

Voluntary Discharge in Pediatrics Units of Different Hospital Settings with a Focus on Nigeria

¹Babatunde Ibitoye Oluwaseun, ²Omolayo Adebukola Olubosedo, ³Imole Yemitan Ayobami, ⁴Adebola Omobusola Ojo, ⁵Olumide Akadri, ⁶Olugbemi T Olaniyan, ⁷Olaleke Bashir Fasasi and ⁸Fransisca Omolara Ibitoye

¹Department of Anatomy, Ekiti State University, Ado Ekiti, Ekiti, Nigeria

²Department of Paediatrics, University of Medical Science Teaching Hospital, Akure, Ondo, Nigeria

³Department of Medicine, College of Medicine, University of Ibadan, Ibadan, Oyo, Nigeria

⁴Department of Paediatrics, Federal Medical Centre, Owo, Ondo, Nigeria

⁵Department of Obstetrics and Gynecology, University of Medical Science Teaching Hospital, Akure, Ondo, Nigeria

⁶Laboratory for Reproductive Biology and Developmental Programming, Department of Physiology, Edo University Iyamho, Okpella, Edo, Nigeria

⁷Omega Golden Fertility, Peninsula Estate, Ajiwe, Ajah, Lagos, Nigeria

⁸Department of Science Laboratory Technology, Rufus Giwa Polytechnic, Owo, Ondo, Nigeria

ABSTRACT

Voluntary discharge from health facilities affects all patient age groups and climates. It is also called “discharge against medical advice” (DAMA) as the decision is opposed to the desire of the physician. There is a peculiarity in pediatric patients when it comes to DAMA since the decision, in most cases, is taken without their consent. The medical consequences suffered by the patient may be grave, ranging from full recovery to death. This work aims to critically analyze, through literature, the gravity of this situation in terms of prevalence, risk factors and condition, associated ethical-legal challenges and possible solutions in low and middle-income settings like Nigeria. A concentrated literature search was done to find papers that were published between 2000 and 2021 in the Cochrane, Pubmed, Google Scholar and Web of Science Databases. The focus of this review is to gain an understanding of regional variations and the factors that underlie DAMA since these will be relevant in designing interventional strategies to ameliorate the trend, especially in low and middle-income nations.

KEYWORDS

Discharge, ethical, legal, morbidity, policy, pediatrics

Copyright © 2023 Oluwaseun et al. This is an open-access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution and reproduction in any medium, provided the original work is properly cited.

INTRODUCTION

Several terms have been used to describe the idea of patients voluntarily leaving a doctor’s care before finishing their treatment, including “taking own leave” (TOL), “absconding,” “leaving the hospital,” “discharging against medical advice” (DAMA), “absent without leave” and walking off¹. This act presents



many challenges for the supervising physician in the pediatric age group because of largely attached legal and ethical considerations². Patient dissatisfaction leads to DAMA, which raises the rates of complications, readmission and mortality. To prevent DAMA, hospital staff must provide patients with holistic care from the time of admission until the patient is medically well³. Although, it happens frequently, hospital staff occasionally encounters patients who refuse to follow a doctor's orders and leave the facility. The risk of negative clinical outcomes increases when these patients leave the hospital, which presents a challenge and concern for hospital staff^{4,5}.

Additionally, because patients frequently trust medical professionals to assist in the treatment of their health issues, it is assumed that advice provided at this time by a health professional will be followed by the patient⁶. This is not always the case, as some patients may decide to discharge themselves against medical advice, leaving the doctor open to moral and legal problems⁷. Although, economic and sociocultural factors have skewed it to this region, DAMA is a global phenomenon that is not just restricted to the developing world⁷. Several clinical specializations are affected by voluntary discharge and no racial or socioeconomic bias exists in this process⁸. The objective of this work is to critically analyze, through literature, the gravity of this situation in terms of prevalence, risk factors and condition, associated ethical-legal challenges and possible solutions in low and middle-income settings like Nigeria. It is our hope that it will also assist to gain an understanding of regional variations and the factors that underlie DAMA, since these will be relevant in designing interventional strategies to ameliorate the trend, especially in low and middle-income nations.

