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Original Research Article

Discharge against medical advice in the neonatal unit of Rivers State University Teaching Hospital, Nigeria: a two-year prospective study

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ABSTRACT

Background: Discharge against medical advice (DAMA) is a silent contributor to neonatal morbidity and mortality in Nigeria. Parents' autonomous decision to discontinue medical care of their babies admitted remains an ethical contention that is frustrating for pediatricians and portends poor neonatal outcomes. DAMA remains a challenge arising from an interplay of parental and hospital-related factors. Hence, epidemiologic data are needed, where none previously exists. Aim of the study was to determine the prevalence, neonate and family sociodemographic characteristics, morbidity pattern and reasons for DAMA among neonates admitted to the Rivers State University Teaching Hospital.
Methods: A prospective observational study was conducted among neonates admitted from April 2021 to March 2023.
Results: Of 1830 neonatal admissions, 87 were discharged against medical advice giving a DAMA prevalence of 4.8%, of which 48 (55.8%) were females. Most, 66 (75.9%) were born at term, 51 (58.6%) had normal birth weight, 38 (43.7%) admitted at <2 hours of life and (41.4%) were above 2nd birth order. Forty-seven (54%) of mothers, 41 (47.1%) of fathers had tertiary education and 61 (70.1%) were of low/middle socioeconomic class. Neonatal sepsis (61.2%) and neonatal jaundice (31.8%) were the commonest morbidities. Most, 65 (74.7%) of DAMA cases occurred in the 1st week of life and the father 63 (73.3%) was the main requestor of DAMA. The commonest reason for DAMA was financial constraints 50 (57.5%).
Conclusions: The prevalence of DAMA was 4.8%. Neonatal sepsis and neonatal jaundice were the commonest morbidity with financial constraints being the main reason for DAMA. The father was the requestor for DAMA in the majority of the cases.

Keywords: Discharge against medical advice, Neonates, Rivers State

INTRODUCTION

Discharge against medical advice (DAMA) is a concerning public health issue, especially among neonatal populations as it contributes to increased morbidity and mortality.[1-3] Neonates are physiologically vulnerable, and the risk associated with discharging them against medical advice is greater compared to other age groups.[4] DAMA in the context of neonatal settings is said to occur when parents/caregivers autonomously decide to discontinue medical care of their sick babies admitted in neonatal units. While the occurrence of DAMA is frequently unanticipated, challenging and upsetting for the treating paediatrician to discharge a sick newborn against medical advice, the consequences are double-edged because it puts a tremendous burden on the healthcare system and the family by raising the rate of both hospital readmissions and out-of-hospital deaths.[4,5]

Oftentimes, the choice to stop treatment of the hospitalized unwell neonate is frequently made by their parents or a significant family member.[4,6-8] This is especially

disconcerting because it violates children's rights and presents legal concerns. Although problems related to DAMA have clinical, economic, ethical and medicolegal consequences, they are frequently disregarded thus DAMA is still an under-evaluated topic in countries with limited resources, especially in neonates.[9] Worrisomely, it is a silent contributor to neonatal morbidity and mortality in Nigeria.[8]

Although DAMA among neonatal units is not uncommon in hospitals around the world, the frequency, risk factors and reasons for it vary. In low and middle-income countries the prevalence of DAMA in the neonatal period ranges from 1.6% in Saudi Arabia and 18% in Nepal to 24.2% in India.[9-11] However, DAMA prevalence among neonates admitted to tertiary hospitals in Nigeria ranged from 1.7 to 11.2%.[1,4,6-8,12] The discrepancies in prevalence reported ought to be taken in context and may be due to differences between two principal factors: Parental factors such as socioeconomic class, socio-cultural/religious belief system, literacy level, as well as healthcare-seeking behaviour of parents and hospital-related factors such as the hospital location – rural versus urban setting, distance of hospital from home, services offered by the various facilities like availability of conducive accommodation, inconvenience of the hospital (inability to care for other children and/or lost days at work) and time-scale differences in the studies, plausibly account for the observed differences.[6,7,10,13,14]

