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Paediatricians' Perspectives on Discharge Against Medical Advice in Children in Southwest Nigeria: A Qualitative Study

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Abstract

Background: A paediatrician, as a child advocate, is trusted with actions that promote the health and well-being of children. He is caught between deciding what he thinks is best for the child and the caregiver's preferences, including a request to discharge against medical advice (DAMA).

Objective: To survey how paediatric resident doctors in a tertiary public health facility perceive, react to and manage DAMA requests by patients and their caregivers.

Methods: An in-depth interview of paediatric senior residents of the Federal Teaching Hospital, Ido-Ekiti, Ekiti State, Nigeria. The data were transcribed and analysed using the thematic framework approach for qualitative data.

Results: The residents demonstrated a sound understanding of the definition of DAMA, which refers to a situation where a child is taken home before the attending physician has issued the discharge order. However, they differ in their perception of whether the caregivers understand the implications of their actions for DAMA. The caregiver, typically the father, signs the DAMA form. The major reason for DAMA is financial constraints. In contrast, the other reasons include caregiver burnout, unfriendly hospital environment, poor prognosis, poor communication and attitude of health workers, and religious and cultural beliefs. The caregiver, typically the father, signs the DAMA form.

Conclusions: Paediatric DAMA has the potential to increase morbidity and mortality rates. Caregivers should be adequately counselled, and the DAMA form must be signed to absolve the physician of complicity in the event of an adverse outcome post-discharge.

Keywords: Discharge Against Medical Advice, Health financing, In-depth Interview, Qualitative study.

Introduction

As a child advocate, the paediatrician promotes those social, economic, educational, and political changes that ameliorate the sufferings and threats to the health and well-being of children through professional work and expertise. Discharge against medical advice (DAMA) is a situation in which a patient decides to leave the hospital premises before the managing physician recommends discharge. [2, 3] A patient or their

caregiver may request DAMA despite adequate counselling. In paediatric practice, the caregivers, which most times are the parents, have the autonomy to request the discharge of their children. The physician is bound by the Hippocratic oath to uphold the welfare of his patient at all times. However, in cases involving children, the paediatrician is sometimes caught between deciding what he thinks is best for the child and the parent's decision, which may be contrary to his evaluation of the patient. Children are at the receiving end of this unfavourable decision, which could worsen the morbidity and mortality statistics. [3]

The prevalence of DAMA varies from one region of the country to the other and from country to country. [3-6] It is high in the low-resource countries with suboptimal health services. Prior studies have shown that financial constraints are a major cause of DAMA. [3-5] Payment for healthcare services is mainly out of pocket, with only a few benefiting from healthcare insurance schemes. [9] In Nigeria, about five million people, representing 3% of the population, have health insurance coverage through the National Health Insurance Scheme (NHIS). [10]

Other reasons noted for DAMA include unfriendly hospital environment and health personnel, poor prognosis, pressure from the place of work, family discord, unsupportive spouse, caregiver burnout, and cultural and religious beliefs. [4, 12, 13] There is limited literature on the perspectives of paediatric resident doctors regarding DAMA in children. This study, therefore, aimed to survey how paediatric residents in a tertiary government health facility perceive, react to and manage DAMA requests by patients or their caregivers.

Methods

Study setting

This study was carried out at the Federal Teaching Hospital, Ido-Ekiti (FETHI), Ekiti State, Nigeria. FETHI is a federal government-owned tertiary health facility located in a serene rural environment in the southwestern part of Nigeria. The Department of Paediatrics has specialists running various subspecialty units, resident doctors at various stages of their training, and other support staff, including nurses, health assistants, pharmacists, and laboratory scientists. This department caters for all children under eighteen years of age.

Ethical considerations

Ethical clearance was obtained from the Ethics Committee of FETHI (ERC/2025/06/17/1296A) and all the participants signed to give informed consent for inclusion in the study.

Study design

This is an in-depth interview (IDI). A qualitative study that aims to describe how paediatric residents view and react to DAMA among sick children.

Respondents for IDI: Respondents were recruited purposively. Ten key informants were selected. These comprised senior residents (SR) in the Department of Paediatrics. To be an SR, one must have spent at least three years in training, passed required qualifying examinations and be a member of either of the postgraduate medical colleges, the National Postgraduate Medical College of Nigeria or the West African College of Physician, charged with the responsibility of postgraduate training of medical and dental doctors in Nigeria and West Africa.