VOLUNTARY DISCHARGE OF PEDIATRICS PATIENT IN CIVILIZED WORLD

There is dearth of information on the World wide prevalence of pediatrics DAMA, however, higher prevalence has been seen in certain pediatrics subpopulations⁹. In a study of children in a few tertiary health facilities in Australia, it was discovered that voluntary discharge, which accounts for 0.5% of all admitted cases, was more common among males than females (58 vs. 42%). According to reports, these kids ranged in age from 2 to 6 years old. It was illuminating that a higher proportion of patients were from the high to middle and low social classes¹⁰. DAMA rates have increased over the past ten years, according to a recent study from the USA. Given that these patients have a higher risk of readmission and higher morbidity and mortality, this is a significant public health issue^{11,12}. Discharge against medical advice is uncommon in pediatric practice in the UK but is known to occur and can jeopardize the health of the child¹².

PEDIATRICS VOLUNTARY DISCHARGE IN LOW AND MIDDLE-INCOME COUNTRIES WITH A FOCUS ON NIGERIA

The majority of studies on DAMA are from low and middle-income (LMIC) nations in Africa and the Middle East, where the incidence of DAMA among pediatric patients range from 1.5% to over 6% both between and within countries. Due to financial difficulties and the scarcity of resources, it has been hypothesized that the rate of voluntary discharge in LMIC countries doubles that of high-income countries¹⁰. Similar to adult patients, children who are discharged from the hospital against medical advice by their parents or caregiver run a higher risk of readmission and morbidity because their health deteriorates at home, increasing the cost of their care¹⁰.

A study on pediatric discharges against medical advice at a tertiary health facility in Bayelsa State, Nigeria, revealed a prevalence rate of 7.5%, with a male-to-female ratio of 1.4:1 and a gender breakdown of 57.5% male and 42.5% female. The most typical diagnoses in the neonatal age group were septicemia (32.6%), birth asphyxia (27.9%) and preterm (14.0%), whereas the most typical illnesses in older children were respiratory tract infections (18.2%), severe malaria (15.6%) and septicemia (14.3%). A large portion of DAMA patients was from lower and middle-class backgrounds and they more frequently occurred in the first seven days after admission⁹.

DECISION OF VOLUNTARY DISCHARGE AMONG THE PEDIATRICS AGE GROUP

Decisions to DAMA are generally made by parents and fathers were the signatories to the discharge documents in 68% of cases¹³ although sometimes big children become involved in making this choice. To prevent DAMA as much as feasible, older children should be involved in the decision-making process. DAMA may result in poor outcomes, with a readmission rate of 15% within 48 hrs of the child returning home. Patients with poor outcomes frequently cause the pediatric medical unit to face legal action. It was discovered that 97.7% of patients who left hospitals against doctors' orders signed DAMA forms, while just 2.3% fled the facility, demonstrating the prevalence of official paperwork¹⁴. If DAMA becomes inevitable, there should be a responsible adult who is ready to take the child home¹⁵. Child protection concerns should be raised when patients choose DAMA and an impending health emergency is anticipated. Pediatric DAMA presents a moral conundrum for pediatricians who must weigh the autonomy of the parents against the need to give the kid the care they need¹⁰.

FACTORS RESPONSIBLE FOR VOLUNTARY DISCHARGE

Several noted causes of voluntary discharge can be systematically divided into the following parts:

Hospital and medical personnel are accountable for 41.2 and 35.2% of patients who have DAMA, respectively, whereas patient-related factors account for 43.9% of DAMA causes. If the trend of DAMA is to be reversed, it is crucial to address these issues¹⁶.

Patient-related factors: A significant aspect affecting DAMA is the patient's financial situation and the need for his or her presence at work. Priority should be given to preventing voluntary discharge because the patient's socioeconomic status has a substantial impact on health behaviors¹⁷.

