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Discharge against medical advice: what to do, doctor?

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Abstract

This paper examines the procedures recommended by Brazilian medical councils regarding "discharge against medical advice". An exploratory and documentary research was conducted to identify and analyze several council publications regarding questions and doubts raised by physicians when faced with discharge requests. Solutions proposed to the issue at hand (ethical-legal insecurity of physicians in authorizing discharges) were analyzed based on ethical-legal frameworks, aiming to provide physicians with greater security and tranquility in conducting this procedure.

Keywords: Patient discharge. Physician-patient relations. Patient rights. Personal autonomy. Decision making. Drug prescriptions.

Resumo

Alta médica a pedido: o que fazer, doutor?

Este artigo aborda as condutas preconizadas pelos conselhos de medicina do Brasil relacionadas à "alta médica a pedido". Trata-se de uma pesquisa documental e exploratória, que buscou identificar e analisar diversas manifestações dos conselhos acerca de questionamentos e dúvidas suscitadas pelos médicos quando se deparavam com pedidos de alta médica. Para tanto, utilizou-se o método de análise hipotético-dedutivo. A partir da problemática apresentada (insegurança ético-jurídica dos médicos no deferimento dos pedidos de alta), levantaram-se as soluções propostas às questões atinentes ao tema destinadas aos conselhos de medicina. Elas foram analisadas criticamente à luz do ordenamento ético-jurídico, com vistas a proporcionar ao médico maior segurança e tranquilidade na condução desse procedimento.

Palavras-chave: Alta do paciente. Relação médico-paciente. Direitos do paciente. Autonomia pessoal. Tomada de decisões. Prescrições de medicamentos.

Resumen

Alta médica por solicitud: ¿qué hacer, doctor?

Este artículo discute la conducta recomendada por los consejos de medicina de Brasil respecto al "alta médica por solicitud". Se trata de una investigación documental y exploratoria, que pretendió identificar y analizar diversas manifestaciones de los consejos sobre los interrogantes y dudas planteadas por los médicos ante las solicitudes de alta médica. Para ello, se utilizó el método de análisis hipotético-deductivo. Con base en el problema presentado (inseguridad ético-jurídica de los médicos en la concesión de solicitudes de alta), se plantearon propuestas de solución a cuestiones relacionadas con el tema dirigidas a los consejos de medicina. Se utilizó la perspectiva ética-jurídica, con el objetivo de brindar mayor seguridad y tranquilidad al médico en la realización de este procedimiento.

Palabras clave: Alta del paciente. Relaciones Médico-paciente. Derechos del paciente. Autonomía personal. Toma de decisiones. Prescripciones de medicamentos.

Research

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In their daily practice, especially when working in emergency departments and hospitals, physicians regularly come across requests to be discharged made by patients or family members. This occurs for several reasons, such as: not wishing to continue with the care provided, poor technical/human quality of the healthcare team, a feeling of improvement of symptoms that originally led them to seek care, sometimes associated with long waiting times to receive care or do tests and receive results.

In cases where the attending physician agrees with the decision to self-discharge, there is no problem to be faced. However, when there is disagreement, an important ethical-legal impasse arises: the clash between the patient's autonomy and the physician's duty to prevent a situation of serious and imminent danger to life.

This article addresses this issue without intending to be exhaustive, given its broadness. What should doctors do in such cases? How should the physician behave in order to avoid future complications, both legally and with medical councils? Several opinions by Brazilian medical councils on the subject are herein compiled in order to identify and analyze the recommendations set forth. Scientific publications on the subject are presented, as well as Brazilian ethical and legal frameworks, aiming to provide greater security and reassurance in dealing with self-discharge.

Method

This is a bibliographical research whose primary data sources are resolutions, opinions, recommendations, technical notes and decisions issued by Brazilian medical councils (federal and regional), in addition to scientific papers related to "discharge against medical advice," published by August 2020. The goal was to select legal provisions, frameworks and interpretations that addressed the issue in order to delve deeper into discussions on discharge against medical advice.

