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Research Article

LAMA

A study of leave against medical advice (LAMA) in eye camp patients of ophthalmology department in a tertiary care center

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Introduction: To scientifically document and understand Leave Against Medical Advice (LAMA) characteristics of the patients selected for comprehensive eye care management from rural eye campsite. **Methods**: This was a cross-sectional study, where the demographic details, diagnosis, and details of LAMA were documented and then analyzed to find out if any peculiar pattern was seen among them. **Results:** Out of 840 patients over a period of 7 months, 26 (3.09 %) were seen leaving against medical advice, the majority being females (54 %). Most of the patients were in the age group of 61-70 years (42.3 %) and from long-distance camps (61.5%). They were accompanied by one of the family members (42.2%), with the majority of them leaving due to medical reasons (43.3%), seen mostly in the rainy season and festive months. **Conclusion:** LAMA is an indicator of the effectiveness of the community health care delivery system. Better insight into the reason requires understanding their social, economic, cultural, and educational status. Reducing the number of LAMA patients can have a positive impact on the optimal utilization of resources and improve the health status of the community.

Keywords: LAMA, leave against medical advice, Ophthalmology, Outpatient department, Cataract, Eye camp

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Introduction

'LAMA' i.e. Leave Against Medical Advice is one of the commonly used terms for absconding, which includes those patients who insist upon leaving the hospital against the expressed advice of the treating doctor [1].

When a patient gets absconded from the hospital, other commonly used terms are 'AWOL' (Absence Without Leave), 'elope', 'abscond', 'escape', 'unauthorized absence', 'irregular discharge', 'DAMA' and many others. The time period to declare the patient as 'absconder' can range between 1-72 hours which can differ according to the admission-discharge policy of each hospital [2].

However, in situations where the patient leaves the hospital without notification from the treating team is called AWOL/ Elopement, which is a form of DAMA. Contrasting from 'LAMA', here the essential element of doctor's expressed advice against leaving is lacking [3].

A LAMA patient becomes a matter of concern and challenge for the health care industry and can be perceived as the inadequate doctor-patient relationship, unsatisfactory communication, failure to adhere to patients' rights and responsibilities, and burden on morbidity (and mortality), with multifactorial causative factors [4].

Also refusing the treatment advised can be considered as a form of non-compliance from the patient's part and can lead to unpleasant incidents [5].

This prospective study was conducted to scientifically document LAMA characteristics of the patients selected for comprehensive eye care management from rural eye campsite.

As per the protocol all patients requiring hospital-based care were counseled by a consultant ophthalmologist or resident examining them, the Public Relations Officer (PRO), and health official at the campsite regarding the plan of care. The demographic details and diagnosis was recorded at the point of the first contact.

As LAMA disrupts the care chain of the ophthalmic care system rendered to rural camp patients and reflects its quality, it can be considered as a key indicator for the success of national control of blindness.

Understanding the profile of LAMA patients can be Helpful in improving community health care service. Also when understood and applied to all the patients in general it can minimize legal implications. This is a poorly understood

Methods and Materials

Aspect of the health care delivery system [6].

Setting: Department of Ophthalmology at Sri Devaraj Urs Medical College and Hospital, Kolar, Karnataka, India.

Type of study: Cross-sectional study

Duration: 7 months (June 2019 to December 2019)

Sampling methods: A total of 840 patients screened at eye camps were recruited for the study coming to the eye campsite for screening in that particular campsite were included in the study.

As there was no similar study, the sample size was based on a study by N. Khisty et al [7] for LAMA in the psychiatric patient.

Data collection procedure and inclusion criteria: The following protocol was practiced for rural eye camps:

Two camps were conducted every week under the aegis of the DBCS (District Blindness Control Society). The schedule of campsites is prepared by the District Health Officer (DHO) with inputs from Public Relations Officer (PRO) dedicated to Ophthalmology in such a manner to that area within 60kms from the hospital (short distance camps) and distance of 60-120kms (long-distance camps) were covered.

The Ophthalmology PRO visits the campsite one day prior to the scheduled camp day, distributes the pamphlets which contain details of transportation, requisite documents, expected duration of hospital stay, and treatment.

On the day of the camp, the ophthalmology consultant and/or resident conduct the primary screening after registration at the campsite. Those requiring ophthalmic surgical or medical care like cataract, glaucoma, diabetic retinopathy, and other conditions were selected, counseled regarding management. The patients usually are from the same place as the campsite or nearby rural areas and accompanied by a family member or attendant.

As the details of the camp are made known a day earlier, the consent to get treated is implied in all

The patients attending the camp, who were the study population for the research. Sufficient time is given for the patient to understand and discuss with their family member or attendant and clarify any doubt regarding the process. Patients who fail to board the camp vehicle were also considered as LAMA and included in the present study. All the patients selected are brought to the hospital by the camp vehicle, implying the voluntary consent for further service.

