Discharge by request: study on the perception of patients and professional

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Abstract

Discharge by request generates ethical and legal dilemmas in the day-to-day of a hospital. This study analyses the perception of patients and the multi professional team (doctors, nurses, social workers and psychologists) on discharge by request in a public maternity hospital in Fortaleza, Ceará. It is a documentary and bibliographic study that consists of a qualitative descriptive research , using simple observation and semi-structured interviews with 16 participants (eight professionals and eight patients) and content analysis based on Bardin's model. As a result of the axes of analysis in the process of discharge by request, it was found that from the professionals viewpoint the reason why patients ask for discharge by request is lack of family support; now, for the patients, fatigue and hospital stress are the main reasons why they ask for discharge by request. We conclude that to understand the perspective of the patient who asks for discharge by request, beyond its legal aspects, that is, in the validation of their autonomy, is a challenge for professional teams who act in the context of hospitalisation.

Keywords: Personal autonomy. Patient rights. Professional-patient relations.

Resumo

Alta a pedido: estudo sobre a percepção de pacientes e profissionais

A alta a pedido no cotidiano hospitalar gera dilemas éticos e legais. Este estudo analisa a percepção dos pacientes e da equipe multiprofissional (médicos, enfermeiros, assistentes sociais e psicólogos) sobre a alta a pedido, em maternidade pública de referência em Fortaleza, Ceará. Consiste em pesquisa qualitativa do tipo descritiva, de base documental e bibliográfica, a partir de observação simples e entrevista semiestruturada com 16 participantes (oito profissionais e oito pacientes), e na análise de conteúdo de Bardin. Como resultado dos eixos de análise no processo da alta a pedido, constatou-se que, para os profissionais, é impulsionada pela falta de suporte familiar; já para as pacientes, cansaço e estresse hospitalar são os principais motivadores. Concluímos que compreender a perspectiva do paciente que solicita a alta a pedido, para além dos aspectos legais, isto é, na validação de sua autonomia, é desafio para equipes que atuam no contexto da internação.

Palavras-chave: Autonomia pessoal. Direitos do paciente. Relações profissional-paciente.

Resumen

Alta por solicitud: estudio sobre las percepciones de los pacientes y los profesionales

El alta por solicitud en la cotidianidad hospitalaria genera dilemas éticos y legales. Este estudio analiza la percepción de los pacientes y del equipo multiprofesional (médicos, enfermeros, asistentes sociales y psicólogos) sobre el alta por solicitud, en una Maternidad pública de referencia en Fortaleza, Ceará. Consiste en una investigación cualitativa, de tipo descriptiva, de base documental y bibliográfica, a partir de la observación simple y de una entrevista semiestructurada con 16 participantes (ocho profesionales y ocho pacientes), y del análisis de contenido de Bardin. Como resultado de los ejes de análisis en el proceso de alta por solicitud, se constató que para los profesionales la misma está motivada por la falta de apoyo familiar; en el caso de los pacientes, el cansancio y el estrés hospitalario constituyen las principales motivaciones. Concluimos que comprender la perspectiva del paciente que solicita el alta, más allá de los aspectos legales, esto es, la validación de su autonomía, constituye un desafío para los equipos que trabajan en el contexto de internación.

Palabras clave: Autonomía personal. Derechos del paciente. Relaciones profesional-paciente.

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Research

Hospitalisation is a therapeutic practice dating from the end of the 18th century. During the Middle Ages, hospitals were associated with monasteries and churches that functioned, in part, as charities that welcomed lepers and people suffering from hunger and epidemics that plagued Europe. Therefore, hospitals were only recognised as a place destined to cure around 1780, because until then it was only a place where poor patients were housed[1].

The first hospital in Brazil was the *Santa Casa da Misericórdia de Santos*, in São Paulo, inaugurated in November 1543, on the initiative of the Portuguese Braz Cubas. Other hospitals appeared, during the Colony and the Empire periods, in the model of the *Santas Casas* (Holy Houses) of Portugal. Their primary objectives were to provide charity and shelter to the poor and the homeless[2].