Predictors or risk factors of neonatal DAMA previously reported in earlier retrospective studies conducted in Nigeria among admissions in tertiary hospitals include; having a neonate admitted for low birth weight, length of hospital stay, cultural beliefs, low socioeconomic status, social issues, vaginal birth and birth asphyxia.[8,12,15] Also, other studies within and outside Nigeria found that DAMA often occurred within the 1st week of admission.[6-8,12,14] However, some studies in India found the presence of congenital anomalies and a study in China found younger maternal age, neonates that are small for gestational age and have low Apgar scores to be significantly associated with neonatal DAMA.[2,5,16] Yet, another study from Saudi Arabia differed, as the author suggested that the risk factors for neonatal DAMA were difficult to predict because they were numerous.[10]

Co-existing disease conditions can influence the parental choice to allow their infants complete treatment while on admission.[2] The pattern of neonatal diseases reported among neonates DAMA from previous studies demonstrates that variations exist between and within countries. While most studies in Nigeria document neonatal sepsis, birth asphyxia and prematurity as the common neonatal co-morbidities, a study conducted in India where families were contacted via telephone following DAMA, reported the presence of congenital malformations and cardiac malformations to have accounted for over half (58.6%) and about two-fifths (43.7%) of DAMA cases respectively.[5-8,12,15] The authors highlighted that four out of five (80%) neonates with DAMA died within a median of 11 days post-DAMA. On the contrary, more often than not, in the Nigerian setting, neonates DAMA are lost to follow-up and are at an increased risk of death which go largely unrecorded.[15]

All studies in Nigeria that focused on neonatal DAMA reported that the main reason given by parents or caregivers requesting discharge against medical advice was financial constraints.[1,4,6-8,12,15] Other reasons were falsely perceived improvement, dissatisfaction with medical care and treatment, high cost of treatment, inconvenience of hospitalisation accommodation, resort to alternative therapies and lack of clinical improvement. In Studies conducted in other countries outside Nigeria, other reasons reported included the need to continue their care in a better facility, inadequate counselling and perceived poor prognosis besides financial constraints.[3,16]

Studies on neonatal DAMA in Nigeria are relatively few. Earlier studies done in Port Harcourt, Rivers State were retrospective in nature , conducted over a decade ago, were in another tertiary facility sited in a different local government area and suggested an increasing DAMA prevalence among admitted newborns from 4.3% to 15%.[8,17] Therefore, the authors of this present study considered it justifiable and aimed to determine the burden of neonatal DAMA, the family and baby characteristics, the morbidity pattern of the affected neonates and the timing of occurrence and reason(s) for DAMA at the Rivers State University Teaching Hospital.

METHODS

This was a prospective observational study carried out on all neonates admitted into the special care baby (SCBU) unit of the Rivers State University Teaching Hospital (RSUTH) over 2 years, from 01 April 2021 to 31 March 2023.

The Rivers State University Teaching Hospital is a 375-bed hospital which has a variety of clinical speciality and non-clinical departments, situated in Port Harcourt, the South-South geopolitical zone of Nigeria. The Rivers State Government is the owner of this multi-specialty tertiary medical centre. It functions as a referral hospital for all the state-owned primary and secondary healthcare facilities, as well as for private hospitals and referrals from neighbouring Nigerian States within the Niger Delta. The SCBU, domiciled in the Department of Paediatrics, is a 30-bed unit that admits all newborns aged 0 to 28 days who were either born in the hospital or those whose mothers registered and gave birth at other state-owned primary health centres, general hospitals, private health facilities as well as traditional birth attendants (TBA). It offers daily Level I to III NICU services and is manned by three consultant Paediatricians, senior and junior residents in Paediatrics, house officers, and paediatric nurses of different cadres in addition to other auxiliary and administrative staff.

Inclusion criteria were all neonates admitted into the SCBU during the study period whose parents/caregivers gave consent whereas neonates whose parents/caregivers did not give consent were excluded from the study. Convenient sampling method was employed.

