


Discharge against Medical Advice in Obstetrics and Gynecology Units of Two Hospitals of Yaoundé

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Abstract

Introduction: Discharge against medical advice is a public health problem affecting all healthcare facilities worldwide. It can have serious repercussions for the patient. The objective of this study was to determine the frequency and typical profile of patients who were discharged against medical advice in the gynecology and obstetrics departments of Yaoundé. **Methods and Materials:** We conducted a descriptive cross-sectional study in two hospitals in Yaoundé, covering the period from January 2022 to December 2024. **Results:** Of the 4476 admissions recorded, we observed 174 cases of discharge against medical advice and retained 143 patient files. The median age was 27 years. 60.8% of the patients had a secondary education, and 56.7% had no income. They consulted spontaneously in 56.6% of cases for pelvic pain (48.3%) and vaginal bleeding (38.5%). The main diagnoses upon admission were postpartum hemorrhage (20.3%), severe malaria during pregnancy (14.7%), and premature rupture of membranes (13.3%). Discharge against medical advice was initiated by the patient in 39.2% of cases; it was justified by financial difficulties (85.3%). The discharge against medical advice form was present in 75.5% of cases but did not meet all compliance criteria. **Conclusion:** Discharges against medical advice from gynecology and obstetrics services primarily involved young women and were justified by financial difficulties.

Keywords

Discharge against Medical Advice, Gynecology and Obstetrics, Determinants, Yaoundé

1. Introduction

Discharge against medical advice (DAMA) is a concept used in medicine to indicate that a patient, despite being fully aware of the potential complications of their illness, decides to discontinue the proposed treatment and leave the hospital [1]. It represents a discontinuity in the administration of care that has repercussions for the patient and their family, characterized by relapses, readmissions, increased medical costs, and even death [1]. Various factors are associated with DAMA, including individual, environmental, and sociocultural factors. On an individual level, insufficient financial resources, preference for traditional treatment, erroneous sensation of improved medical condition, and a lack of trust in the healthcare team are cited as contributing factors. Environmental factors include the high cost of healthcare, long waiting times, commercialization of medicine, poor communication, and inadequate support. Finally, on a sociocultural level, the absence of family and spiritual support is cited as a contributing factor [1]-[3]. The frequency of DAMA in emergency services in a US study was 2.7% [4]. It was 7.2% in Nigeria in 2011 [5].

The lack of data concerning this phenomenon in gynecology and obstetrics services in Cameroon motivated the present study; the objective was to draw up the situation regarding discharges against medical advice in the city of Yaoundé.

2. Methodology

We conducted a descriptive cross-sectional study with retrospective data collection covering the period from January 1, 2022, to December 31, 2024. The study setting was the gynecology and obstetrics units of the Central Hospital of Yaoundé and the Gynaeco-Obstetric and Paediatric Hospital of Yaoundé.

The study population consisted of all admitted patients. We included all those who were discharged against medical advice and who had usable medical records. The case inclusion was exhaustive over the study period.

We identified patients who were reported as discharged against medical advice on every admission's log. The medical records were retrieved and phone numbers were identified. Patients were called in order to obtain verbal informed consent and interviewed. During the interview, data in relation to reasons for leaving the hospital and destination were collected.

Ethical clearance was obtained from the Institutional Research Ethics Committee of the Faculty of Medicine and Biomedical Sciences at the University of Yaoundé I.

3. Results

During the study period, we recorded 4476 admissions to the obstetrics and gynecology units, of which 174 were discharged against medical advice (DAMA), representing a frequency of 3.89%. We excluded 31 cases and ultimately retained 143 patient records.

The median age of the patients was 27 years, with an interquartile range of 22 to 32 years and a range of 17 to 62 years (see **Table 1**). The most represented age group was 20 - 29 years, with 69 cases (48.3%). Adolescents accounted for 21 cases (14.7%). Regarding marital status, 69 patients (48.3%) were single. A secondary education level was reported in 87 patients (60.8%). Unemployed patients and students accounted for 77 (56.7%). The majority of patients resided in the city of Yaoundé (84.6%).

Table 1. Population distribution according to socio-demographic data.