Thirty-three documents were found in website of the Federal Council of Medicine (CFM), using the terms "discharge" and "medical discharge" as subject descriptors and the term "discharge against medical advice" as text descriptor.

In turn, the search for scientific papers was carried out in indexed journals on the Virtual Health Library (VHL) database, using concurrently for "title, abstract and subject" the health sciences descriptors "patient discharge," "patient rights" and "personal autonomy" in Portuguese. The search turned up 25 scientific articles, of which, based on the abstracts, 15 were found to be relevant to the subject addressed in this work. Only two of them were Brazilian, which highlights the urgent need for greater depth and discussion in the Brazilian academic milieu regarding this bioethical dilemma experienced by healthcare providers.

Lastly, the hypothetico-deductive method of analysis was applied. Based on the problem presented (ethical-legal insecurity of physicians to deal with discharge against medical advice), the solutions proposed by medical councils for some issues related to the subject were listed and critically analyzed in the light of current ethical-legal knowledge, with a view to verifying their suitability.

Discussion and results

Inadequacy of the expression "discharge against medical advice" and its widespread use

Discharge against medical advice (also called "against medical advice – AMA" [1], "administrative discharge" [2], "self-discharge" [3] "discharge on request against medical advice") [4] is an expression widely used in health institutions to refer to a patient's choice to interrupt the in-hospital medical care they are undergoing despite medical advice to the contrary [5].

This is actually an inappropriate term since "hospital discharge" is a medical act [6], and, therefore, one can only speak of "discharge" if the physician agrees to release the hospitalized patient. This is an exclusive prerogative of physicians according to Article 4 of Law 12,842/2013, which provides as an activity reserved to physicians: (...) *XI – indication of hospitalization and hospital discharge in healthcare services* [7].

It would be better, as proposed by the Brazilian Ministry of Health, to speak of "withdrawal

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from care," understood as the patient leaving the hospital against medical advice, with official communication to the hospitalization sector, prompted by the patient's or responsible agent's decision to terminate the type of care being provided [8].

However, one must recognize that the term "against medical advice" is culturally rooted, since it is used by numerous health institutions, which even have "AMA forms" [9] to be signed by patients who wish to interrupt inpatient care. The expression is used by most physicians, who sometimes include in the medical record the patient's desire to suspend care, even after being told of the health risks resulting from such interruption [10].

In view of the above, the Regional Council of Medicine of the State of Paraná (CRM-PR), in Opinion 1,883/2007, pointed out that reflection and analysis are required so that the term "against medical advice" is changed to convey its real meaning [11].

Autonomy to decide on medical care

After a long period following the paternalistic Hippocratic tradition, in which the physician was given the power to decide what was best for the patient, the physician-patient relationship has recently gained a new perspective based on patient autonomy, considered one of the current bioethical principles [12].

The word autonomy comes from Greek *autos* (self) and *nomos* (rule, domain, government, law), and was incorporated into medicine to express patients' capacity for self-government [13], giving them responsibility for making decisions about medical matters that concern them.

Patient autonomy presupposes the existence not only of a legal capacity, in which legislation defines who is capable of exercising rights, such as those related to the conduct of one's own life, including health care, but also of a cognitive capacity, which involves evaluating the free and informed judgment of individuals to manage their own life [13,14].

According to the jurist Ana Thereza Meirelles, in its cognitive dimension, autonomy is established when the requirements of information, discernment and absence of external constraints are present. Thus, it is understood that *information is acquired through the physician's duty to explain. Discernment can be defined as the ability to understand what is explained and make an informed decision about the risks and possible results. External constraints are vices of consent or social vices* [14].

Henceforth in this article, legal capacity will be referred to simply as "capacity" and cognitive capacity as "competence." As important as the analysis of discharge against medical advice is to know whether the person asking to be discharged has the capacity/competence to do so, or, when the patient is incapable of communicating, whether the person representing them may legally do so.