According to the Ikefuan study, the most common causes of DAMA were financial difficulties, a lack of financial support and a lack of insurance¹⁸. Patients' choices may be influenced by their financial situation. The parent most frequently pressures the child to leave the hospital because they have other children at home who also need them to be there^{19,20}. The perception by patients that their health conditions have improved enough for them to leave the hospital is another germane factor that has increased the occurrence of DAMA.

Another element influencing DAMA is the degree of confidence in the managing physician's competence^{12,21}. Patients who has DAMA in the past and had little or no trust in the managing physician were found to have increased levels of DAMA^{12,22}. The main cause of DAMA is thought to be patient dissatisfaction with medical treatment and care. Patients' lack of confidence in the medical community and their terrible prior hospitalization experiences were stated as causes for leaving the hospital. Dissatisfaction with medical staff, medical services and medical evaluation procedures, particularly in teaching hospitals where training is prioritized alongside care, is a significant factor in patients defying medical advice and leaving the facility^{15,23}. Age (less than 2 years old or in the adolescent age group), male gender, a hospital stay of 48 hrs or less, financial constraints, a lack of health insurance and a lower socioeconomic status are all risk factors for DAMA in children¹⁰.

On many occasions, the patient's parent remains adamant despite efforts by medical staff to dissuade DAMA, parents are however not free to make this type of decision which can be ominous to their child's health¹⁴. According to recent studies, the persistent character of DAMA has been predisposed by the shifting trends in disease from communicable to non-communicable²⁴.

Hospital-related factors: Regarding the patient's discontent with hospitalization, the cleanliness of the facility had the greatest influence. People are aware of the health dangers (imminent infection risk) connected to a dirty hospital environment. This issue can be resolved by the unit in charge of cleanliness

and waste management effectively monitoring the hospital environment. The level of care offered at the facilities also serves as an incentive for the patient. According to Joubert *et al.*²⁵, the four core ideas of efficacy, efficiency, equity and humanism can be used to assess the quality of healthcare services²⁶. Providers of care should always treat the clients with empathy and respect¹⁵. A contributing reason to rising DAMA may be a shortage of available medical workers and the absence of a resident physician in an institution. The establishment of emergency medicine physicians and employing more staff may be the way out²⁷. Patients' faith in the healthcare system will increase if there are fewer interruptions to healthcare services and if medical facilities are well-equipped²⁶.

Medical staff: It is expected that the medical staff will give the patients enough information regarding their ailment, any potential side effects, treatment options and the associated medical care. However, it was shown that the majority of patients lack the requisite knowledge regarding the negative repercussions and outcomes of their choices³⁰. Good relationship between the medical staff and the patient is considered the main factor to decrease DAMA²⁸.

According to research, 6.1% of patients have DAMA as a result of inadequate care from medical personnel²⁹. The tendency of DAMA could be slowed down by positive attitude changes toward patients. Insufficient health insurance coverage and ongoing health worker strikes also encourage patients to hunt for an apparent cheaper option¹⁴. Among new trainees, the attitude of being helpful despite readmission following DAMA needs to be reinforced. Lack of knowledge regarding the potential consequences of the patient's choice may be caused by the heavy workload of the few available health professionals¹⁰.

Discharges against medical advice happen when patients leave the hospital before a designated clinical endpoint, against the doctor's advice. This is a problem that doctors and other healthcare professionals have been dealing with for a long time. The number of voluntary discharges can be decreased with the help of nurses by educating patients thoroughly and consistently about their health. Nursing professionals have an ethical duty to promote social justice, provide care and encourage interdisciplinary cooperation. The institutions will assist by facilitating and developing an environment that will create exciting contact and relationships between professionals and also between them and the patients and this must be maintained during admission^{19,30}.