The choice of type of treatment became more complex after the improvement of the medical area during the 1930s and 1940s an the subjectivity of the patient became an important factor in the doctor-patient relationship. However, health practices had not been improved and collective attitudes were not based on communication, observation and teamwork[3].

During the hospital stay, when the patient is under the care of a doctor, it is the doctor's prerogative to decide the best time to discharge or not a patient. However, there are cases in which the patient, for various reasons, requests to be discharged from the hospital in what is called "discharge at request".[4] Some of the reasons for discharge at request are: lack of accompanying person to support, difficulty in finding reliable caregivers for their children or even long-term hospitalisation.

The discharge at request is part of the medical routine; however, its legal and ethical aspects are not well defined[4]. In this situation, it is recommended that, in the absence of risk to the life of the patient, neither the physician in charge nor the hospital can harm the principle of autonomy, restricting patients individual freedom and their right to come and go. However, in cases of imminent danger to the individual's life, the doctor may refuse to accept the discharge at request. This prerogative is provided by the article 56 of the *Código de Ética Médica* - CEM (Code of Medical Ethics), which states that the doctor can intervene in a way contrary to the patient's wishes[5].

In addition to the patient's doctor, the discharge at request is a situation that involves the multi professional team that acts jointly in patient care. Thus, we can highlight the categories involved in these situations: nursing, social service, psychology and medicine. In addition to providing therapeutic care, the team is also responsible for guiding and clarifying the patient's clinical conditions and possible consequences of his or her decision.

In practice, the patient should be informed and oriented about the procedure that is proposed to him, be it diagnostic examination or therapeutic conduct. We emphasise that it is the physician's responsibility to provide information on health status in a language accessible to the patient. Other professionals should also have an approach that complements health guidelines[6].

On the rights of users of health systems, public or private, we have the "*Carta dos Direitos dos Usuários da Saúde*"[7] (Charter of the Rights of Health System Users), which defines six basic principles that ensure citizens the basic right to join these systems. Among the principles, the fourth ensures care that respects the values and rights of the patient in order to preserve their citizenship during treatment.

Emphasis should be given to some reflections on the significance of the discharge and the autonomy of the user in the health service, in addition to the procedures that the team should adopt collectively, and finally, how to make possible the right of the patient to autonomy, considering that it is a public health service of an unequal society[8]. Autonomy can be thought of as a condition of health and citizenship, a fundamental value. However, it is not absolute, because when analysed in the more general field of politics and the life of individuals, autonomy might be reduced. The relations of autonomy/dependence are always present, either at the individual level or at the level of societies[9].

Bioethics is based on four fundamental principles: beneficence, non-maleficence, autonomy and justice. Regarding the ethical aspects of discharge at request, we emphasise that autonomy is one of the most important aspects together with beneficence. In this sense, Silva et al.[10] affirm that the principle of autonomy has its roots in the Kantian philosophy, which is one of the pillars of contemporary clinical bioethics originated from Principlism.

The main objective of this study was to analyse the perception of patients and the multi professional team, i.e., doctors, nurses, psychologists and social workers, about the discharge requested by women hospitalised in the various sectors of a reference public maternity hospital located in the city of

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Fortaleza, Ceará: puerperal, postoperative and observation ward, emergency and delivery room.

The research is a result of the *Trabalho de Conclusão de Curso* (TCC- Course Completion Work) of the Multi professional Integrated Residency in *Atenção Hospitalar à Saúde (* Hospital Health Care), where one of the authors worked as a social service resident in the area of the health of women and children. In this context, the experience came from the observation, planning and execution of several multi professional and interdisciplinary actions, as well as the assistance to hospitalised patients, being the social service one of the categories called to accompany and mediate the demands of discharge at request.

According to the hospital's database, 104 discharges at request were asked in 2016, with an average of 8 requests per month. There were 36 cases during the data collection period between June and September. We verified that the request usually occurs in some specific sectors of the unit, such as the obstetric clinics, where the patients are hospitalised in a minimum period of 48 hours; in the observation wards, where, depending on the clinical picture, they may be hospitalised until the day of delivery, that is, days or months; in the gynaecological surgeries; emergency room and delivery room. Other sectors of the Maternity such as maternal Intensive Care Unit, outpatient clinics and surgical center were not considered because they did not present a demand of discharge at request.