Legally speaking, the rule of thumb is to define capacity according to age (Articles 3 to 5 of the Civil Code) [15]. Thus, in principle, from the age of 18, individuals are able to decide the course of their life, taking responsibility for their decisions; for minors under the age of 16, decisions regarding health care are taken exclusively by their legal guardians (usually the parents); and adolescents between 16 and 18 years are given a relative decision-making capacity, with the assistance of their parents, i.e., they can and should be consulted in decision-making together with their parents, but, in the event of disagreement, the decision of the latter prevails.

However, it should be noted here that the Brazilian Federal Constitution [16] (Article 227) and the Statute of the Child and Adolescent (ECA) [17] (Article 4) limited the decision-making power of parents in the best interest of children/adolescents, submitting it to possible examination by the judiciary to reassess whether it corresponds to the most appropriate decision. They also provide that it is also up to society and the government to ensure the right to health of children and adolescents.

For that reason, the Regional Council of Medicine of the State of Rio Grande do Sul (Cremers), in Opinion 7/2018, recommends the following to its members: *if there is disagreement with the family or guardians of hospitalized children regarding continuity of hospital care, physicians who are convinced of the benefits of the care provided to minors should contact the hospital's legal department to take the necessary*

measures with the Child Protective Service and the Public Prosecutor's Office in order to guarantee the respect and defense of the best interests of the child or adolescent [2].

Lastly, it should be noted that there are exceptions to the aforementioned age criterion, but in all situations legal action is necessary, as in the cases of emancipation and interdiction. Therefore, until proven otherwise, the capacity of patients based on age must be acknowledged.

With regard to competence, the aim is to verify whether individuals are able to make full use of their mental faculties, understanding the medical care being proposed and acting autonomously. For Professor Maria Casado, this assessment relates to patients' capacity *to understand the relevant information about their health condition, communicated in an appropriate and understandable way by the physician; to understand the consequences arising from each decision; to reason based on the information provided and their own values; and to communicate their decision clearly and repeatedly* [18].

Thus, as pointed out by the Regional Council of Medicine of the State of Bahia (Cremeb) in Opinion 11/2019 [10], in the case of AMA, the physician has the duty to investigate the patient's reasoning process if they suspect that it is compromised (such as a condition of delirium or psychosis), with possible psychiatric and/or neurologic support in this assessment, and carefully enter all conclusions in the medical record.

Likewise, the Regional Council of Medicine of the State of Rio de Janeiro (Cremerj) recommended in Opinion 86/2000 [19] that in cases where there is mental alteration, preventing patient self-discernment and broad autonomy, the person responsible for the patient, if any, must be contacted. CRM-PR, in Opinion 1,883/2007 [11], determines that, in the case of AMA, the physician must assess the decision-making capacity of the patient or their legal agent [11].

Similar to ECA [17], the Statute of Persons with Disabilities (Article 10) assigned to the government the duty to guarantee, throughout life, the dignity of persons with disabilities, understood as *those who have long-term impediments of a physical, mental, intellectual or sensory nature, which may hinder their full and effective participation in society on an equal basis with others* [20].

Thus, in the case of a patient without competence due to mental or intellectual disability, the physician, understanding that the legal agent's decision is not the best for the patient, may request an examination by the judiciary in the individual's best interest. Such a possibility was outlined in the arguments of CFM Resolution 2232/2019 [21], which addressed care refusal by patients and conscientious objection in the physician-patient relationship, prioritizing the dignity of incapable patients, minors or adults, who are not in full use of their mental faculties, regardless of whether they are represented or assisted.

The resolution provides that, in the event of insurmountable disagreement between the physician and the patient's representative, legal agent or family members regarding the proposed treatment, physicians should report the fact to the competent authorities (Public Prosecutor's Office, police, child protective service, etc.), aiming at the best alternative for the patient [21].

As seen, in situations where the patient does not have the capacity and/or competence to decide on the provision of care, consent is given by the legal agent (Article 22 and 31 of the Code of Medical Ethics – CME) [22], who is usually a companion or close family member (spouse, children, parents) [23]. At this point, physicians sometimes face a problem regarding the lack of legal criteria to choose the agent, especially when there is a difference of opinion among family members.