Data collection

An interview guide with a stem of seven questions was used for the interviews. Audio recordings of the discussions were done. Additionally, the researcher took field notes. The

interviews were conducted in a quiet office, and each took about twenty to thirty minutes. The respondents were encouraged to air their views till the point of saturation. Respondents were asked to sign a consent form before the commencement of the interviews and were given a copy of the signed consent form to take with them.

Data analysis

The qualitative data was transcribed and analysed using the thematic framework approach for qualitative data. Different segments on DAMA were coded under different subheadings in the interview guide. Where new instances are raised, a distinct category is created. A dominant point from the interviewees was taken as a theme. These themes, which emerged at the end of the interviews, were compared with previous themes from prior studies.

Results

Ten SRs participated in the IDI. There were two males and eight females. On ethnicity, eight were Yoruba, and one each of Igbo and Annang. Seven segments snowballed into themes during the discussion. The caregiver, typically the father, signed the DAMA form.

What is the definition of DAMA?

All respondents demonstrated a sound understanding of the definition of DAMA.

"*DAMA is when a patient or caregiver decides to terminate the care received in the hospital despite adequate counselling not to do so*."

"*DAMA is when the patient or caregiver decides to abandon treatment received in the hospital to go home against the doctor's advice*."

"*It is when a patient who is receiving care in the hospital decides to leave the hospital despite being counselled by the health care worker".*

Perception of DAMA

The respondents differed in their perception of whether the caregivers understood the implications of their actions to DAMA or not. While the majority, 80%, believed that the caregivers understand the impact but act based on their inability to fund treatment or other reasons for DAMA, 20% believed caregivers do not understand the implications of their actions until worse morbidity or mortality sets in. The respondents felt uncomfortable and saddened at every request of DAMA, knowing that it is the sick children who bear the implications of these decisions. However, on a few occasions, when caregivers are aggressive and uncooperative, or worse still when dealing with a challenging or futile case, 10% of the respondents agreed that they feel relieved when DAMA is requested.

"*I feel very sad as a child advocate because the goal of every paediatrician is to see their patient get well" "I don't feel relieved at all because I know that the child is not likely to receive any medical care at home*".

"*The feeling depends on the severity of the illness. If it's an uncooperative or aggressive caregiver, I feel relieved of the burden of having to manage a sick child and keeping up with the bad attitude of the caregiver, and worse still, when there is a threat to my life if I don't allow them to go. On the other hand, I feel empathic for the sick child who is my primary concern*."

"*Even if the feeling of relief is there, my concern about what quality of care the child will get outside the hospital facility supersedes any feeling of relief. I feel sad because the decision is being made on behalf of the child*".

"*It depends; sometimes I am indifferent, and on few occasions, I feel relieved of letting go of a burden*."

Actions taken to prevent DAMA

To prevent DAMA, respondents inquire about the reason for DAMA and counsel caregivers on the

diagnosis, interventions made so far, prognosis, and the possible outcomes of DAMA. They inform the managing consultant, whose counsel some of the caregivers listen to and change their minds out of respect. The respondents also raise money among themselves and other staff members to assist in settling some hospital bills and paying for medications. In some instances, they write to request funds from the departmental indigent fund, called the "*alaanu* fund", to minimise prescriptions, change medications to a less expensive alternative with similar or near-similar efficacy and potency, and write to hospital management soliciting for some bills to be defrayed. For caregivers needing more time off work, written letters are addressed to the caregiver's employer to support such request, stating the reason and the projected duration the caregiver will be away from work. If, after every effort, the caregiver insists on leaving, the details of the reasons for DAMA are documented explicitly, and the caregiver is made to sign the DAMA form. In most cases, the father signs the DAMA form.

"*One of the major things we do is try to raise money because, as we know, one of the major causes of DAMA is low finances. We help to purchase some drugs and, in some cases, change the drug to a less expensive one, still trying to achieve the same purpose*."