The primary outcomes included the proportion of neonates discharged AMA and reason(s) for DAMA while the secondary outcomes included who requested the neonate to be discharged AMA, the time duration from admission to DAMA, birth and family characteristics of the neonates, morbidity pattern and the day and month in the year the DAMA form was signed.

All babies admitted were consecutively recruited by research assistants throughout the study period. A pre-tested research proforma was used to obtain information prospectively as babies were admitted into the SCBU and caregivers opined having their infant(s) discharged AMA. Before the commencement of the research, all members of the research team were acquainted with how to complete the research proforma when parents/caregivers requested DAMA, despite adequate counselling carried out on the need to continue inpatient care of the baby with/without the DAMA form being signed. Parents were informed before filling out the form of the intention of the research and consent was obtained to use their reasons and other sociodemographic characteristics to enable the researchers to understand their motives for DAMA.

All caregivers who requested a DAMA with/without signing the DAMA form were first of all adequately counselled on the likely consequences and the unit consultants were reliably informed.

The ethics committee of the hospital approved the study. Consent was also obtained from the parents/caregivers of the babies who requested and/or signed the DAMA form.

The information obtained was entered into an excel sheet and analysed using statistical package for the social sciences (SPSS) version 25. Results were presented as frequency, percentages, bar charts and line graphs.

RESULTS

Family socio-demographic characteristics

The majority 54 (62.1%) of mothers whose babies were discharged against medical advice were above 30 years and married 85 (97.7%). Most 47 (54%), had a tertiary level of education and about a third 27 (31%), were businesswomen/traders. The majority 62 (71.3%) were multiparous and delivered via caesarean section 66 (75.9%). The fathers had mostly 41 (47.1%) tertiary education and were businessmen/traders 32 (36.8%). About two-thirds 61 (70.1%) of them were of the low and middle socio-economic class and the majority, 62 (71.3%) resided in urban areas as seen in Table 1.

Table 1: Family socio-demographic characteristics.

Variables	Frequency, n=87 (%)
Mother's age (years)	
20–30	33 (37.9)
>30	54 (62.1)
Mean	31.77±5.03 years
Marital status	
Married	85 (97.7)
Single	2 (2.3)
Mother's level of education	
Primary	6 (6.9)
Secondary	34 (39.1)
Tertiary	47 (54.0)
Mother's occupation	
Business/trader	27 (31.0)
Artisan	13 (14.9)
Professional	7 (8.0)
Public service/civil service	15 (17.4)
Housewife/unemployed	25 (28.7)
Parity	
Primiparous	18 (20.7)
Multiparous	62 (71.3)
Grand multiparous	7 (8.0)
Type of delivery	
SVD	21 (24.1)
CS	66 (75.9)
Father's level of education	
Nil formal education	5 (5.7)
Primary	5 (5.7)
Secondary	36 (41.4)
Tertiary	41 (47.1)
Father's occupation	
Business/Trader	32 (36.8)
Artisan	8 (9.2)
Professional	16 (18.4)
Public service/civil service	26 (29.9)
Unemployed	5 (5.7)
Socio-economic status	
Low	31 (35.6)
Middle	30 (34.5)
High	26 (29.9)
Place of residence	
Urban	62 (71.3)
Suburban	13 (14.9)
Rural	12 (13.8)
Religion	
Christianity	86 (98.9)
Islam	1 (1.1)

Characteristics of the babies who were discharged against medical advice

Of 1830 admissions during the period of study, 87 were discharged against medical advice giving a prevalence of 4.8%. Females predominated with an M: F ratio of 1.2:1.

About two-fifths (41.4%) were above the 2nd birth order. Almost half, 38 (43.7%) of the neonates' DAMA were admitted at <2 hours of life. Whereas, most 66 (75.9%) were delivered at term (gestational age of 37–41 weeks), close to two-thirds, 51 (58.6%) had normal birth weights as seen in Table 2.

Table 2: Characteristics of the babies who were discharged against medical advice.