Variables	Occurrence (N = 143)	Percentage (%)
Age (years)		
<20	21	14.7
20 - 29	69	48.3
30 - 39	46	32.2
40 - 49	5	3.5
≥50	2	1.4
Marital status		
Single	69	48.3
Married	38	26.6
Cohabitation	34	23.8
Widow	2	1.4
Level of study		
Primary	14	9.8
Secondary	87	60.8
High	42	29.4
Occupation		
Unemployed/Jobless	44	30.8
Informal sector	42	29.4
Student	37	25.9
Private sector	12	8.4
Civil servant	8	5.6
Residence		
Yaoundé	121	84.6
Yaoundé outskirts	17	11.9
Other towns	5	3.5

Table 2, showing the patients' comorbidities and gynecological history, indicates that multiparous and grand multiparous women constituted 13.3%. The frequency of comorbidities was 7%, dominated by HIV infection and high blood pressure.

Table 2. Distribution of the population according to comorbidities and gynecological history.

Variables	Occurrence (N = 143)	Percentage (%)
Parity		
Nulliparous (0)	42	29.4
Primiparous (1)	34	23.8
Pauciparous (2 - 3)	48	33.6
Multiparous (4 - 5)	16	11.2
Grand multiparous (≥ 6)	3	2.1
Comorbidities		
None	133	93
HIV infection	6	4.2
High blood pressure	3	2.1
Diabetes	1	0.7

Regarding the mode of admission, 81 patients (56.6%) came on their own initiative and were accompanied by a family member in 135 (94.4%). The most frequent reasons for admission were abdominopelvic pain (48.3%), vaginal bleeding (38.5%), asthenia (26.6%), and headaches (17.5%), as shown in **Table 3** below.

Table 3. Distribution according to mode and reason for admission.

Variables	Occurrence (N = 143)	Percentage (%)
Admission		
Own initiative	81	56.6
Referred	62	43.4
Patient assisted by family member		
Yes	135	94.4
No	8	5.6
Reasons of admission		
Abdominopelvic pain	69	48.3
Per vaginal bleeding	55	38.5
Asthenia	38	26.6
Headaches	25	17.5

Continued

Per vaginal loss of liquor	19	13.3
Fever	10	7
Vomiting	5	3.5
Seizure	4	2.8
Swelling	2	1.4
Blurred vision	1	0.7

Figure 1 shows that postpartum haemorrhage (20.3%), severe malaria during pregnancy (14.7%) and premature rupture of membranes (13.3%) were the main diagnoses on admission.

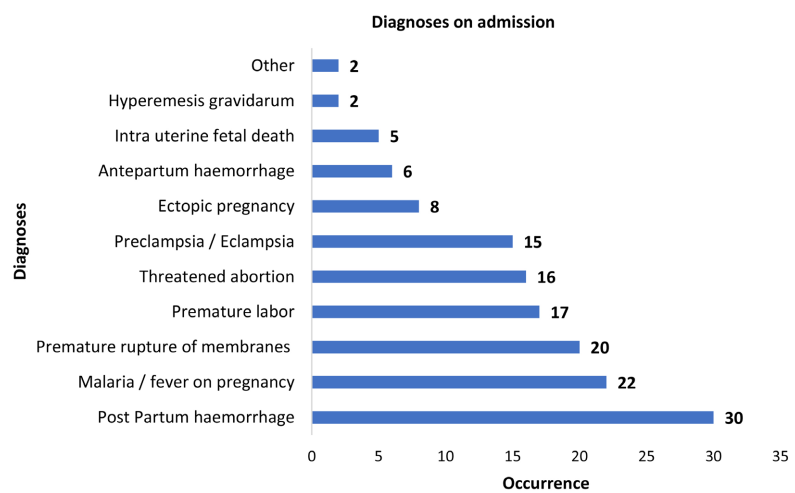


Figure 1. Population distribution according to admission diagnoses.

The median length of hospital stay was two days (interquartile range 1 - 3 days), with a range of 1 to 10 days. Discharge was initiated between the first and second day in 107 cases (74.8%), as shown in **Figure 2**.