MEDICAL IMPLICATIONS OF VOLUNTARY DISCHARGE IN PEDIATRICS

Patient self-discharge without finishing their treatment is a concern in healthcare and is closely linked to readmission and a subpar treatment result. It disrupts treatment regimens and is closely linked to higher rates of morbidity and mortality, readmission and utilization of medical services^{10,31}. Patients who engaged in DAMA are reluctant to visit the same facility again due to feelings of guilt for engaging in DAMA in the first place, shame and concern for the hospital staff's reaction³².

In circumstances where patients are contemplating leaving or do depart before their assessments and urgent treatments are finished, it is suggested that the healthcare provider assess, investigate, mitigate, explain and document the framework²⁰. The patient's condition may worsen following DAMA, possibly to the point of death, or the patient may experience long-lasting side effects and make the therapeutic outcome unsatisfactory. Additionally, the patient's readmission due to his or her serious condition results in additional expenses for the healthcare system, maybe as a result of the disease relapsing, which is a problem worth noting and discussing^{20,32}. A DAMA research in Chichester with children ages 0 to 18 found a 15% readmission incidence within 48 hrs of the child returning home³¹.

The study also revealed that on occasion, against medical advice, seriously ill children are carried home, raising the possibility of legal repercussions for the pediatric team³¹. Patients who engage in DAMA

undermine the duty of care of hospital administration and healthcare personnel in addition to endangering their health³¹. Patients who object to medical care that seems to be required and in their best interests present a difficult medical, moral and legal problem. Before allowing DAMA, the matter must be carefully examined to determine whether the person making the decision has the legal ability.

Although they may not provide legal immunity on their own, written documentation of a patient's rejection to follow medical advice in the form of an "AMA" may be helpful for evidential purposes³³. This is typically addressed by having the patient or parent sign a statement acknowledging that the decision was made voluntarily and that they are aware of any potential repercussions¹⁷. When medical practitioner fails to critically manage legal and ethical issue surrounding pediatrics DAMA, it may lead to being sued³⁴.

Therefore, ratifying DAMA does not always confer immunity or legal protection. It is essential to appropriately examine, counsel and educate the patient and their family members. Parents or caregivers must be made aware that the patient may be readmitted if they are suspected of having the current condition or a future illness, or if a symptom does not resolve as anticipated³⁵. The doctor must make sure that each of these actions is accurately recorded in the patient's records and that the patient's or the authorized surrogate decision maker's real signature is attached to the discharge form in the presence of witnesses³⁵.

An effort should be made to translate the DAMA form into the user's native tongue. The managing team has the option to ask the court for approval of an uninvited or required hospitalization. Even after the medical team's best efforts, if the patient persists, the counseling and discharge procedure needs to be thoroughly documented³⁵. However, some have claimed that the use of the DAMA form in pediatric treatment should be severely discouraged because it could be interpreted as medical neglect, opening the door to legal action and patient morbidity. Organizations that provide healthcare services should make sure that no DAMA forms are used in relation to minors³⁶. The problem is that, in most circumstances, the youngster does not have the legal capacity to make the appropriate decisions while also bearing the brunt of the consequences¹². The wellbeing and safety of the child should always come first. Medical personnel must evaluate the risk, record it and make sure the child's continued medical care is not jeopardized.

ETHICAL ISSUES ASSOCIATED WITH DAMA

Physicians encounter a frequent but difficult ethical conundrum when dealing with patients who want to leave the hospital against medical advice (AMA). When patients choose a course of treatment that aligns with their values, needs and preferences, physicians are required to respect that patient's autonomy. However, a doctor's moral duty is to act in the patient's best interests by safeguarding those interests. A doctor still has a very difficult time handling this moral dilemma, especially when it involves young patients. There are many indications of life-threatening problems under discharge situations, which raises major ethical concerns³⁷. All medical professionals should strive to reduce or even prevent DAMA by making hospitals comfortable for patients, offering youth consulting services, training staff on how to interact with one another, giving patients in need the best, most affordable assistance and resolving housing issues for patients and their companions³⁵.

