Request for a medical discharge order against medical advice without imminent risk of death

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Abstract

The response to the request by a patient for a medical discharge order against medical advice without imminent risk of death is no more than respecting his or her autonomy. Yet this is not a peaceful issue. The objective of this study was to describe the conduct of doctors facing demands for medical discharge. A qualitative type case study was conducted based on semi-structured individual interviews with doctors of the Emergency Unit of HC-FMRP-USP. Eight interviews were recorded, transcribed, and the data was analyzed by content analysis. We found that doctors stress the importance of informing the patient about the risks of their decision, which should be respected if he or she maintains his position; and also highlighted the importance of documentation and the impossibility of issuing prescriptions when there is no scientifically recognized alternative. The concern of the doctor regarding the legal implications of accepting the patient's request was also noted.
Keywords: Patient discharge. Personal autonomy. Bioethics.

Resumo

Alta a pedido contra indicação médica sem iminente risco de morte

O atendimento à solicitação pelo paciente de alta a pedido contra indicação médica, sem risco iminente de morte, nada mais é do que garantir a autonomia desse paciente. Entretanto, não se trata de tema pacífico. O objetivo deste trabalho foi caracterizar a conduta do médico diante da alta a pedido. Realizou-se estudo de caso qualitativo, a partir de entrevistas individuais semiestruturadas com médicos assistentes de hospital público universitário. Foram realizadas oito entrevistas, gravadas e transcritas, e os dados, trabalhados por análise de conteúdo. Concluiu-se que os entrevistados consideram importante esclarecer o paciente acerca dos riscos de sua decisão, que deverá ser respeitada caso a mantenha; reconhecem também a relevância da documentação de alta e a impossibilidade de emitir receita quando não há alternativa cientificamente reconhecida. Evidencia-se, ainda, a preocupação do médico quando às implicações legais de atender ao pedido do paciente.
Palavras-chave: Alta do paciente. Autonomia pessoal. Bioética.

Resumen

Alta por solicitud contra indicación médica sin riesgo inminente de muerte

La respuesta a la solicitud de alta de parte del paciente, cuando ésta es contraria a la indicación médica, sin riesgo inminente de muerte, apunta a garantizar su autonomía. No obstante, no se trata de un tema poco polémico. El objetivo de este estudio fue caracterizar la conducta del médico ante el pedido de alta. Se realizó un estudio de caso, de carácter cualitativo, a partir de entrevistas individuales semi-estructuradas con médicos asistentes del hospital público universitario. Se realizaron ocho entrevistas, las cuales fueron grabadas y transcritas, constituyendo los datos trabajado en el análisis de contenido. Los datos muestran que los entrevistados destacan la importancia de aclarar al paciente los riesgos de su decisión, la cual deberá ser respetada en caso de que se sostenga; destacan también la importancia de la documentación y la imposibilidad de emitir recetas cuando no existe una alternativa científicamente reconocida. Se evidencia, además, la preocupación del médico en relación a las consecuencias legales de atender a la petición de la paciente.
Palabras-clave: Alta del paciente. Autonomía personal. Bioética.

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Declaram não haver conflito de interesse.

Over the last decade, the debate over the limits of patient autonomy in Brazilian society has intensified, especially among medical councils. Proof of this are the provisions of the Código de Ética Médica (CEM – Code of Medical Ethics), in force since 2010[1]. Among other matters, these regulations make it clear that the patient should have his or her autonomy protected, including in cases of terminal illness, provided that the doctor meets the required duty of providing information.

In this context, Resolution 1,995/2012 of the Conselho Federal de Medicina (CFM - Federal Council of Medicine), which regulates the right of the patient to record their advance directives of will can also be cited[2]. Despite these advances, there are many cases related to patient autonomy in which the doctor cannot determine, with a minimum of ethical and legal certainty, what is the best decision to be made. Obviously, there are particular situations that can only be decided on a case by case basis. However, without a minimum of guidance as to conduct the practicing of medicine could become unviable, given the endless possibilities of accountability in civil, criminal and ethics.

From a legal point of view, the autonomy of the patient to refuse treatment follows from the principle of legality established in paragraph 2 of Article 153 of the Federal Constitution, which states: *No one shall be obliged to do or refrain from doing something except by virtue of law*...[3]. This means that a patient would only be required to undergo treatment if there was a law that determined him or her to do so.