It is not uncommon for siblings to have different opinions regarding the care provided to their parents. Even between parents, impasses sometimes arise. Likewise, one often sees conflicts between the patient's parents, or children from a previous marriage, and the current spouse [23].

In cases where family members hold conflicting opinions, if patients who are unable to express their desire freely and autonomously do not designate an agent for this purpose and do not communicate their desires in an advance directive, CFM recommends referring the case to ethics collegiate bodies, pursuant to Article 2, paragraph 5 of CFM Resolution 1,995/2012:

Article 2 (...) *§ 5 If there is no advance directive, designated agent or family members available, or if there is lack of consensus among the latter, physicians will refer the case to the Bioethics Committee of the institution, if any, or, in the absence thereof, to the Medical Ethics Committee of the hospital or to the Regional and Federal Council of Medicine to support their decision on ethical conflicts, when they deem this measure necessary and convenient* [24].

In short, if the legal and cognitive requirements are present, i.e., capacity and competence for decision making, the patient's/agent's choice to interrupt the treatment must be considered valid and therefore examined, with the proviso of a possible alternative judicial opinion in the best interest of the patient.

Patient rights versus physician's duty

The sayings "your right ends where mine begins" and "every right has a corresponding duty" invite us to engage in legal and ethical reflections on the conflicts of rights and the need to think about them [25], seeking to define precisely each one among so many that exist.

It is no wonder that AMA poses so many challenges to medical councils. If, on the one hand, rests patient autonomy, which gives patients the right to interrupt hospitalized care, according to Article 31 of the CEM [22], the constitutional guarantee of freedom of movement and of not being obliged to do or not do anything, other than by virtue of the law (Article 5, items II and XV of the Federal Constitution) [16]; on the other hand, lies the physician's duty to do everything possible to benefit the health and life of the patient (Article 32 of the CEM) [22], the obligation to assist invalid or injured persons in serious and imminent danger (Article 135 of the Penal Code) [26], under penalty of being held liable for failure to provide assistance, and the right to intervene, even against the patient's will, in case of imminent danger of death (Article 146, § 3, I, of the Penal Code) [26].

As a guideline in this clash related to AMA, the physician should always ascertain, first of all, whether the withdrawal of hospital care will result in imminent danger of death for the patient. This is the watershed for agreeing or not with the request for discharge. If there is no imminent risk of a lethal outcome, the patient must be discharged, even if the attending physician is against it for understanding that the aforementioned interruption of hospital care will cause them any harm.

It is opportune to quote the conclusion of Marco Segre, board member of the Regional Council of Medicine of the State of São Paulo (Cremesp), enshrined in Opinion 14,206/1997: a hospital is not a prison and a hospital discharge is not an order of release [27]. It is a matter, therefore, of observing the principle of autonomy, which, as stated by professor Genival França, gives patients the *right to decide their own destiny and lead their life as they wish* [28]. In this case, it is not for the physician to adopt an outdated paternalistic behavior in the name of beneficence.

However, this same right of individuals to lead their life and do with their body as they please is limited insofar as there is also a duty to live, imposed by the ethical-legal order. They are not authorized to threaten directly and immediately their own existence, even if the attempt is not punishable, as in the case with suicide. This duty to live is expressed in hospital if the patient's decision to interrupt treatment leads to an imminent danger of death, a circumstance in which the request to be discharged should be categorically denied.

Article 31 of CEM corroborates this understanding when it provides that the physician is forbidden *to disrespect the right of the patient or his legal agent to decide freely on the execution of diagnostic or therapeutic practices, except in cases of imminent danger of death* [22]. Moreover, Article 146 of the Penal Code, in addressing illegal constraint, authorizes *medical or surgical intervention, without the consent of the patient or his agent, if justified by imminent danger to life* [26].

