatric and neonatal patients in Benin City[17] and Port Harcourt.[18] The enormity of this difference can be further appreciated if one considers that the patients that clearly expressed their desire to seek other treatment options are likely to be very dissatisfied with their treatment outcomes, and therefore only bolder than those that left by just citing poor treatment outcome. The very high proportion of patients obtained in our study who wished to try other treatment options is however not surprising, considering that non-communicable diseases are more likely to be seen as being of supernatural origin or influence, and therefore not too amenable to the type of health care given in a modern hospital.[23]

Financial constraint was the main reason given by the patients in the other Nigerian studies, [17, 18, 20, 21] but was cited by just 27.97% of the patients in our study. It is however known that medical services for non-communicable diseases are often much more expensive than those for communicable diseases,[24] and in countries like Nigeria without health insurance, where out-of-pocket payment of services is the norm, the ability to pay is often a matter of life and death. But, the fact that financial constraint came a distant second in the reasons given by the patients for asking for discharge, might be indicative of how desperate the patients were for effective services. It also shows a willing to pay for services that should provide further impetus for the immediate adoption of the WHO's Innovative Care for Chronic Condition (ICCC) framework.

This study also found that only two patients (1.69%) were able to personally sign the discharge document, whereas relatives and religious leaders played very significant roles in discharging the patients against medical advice. This is much lower than the 40.7% recorded in the Enugu study,[20] and could be because the patients in our study were in

more serious condition, such that they couldn't sign the discharge document. The prominent roles played by the relatives and religious leaders to get the patient discharged, might be their last ditch effort to save the lives of the patients, outside the hospital, especially as most of the patients were below the age of 60 years, and therefore still within the productive age group.

Although, studies carried out in developed countries suggest that these decisions might not be from rational minds, and are often influenced by illicit drugs,[19] the findings of our study seem to suggest the contrary. About half of the patients in our study were in the middle socio-economic class, suggesting that they have enough capacity to make a considered decision. Also, although discharge against medical advice often results in the untimely death of the patient, the prominent roles played by the patients' relatives and religious leaders, who have reputation and interest to protect, suggest that the action is most likely an honest attempt to save the patient, at least according to their understanding.

CONCLUSION

Discharge against medical advice for chronic non-communicable diseases is often due to poor treatment outcome, and an honest attempt to get a better treatment for the patient. Serious efforts should be made to improve the effectiveness of the care given to patients, especially the immediate adoption of the WHO's Innovative Care for Chronic Condition (ICCC) framework.

References

1. Murray C, Lopez A. The global burden of disease: a comprehensive assessment of mortality and disability from disease, injuries and risk factors in 1990 and projected to 2020. Boston, MA: Harvard University Press, 1996.

2. World Health Organization. Current and future long-term needs. Geneva: World Health Organization, 2002: 1 – 17.

3. National Expert Committee on Non-communicable diseases in Nigeria. Final report of a national survey. Lagos. Federal Ministry of Health and Social Services. 1997.

4. Wokoma FS, Alasia DD. Blood pressure pattern in Barako: a rural community in Rivers State, Nigeria. The Nigerian Health Journal 2011; 11: 8 – 13.

5. Adefuye BO, Adefuye PO, Oladapo OT, Familoni OB, Olurunga TO. Prevalence of hypertension and other cardiovascular risk factors in an African sub-urban religious community. Nigerian Medical Practitioner 2009; 55 (1-2): 4 – 8.

6. Unachukwu CN, Agomuoh DI, Alasia DD. Pattern of noncommunicable diseases among medical admissions in Port Harcourt, Nigeria. Nigerian Journal of Clinical Practice 2008; 11 (1): 14 – 17.

7. Odenigbo CU, Oguejiofor OC. Pattern of medical admissions at the Federal Medical center Asaba: a two year review. Nigerian Journal of Clinical Practice 2009; 12 (4): 395 – 397.

8. Epping-Jordan JE, Pruitt SD, Bengoa R, Wagner EH. Improving the quality of health care for chronic conditions. Qual Saf Health Care 2004; 13: 299 – 305.

9. Wyatt HV. The popularity of injections in the Third World: Origins and consequences for poliomyelitis. Social Science and medicine 1984; 19: 911 – 915.

10. Gulliford MC, Alert CV, Mahabir D, et al. Diabetes care in middle-income countries: a Caribbean case study. Diabet Med 1996; 13:574–81.

11. Akpa MR, Alasia DD, Emem-Chioma PC. An appraisal of hospital based blood pressure control in Port Harcourt, Nigeria. The Nigerian Health Journal 2008; 8 (1-2): 27 – 30.

12. Sani MU, Mohammed AZ, Bapp A, Borodo MM. A three year review of mortality patterns in the medical wards of Aminu Kano Teaching Hospital, Kano, Nigeria. The National Postgraduate Medical Journal 2007: 14 (4): 347 – 351.

13. Arodiwe EB, Tke SO, Nwokediuko SC. Case fatality among hypertension-related admissions in Enugu, Nigeria. Nigerian Journal of Clinical Practice 2009; 12 (2): 153 – 156.

14. Kroeger A. Anthropological and socio-medical health care research in developing countries. *Soc Sci Med* 1983; 17: 147 – 161.

15. Deribe K, Hailekiros F, Biadgilign S, Amberbir A, Beyene BK: Defaulters from antiretroviral treatment in Jimma University Specialized Hospital, Southwest Ethiopia. Trop Med Int Health 2008; 13 (3): 328 – 333.

16. Dilger H. Healing the Wounds of Modernity: Salvation, Community and Care in a Neo-Pentecostal Church in Dar Es Salaam, Tanzania. Journal of Religion in Africa 2007; 37(1): 59 – 83.

17. Onyiriuka AN. Discharge of hospitalized under-fives against medical advice in Benin City, Nigeria. Nigerian Journal of Clinical Practice 2007; 10 (3): 200 – 204.

18. Opara PI, Eke GK. Discharge against medical advice amongst neonates admitted into a special care baby unit in Port Harcourt, Nigeria. The Internet Journal of Pediatrics and Neonatology, 2010; 12(2): 2.

19. Alfandre DJ. I'm Going Home": Discharges against medical advice. Mayo Clin Proc. 2009; 84 (3): 255 – 260.

20. Eze B, Agu K, Nwosu J. Discharge against medical advice at a tertiary center in southeastern Nigeria: sociodemographic and clinical dimensions. Patient intelligence; 2010; 2: 27 – 31.

21. Alebiosu CO, Raimi TH. A study of hospital patients' discharge against medical advice in the Ogun State University Teaching Hospital, Sagamu, Nigeria. *Nigeria Medical Practitioner*. 2001; 40: 33 – 35.

22. World Health Organization. Innovative care for chronic conditions: building blocks for action. Geneva: World Health Organization, 2002.

23. De-Graft Aikins A. Living with Diabetes in Rural and Urban Ghana: A Critical Social Psychological Examination of Illness Action and Scope for Intervention *Journal of Health Psychology* 2003; 8(5): 557 – 572.

24. Goudge J, Gilson L, Russell S, Gumede T, Mills A. Affordability, availability and acceptability barriers to health care for the chronically ill: Longitudinal case studies from South Africa. *BMC Health Services Research* 2009, 9:75 doi:10.1186 / 1472-6963-9-75.