"*I try to find out the reason why they want to leave, and if it is what I can bridge the gap, I do. For those who needed an official excuse from work, I try to get them a letter of excuse for the time being. We also write for funds from the 'alaanu' purse. If, despite all efforts, the parent insists on leaving, I ensure that proper documentation of their reason is completed and have them sign the DAMA form. This signing is important in case of legal action*."

"*I counsel them again; I avoid unnecessary prescription, inform the superior and most times when they hear the superior officer speak, they occasionally have a change of mind out of respect or better understanding, try to make the environment convenient*."

Reasons for DAMA

The respondents all agreed that the most common reason why patients seek DAMA is financial constraints. Other reasons put forward included ignorance or denial of the diagnosis, caregiver burnout, poor prognosis, or when they could not appreciate improvement in the child's condition, uncomfortable hospital environment, and poor attitude of health workers. Additionally, family disharmony, myths, religious beliefs, and workplace pressure were among the reasons identified.

"*Major reason for DAMA is finance; a parent needs to go back to work, caregiver burnout, no improvement in child's condition, or probably someone told them it's a spiritual attack*."

"*Caregiver burnout, displeased with care rendered, financial constraint, family discord when there is no support from the other spouse, pressure from the workplace if it's a terminal illness. The attitude of some health workers can be discouraging*."

"*When they say they want to go seek spiritual help, we encourage them to stay in the hospital, and their spiritual father can be praying from wherever they are. And should the spiritual father come, we allow them in to see the patient. This is more common among Christians. We allow their pastors to visit the patient. We do not allow any act that inflicts bodily harm or practices that conflict with orthodox therapy*."

Receiving DAMA patients back

All the respondents were glad to receive the patients back.

"*We accept them with all joy. I sit them down to counsel them all over again.*"

"*Before they leave, we emphasise they could come back when they change their mind. So, when we see them come back, it is all joy for us*."
"*We accept them and don't castigate them, although as humans, it is difficult not to remind them of our counselling not to leave in the first place*."

Reduction of DAMA

At the top of the list of suggestions from respondents regarding ways to reduce DAMA is improved healthcare financing. More people should be enrolled in the National Health Insurance Scheme (NHIS). Good communication regarding prognosis and the course of management, showing empathy and making the hospital environment more caregiver-friendly are other possible ways to reduce the DAMA rate.

"*The government should enrol more of the populace in health insurance. This is to cover a larger population like the artisans and farmers, make the hospital environment convenient like where the parents could sleep at night, educate the community and religious heads*."
"*Create a friendly environment, avoiding unnecessary prescription, the patient should be treated well, get their trust and confidence, do not shout at them, provide water and light on the ward, and health insurance should be made available to all*."

Effect of DAMA on paediatric practice

All the respondents agreed that DAMA affects their practice in various ways. These include unfulfillment of practice, depression, worsening of the morbidity and mortality rates, and loss of data for research.

"*It is sad and depressing when you don't get to see the end of your labour over a child; the clinical course worsens at home, and the next thing you hear is that the child is dead. This can be disheartening*."
"*As a paediatrician, it raises our statistics like childhood mortality; some cases are useful for research, and when these patients are lost, it does not allow that area to be researched*."

Discussion

From the respondents' perspective, DAMA occurs when a child is taken home before the attending physician has certified the child as fit for discharge. This definition is similar to that found in most literature. [3, 12-15] This perspective is different from a similar qualitative study done among paediatric residents in Zamboanga City Medical Centre (ZCMC) in the Philippines, where the DAMA definition is tied to either the reason for discharge, such as DAMA- finance or poor prognosis, DAMA- terminal. [2]

The respondents are saddened when caregivers present with DAMA requests. The emotional state of the residents varies from that of the paediatric residents of ZCMC, who expressed feelings of frustration in response to DAMA's request yet demonstrated a sense of respect for parental autonomy and acted in the child's best interest.[2] The resident's initial response is to inquire about the reason for wanting to a DAMA. The managing consultant is informed and also speaks to the caregivers about their decisions. Few of the caregivers agree to stay out of respect for the senior physician's counsel. If the reason for DAMA is modifiable, for example, if it is based on financial constraints, the residents rally around and tax themselves, as well as other health workers, for financial assistance through voluntary donations. Also, they write to get funds from the departmental indigent fund pool. If the reason for DAMA is pressure from the caregiver's workplace, the residents provide official support for such a request through a letter of support from the managing consultant, stating the need for the caregiver to stay off work for a projected duration to care for the sick child. The hospital's social workers are also invited to assess the patient's and

family's psychosocial functioning and provide emotional support as needed. [16]