PREVENTION OF DAMA

It is crucial to instil a culture of compliance with the recommended therapeutic procedure among people in order to eliminate the DAMA problem. Additionally, hospital welfare facilities must be improved, medical staff performance must be monitored, family awareness must rise and patient-staff relationships must be strengthened²⁷. Medical bill coverage and improved blood supply will also minimize this situation¹⁴. A good national health policy should be developed by the government, patients and carers

and the medical team should communicate better. Palliative and end-of-life care should also be supported effectively and people should be informed of advance directives³⁸. To lessen DAMA, it is advised that the Health Insurance Scheme be strengthened, traditional medical practices be strictly regulated and targeted health education be provided³⁸. One of the biggest factors in DAMA was the inability to pay the hospital cost. The budgetary resources allotted to health institutions must be increased by the government at all levels to cover emergency services at all stages of patient care. The National Health Insurance Scheme (NHIS) should be energetically pursued and every effort should be made to ensure its success³⁹.

To prevent DAMA and allow for the continuation of treatment, medical staff must be alert enough to identify patients who are in danger. The information exchange between the patient and the doctor or other medical staff is crucial to a discharge plan. Patients have a fundamental right to the required information regarding their condition, its impact and available treatments. As a result, this fact has become law in many nations. The WHO's Innovative Care for Chronic Conditions (ICCC) framework should be adopted right away to correct the act of DAMA³⁵.

CONCLUSION

DAMA in the pediatrics age group is still very common in low- and middle-income nations. Many factors have been identified as the causes which are mostly from economic and cultural backgrounds which put the medical personnel in a difficult position that can bring litigation in some circumstances. It is important that people and patients alike are given reorientation by constant education and also by giving relevant information to the religious leaders. Governments in developing nations should prioritize health, empower women and improve the economy generally as economic reasons remain crucial for defaulting medical care. Parents may be able to make better judgments by being properly educated and having the negative repercussions of denying complete treatment explained to them in a language they can comprehend. This will help prevent financial loss and related medical difficulties.

SIGNIFICANCE STATEMENT

DAMA is a common problem and presents a daunting challenge to the managing team. It also has the risk of resulting in worsening morbidity or even result to mortality. For the healthcare facility, legal tussle could result in its attendant challenges. Some of these effects that are often lost on the healthcare team have been emphasized. This study has attempted to bring to the fore the challenges presented by DAMA, the predisposing factors especially the need for funding. Education of patients and caregivers on the potential dangers of DAMA and the need for the amicable resolution of conflicts between the facility and patients to significantly limit the occurrence of DAMA is presented in this study.

REFERENCES

1. Spooner K.K., J.L. Salemi, H.M. Salihu and R.J. Zoorob, 2017. Discharge against medical advice in the United States, 2002-2011. *Mayo Clin. Proceed.*, 92: 525-535.
2. Kavanagh, A., O. Ostrow and R.Z. Shaul, 2020. Discharge against medical advice (DAMA) in paediatrics: An approach to promote safety and ethics. *Paediatr. Child Health*, 25: 12-15.
3. Alfandre, D.J., 2009. "I'm going home": Discharges against medical advice. *Mayo Clinic Proceed.*, 84: 255-260.
4. Joolae, S. and F. Hajibabae, 2012. Patient rights in Iran: A review article. *Nurs. Ethics*, 19: 45-57.
5. Querques, J., N. Kontos and O. Freudenreich, 2014. Discharges against medical advice. *JAMA*, 311: 1807-1808.
6. Ohanaka, E.C., 2002. Discharge against medical advice. *Trop. Doctor*, 32: 149-151.
7. Ibekwe, R.C., V.U. Muoneke, U.H. Nnebe-Agumadu and M.A.U. Amadife, 2009. Factors influencing discharge against medical advice among paediatric patients in Abakaliki, Southeastern Nigeria. *J. Trop. Pediatr.*, 55: 39-41.