Variables	Frequency, n=87 (%)
Sex	
Male	39 (44.8)
Female	48 (55.2)
Birth order	
First	24 (27.6)
Second	27 (31.0)
Third and above	36 (41.4)
Age at presentation (hours)	
<2	38 (43.7)
3–4	23 (26.4)
≥5	26 (29.9)
Gestational age (weeks)	
<37	19 (21.8)
37–40	66 (75.9)
>41	2 (2.3)
Birth weight (kg)	
1–1.5	1 (1.1)
>1.5–2.5	15 (17.2)
>2.5–3.9	51 (58.6)
≥4.0	20 (23.0)

Morbidity pattern in neonates who were discharged AMA

The commonest disease among neonates discharged AMA was NNS (61.2%) followed by NNJ (31.8%), hypoglycaemia (24.7%) and prematurity/LBW (22.3%) (Figure 1).

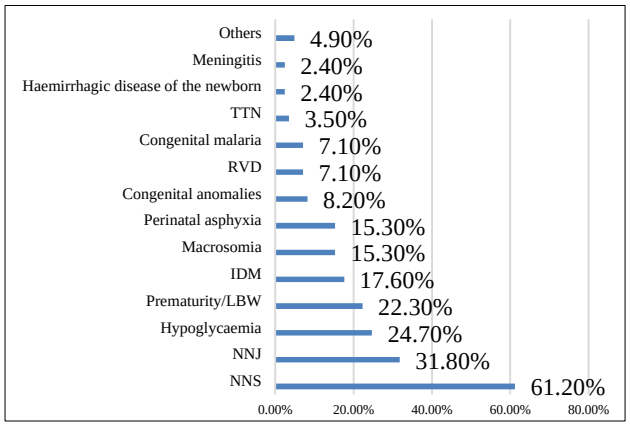

Figure 1: Morbidity pattern in neonates who were discharged against medical advice.

NNS-Neonatal sepsis, NNJ- neonatal jaundice, LBW- low birth weight, IDM- infant of diabetic mother, RVD- retroviral disease, TTN- transient tachypnoea of the newborn

Characteristics of neonates discharged against medical advice

The majority, 65 (74.7%) of neonates were discharged against medical advice within the 1st 7 days of life and the request for DAMA was mostly 63 (73.3%) by the father only. There was a history of previous DAMA by only 2 (2.3%) participants and the DAMA form was signed by the majority of caregivers 82 (94.3%) (Table 3).

Table 3: Characteristics of neonates discharged against medical advice.

Variables	Frequency, n=87 (%)
Duration of stay	
0–7	65 (74.7)
8–14	18 (20.7)
≥14	4 (4.6)
Caregivers requesting DAMA	
Father only	63 (73.3)
Mother only	25 (29.1)
Father and mother	25 (29.1)
Relative(s)	6 (7.0)
Friends	1 (1.2)
Previous history of DAMA	
Yes	2 (2.3)
No	85 (97.7)
DAMA form signed	
Yes	82 (94.3)
No	5 (5.7)

Day of week DAMA was requested

Neonates were discharged AMA mainly on Tuesday of the week 18 (20.7%), followed by Friday 15 (17.2%), Monday 14 (16.1%) and Wednesday 14 (16.1%) while the least was on Saturday 3 (3.4%) (Figure 2).

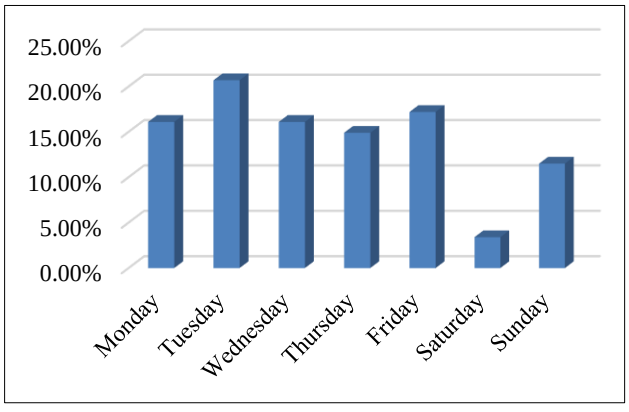

Figure 2: Day of week DAMA was requested.