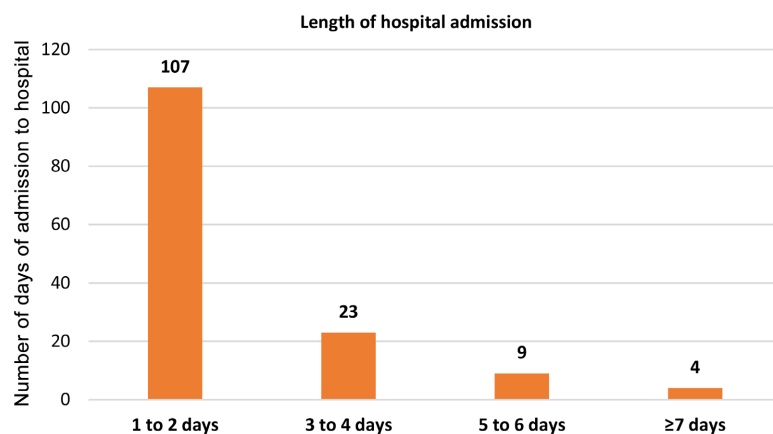


Figure 2. Population distribution according to length of hospital admission.

Table 4 below presents the potential factors for discharge. The behavior of medical staff was considered pleasant in 141 cases (98.6%), the technical facilities of the healthcare center were adequate in 142 (99.3%), and a waiting time of less than 30 minutes before being seen was recorded in 111 cases (77.6%). Financial barrier was reported in 127 cases (88.8%).

Table 4. Distribution according to potential exit factors.

Variables	Occurrence (N = 143)	Percentage (%)
Good perception of healthcare		
Yes	143	100
No	0	0
Behavior of medical staff		
Friendly	141	98.6
Indifferent	1	0.7
Aggressive	1	0.7
Adequate equipment and infrastructures		
Yes	142	99.3
No	1	0.7
Waiting time		
<30 minutes	111	77.6
30 - 59 minutes	32	22.4
Financial barrier		
Yes	127	88.8
No	16	11.2
Understanding of medical instructions		
Yes	137	95.8
No	6	4.2

Regarding the discharge initiative (**Table 5**), the patient and her parents were the initiators in 56 (39.2%) and 43 (30.1%) cases, respectively. Financial difficulties and a perception of excessively long waiting time were the most frequently cited reasons, with 120 (83.9%) and 15 (10.5%) cited reasons, respectively. After discharge, 136 patients (95.1%) returned home. The outcome was marked by re-admission to the same healthcare facility in 20 cases (14%) due to complications.

Table 5. Distribution according to discharge method and patient outcome.

Variables	Occurrence (N = 143)	Percentage (%)
Nature of the initiator of DAMA		
Patient	56	39.2

Continued

Parents	43	30
Husband	37	25.9
Other family member	7	4.9
Reasons of DAMA		
Financial difficulties	120	83.9
Excessive long waiting time	15	10.5
Fright and frustration from hospital personnel	7	4.9
Inadequate healthcare or services	1	0.7
Destination after DAMA		
Home	136	95.1
Other health facility	7	4.9
Readmission in the same hospital		
Yes	20	14
No	123	86
Diagnosis upon readmission (n = 20)		
Hypovolemic shock	4	20
Ruptured ectopic pregnancy	3	15
Eclampsia	3	15
Others (fever, pain, bleeding)	10	50

Table 6 summarizes the medico-legal conditions of the DAMA. It shows that 14 patients (9.8%) had no document attesting to their signature on the DAMA (n = 14). Regarding the designation of DAMA, it was a separate form in 108 cases (75.5%) and the patient's medical file in 21 cases (14.7%). As part of the information reported on the form, there were: patient's understanding of the risks incurred in 128 cases (99.2%), patient's signature in 111 cases (86%), and signature of the patient's witness in 80 cases (55.9%). Still, there were missing components.

Table 6. Distribution according to the components of the DAMA form.