8. O'Neill, D., 2013. Guardians of the demographic dividend. *Australas. J. Ageing*, 32: 6-35.
9. Duru, C.O., O. Peterside and A.O. Ududua, 2014. Paediatric discharges against medical advice at a tertiary health centre in Bayelsa State, Nigeria. *Niger. J. Paediatr.*, 41: 90-95.
10. Sealy, L., K. Zwi, G. McDonald, A. Saavedra, L. Crawford and H. Gunasekera, 2019. Predictors of discharge against medical advice in a tertiary paediatric hospital. *Int. J. Environ. Res. Public Health*, Vol. 16. 10.3390/ijerph16081326.
11. Yong, T.Y., J.S. Fok, P. Hakendorf, D. Ben-Tovim, C.H. Thompson and J.Y. Li, 2013. Characteristics and outcomes of discharges against medical advice among hospitalised patients. *Intern. Med. J.*, 43: 798-802.
12. Ashrafi, E., S. Nobakht, M.S. Keykaleh, E. Kakemam, E. Hasanpoor and M. Sokhanvar, 2017. Discharge against medical advice (DAMA): Causes and predictors. *Electron. Phys.*, 9: 4563-4570.
13. Shekerdeman, L.S., N.R. Mahmood, K.K. Wolfe, B.J. Riggs and C.E. Ross *et al.*, 2020. Characteristics and outcomes of children with Coronavirus Disease 2019 (COVID-19) infection admitted to us and canadian pediatric intensive care units. *JAMA Pediatr.*, 174: 868-873.
14. Yusuf, M.B., J.D. Ogunlusi, S.O. Popoola, S.O. Ogunlayi, W.O. Babalola and K.S. Oluwadiya, 2017. Self-discharge against medical advice from tertiary health institution: A call for concern. *Niger. Postgrad. Med. J.*, 24: 174-177.
15. Macrohon, B.C., 2012. Pediatrician*s perspectives on discharge against medical advice (DAMA) among pediatric patients: A qualitative study. *BMC Pediatr.*, Vol. 12. 10.1186/1471-2431-12-75.
16. Moda, H.M., F.M. Dama, C. Nwadike, B.S. Alatni and S.O. Adewoye *et al.*, 2021. Assessment of workplace safety climate among healthcare workers during the COVID-19 pandemic in low and middle income countries: A case study of Nigeria. *Healthcare*, Vol. 9. 10.3390/healthcare9060661.
17. Howat, P., D. Sleet, B. Maycock and R. Elder, 2007. Effectiveness of Health Promotion in Preventing Alcohol Related Harm. In: *Global Perspectives on Health Promotion Effectiveness*, McQueen, D.V. and C.M. Jones (Eds.), Springer, New York, ISBN: 978-0-387-70973-4, pp: 163-178.
18. Ikefuna, A.N. and I.J. Emodi, 2002. An assessment of factors influencing hospital discharges against medical advice of paediatric patients in Enugu: A review of 67 cases. *Niger. J. Paediatr.*, 29: 1-4.
19. Youssef, A., 2012. Factors associated with discharge against medical advice in a Saudi teaching hospital. *J. Taibah Univ. Med. Sci.*, 7: 13-18.
20. Kabirzadeh, A., E. Rezazadeh and B.S Mohseni, 2011. Prevalence and causes of patient self discharge against medical advice in children of Boo-Ali Hospital in Sari in 2009. *J. North Khorasan Univ. Med. Sci.*, 2: 57-62.
21. Kraut, A., R. Fransoo, K. Olafson, C.D. Ramsey, M. Yogendran and A. Garland, 2013. A population-based analysis of leaving the hospital against medical advice: Incidence and associated variables. *BMC Health Serv. Res.*, Vol. 13. 10.1186/1472-6963-13-415.
22. Shirley, J.L., 2018. Social Justice and the Ethics of Care: A Nursing Perspective. In: *Against-Medical-Advice Discharges from the Hospital*, Alfandre, D. (Ed.), Springer International Publishing, Cham, Switzerland, ISBN: 978-3-319-75129-0, pp: 73-81.
23. Shirani, F., M. Jalili and A.E.H. Soleimani, 2010. Discharge against medical advice from emergency department: Results from a tertiary care hospital in Tehran, Iran. *Eur. J. Emerg. Med.*, 17: 318-321.
24. Ogunmola, O.J. and O.Y. Oladosu, 2014. Pattern and outcome of admissions in the medical wards of a tertiary health center in a rural community of Ekiti State, Nigeria. *Ann. Afr. Med.*, 13: 195-203.
25. Joubert, G., R. Ehrlich, J.M. Katzenellenbogen and S.S. Abdool Karim, 2007. *Epidemiology: A Research Manual for South Africa*. 2nd Edn., Oxford University Press, Southern Africa, Cape Town, ISBN: 9780195762778, Pages: 354.
26. OECD, WHO, WBG, 2018. *Delivering Quality Health Services: A Global Imperative*. World Health Organization, Geneva, Switzerland, ISBN: 9789264300309, Pages: 96.
27. Noohi, K., S. Komsari, N. Nakhaee and V.Y. Feyzabadi, 2013. Reasons for discharge against medical advice: A case study of emergency departments in Iran. *Int. J. Health Policy Manage.*, 1: 137-142.