Months of the year DAMA was requested

Most of the neonates were discharged AMA in the month of February 20 (23.0%) followed by March 17 (19.6%) and

July 10 (11.5%) while the least was in November 2 (2.3%) (Figure 3).

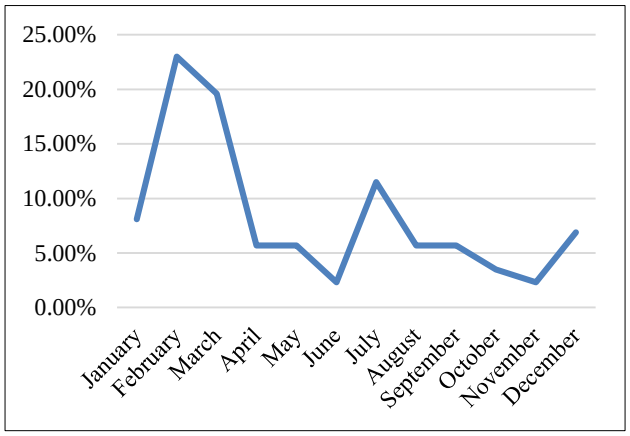

Figure 3: Months of the year DAMA was requested.

Reasons for DAMA

The commonest reason for DAMA was the cost of hospitalization/financial constraint 50 (57.5%) followed by admission not convenient 32 (36.8%), duration of hospitalization 18 (20.7%) and admission not necessary 18 (20.7%) while the least was the attitude of nurses 1 (1.1%) (Table 4).

Table 4: Reasons for DAMA.

Variables	Frequency, n (%)
Cost of hospitalization/financial constraint	50 (57.5)
Admission not convenient	32 (36.8)
Duration of hospitalization	18 (20.7)
Admission not necessary	18 (20.7)
Perceived improvement	17 (19.5)
To seek healthcare elsewhere	8 (9.2)
Advice from relatives and friends	6 (6.9)
Parents have paused means of livelihood	6 (6.9)
To seek spiritual healing and prayers	3 (3.4)
Baby not improving	2 (2.3)
To take home for naming	2 (2.3)
Drugs are not working	2 (2.3)
To seek care from traditional practitioners	2 (2.3)
Poor attitude of staff	1 (1.1)

DISCUSSION

The prevalence of DAMA amongst neonates in the Rivers State University Teaching Hospital of 4.8% in the present study was similar to the 4.3% reported in a previous study [8] in the same locality, Port Harcourt done more than a decade ago but higher than the 3.97%, 3.9%, 1.7%, 1.6% and 1.5% reported in Bayelsa southern Nigeria, Bangladesh, India, Saudi Arabia and Australia respectively.[10,18-21] Much higher prevalences of 6.7%, 7.5%, 7.7%, 9.3%, 11.1% and 25.4% were documented in Abuja northern Nigeria, Edo state southern Nigeria, India, Jigawa, Gombe northern Nigeria and India respectively.[1,4,5,7,14,22] These differences could be attributed to different geographic locations, variation over time even in the same locality, socioeconomic status, ignorance, cultural factors as well as the availability of health insurance.

In the present study, more females were DAMA than their male counterparts as also documented in other studies in Nigeria and India.[5,12,22,23] The reason may not be far-fetched and unrelated to gender bias as observed in our environment where the male sex is protected more and given better preferences than the females. However, in other studies in Nigeria, India and Saudi Arabia, males predominated.[1,4,7-10,18,24] The reason for this difference could not be ascertained. Nevertheless, Ashish et al in their study showed that the sex of neonates was not a factor in the parental decision to DAMA.[20]

Interestingly, children with birth orders three and above were discharged most against medical advice while the least were children of 1st birth orders. This corroborates the findings of the study by Ashish et al who observed that mothers with higher previous parity had about 6 times increased odds of DAMA than mothers with lower previous parity.[20] This could be attributed to the experience gained with increased parity.