In São Paulo, the then governor Mario Covas sanctioned a law that would later bear his name: State Law 10,241/1999, which defines the rights of users of the state health services in São Paulo. Some paragraphs of Article 2 are closely related to the subject at hand, especially paragraph VII, which secures a patient's rights to *consent to or refuse, in a free, voluntary and informed manner, with adequate information, the diagnostic and therapeutic procedures be performed on him or her*[4]. At federal level, in the spirit of the Covas law, is Ministry of Health Decree 1,820/2009[5], which deals with the rights and duties of healthcare users. Article 4 provides in its paragraphs: the choice of place of death; the right to choose alternative treatment, if any, and consideration of refusal of the proposed treatment. Finally, the CEM reaffirms, in articles 22, 24 and 31, that the doctor can only disregard the right of the patient in case of the imminent risk of death. This means that, even though it may be his or her intention to benefit the patient, a doctor cannot refuse said patient hospital discharge, if the request is against medical advice and there is no risk of imminent death.

Therefore, this raises the question: from a legal point of view, are doctors confident of their actions in such a situation? In other words, what attitude do doctors consider legally appropriate when a patient requests discharge against medical advice without imminent risk of death? As we have said, while in many situations the facts of the relevant case must be applied, guidelines should be established. After all, if the doctors themselves fail to properly respond to this situation, what can be expected from law enforcement officers, namely judges, prosecutors and lawyers, who have no experience of medical reality?

Theoretical framework

Hospital discharge is the private act of the doctor, as defined by Rey[6] and pursuant to Article 4, section XI, of Law 12,842/2013, known as the Medical Act Law[7]. Therefore, the CRM-SP Consultant Opinion 41,848/1996 of councilor Donizetti Dimer Giamberardino Filho, for example, specifies that the term "request for discharge" is not suitable, as it would in theory be the recommendation of the patient himself or herself. It is suggested that it is preferable to use the term "refusal of treatment." Indeed, the patient has no technical, nor legal, capacity, to make his own clinical evaluation and grant him or herself "hospital discharge"[8].

However, the fact is that standard "hospital discharge forms" used in hospitals across the country, provide only the following options for the patient leaving the hospital: 1) discharge by medical order; 2) discharge by absence; 3) discharge by transfer; 4) discharge by request; 5) discharge by flight; and 6) discharge by death. The discharge document should always be signed by the doctor, regardless of whether or not he or she agrees with it being granted. Thus, although inappropriate, the term "discharge by request" appears in the discharge form and has today become a reality of medical practice.

A brief description of each type of discharge mentioned on the discharge forms is useful. "Discharge by medical order" is the most common outcome, where the doctor, after evaluation, grants a discharge at the end of treatment or based on the possibility of outpatient treatment. "Discharge by absence" is granted by the doctor to a patient who is absent from the hospital for a certain period, after which he or she will return to the hospital. In

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"discharge by transfer," the doctor allows the patient to continue hospital treatment in another hospital; in other words, the patient does not return home, but is transferred to another hospital. In "discharge by death," the death of the patient is diagnosed by the doctor who will complete the death certificate in cases of natural deaths by known cause; in other cases, there is a need for an autopsy by the Coroner's Service or the Medical-Legal Institute. "Discharge by flight" occurs when the patient escapes from hospital without the knowledge of the health team; it should be emphasized that in such cases, the hospital and the health team can be held accountable for failure of the duty to guard by which they are bound. Finally, "discharge by request" is the mode in which the patient requests a discharge, despite medical advice.

The term "discharge by request", described alone, without any other qualifying term, seems inadequate, and may lead to the false impression that the doctor agrees with the discharge, when in fact he or she did not recommend it. Therefore, it should be clarified that discharge in this case is at the patient's request and against medical advice. It is, therefore, a "discharge by request against the doctor's advice," a more appropriate term for the situation [9].

One of the most important issues to be determined in cases of discharge by request against medical advice is if the patient is in imminent risk of death, since, according to Article 22 of the CEM, this would be the only situation in which the doctor can override the consent of the patient without committing an ethical violation. The meaning of "imminent risk of death" in the legal environment is the *concrete and imminent likelihood of a lethal outcome* [9]. Imminent risk of death, for the purposes of this study, is a situation where the patient has a high probability of dying in the next few minutes or hours if the chosen medical intervention is not performed. This is the case, for example, with medical treatment of refractory postpartum hemorrhage, where surgery (hysterectomy) is the formally recommended treatment; if this is not performed, there is a high probability of death. Victims of car accidents who arrive at the emergency room with tension pneumothorax are also considered at imminent risk of death; in this situation, if surgical drainage of the chest is not carried out, the probability of death is very high.