Method

This is a descriptive and documentary qualitative research[11], through the study of the agreement term for "discharge at request", and bibliographic research, developed in a reference public maternity hospital in Fortaleza, Ceará, Brazil. Data collection took place in some sectors of the Maternity where there is reporting of discharge at request: obstetric clinics, surgical clinic, delivery room and emergency room. Considering the workforce of the aforementioned sectors, we have about 35 active professionals who were involved in cases of discharge at request, between June and September 2016.

The research universe consisted of eight professionals from the care team (doctors, nurses, social workers and psychologists) and eight patients. As for the latter, participants aged 18 or over were the inclusion criteria, considering that in this way the individual had full legal right to act on his or her own, without the need for authorisation from third parties. The Exclusion criteria included children and adolescents.

The category of professionals of the multi professional team involved in the process of granting discharge at request was made up of two professionals from each category. The inclusion criteria were professionals that provide assistance in obstetric clinics, emergency or delivery room and that consequently are called in case of discharge at request. Now, the exclusion criteria apply to professionals who are not normally involved in the processs of discharge at request, such as physiotherapists, nutritionists and pharmacists, among others.

Regarding the instrument of data collection, a semi-structured interview was used, with the following guiding questions: which reasons lead to the discharge at request; how the process of granting discharge at request is conducted; what would prevent discharge at request; why a patient who has not been discharged can leave the hospital; how the opinion of family members influences the decision making. The interviews were recorded with authorisation of the subjects and the use of *termo de consentimento livre e esclarecido* (TCLE- informed consent form).

In addition, simple observation was central to the research. It was not only a question of seeing, but of examining reality, knowing people, things, events and phenomena[12]. It is recorded that the research followed the criterion of data saturation because of its qualitative aspect -Theoretical saturation is defined as the phase of qualitative data analyses when interrupt the capture of information obtained from people or groups is interrupted, without neglecting information with relevant explanatory potential[13].

The answers from the interviews were transcribed literally, respecting the colloquialism of the language. We used, in order to identify the participants, names of the categories for the professionals who were interviewed and names of birds for the patients, considering that the symbolism refers to the idea of "freedom" or. of "free beings".

We used content analysis to systematise the data in three stages: pre-analysis, in which the material to be analysed was organised; study of the material and treatment of the results, when categories were defined and the content was coded; inference and interpretation, used for the treatment of results and the critical and reflexive analysis of the data collected[14].

Regarding ethical aspects, this study was submitted to the *Comitê de Ética e Pesquisa da Maternidade Escola Assis Chateaubriand* - Meac (Ethics and Research Committee of the Maternity

School Assis Chateaubriand), following the ethical precepts governing beneficence, non-maleficence and justice regulated by the *Conselho Nacional de Saúde* - CNS (National Health Council) through the Resolution CNS 466/2012[15].

Results and discussion

There were eight interviewees from four categories in the professionals' group, totalling two professionals from each group. The age range was from 28 to 48 years; the time spent in the institution was less than one year, as well as the employment relationship associated with the *Empresa Brasileira de Serviços Hospitalares* (EBSERH - Brazilian Hospital Services Company), in relation to most interviewees. Table 1 has some information about the professional profile of the interviewees. It has been elaborated using data from the documentary analysis.

As for the patients, the age range was between 21 and 37 years. There is a predominance of married women or living in stable union; all women have children and stayed longer than four days. Regarding the clinical picture, there are 4 cesarean section after care, 3 pregnant women and 1 dilation and curettage. Table 2 presents more information on the profile of the patients interviewed:

Table 1. Profile of professionals interviewed

Professional	Age	Years of work	Employer
Doctor	40	11 years	EBSERH
Doctor	28	1 year	RESMED
Social Worker	48	5 months	EBSERH
Social Worker	39	5 months	EBSERH
Nurse	34	10 months	EBSERH
Nurse	38	1 year	EBSERH
Psychologist	32	5 months	EBSERH
Psychologist	30	5 months	EBSERH