Variables	Occurrence	Percentage (%)
Type of form used (n = 143)		
Designated form	108	75.5
Medical record of the patient	21	14.7
No form	14	9.8
Components of DAMA form (n = 129)		
Patient's understanding of the risks incurred	128	99.2

Continued

Patients' signature	111	86
Witness' signature	80	55.9
Healthcare provider' signature	1	0.8
Mention of the risks incurred	0	0
Number of attempts to persuade the patient after first refusal	0	0
Mention of "read and approved"	0	0

4. Discussion

We noted a frequency of discharge against medical advice (DAMA) of 3.89%, making it a public health issue. The proportion of patients who leave the hospital against medical advice varies from country to country and from department to department. Akibodewa *et al.* in Nigeria in 2016 reported a frequency of 0.7% in obstetrics and gynecology departments. The same study observed a frequency of 8.1% in the internal medicine department, a frequency of 6.7% in the surgical department [6], and an overall frequency of 3.2%. Meanwhile, Ngongang *et al.* reported a frequency of 45.7% [7].

In high-income countries, dissatisfaction with care is among the main causes, while in developing countries, difficulties in financing healthcare are often the primary reason for DAMA [5] [8]. It is also observed that the frequency of DAMA is higher in emergency and psychiatric departments [9].

The median age of the patients in our series was 27 years, with a range of 17 to 62 years. The majority of them were between 20 and 29 years old (48.3%). Akibodewa *et al.* in Nigeria in 2016 found a mean patient age of 40.5 ± 19.3 years [6]; while Karimi *et al.* reported a mean age of 34 ± 23 years [9].

Regarding the patients' occupations, 30.8% were unemployed/housewives and 25.9% were students. Most of the patients in our study had a secondary education (60.8%). Noohi *et al.* also noted that half of the patients were unemployed [10]. It is accepted that a low level of education can lead to impaired communication with healthcare providers, poor risk assessment by the patients and increased risk of DAMA [9].

Concerning the admission process, we observed that most patients came on their own (56.6%), primarily for abdominopelvic pain (48.3%), often in association with vaginal bleeding (38.5%). The main diagnoses were postpartum hemorrhage (20.3%), severe malaria on pregnancy (14.7%), and premature rupture of membranes (13.3%). We observed that the majority of patients who left against medical advice (56%) presented with potentially life-threatening conditions upon admission.

We noted high patient satisfaction with the reception/care (100%), facilities/equipment (99.3%), and the positive conduct of the medical staff (98.6%). However, the waiting time was perceived as prolonged in 22.4% of cases.

In our study, financial difficulties were the major cause of DAMA (85.3%), followed by excessive treatment delays (10%). Connie *et al.*, in a study in the United States, found that DAMA was due to extrinsic obstacles such as children and family responsibilities in 50.9% and intrinsic obstacles such as hospital conditions and stress in 40.9% [11].

In our study, the patient and her parents were the primary initiators of the DAMA in 39.2% and 30.1% of cases, respectively. According to Sogoba *et al.*, the parent initiated the discharge in 82.7% of cases, while the patient only decided to leave in 17.3% [12].

The readmission rate was 14% after DAMA due to complications. Ngongang *et al.* made the same observation in 2024 at the Yaoundé Emergency Center, noting that patients were readmitted with more complications than their initial condition at first admission [7]. Thus, a worsening of the initial condition or the occurrence of any complication would justify patients returning to the healthcare facility.

In our study, 9.8% of patients had no paper attesting the DAMA. We also observed the absence of numerous components of the DAMA form. This demonstrates a lack of knowledge of these components by practitioners in our context.

5. Limitations

This was a retrospective study which carries limitations such as incomplete files and bias in patients' memory. Besides, since readmissions were only captured if patients returned to the same hospital, outcomes may differ.

6. Conclusion

Discharges against medical advice affected 3.89% of patients in the Obstetrics and Gynecology departments of Yaoundé. The typical patient was a young, single woman with a low income who stayed 1 to 2 days in the healthcare facility and then returned home. She returned for a consultation in 14% of cases due to a complication at the same facility.

Conflicts of Interest

The authors declare no conflicts of interest.

Contribution of Authors

Edith Cynthia Foyet drafted the first version. Serge Robert Nyada, Christiane Nsahlaï, Cliford Ebong Efontane, Isidore Tompeen, Véronique Batoum Mboua, Pascale Mpono Emenguele, and Michèle Mendoua read and approved the final version. Éric Nseme and Julius Dohbit Sama supervised the research.

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