In the present study, older women above 30 years were more involved in neonatal DAMA. This could be because older women involved in childbirth are usually more stressed from the delivery and possibly may have co-morbidities because of their age and are more likely to stick to their experiences from previous deliveries. Term neonates and neonates with normal birth weights were predominantly DAMA. This was also the case in other studies.[5,8-10,12] Term and normal weight babies especially in the absence of serious medical conditions are usually active and thus could be erroneously perceived as stable and as such more likely to be discharged AMA.

More than three-quarters (75.9%) of neonates who were discharged AMA in the present study were delivered via caesarean section (CS). Women who had CS may be overwhelmed and stressed by the surgery and therefore may opt for early discharge of their sick babies not taking into consideration the implications. In contrast, however, spontaneous vaginal delivery (SVD) was reported as being commonest in other studies.[1,7,8,10,12] This was attributed to earlier ambulation than their counterparts who had CS.

The commonest morbidity documented in the present study was neonatal sepsis (NNS) followed by neonatal jaundice, hypoglycaemia and prematurity. Neonatal sepsis being the commonest morbidity in neonates DAMA was also reported by Opara and Eke, and Kumar in a previous

study in Port Harcourt, Nigeria and India respectively.[8,9] Perinatal asphyxia was reported as commonest among neonates DAMA in Sokoto, Gombe and Ogbomosho Oyo state, Nigeria whereas prematurity was commonest in Jigawa and Zamfara, northern Nigeria.[1,7,12,23,25] Neonatal jaundice which was the commonest morbidity documented in Benin City Nigeria was 2nd commonest in the present study.[4] These variations in the morbidity pattern among neonates DAMA could be due to differences in geographic locations, varying morbidity patterns as well as variation over time. It is pertinent to note that the commonest disease conditions in the neonates' DAMA in the present study could have grave consequences, both short and long-term when not treated adequately. Thus, favourable policies by the Government, as well as adequate education/ counselling of parents/caregivers, would be of essence to reduce or eliminate this untoward behaviour.

Close to half (43.7%) of neonates' DAMA were admitted within the 1st 2 hours of life. Similarly, Onankpa and Abolodje, Opara and Eke and Kumar reported 76.2%, 55.2% and 52.16% of neonates who were DAMA were admitted within the 1st 24 hours of life.[8,9,12] This thus showed the severity of the illness as observed in a 5-year retrospective study in India where 80% of neonates who were DAMA died within 5–35 days of DAMA thus contributing significantly to neonatal mortality.[5] Therefore, health education of women and the general populace on the dangers of DAMA would help reduce this menace.

The majority of neonates were DAMA within the 1st week of life as similarly reported in other parts of Nigeria and India.[1,7,9,18] It is noteworthy that the 1st week of life is critical in the life of a neonate as most deaths occur during this period and as such this trend is worrisome and must be discouraged to reduce neonatal morbidity and mortality. Contrary to the present study however, DAMA was observed most by the 2nd week of life (8–14 days) as reported by Onankpa and Abolodje in Sokoto, Nigeria while Al-Turkistani in Saudi Arabia reported an average duration of stay of neonates DAMA as 10±7.7 days.[10,12]