Table 2. Profile of patients interviewed

Patients	Age	Civil status	Duration of hospitalisation	Number of children	Clinical picture
Hummingbird	21	Stable Partnership	7 days	1	Pregnant and pyelonephritis
Rufous-bellied thrush	24	Married	7 days	1	Cesarean
Rufous-collared Sparrow	24	Married	21 days	1	Cesarean/Eclampsia
Canary	28	Stable Partnership	7 days	2	Cesarean
Chestnut-bellied Seed-finch	29	Married	4 days	2	Cesarean
Southern lapwing	31	Stable Partnership	4 days	1	Pregnant and hypertension
Sparrow	33	Single	5 days	3	Pregnant and hypertension
Swallow	37	Single	1 days	3	Curettage

It is worth mentioning that when a patient requests discharge from the hospital without finalising the appropriate treatment indicated, the patient may be putting her life and the baby's life at risk. For example, patients with hypertension may have fetal distress if they can not control the pressure; those diagnosed with pyelonephritis, kidney infection, can have serious problems during the pregnancy.

Four categories were considered in this article, based on what the participants had to say, in order to discuss the results: 1) discharge at request: reasons that lead to the decision making; 2) giving up on the request; 3) conduction of the process of discharge at request; 4) discharge at request: prerogative of the patient's autonomy.

Discharge at request: reasons that lead to the decision making

Regarding the hospitalisation process, we discuss the various factors that interfere with the individual's life during hospitalisation, since many patients during this period remain alone, are not

called by their own name, end up characterised by bed number or name of diagnosis, being often submitted to embarrassing examinations and procedures[16].

Regarding the question about the main reasons that lead the patient to request discharge on request, we identified in the speeches of 62.5% of the patients that the fatigue and stress generated by hospital admission are the main reasons that make them want to go home earlier. We found out that hospitalisation for the treatment of a disease often does not represent something positive to the patient and may be perceived as an unwanted experience: "I no longer feel anything. Tired of staying here, we get sicker "(Hummingbird); "I'm tired of staying here, I want my house" (Chestnut-bellied Seed-finch).

Hospitalisation is a new situation for many people, which causes worry and fears. The patient, as a way of guaranteeing their integrity, uses defense mechanisms, such as denial, regression and isolation, in many cases, compromising their relation with the treatment and even aggravating their clinical state[17]. When the patient is hospitalised, there is a personal routine, which can lead to stressful factors arising from suffering, from the feeling of abandonment, from the fear of the unknown, and the hospital ends up having a isolating function[18].

Corroborating the previous idea, we noticed in the speeches of the professionals that 87.5% of them believe that the main reasons for the patient to request discharge at request are linked to family issues, especially the difficulty of leaving their children in the care of other people: "there are social issues, they have other children at home, the husband can not take care of the children so the children have to stay with a neighbour, I think it's more like that "(Doctor); "I also see women who have many children and do not have family support, what makes them want to leave" (Psychologist).

Besides the separation of what is familiar and brings safety (home, work, friends), the patient encounters a team of unknown professionals and stays in generally uncomfortable accommodations. In addition, there is the possibility of sharing the room with another patient and of feeling physical pain[19].

Many factors collaborate to increase discharge at request: Lack of information regarding treatment and procedures, cultural and religious aspects, the need for family survival/maintenance, the patient being wanted for child care, home care and problems with leave of work as many of them assumed the role of head of the household[20].

Giving up on the request

During the hospitalisation period, the patient faces moments of loneliness, especially when the visitation time of loved ones and relatives is reduced or when they can not visit the patient for different reasons. To the dependence on the care of others are added practices that constitute the day to day in the hospital, where the body of the patient happens to be the main place of diverse manipulations, realised by many hands: nursing professionals, doctors, students, among others[21].

We learned that several factors may contribute to attenuate the stress generated by the hospitalisation. Patients, when asked what would change their minds about asking for discharge highlighted several different possibilities: two interviewees (25%) claimed that they would continue the treatment if it wasnt' for the absence of company: "There is no one to stay with me and I do not want to be here alone. I do not like being hospitalised "(Sparrow). Three interviewees (37.5%), however, said they would remain if there was no delay in the test results: "If the result of the exams that are not ready were ready by noon then I would wait but the results should be ready only by 6 pm. I can't stand to stay here anymore "(Canary).