The patients were received at Sri Devaraj Urs Medical College and Hospital, registered as inpatients (with demographic data such as age, sex, occupation, address, and marital status) and written consent was taken. Inpatient care included complete evaluation, diagnosis, and treatment. Patients were also evaluated for co-morbid conditions like diabetes and hypertension. Accordingly, they were scheduled for cataract surgery within 24-48 hours after satisfying the standard pre-operative checklist (Category A).

Regular daily ward rounds were done in the morning and evening by ophthalmology consultants and residents, where personal counseling about treatment was made well understood to patients and their attendants. The Ward nurse and intern monitors the inpatients and interact with them whenever necessary.

Patients with severe comorbid conditions that require systemic stabilization were scheduled for surgery only after getting fitness for the same (Category B). However, if the ophthalmic condition requires only medical management it was started promptly. Patients with untreatable conditions like advanced glaucoma, diabetic eye disease, age-related macular degeneration, optic atrophy, etc.

With nil or minimal visual prognosis are counseled and screened for ocular diseases in the other eye (Category C). Patients of Category B and C were required to stay longer than the patients undergoing in category a usual cataract surgery.

Few of them were found demotivated and reluctant for further treatment and are seen leaving against medical advice. Any patient not found in the hospital from 4 or more hours was considered as LAMA and is also included in the present study. LAMA were reported by consultant/ residents/ intern/ nurse. Soon afterward the patients on adjacent beds were interviewed, patient's records were reviewed and the possible reason for LAMA was analyzed.

Result

Out of 840 camp patients, 26 subjects were found LAMA.

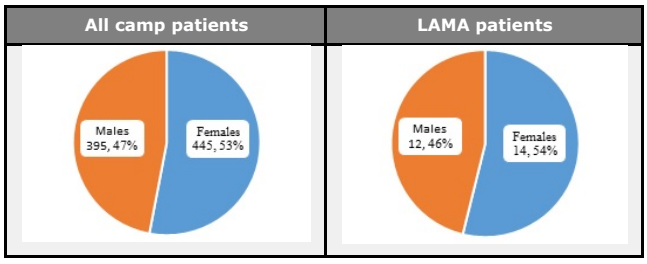

Fig:1-Gender wise distribution of all camp patients and LAMA patients (numbers of patients, percentage).

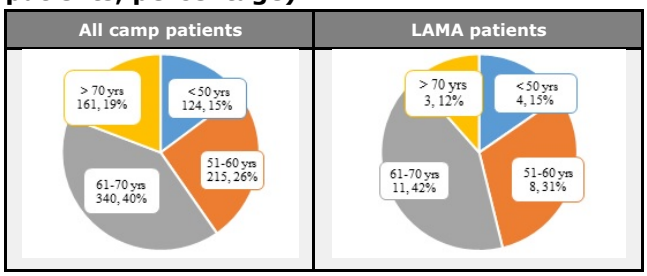

Fig-2: Age-wise distribution (in years) of all camp patients and LAMA patients (number of patients, percentage).

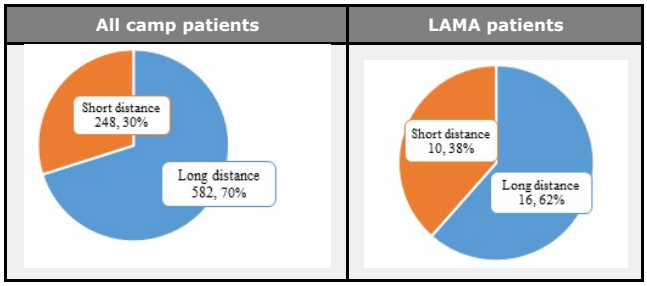

Fig-3: Camp distance-wise distribution of all camp patients and LAMA patients (number of patients, percentage).

Table-1: Comparison of age, gender, and campsite distance between LAMA patients and non-LAMA patients (who complied with the 'Admission- in patients- discharge policy' of the hospital).

		LAMA patients		Non-LAMA Patients		P-value
		N	%	N	%	
Age Group	<50 years	4	15.4	120	14.7	0.772
	51-60 years	8	30.8	207	25.4	
	61-70 years	11	42.3	329	40.4	
	>70 years	3	11.5	158	19.4	
Gender	Female	14	54	431	52.9	0.928
	Male	12	46	383	47.1	

Campsite	Long distance	16	61.5	566	69.5	0.392
	Short distance	10	38.5	248	30.5	

Table-2: Profile of LAMA patients and an accompanying person.

Accompanied by	Number of patients	Percentage
Other camp patients	10	38.5
Husband	5	19.2
Relative	3	11.5
Alone	5	19.2
Wife	3	11.5
Total	26	100.0

42.2% of LAMA patients were seen absconding with one of the family members.

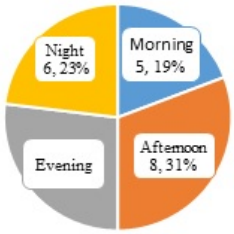

Fig-4: Time of LAMA noted (number of patients, percentage).