Poor communication or dissatisfaction with the quality of service provided by doctors, nurses, and other healthcare staff members is also a reason for DAMA. However, none of the residents admitted to having caused a patient to leave against medical advice due to poor communication or mistreatment, though they acknowledged that the attitudes of some other types of health personnel could be discouraging to patients. This finding is similar to what was noted in ZCMC, where the residents exonerated themselves of any blame but reported that some nurses encouraged patients to DAMA to reduce their workload. [2]

Myths and religious beliefs significantly influence individuals' lifestyles and perceptions of illness, often shaping how caregivers respond to a child's medical condition. In some cases, caregivers opt for DAMA because they believe the illness is the result of a 'spiritual attack' and wish to seek spiritual intervention. While residents are generally opposed to discharging such patients prematurely, they counsel caregivers by emphasising that spiritual support can be offered from any location. At the same time, the child continues to receive medical care in the hospital. They often explain that "there is no physical barrier in the spiritual realm, and prayers can be made from anywhere." In instances where caregivers request that a spiritual leader visit the child in the hospital, paediatricians typically allow this, provided there is no physical intervention such as scarification or the administration of unorthodox substances.

The residents are amiable to the patient and caregiver when they represent for re-admission. This reaction is similar to the residents from ZCMC, who said they did not mind treating the patient again. However, the residents disagree on the caregiver's lack of understanding of the implications of their request. While some of the residents believe that the caregivers understand the implications of their actions but act based on their current state of stress from financial burnout and pressure from an uncooperative partner or workplace, others residents believe that they do not fully understand their actions until worse complication or death result after they have left for home. This is, however, different from the study in the Philippines, where the paediatric residents believe there was no lack of comprehension on the part of the parents about the need for complete treatment, as the paediatricians reported speaking a variety of local dialects and are diligent with explaining the situation to the parents. [2]

The residents agreed that DAMA has a negative connotation on their practice. There was an expression of hopelessness, as these patients were unlikely to receive any form of medical care at home. The joy of every paediatrician is to see their patients get well and, thereafter, get discharged. But DAMA does not give room for that. This takes away the joy and satisfaction that paediatricians derive from meeting the needs of their patients. Additionally, DAMA impacts research as cases are not followed to completion, resulting in data loss. A discharged patient can deteriorate while at home and die, thereby worsening the paediatric mortality rate.

A resident emphasised the importance of thoroughly documenting all processes involved in a DAMA case, including the proper execution of the DAMA form, as a safeguard against potential litigation in a society that is increasingly aware of its legal rights. However, it is crucial to educate residents that a signed DAMA form alone does not offer complete legal protection to the attending physician. Therefore, every possible effort should be made to prevent DAMA. Comprehensive documentation, including detailed records of discussions with the

patient and caregivers, is essential. Legal protection is best ensured when it is documented that the patient and their caregivers were fully informed of the risks, benefits, and available alternatives and that their decision to leave was made voluntarily and with complete understanding. [17]

Limitation

The opinion on DAMA shared in this study is purely that of the paediatric residents of FETHI. It does not reflect those in private hospitals or other government hospitals operating at different levels of healthcare delivery.

Conclusion

The primary reason for DAMA is financial hardship, which restricts access to ongoing care. Other contributing factors include lack of awareness, misdiagnosis, caregiver fatigue, an uncomfortable hospital environment, cultural myths, religious beliefs, and negative attitudes toward healthcare workers. Paediatricians may only be protected from potential legal consequences after thoroughly counselling patients and caregivers about the risks, benefits, and available alternatives and ensuring that their decision to leave was made voluntarily and with a complete understanding.

Authors' Contributions: AEO conceived and designed the study and drafted the manuscript. FOB and AIA did the literature review while AFM and O-AO analysed and interpreted the data. AAE, AAC, SPO, OIA, OKO, AEO and OOL revised the draft manuscript. All the authors approved the final version of the manuscript.

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