Several possibilities were pointed out by the patients as a reason to avoid discharge at request; however, among those cited, the one that attracts the most attention is related to the delay in the results of the exams. The fact that they have to wait for the result of an exam causes great stress on the patient who has been hospitalised for many days. The delay of the results, therefore, influences the capacity of the user to withstand the inconvenience of staying in the institution and can affect the health of the population, leading them to seek easier ways, such as self-medication, treatment abandonment, among others[22].

We refer, as complementary information, to the satisfaction survey performed by Santos and Lacerda[23] in six hospitals in João Pessoa, Paraíba, Brazil, on which 170 patients participated. Of these, 61% reported dissatisfaction with their medication due to delays in medical prescription because of lack of medication in the institution, causing the patients to take their medicine in the wrong time, thus impairing the effectiveness of the treatment. Now, 76% complained about the delays in the delivery of the laboratory tests, pointing it as one of the main causes of the prolongation of the patients' stay in public hospitals.

Returning to the findings of this research, we identified in the group of professionals that 62.5% think that discharge at request could be avoided

if the patients had more family support, constant companions and visitors. One of the interviewees exemplifies this question: "I think if she had had support of her family, clarification by the team, why she is there, which exam she is waiting for, because many do not understand their health / illness process" (Nurse). Thus, we see that the professional repeats the same claim of the category discussed above, always referring to the absence of the family as a determining factor in the discharge at request.

Based on such assumptions, several factors may be the cause of family absence during a patient's hospitalisation period, such as residing in another municipality, not being able to leave other family members alone at home, not having the financial means to go to the hospital, having health problems that prevent them from accompanying or visiting the patient, or even a dislike for the hospital environment. It is evident that there is a lack of defining practices to promote the inclusion of family members in the hospital space, since many of them find it difficult to understand that they are fully entitled to accompany the patient in the hospita[24].

It is noticed, from the professionals' statements, that the absence of the family in the period of hospitalisation, whether as a visit or companion, is one of the great factors for the patient wanting to leave the hospital unit. However, when asked about the role of relatives in the discharge at request situation, all the professionals answered that they are more hindering than helpful in the patient's decision-making: "In my day to day practice I see that, unfortunately, the family influences in a negative way more often than not " (Doctor). Other professionals corroborate this statement: "It is very relative. Sometimes it is the family member who wants to leave and is putting pressure on the patient "(Psychologist); "The family hinders this matter yes. They put pressure on the patient to leave ". (Nurse).

It becomes clear in the content of those speeches that there is a great contradiction because while the family is criticised for not being present to support the patient, the family is at the same time rejected by the team because of their "negative influence". In the eyes of the team, the companions, family and friends are devalued when they are supportive of the patient's decision and contrary to the professionals' recommendations.

Still on this point, we saw in the patients' speeches that the family is generally supportive of the decision-making about discharge from the hospital, but 62.5% of the relatives interviewed prefer to leave decisions about discharge to doctors. "My husband did not agree that I would leave without a medical discharge, but he did not try to convince me otherwise, he came here to sign the form (Hummingbird); "My husband does not want me to leave, but he does not want to see me anxious and stressed either" (Rufous-bellied thrush). However, family members agree to take responsibility after the discharge against medical advice, understanding that the patient is tired or has other difficulties that prevent her from staying hospitalised.

Conduct of the process of discharge at request

Discharge at request is a unique procedure and requires a set of instruments, such as the form or term used in the discharge request. There is currently no standardised document among the Country's health institutions normalised by regulatory agencies. Some hospitals don't even have their own form and record the procedure in the medical record. Informed consent may be oral or written, but the written form, especially from a legal point of view, is the most advisable.

Some authorisation terms are referred to as "discharge request," "discharge at request against medical advice," "discharge at request," "voluntary hospital discharge," and "discharge term at patient's request." They all have the same purpose despite the different names, because what we see in these situations is the presence of a non-indemnity clause, in which the patient assumes all responsibility about the act. However, the most appropriate expression would be "discharge at request against medical advice"[4].