Objective, case studies and method

The objective of the present study was to characterize the conduct of doctors when faced with a request for discharge against medical advice without imminent risk of death, as well as their reasons for such conduct.

A case study with a qualitative approach, based on semi-structured individual interviews, using thematic mode content analysis, was carried out [10]. By the nature of the data studied, a qualitative approach was considered the most appropriate, as probability samples were not used and the frequency with which certain behavior or opinion occurred was not studied. Instead, the aim was to seek to understand how the subjects form and distinguish their perceptions, opinions and attitudes about a fact, which cannot be quantified *a priori*.

The study was carried out in the Emergency Room of the Hospital das Clínicas da Faculdade de Medicina de Ribeirão Preto of the Universidade de São Paulo (the Clinical Hospital of the Riberao Preto Medical School of the University of Sao Paulo) (UE-HC-FMRP-USP). An individual invitation was sent by email to 16 clinical medical assistants from the ER, half of whom agreed to take part in the research. Interviews were then scheduled between the eight doctors and the interviewer.

Each participant was presented with a free and informed consent form, and the interview was held in the meeting room of the Emergency Room. The interviews were audio recorded using Sony Sound Forge software, and followed a semi-structured, dynamic and flexible script. The script considered everyday situations for a doctor, in hypothetical cases in which a patient not at risk of imminent death requested a discharge against medical advice.

The initial analysis process took place simultaneously with data collection. All the words were fully transcribed. The names mentioned by the subjects were recorded by the letter "S" plus a sequence number to ensure anonymity. As the transcripts were read over, square brackets were added when it was necessary to emphasize ideas that had come to mind based on what was heard, which became the nuclei. The nuclei were removed from the data and after comparison, were grouped by similarities and differences, forming the thematic categories.

Results and discussion

Of the eight doctors interviewed, six were male and two female. Ages ranged from 30 to 55 years, with a mean age of 31 years. In terms of specialization, there were three nephrologists, two cardiologists, one geriatrician, an endocrinologist

and a hematologist. The time spent practicing medicine was between 7 and 30 years, with an average of 11 years. Service in the Emergency Room ranged from 3 months to 22 years.

Data analysis revealed two thematic categories: 1) the obligation to meet the request of the patient and the responsibility of the doctor; 2) documentation of discharge by request, multidisciplinary assessment and providing a prescription.

Obligation to meet the request of the patient

The situations represented in the "interview script" deal with simulations of everyday medical practice involving discharge requests without imminent risk of death in legally capable patients who are competent to make decisions. In these situations, the vast majority of doctors recognized the rights of the patient, but stressed the need for clarification. Only after the patient knows and accepts all the risks of his or her request can such a request be granted. Participants also stressed that clarification can, in itself, help the patient to review his or her decision. However, some doctors would not grant the request for discharge, even when the risk of death was not imminent, but possible in the near future (days, for example):

"We explain to her the need to remain hospitalized; the need to complete the antibiotic treatment while in hospital; the first thing is to try to explain the disease and the importance of staying in hospital. Most of the time she rethinks and changes her mind. She doesn't want to stay in hospital, we have to note that very clearly in the medical record. She is aware and her critical judgment is intact, so we end up granting the request for discharge" (S1);

"Again, I try to provide guidance about the risks of early discharge, of not performing all the tests to complement the evaluation. Still, if he wants to be discharged, I would grant discharge by request and prepare a prescription with all the medications that he should take. I'd schedule a return visit to the outpatient clinic and grant discharge by request" (S2);

"We don't grant discharge in these cases, even though she had shown significant clinical improvement. You say that there is no imminent risk of death, but the potential risk is too great" (S4);

"I would not grant the discharge request nor sign anything, and would inform her that if she wanted to leave or escape, she would leave the health service but not under my authorization, nor would I write anything in the file: 'patient requests discharge', nothing of the kind" (S8).

Most of the opinions of the Conselho Regional de Medicina do Estado de São Paulo (CRM-SP – Regional Medical Council of São Paulo) agree with the understanding that the patient's autonomy should prevail in cases of discharge requests against medical advice. Consultant Opinion CRM-SP 41848/1996, for example, specifies that *once the patient has been fully informed of his or her situation, treatment strategies and prospects for their life and health (evidence of this should be recorded, as protection for the doctor) it is the patient who will decide whether to accept, or not, the therapeutic approach* [11].