Fathers only were the requestor for DAMA in close to three-quarters (73.3%) of the cases in the present study. This corroborates the 72.1%, 76.7% and 77.6% documented by Olasinde et al, West et al and Opara and Eke in Ogbomosho, Bayelsa state and Port Harcourt respectively.[8,18,23] Jalo et al in Gombe, Nigeria reported as high as 89% of fathers requested DAMA while about two-thirds of fathers in Jigawa and Edo state Nigeria reported similar findings.[1,4,7] This trend is not surprising in our environment where fathers who are heads of the home are not only solely responsible for the decision-making but also for financial obligations. This is reflected by the finding in this study where the mothers were the sole requestor of DAMA in less than 1/3rd (29.1%) of cases as was also observed in Ogbomosho, Jigawa state, Port Harcourt and Edo state accounting for 25.6%, 22.8%, 12.1% and 5.1% respectively.[1,4,8,23] It is pertinent to note that decision-making in the home was not based on the level of education as all the mothers in the present study had a form of formal education with more than half (54%) with tertiary education but rather socio-cultural factors were more implicated. In addition, more than one-quarter (28.7%) of mothers were unemployed/housewives and thus are less likely to meaningfully contribute financially to the upkeep of their homes and as such would depend on their husbands for any decisions related to finance. Cultural and religious issues that prevent women from making key decisions in the house may also be to blame.

Most DAMA was signed during the weekdays (Tuesday, Monday and Wednesday) as also documented by Kumar and Olasinde et al.[9,23] In contrast, the majority of DAMA occurred during the weekends (Saturday and Sunday) as reported by Abbas et al and Al-Turkistani.[10,26] Month-wise, most DAMA took place in February, March and July in the present study, May was reported in Saudi Arabia whereas March and October were reported in India.[9,10] This shows that DAMA could occur any day of the week and month of the year.

The commonest reason given for neonatal DAMA in the present study was the cost of hospitalization/financial constraint followed by admission not being convenient, duration of hospitalization and admission not necessary in descending order. Financial constraint was similarly reported as being the commonest reason for DAMA in most other studies.[1,4,7,8,12,14,20,23,24] This is not surprising due to the harsh economic situation in Nigeria which affects especially the low socioeconomic class which in this study were most involved in DAMA as also documented in other studies.[1,4,5,8,12,18] This was however not the case in a study in India where treatment and investigations were free of charge and mothers fed freely in the hospital, parents requested DAMA majorly to take their children to higher centres.[9] Other studies in Oman and Saudi Arabia also documented non-financial reasons for DAMA because of the presence of health insurance.[10,27] In Nigeria however, health care is largely financed by parents as only 2.5% of Nigerians are covered by the National Health Insurance Scheme (NHIS).[28] Hence, better coverage of health insurance as seen in the developed world will go a long way in the reduction of DAMA. It is worthy of note that the issue of finance was not considered in some studies done outside Nigeria.[10,29] The hospital not being convenient to stay was the second commonest reason for DAMA in the present study. This could be attributed to the fact that the in-hospital mothers' room accommodates only eight persons at a time which is grossly inadequate for the number of babies admitted to the special care baby unit. Duration of hospitalization which was the third commonest in the present study was also one of the commonest reasons in other parts of Nigeria.[4,9,23] Interestingly, seeking traditional medical care which accounted for up to 9.6% of cases in Sokoto, northern Nigeria was extremely low, 1.1% in the present study while 'no improvement' as a reason, was documented as one of the commonest reasons for DAMA

by caregivers in many studies accounted for one of the least reasons in the present study, being 2.3%.[1,4,7,8,12,14] It is also pertinent to highlight that attitude of the staff was one of the least reasons for DAMA being 1.1% in the present study, contrary to the 19.5% documented in a study in India.[14]

Limitations

This was a single centred study hence the findings may not be generalizable to other settings. The reasons for DAMA were concluded solely on the responses of the parent(s) which may not have been entirely accurate as the healthcare team's perspective was not taken into account and could have affected the overall reported prevalence.

CONCLUSION

The prevalence of DAMA among neonates in the Rivers State University Teaching Hospital was 4.8% with female preponderance. The commonest morbidities among neonates discharged AMA were neonatal sepsis, neonatal jaundice, hypoglycaemia and prematurity. Fathers were the most requestor of DAMA with the commonest reason for DAMA being the cost of hospitalization/financial constraint. Consequently, improved socioeconomic status of families, proper and comfortable accommodation for mothers and increasing NHIS coverage, as well as, educating the populace on the ills of DAMA would go a long way in the drastic reduction of DAMA among neonates admitted in tertiary centres.

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