It is worth mentioning that in some institutions, the term is signed by a relative who will be responsible for the discharge at request, that is, the document is not signed only by the patient. The question remains: if the patient is a subject with autonomy, shouldn't the patient be the only responsible for his or her own decision? In the hospital where this research was carried out, the willingness of the patient to self discharge is conducted through a specific process: A multi professional team and physician talk with the patient about their clinical situation, advise on the risks of the decision and, if they are not successful in the attempt to dissuade the patient, then the doctor writes the report summarising the circumstances of the discharge, and the patient and a family member sign the agreement on the discharge at request.

Regarding the multi professional team's orientations, 100% of the participants (professionals and patients) mentioned the importance of the dialogue in this situation, presenting the risks

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and explanations about the clinical picture to the patient: "It is very important the participation of all the team involved, so that the patient feels more secure, that she understands the importance of the hospitalisation and does not want to leave "(Nurse). "I know it's important, they're trying to help me, but I'm fine and tired of staying here" (Rufous-collared Sparrow). We see that information is crucial to the process of conducting discharge at request, whereas the patient should be aware of all the risks and consequences of her attitude.

When asked about the guidelines that they took most into account, 100% of the patients mentioned the dialogue with the doctor. At the same time, 76% mentioned the social worker, 62% cited the nurse's performance and only 37% mentioned the psychologist. Thus, one can see how medical opinion still has great importance for patients in relation to other professional categories.

Discharge at request requires a specific flow. 62.5% of the patients considered the flow of the process easy to deal with, as they were guided by professionals and supported by relatives: "It was hassle free, I wanted to leave, they guided me, and my mother signed the term" (Southern lapwing). 75% of professionals see this type of discharge as a bureaucratic process that involves the entire multi professional team which, in turn, will guide the patient: "*Bureaucracy is important, the terms are essential. I believe it is a necessary process, we made it clear that the hospital will not punish her*"(Social Worker).

Given this, it can be said that the process is not so bureaucratic for the patient, even because it is not the patient who must follow the procedures defined in the hospital process of discharge at request. Considering the patient's words we realize that the professional team can provide the necessary guidelines and even instill confidence. Now, the professionals consider what has been characterised as a bureaucracy to be essential, either because it responds to the demands for recording the situation or even because they believe that the longer the discharge process takes to be completed, the greater the chances of convincing the patient to give up the idea.

In this context, we observed that some professionals, due to the risks to which the patient is exposed, were disappointed by not being able to reverse their decision, even considering their right to decide on the matter. Another issue observed is that generally the time of the decision of the patient is not always the same of the team, because from the moment that the patient requests to be discharged, the routine of the professional is changed, that is, he or she leaves aside the care to other patients in order to try to change the decision of the patient, generating tension in the context of the work.

Discharge at request: autonomy prerogative

In the current context, where the patient is considered to be an integral being whose subjectivity needs to be weighed in the attention process, the traditional paternalistic model of medicine where the physician decides in the name of the patient the best treatment is no longer accepted. The patient has become the protagonist of his or her therapy, their freedom is protected and they can makes decisions about their care. Therefore, a more independent attitude towards therapies is required, and health professionals should be aware of this fact and be able to deal with the various challenges that will arise in the day-to-day[25].

When asked about why a patient could not leave the hospital even without having had an official discharge, 75% of the patients interviewed referred intuitively to citizenship, the Federal Constitution and adulthood, supported by common sense, without presenting a very detailed reflection on what would be their civil and social rights: "Because as a citizen I have the right to come and go, I am not stuck in the hospital. I am responsible for my baby and I understand what happens to him and me "(Swallow). Another interviewee quoted the issue of adulthood: "Oh I can't explain, I know I'm wrong, but I'm of age and I decide this" (Rufous-bellied thrush).

We verified that patients are not aware of health as a right or that their well-being involves subjective criteria, seeing that they present a superficial discourse when referring to legal aspects of the 1998 Federal Constitution. The analysis of their statements revealed the fragility of this knowledge in terms of the notion of citizenship, considering both their rights as a whole and the specific right to health[22]. However, one can not overlook the statements of the patients, which articulate a discourse about the right to leave the institution as part of the guarantee of coming and going assured in article 5, subsection XV of the Federal Constitution[26].