Similarly, Consultant Opinion CRM SP-1665-13/1986 makes a number of recommendations regarding the obligation of doctors to alert the patient and/or their caregivers about the risks of discharge; and confirms the position that the doctor must respect the patient's autonomy. According to the judgment, the doctor must answer the request of a patient for discharge after informing him or her – in a wide-ranging, complete and unrestricted manner – the advantages, disadvantages and consequences that discharge may ultimately cause, as well as whether there is a risk of death or serious injury. The opinion emphasizes that the other members of the team (doctor, nurse, social worker, etc.) should also provide clarification to the patient and that if he or she insists on requesting discharge, the doctor should accept such a wish. It further states that the term of responsibility signed by the patient *has the sole purpose of serving as a document stating that the risks, advantages and disadvantages were properly explained, and should include all such explanations* [12].

At this point of the discussion, it should be made clear that when discharge is not recommended to the patient, allowing his or her "flight" should not be considered a reasonable alternative; not least because such situations could result in the hospital being held accountable for failing to comply with its duty to guard the patient. Every hospitalized patient may have, at any time, an anxiety crisis and decide to escape from the hospital; therefore, the hospital should not permit flight without first providing treatment, verifying the patient's ability to decide and informing him or her of the consequences of the attitude taken.

However, what has truly raised discordant voices, not only in the CRM-SP but in other regional medical councils is the issue of post-discharge

responsibility. In other words, the crucial point that causes the most controversy is the possibility of the health conditions of the patient deteriorating after discharge is given against medical advice. In this case, who is responsible? In our study, doctors who recognized the patient's right to discharge by request declared that responsibility for any worsening of health status lies solely with the patient, as he or she has made his or her decision after the risks being assumed have been duly clarified:

"More the patient's than ours. Because if it was explained to him, in fact not just to him but also to his family, and if we have tried all the other options, there is not much more we can do. If he is in imminent risk of death, then we will be able to do something, according to ethics. While he is not at such imminent risk, we have to do what he wants. Respecting his autonomy" (S5);

"I wouldn't feel responsible for what happened, if I had advised the patient well, and had it all written down" (S2);

"From the moment that you respect his autonomy and the patient is informed, I imagine that ethically you will have no liability" (S4);

"The responsibility will be the patients. It would not be the doctor's, no. If the patient was lucid, informed, and able to make decisions. There is free will" (S3).

Some medical opinions formally recorded by the CRM-SP to answer this question describe conflicting opinions [13]. The aforementioned Consultant-Opinion 1665-13/1986 expressed the following understanding: (...) *the hospital and the doctor, provided they have obeyed the recommendations expressed in this opinion, are relieved of their legal and ethical responsibilities from the time that the patient in question leaves the hospital premises and not before* [12]. In a diametrically opposite position, Consultant-Opinion CRM-SP 16948/1999 considers that the patient's signature on the request for discharge does not relieve the medical professional from responsibility, if the patient's condition deteriorates and it is proven that it was imprudent to let him or her go [14]. Following the same line of reasoning, Consultant-Opinion CRM-SP 30,467/1991 states that the *term of responsibility signed by the patient or his or her guardians will only be valid if the discharge requested does not pose harm to the patient. Otherwise the doctor granting such discharge is performing an act of negligence and may, by performing this act, be held responsible in accordance with current legislation* [15].

These last two opinions invoke, for greater understanding, the thoughts of the French jurist Genival Veloso, according to whom the term of responsibility signed by the patient in the event of the request for discharge *will only have value if [*such discharge*] does not involve serious harm to health or the patient's life* [14]. It is important to note that neither of the opinions describes the alternatives available to the doctor, or even what should be done to deny a request for discharge when there is a risk of worsening the health conditions of the patient.

We must consider, however, that discharge by request against medical advice will almost certainly result in the risk of a deterioration of health status; because, if the doctor has to admit that there is no risk associated with the request for discharge, he will also have to admit that there is no need for hospitalization, which also results in an ethical violation. In other words, if the doctor hospitalizes a patient for treatment it is because this treatment cannot be performed outside the hospital (intravenous treatment, for example); and if the patient requests discharge, it is clear that he or she is running a risk, otherwise he or she would not be hospitalized in the first place. Therefore, to demand that the doctor guarantees that there is no risk involved with discharge by request against medical advice with no imminent risk of death is to demand the impossible.