In these cases, the danger of death must be imminent, that is, current and probable. Current is understood as something happening in the present, near, immediate time. Probable, in turn, is different from possible, as the latter means "able to occur" whereas the former means "likely to occur," i.e., there is reasonable certainty as to the lethal outcome based on scientific evidence. At this point, it relevant to analyze the considerations of the penal law expert Nelson Hungria about medical intervention in the face of imminent danger to life:

Simple danger to health is not enough, nor is remote or uncertain danger to life. Medical or surgical intervention must be necessary, urgent, unavoidable, to stave off the imminence of the patient's death. There must be an objective, concrete reality of danger to life, which, certainly or very likely, according to scientific recommendation, will be subdued by the treatment to be applied. An incidental possibility of a lethal event or one conditional on potential complications is not enough. Arbitrary treatment is disallowed even in cases where, although the death of the patient is predictable, there is a more or less prolonged period of survival [29].

It is important to stress that legal authorization to intervene even against the patient's will is limited to imminent danger of death, not extended to any and all occurrences of harm, even if serious and irreparable, if there is no imminent danger of death.

Thus, if a diabetic patient seeks a hospital emergency room to treat a foot ulcer resulting from vascular impairment caused by diabetes (peripheral arterial occlusive disease – PAOD) and, during the hospital stay, asks to be discharged before the indicated revascularization surgery, maintaining their intention even after being informed about the need for surgery and the risk of amputation of the foot, if treated improperly, there is no way to deny the discharge, even if it results in serious and irreparable damage with the progression of vascular impairment consistent with amputation of the limb, for which the physician cannot be held responsible.

This understanding is based on Cremesp Opinion 51,723/2005, which, in addressing the specific issue of AMA risks, provides that (...) *in case of indispensability of hospitalization to guarantee treatment and safeguard the patient's life and physical and mental health, discharge against medical advice implies a situation of danger for which the health provider cannot be held liable* [30].

Discharge against medical advice will always involve a risk of worsening the patient's health condition [5]. If there were the possibility of adequate outpatient treatment, there would be no reason to oppose the patient's request, since AMA is not to be confused with refusal of treatment. AMA can certainly be motivated by a refusal to undergo any treatment proposed in an inpatient setting, but not every refusal of treatment leads to AMA. The patient can, for example, merely refuse the proposed treatment and be open to other therapeutic options available in the hospital.

In summary, in compiling the recommendations of medical councils regarding discharge against medical advice, it is concluded that when they disagree with the desire to be discharged, physicians must initially try to find out the motivation of the patient/agent, aiming to dissuade them, if possible. To this end, the physician must inform the patient about the clinical condition, available diagnostic and/or therapeutic options and possible consequences of the interruption of inpatient care, among other queries related to the case.

If this is unsuccessful, the imminent danger of death arising from the interruption of hospital care must be assessed and, if absent, the physician must agree with the self-discharge, prioritizing the patient's autonomy. If the aforementioned danger is ascertained, the principle of autonomy is superseded by that of beneficence and the self-discharge should be denied.

CFM Opinion 33/2000 states that *the fact that such patients are unable to express their desire is irrelevant, since, even with a prior declaration of the desire not to be treated, the treatment must be carried out regardless of the patient's consent, if there is imminent danger to life or danger of death due to omission of treatment* [31]. In turn, Opinion 7/2019, of the Regional Council of Medicine of the State of Minas Gerais (CRM-MG), states that *in the case of imminent danger to life, the request* [AMA] *should not be accepted by the physician, and, in the absence of danger, it should be authorized by the physician after the signing of an AMA form and the comprehensive recording in the medical files of the clinical evolution and decision by the patient or legal agent* [32].

According to Opinion 11/1997, of the Regional Council of Medicine of the State of Mato Grosso do Sul (CRM-MS), (...) *the only situation in which the physician should not, under any circumstances, agree with the "discharge against medical advice" is one in which imminent danger*

to the life or serious risk to the patient's health is well established.[4] CRM-MG Opinion 54/2018 points out that *in the case of AMA that does not endanger the patient's life , neither the attending physician nor the hospital can violate the former's principle of autonomy, restricting his/her right to "come and go" (...). This is the behavior to be adopted, unless there is imminent danger of death, in which case the rule changes, privileging the effort to save to the detriment of the autonomy of the patient or his family*[1].