From this point of view, we highlight some philosophers who discuss freedom as something inherent to citizenship. Analysing the work of Rousseau and Kant from the perspective of freedom, Carvalho[27] affirms that in Rousseau's book "The social contract[28]" the word "freedom" can be taken as synonymous with autonomy. Freedom is not to act without norms, it implies the willingness

to follow the norms that the moral subject itself imposes. Freedom is subdivided into internal (moral obligation) and external (legal obligation) in Kant's view[29].Thus, right is an exteriorised freedom.

When talking about law, one must raise an important question about this prerogative: is the patient legally backed up in his decision-making when leaving without medical advice? Firstly, the patient has to be aware and instructed, and there can't be ignorance about medical acts. Their decisions must be accompanied by a sufficient degree of reflection. Thus, even if enlightened, if the subject chooses the self discharge, it must be supported by the law[30]. However, we find that many respondents do not fully recognise or even ignore this right to be legally protected.

The opinion of the professionals is formulated in speeches that are different from those identified in the speeches of the patients: 75% of the professionals point to the patient's autonomy as the main reason for asking for discharge at request: "*There is the principle of autonomy. If you are hospitalised, conscious and informed of your clinical condition, you have every right to request discharge." (*Doctor). Another interviewee states: *"I believe that the patient has the right to choose, and autonomy is present in health policies. We have to consider the protagonism of the patient " (*Psychologist).

It was possible to perceive in 87.5% of the professionals' discourses the understanding of what the patient's autonomy means as well as references to users' rights that guide public health policies. Health systems were organised based on the principles of effectiveness, optimisation and efficiency in the 1980s. The notions of quality, equity, satisfaction and autonomy of the user were incorporated from the 1990s onwards. Those concepts built the basis for humanisation in health[31].

One of the main legislation on this subject is the "Carta dos Direitos dos Usuários da Saúde"[7] (Charter of the Rights of Health Users), which outlines six basic principles of citizenship and guarantees the indispensable and dignified right in health systems. From these principles we can highlight the fourth as the most interesting for this discussion. It establishes that it is the right of the user to freely or voluntarily consent to or refuse any diagnostic proceedings, preventive or therapeutic, after having received information and full clarification, unless the user's deliberation entails a risk to public health[7].

In view of this, we can state in summary that the interviewees present different but complementary perceptions on the discharge at request, since freedom is directly related to autonomy. However, patients are not discerning when it comes to the guarantee of their rights, a broader understanding of public health policies and their role as protagonists of their health-disease process. On the other hand, it is up to the professionals to perceive, in addition to legal issues, the needs of each patient and to foster, more and more, their autonomy.

In order to reach such expanded knowledge and to better understand their protagonism, it is not enough that users just attend hospitals and medical centres; it is necessary that the whole population has access to effective formal education in equipped schools with well-trained teachers. Using as reference data about the adult population of Ceará (a Brazilian state) from the 2012 Pesquisa Nacional por Amostra de Domicílios do Instituto Brasileiro de Geografia e Estatística National (Household Census of the Brazilian Institute of Geography and Statistics), we see that the average education of adults (25 years old or more) is around 6.1 years of study. This average was 5.7 years of study in 2008. Thus, we perceive an increase in the years of study by adults[32].

A higher level of education among women than among men has been recorded in the Brazilian national data of 2014 (IBGE / PNAD)[33]. In general, women have, on average, 8 years of education, against 7.5 for men; in the Northeast region, specifically, these numbers vary from 7 years for women and 6.2 years for men. As for educational level, more than half of the population aged 25 and over was concentrated in the levels of incomplete elementary school (32.0%) and high school (25.5%).

Given this, we can not say with certainty which aspect can be taken into account for the patients' lack of knowledge about their rights as SUS - Sistema Único de Saúde (Single Health System) users, since it may be due to either low level of education or a low quality education.