This same understanding is contained in Consultant-Opinion CRM-SP 51,723/2005 [16], complementing Consultant-Opinion CRM-SP 20,589/2000, which, when addressing the specific issue of discharge by request, expressed the following interpretation: (...) *if hospitalization is indispensable to guarantee the treatment and the protection of the life and physical and mental integrity of the patient, discharge by request contradicts the decision of the doctor and results in a situation whose risk the professional is not required to assume* [17].

Documentation, multidisciplinary approach and prescriptions

There is much debate about the legal validity of a "discharge by request document", given the understanding of the two opinions cited (30,467/1991 and 16,948/1999) that its validity would be conditional upon there being no deterioration in the patient's health. As we have seen, guaranteeing such a medical condition is considered impossible, as it would involve the admission that the hospitalization

of the patient is unnecessary. We found that, faced with this dilemma, the doctors participating in this study emphasized the need to document the entire process of clarification in the patient's medical record, regardless of the specific written declaration of the patient:

"I think the best way is to leave it very clearly documented in the medical records. I think the records are the main way of documenting it. It has to be very clearly written in the medical records. Everything that was done, the conversation that the doctor had with the family and with the patient. Make a note in the medical records that the patient has been advised, and that his or her realistic critical judgment is intact, which must also be written in the record. Note that even after all this information, all these recommendations, and the conversations with the family, the patient continued to desire discharge by request" (S1);

"Write in the medical records themselves, the whole procedure, the whole routine, conversations with the patient, clarifying the situation to the patient, and write in the medical record that the patient is alert, oriented, able to make a decision, aware of his medical condition, but that all available methods have been used, and he was not convinced. Talk to family members" (S7);

"There is a more or less ready to use declaration which is not fully valid on account of these issues of clarification, of how far you can go" (S6);

"There was, some time ago, a form that the patient signed saying that he or she was conscious and that he was being discharged. The information we were given was that it had no legal value. This document had no legal weight. So in fact, what we do is leave everything clearly written in the records. We do not ask for anything else, or for the patient to sign a document" (S1).

Indeed, there is no consensus on the best way to record the events that occur in situations of discharge against medical advice. An analysis of legal guidelines, including the resolutions of the regional medical councils, leads to the conclusion that there is no obligation to draw up a specific document, although most of the opinions issued by councils mention the so-called "discharge by request document". Our fear is that this document may be interpreted only as another "disclaimer", which in general are not well-regarded in judicial circles, such as the "non-indemnity clauses" common in service provider contracts. In our view, a detailed description of the clarification process in the medical records (including assessment by a multidisciplinary team), accompanied by the written consent of the patient, would suffice as evidence in the case of calculating liability.

Regarding the desirability or need for evaluation by a multidisciplinary team, the respondents declared themselves in favor, highlighting the role of psychologists and social workers. According to reports, often the patient's refusal to remain hospitalized stems from purely social problems, or a moment of anxiety and fear:

"A psychologist is routine for critical judgment, when you think the patient is anxious, a little scared, we usually call them, yes" (S5);

"I remember that one patient had a dog, and there was no one to give food to the dog. And this was the reason he wanted to leave at all costs. And the person who figured it out was the social worker, who talked to him, and he explained" (S8);

"Especially in these cases, it is ideal to have a multidisciplinary team that is aware of the patient's condition. So that one person will not get overwhelmed. The ideal situation is evaluation by a multidisciplinary team" (S4).

The script of the semi-structured interview included a hypothetical situation to address the issue of the compulsory issuing of prescriptions. In this hypothetical situation there was no scientifically recognized alternative other than intravenous treatment exclusively carried out in hospital and with no possibility of effective outpatient treatment. The opinion that a prescription should not be supplied if the doctor considered any scientifically recognized outpatient treatment to be impossible prevailed among the doctors, although some of them did not feel confident about this position:

"If I provide a prescription, I'm automatically making the discharge my responsibility. So I do not give it. I even recommend looking for a colleague to continue the treatment, but I would not give a prescription. If I did, I would be compromising myself" (S8);

"We do not usually give prescriptions, because the antibiotic she is using is for hospital use" (S5);

"I think it would be less harmful for her to leave with a prescription than to leave with nothing. If she really had to go, I would prescribe one, yes. I try

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to give a prescription for oral antibiotics or, where appropriate, some patients can take antibiotics intravenously, as though in an outpatient clinic" (S3);

"In this situation, most of the time we try to achieve transition to an oral medication that has a range of coverage similar to what she was taking intravenously. Often we end up preparing a prescription for the patient to complete treatment orally. Even though it is not ideal" (S2).