28. Roodpeyma, S. and S.A.E. Hoseyni, 2010. Discharge of children from hospital against medical advice. *World J. Pediatr.*, 6: 353-356.
29. Demir, M.C., I. Ağaçkiran, Y. Özdamar and M. Boğan, 2021. The pandemic's effect on discharge against medical advice from the emergency department. *J. Surg. Med.*, 5: 433-438.
30. Khalili, M., A. Teimouri, I. Shahramian, N. Sargolzaei, J.S. YazTappeh and M. Farzanehfar, 2019. Discharge against medical advice in paediatric patients. *J. Taibah Univ. Med. Sci.*, 14: 262-267.
31. Nasir, A.A. and O.M. Babalola, 2008. Clinical spectrum of discharges against medical advice in a developing country. *Indian J. Surg.*, 70: 68-72.
32. Hwang, S.W., J. Li, R. Gupta, V. Chien and R.E. Martin, 2003. What happens to patients who leave hospital against medical advice? *Can. Med. Assoc. J.*, 168: 417-420.
33. Derse, A.R., 2018. Legal Considerations of Patient Refusals of Treatment Against Medical Advice. In: *Against-Medical-Advice Discharges from the Hospital*, Alfandre, D. (Ed.), Springer International Publishing, Cham, Switzerland, ISBN: 978-3-319-75129-0, pp: 31-40.
34. Devitt, P.J., A.C. Devitt and M. Dewan, 2000. An examination of whether discharging patients against medical advice protects physicians from malpractice charges. *Psychiatric Serv.*, 51: 899-902.
35. Fadare, J.O. and A.C. Jemilohun, 2012. Discharge against medical advice: Ethico-legal implications from an African perspective. *South Afr. J. Bioethics Law*, 5: 98-101.
36. Duno, R., E. Pousa, J. Sans, C. Tolosa and A. Ruiz, 2003. Discharge against medical advice at a general hospital in Catalonia. *Gen. Hosp. Psychiatry*, 25: 46-50.
37. Kourouma, K.R., M.L. Agbré-Yacé, D. Doukouré, L. Cissé and C. Some-Méazieu *et al.*, 2021. Barriers and facilitators to kangaroo mother care implementation in Cote d'Ivoire: A qualitative study. *BMC Health Serv. Res.*, Vol. 21. 10.1186/s12913-021-07086-9.
38. Paul, G., N. Gautam, P.L. Gautam, R.K. Mahajan and S. Ragavaiah, 2019. Patients leaving against medical advice-A national survey. *Indian J. Crit. Care Med.*, 23: 143-148.
39. Ahmed, L.A., O. Akinboboye, O.S. Ilesanmi and O. Adeleke, 2015. Determinants of discharge against medical advice in a tertiary hospital in a semi-urban area of South-Western Nigeria. *Int. J. Caring Sci.*, 8: 519-529.