Along the same lines, the judiciary has pronounced itself: *it is not up to the judiciary branch, in the Brazilian legal system, to authorize or order medical-surgical and/or hospital care, except in extremely exceptional cases and except when the interests of minors are involved. If the danger to life is imminent, it is the physician's right and duty to employ all kinds of care, including surgery, to save the patient, even against the desire of the patient, family members and anyone else*[33]. (...) *the healthcare provider has the duty, in the event of imminent danger to life, to undertake all necessary steps to care for the patient, regardless of his/her consent or that of family members*[34].

Contrary to the understanding above, there is only the opinion of the board member Marco Segre, recorded in Cremesp Opinion 41,848/1996[35] and approved by the plenary, that the patient's autonomy must be respected even in the face of imminent danger of death, citing as an example the situation of Jehovah's witnesses who refuse to accept blood transfusion.

Despite the assumptions above, I propose that the answers to the inquirer's questions be as follows:
1) Imminent danger to life
a) Should the patient's rights to decide freely on his/her own life be disrespected? Example: cases of patients who no longer wish to be artificially ventilated when in respiratory failure.
b) When there is loss of consciousness, but the patient has previously explained to the doctor the limits of intervention that will be accepted, in view of imminent danger to his/her life, should the doctor continue to respect the patient's wishes? Example: Jehovah's witnesses who refuse to accept blood transfusions.
Answer: My unequivocal option is for alternative b[35].

However, this same advice later changed its recommendations in Cremesp Opinion 16,948/1999[36], in the sense that the patient's desire should only prevail when there is no imminent danger to life.

In order to solve the problem, it is essential to distinguish AMA that does not involve imminent danger to life from the opposite case; only through evaluation and technical opinion can such a distinction be made. In the former situation, the patient's choice prevails, since they have the right to decide on their hospital discharge[36].

Drug prescription in discharge against medical advice

A situation that may raise questions concerns providing the patient with prescriptions in the case of discharge against medical advice, as recommendations differ among medical councils.

CRM-MG Opinion 124/2017[37] and Cremesp Opinion 20,589/2000[38], for example, exempt the physician from prescribing drugs in this case and provide that: (...) *the patient who, duly informed and with no imminent danger to their life, decides to self-discharge against medical advice to remain under hospital care, releases the healthcare provider from the obligation to continue the treatment, as well as to issue a prescription*[37,38].

Other documents take an opposite view, providing that the prescription of medication for use after hospital discharge is a patient right which can only be refused by the physician when the administration of medication appropriate to the case is not feasible outside the hospital or may be harmful to the patient, as stated in CRM-MG Opinion 54/2018: *Upon leaving the hospital, the patient has the right, as much as other patients, to the prescription, the discharge report and the medical certificate*[1].

According to CRM-PR Opinion 2,651/2018, *in a hypothetical case, if a physician does not agree with the hospital discharge and understands that continuing a drug prescription outside the hospital might be harmful to the patient, he/she can refuse to provide the prescription*[39]. In turn, Opinion 11/2019 of the Regional Council of Medicine of the State of Bahia (Cremeb) states that *the refusal to provide a detailed medical report and*

drug prescriptions has been considered behavior that is retaliatory and potentially harmful to patient safety, as is any kind of statement that could be interpreted as abandonment of the patient from the moment of their refusal or self-discharge, or that they may face any type of additional difficulty in case of return to the facility or will be treated as persona non grata in a new consultation [10].

On the subject, Article 32 of CEM provides that physicians *cannot fail to use all available means of health promotion and prevention, diagnosis and treatment of diseases, scientifically recognized and within their reach, in favor of patients* [22], which is why there is a duty to prescribe possible and safe medication to be used outside the hospital, aiming to minimize the damages arising from the interruption of care. It is a harm reduction measure.