Final considerations

The analysis of the patients 'and professionals' perception about the discharge at request presents a strong socio-historical gender aspect as a starting point, considering that women have been responsible, over the time, for the care of the

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private environment, home and children. This fact increases the worries especially when women need health care, as it is the case of the participants of this study, that is, patients who request hospital discharge.

We note that this group's claim of stress and fatigue stems in part from the responsibility of the care of the offspring attributed to the woman. The fact is also validated by the opinions of the professionals interviewed, who also associate personal and family issues to the difficulty in leaving the children in the care of other people.

Another relevant point of the analysis is the fragility of the public health policy, the attendance to the needs of the patients, the lack of inputs during hospitalisation, difficulty in the decision making, delay in the performance and results of lab exams, among other factors mentioned in the text that corroborate the reasons for a longer permanence or a shorter stay in the hospital.

We also emphasise that patients have superficial knowledge about their rights as SUS users. Even though we can not say whether the limitations of their citizenship awareness comes from the level of education or the quality of the education they have received, we can not elaborate on their idea of civil law and autonomy. The professionals presented a more politicised speech, recognising the autonomy of the patient as the main factor to justify the right to discharge at demand.

In summary, we have identified that professionals consider, in particular, the formal aspects that are in the legal arena (laws, regulations, routines and institutional flows), or whether the patients have support of family members and companions; the patients raise concerns about their context and social relations and how influence of their removal from that context leads to what we call hospital stress on the top of limitations of hospital infrastructure and health care.

Simple observation, independent of the participants input, broadened the researcher's look at the matter of discharge at request. We identified some aspects regarding the limitation of the research, such as the availability of the researcher to conduct it at all times, having in mind that the asking for discharge at request can happen at any shift, and may not coincide with the presence of the researcher.

Another important point observed was that patients were already very anxious, very tense and wanting to leave soon when they made the request. Faced with this, the researcher had to be subtle and respectful not to sound as if the researcher was trying to change the patient's mind. Even considering the emotional load of the situation, the patients were willing to be interviewed.

The interviews with the professionals were carried out in shifts and random moments, taking into account their experience with previous situations. In this context, the professionals were able to explain their opinions in a relaxed way.

In addition, we try to focus our analytical approach on discharge at request in an attempt to improve institutional processes, as well as to promote the importance of the patient autonomy. Listening, understanding and validating the needs, desires, feelings and view points of each patient who asks for discharge at request, besides the legal aspects (which formally guarantees this right), are important challenges for teams that work on a daily basis in the context of hospitalisation.

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Participation of the authors

All authors participated in the preparation of the paper. Field data collection was performed by Lorena Loiola Batista. Research planning and data analysis were done by Lorena Loiola Batista and Ana Karla Batista Bezerra Zanella. Lorena Loiola Batista, Ana Karla Batista Bezerra Zanella, Sarah Maria Fraxe Pessoa and Analice Pereira Mota were responsible for the final revision of the manuscript.

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Annex

Interview with the patient

Personal data

Name: _____

Age: _____

Civil status: _____

Days of hospitalisation: _____

Number of children: _____

Reason for hospitalisation: _____

Has companion?: Yes ( ) No ( )

1. What were the reasons for requesting discharge?

_____

2. How the professionals conducted the process of discharge at request? Did you have autonomy?

_____

3. What is the importance of the professionals' recommendations on discharge at request? (Which opinion you took more into account)

_____

4. Which reasons would prevent you from asking for discharge at request?

_____

5. Why, in your viewpoing, a patient can leave the hospital even if the patient has not been discharged by the doctor?

_____

6. In which way family members' opinions influence your decision-making?

_____

Interview with the professional

Personal data

Full name: _____

Age: _____

Profession: _____

Years of work: _____

7. What causes, in your view, a patient to ask for discharge at request?

_____

8. How do you understand the stages of the process of dealing with a discharge at request?

_____

9. What is the importance of professional advice on discharge at request?

_____

10. What main factors would prevent the patient from asking for discharge at request?

_____

11. What is the legal endorsement of the discharge at request? Where does this right come from?

_____

12. In which way do family members' opinions influence the patient's decision-making? Do family members help or hinder this process?

_____