Consultant-Opinion CRM 20,589/2000 [17] states that a *duly informed patient who is not at imminent risk of death, who does not comply with the medical determination to continue with in-hospital treatment [*relieves*] the professional of the obligation to continue treatment and to issue prescriptions*. This position is reinforced by Consultant-Opinion CRM-SP 51,723/2005 [16], according to which the doctor cannot be obliged to issue prescriptions against his personal conviction and in doing so would be assuming responsibility for treatment that he has not recommended. Moreover, the opinion considers that if the doctor agrees to the procedure requested by the patient, there is no need to talk about an obligation to provide prescriptions or discharge by request, since the conduct is consensual; in this situation, the discharge on request against medical advice does not exist, but is instead merely an option for outpatient treatment.

Final considerations

Overall, the respondents agreed with the current thinking that defends the obligation of the physician to inform the patient about the risks of discharge by request against medical advice, and to make every effort to try to convince him or her to undergo the recommended treatment indicated with other health professionals in this process. If, even after all these efforts, which should be properly documented, the patient maintains his or her request for discharge against medical advice, it should be granted, without the doctor involved incurring responsibility for any deterioration of the patient's health conditions.

However, one cannot help but notice the fact that a few participants had great difficulty in dealing with the situations proposed, specifically in regards to what the physician should do when the patient insists on requesting discharge against medical advice, arguing that patients cannot be kept in hospital against their will – hospital is not prison. In this situation, some worrying answers were heard, for example, say that the patient could even escape from the hospital, but discharge would not be granted for fear of future accountability.

In our view, in cases where a patient is not at imminent risk of death, his or her autonomy should prevail, even though a discharge by request implies a worsening of health – even though there would be no recommendation for hospitalization in the first place. The obligation of the medical staff, rather than trying to convince the patient, is to engage with him or her so that he or she understands the scope of the decision, and thus can make an informed choice, documented in medical records. In relation this point in particular, it is proposed that the detailed recording of the clarification process in the patient's medical records is adopted as standard by the Federal Council of Medicine, preferably through a resolution that would define the steps to be met by the professional when performing the correct communication of information to the patient.

Finally, it is concluded that, when dealing with a "request for discharge", the doctor should not simply refuse such a request; on the contrary, it is an opportunity to implement his or her duty to inform the patient as efficiently as possible, so that he or she can exercise their autonomy in a comprehensive manner.

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Participation of the authors

Mariana Vicente Cano participated in the creation of the project, data collection, and the writing and editing of the manuscript. Hermes de Freitas Barbosa participated in the creation of the project and the writing and editing of the manuscript.

Annex

Interview script

1- A 23 year old patient who is 20 weeks pregnant arrives at the emergency room, diagnosed with acute pyelonephritis and with overall poor health. She was hospitalized for treatment of pyelonephritis two months earlier, when hospital restricted use Meropenen (carbapenem) for multi-R *Klebsiella pneumoniae* was used for treatment. The patient is hospitalized for intravenous treatment. At the end of the second day, there is already a significant improvement in her general condition, and the patient can walk in the hospital grounds, despite having a fever in the morning. In the late afternoon, the patient requests discharge against medical advice, saying she will leave "anyway she can" because she feels significantly better. The patient is conscious, oriented and her critical judgment is intact. What is your course of action? Why?

2 - Assuming you accept the request for discharge, knowing that intravenous treatment is formally recommended for such cases, what would be your course of action if the patient requests a prescription for home medication?

3 – A 55 year old patient, with chronic coronary artery disease and with a history of two admissions to the ICU, one for angioplasty and the placing of a stent five years earlier, and another two years previously for revascularization, arrives at the emergency room in distress with intense chest pain. He is very agitated and pale, and in addition to diagnosis, requires sedation. Twelve hours later, the patient regains consciousness in the ICU. He is scared and anxious and is informed of his situation and told that he needs a further coronary exam, which he refuses based on his previous hospitalizations. He requests discharge against medical advice. The patient is conscious, oriented and his critical judgment is intact. What is your course of action? Why?

4 - [If not already mentioned by respondent] In these cases, would you consider evaluation by other medical professionals, and even professionals from other areas of health necessary? Why?

5 - Assuming that all the resources for patient clarification have been exhausted and the patient continues to request discharge, what would be your course of action?

6 – Would you document this situation? In what way?

7 - If the patient's deteriorates after being discharged on request against medical advice without imminent risk of death, who is responsible?

8 - Do you consider allowing the patient to flee from the hospital is a valid alternative? Why?