Therefore, despite the conflicting recommendations, the attending physician, on agreeing with a discharge against their advice, must continue to watch over the health and well-being of the patient as far as possible [22]. Physicians must provide, in addition to the detailed discharge report, guidelines regarding warning signs/symptoms, drug prescriptions as required, inform whether they can be administered outside the hospital, and, above all, reassure the patient that they may return to the hospital and resume care if they so desire in the future.

By thus behaving the physician will not only be doing their utmost duty but also avoiding possible ethical-legal issues related to his practice.

End of Life

As described above, the rule of thumb is to respect patient autonomy, except in case of imminent danger of death, when the request to be discharged should be denied. However, exceptionally, it is possible to agree with AMA even if there is imminent danger of death, in the case of an end-of-life condition due to a serious and incurable disease, according to contemporary scientific knowledge, provided that palliative care is ensured, as provided in CFM Resolution 1,805/2006.

Article 1 The physician may limit or suspend procedures and care that prolong the life of terminally ill patients with a serious and incurable illness, respecting their desire or that of their legal agents.

(...)

Article 2 The patient will continue to receive all the necessary care to alleviate the symptoms that lead to suffering, with right to comprehensive care and physical, psychological, social and spiritual comfort, including the right to hospital discharge [40].

Terminal state is understood as an irreversible condition, regardless of treatment, with a high probability of death in a relatively short period [41]. It is a matter, as argued by the theologian Leo Pessini [42], of surrendering to the finitude of life, imparting dignity to individuals who choose to refuse a futile, sometimes painful treatment, which will in no way change the prognosis of the disease.

The technological advancement of current medicine may result in therapeutic obstinacy, such as in the adoption of disproportionate measures that prolong the life and suffering of terminally ill patients without providing real benefits [24]. Therapeutic obstinacy can prevent orthothanasia (death at the right time), and the establishment of limits for medical intervention seeks to stave off dysthanasia (postponement of the dying process), in which therapeutic intervention is initiated and/or continued, contrary to the will of the terminally ill patient, aimed only at delaying the lethal outcome.

In dealing with advance directives (also known as living wills), Cremeb Opinion 20/2018 [41] addressed the "do-not-resuscitate order," determining that, in case of cardiopulmonary arrest (situation of imminent danger of death), the physician may not attempt to resuscitate an incurably terminally ill patient if they previously expressed their desire not to be subjected to such an intervention.

The circumstances described herein do not mention euthanasia (use of means to shorten life), a prohibited procedure in the Brazilian ethical and legal framework (Article 41 of CEM [22] and Article 121, paragraph 1 of the Penal Code [26]), omission of care (Article 135 of the Penal Code [26]) or patient abandonment (Article 36 of CEM [22]), as palliative care must be administered to avoid suffering, pain and predictable complications of the natural course of the disease.

In view of the above, physicians should agree with discharge against medical advice in the case of terminally ill patients, even if there is imminent danger of death, providing home care whenever possible, thus allowing them to return to the

comfort of their home among their loved ones, if that is their desire.

Final considerations

Discharge against medical advice requires physicians to analyze several variables, such as: capacity and competence of the person asking to be discharged; legal representation of family members to make the request when the patient is unable to express their desire; assessment of danger to life; possibility of prescribing drugs for home use, among others.

Imminent danger of death is the rule of thumb for accepting the self-discharge or not. If there is no imminent danger of a lethal outcome, the physician should agree with the AMA discharge, prioritizing the autonomy of the patient who is capable and competent to choose the care they wish to undergo, even if the attending physician is against it for understanding that the interruption of the hospital care in question will cause some harm.

If there is imminent danger of death, discharge should be denied, except in the specific situation of patients in a terminal state due to a serious and incurable disease, according to contemporary scientific knowledge. In this case, the patient can be discharged, provided that palliative care is ensured.

Although the discharge is against medical advice, the physician must continue to care for the health and well-being of the patient as much as possible. Besides the detailed discharge report, physicians must provide guidance regarding warning signs/symptoms, drug prescriptions as appropriate, inform whether they can be administered outside the hospital and, above all, reassure patients that they may be readmitted and resume care if they so desire in the future.

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