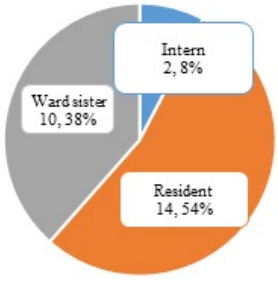

Fig-4: Reporting of LAMA by (number of patients, percentage).

Table-3: Probable reason for LAMA.

	Number of patients	Percentage
Medical	11	42.30
Personal/ unknown	10	38.46
From campsite	5	19.24
Total	26	100.0

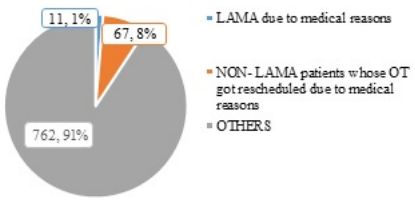

Fig-5: Reporting of LAMA by medical, non-Medical, and other reasons.

Table 4: Reasons for delayed scheduling of OT.

	LAMA patients	Non-LAMA patients	Total
Due to High sugars	7	39	46
Due to High blood pressure	1	17	18
Due to eye discharge	2	5	7
Due to systemic diseases	1	6	7
Total	11	67	78

Table-5: Month-wise Distribution of LAMA patients.

	Leaving against medical advice	
	NO	YES
June	111	6
July	155	6
August	145	1
September	119	0
October	65	7
November	125	2
December	83	4

From the above observations, it was found that the prevalence of LAMA in the present study was 3.09 %, of which the maximum population belonged to the age group 61-70 years (42.3%) with female preponderance (58.3%). Maximum LAMA was seen in patients coming from long distance camps (61.5%) and were usually accompanied by one of the family people for absconding (42.2 %). LAMA was observed mostly in morning timings before ward rounds and usually noted by Ophthalmology residents (53.8%).

However, there was no statistically significant difference as per age/ gender and campsite found between LAMA patient and non-LAMA patient (who followed Admission-inpatient- discharge cycle) with respect to age group, gender, and campsite distance.

The majority of LAMA patients were seen absconding due to being unfit for surgery (42.3%), however p-value 0.504, there was no statistically significant difference. However, there was a statistically significant difference (P-value 0.021) found between LAMA and non-LAMA patients which were more in October being a festival month, and in June and July which is the raining season.

Discussion

Patients refusing medical advice and leave the hospital to pose a challenge to the rural health care delivery system. Comprehensive documentation

May help to understand the profile of such patients [8]. Diversity among the patient population and the nature of treatment may influence LAMA [9].

Leaving against medical advice remains a major healthcare challenge that leads to series of negative health consequences like the risk of complications, irreversible loss of vision (in the current study), increased expenditure, and misuse of resources like time, manpower, and money. Negative publicity, especially in programs associated with the execution of national programs,

Can have a far-reaching negative impact. Tracing the LAMA patients places an additional burden on the health care delivery team [10,11].

54 % of the LAMA population were females (46 % were males) in the present study. There are no Ophthalmology studies done in the past for this. Studies done in psychiatric patients of Hayat AA [12] showed male gender (63.5%) to be a predictor of LAMA discharge. The possibility of this because males being the breadwinner in Indian society might be a little reluctant of getting admitted and operated.

The prevalence of LAMA among rural eye camp patients was 3.09%. Comparable studies have showed prevalence rates 17% [13],13.9% [14], and 0.26% [15]. These studies differed in setting, study population, and specialty.

The highest rate (42.3%) of LAMA subjects belonged to the 61-70 years age group, while in subjects above 70 years it was the minimum (11.5%), which was surprisingly the least. All the LAMA subjects above 70 years, were pseudophakic in other eye and hypothetically their previous experience influenced their decision to LAMA. Contrary to our observation, the younger age group was found to be an important predictor of LAMA, especially in the 21-30 years age group among psychiatric in-patient [13].

In this study, LAMA was not influenced by ocular and/ or systemic co-morbidities, although one would expect a delay in the scheduling of the surgery due to systemic or ocular morbidity to influence the decision of the patient to comply with Protocols. A review of the literature showed no similar studies in Ophthalmology in patients. While a few studies were done in psychiatric inpatients showed alcoholic, drug abusers [16,17] and low education [12] as important predictors of LAMA. None of the referred studies showed ophthalmology inpatients, a study

Done in pediatric and psychiatric wards showed 'open ward doors' had more LAMA incidence than 'locked ward doors' [17]. Patients referred for community rehabilitation and readmission made a large proportion of LAMA. The future plan is to make a survey of camp patients for prior history of LAMA is an extension of a study

Hospitalization may create a sense of insecurity among patients coming from rural eye camp despite prior information and counseling, in many instances

Poor visual prognosis, delayed scheduling for surgery due to systemic/ ocular co-morbidities may influence the patient to leave against professional advice. The influence of family members or other patients cannot be ruled out. The feeling of unfamiliar living conditions and hospital protocols might also be added to LAMA. Empathetic communication [18] from the entire team providing community ophthalmological services can be helpful. Counselors and ward staff need to be educated about LAMA patients and must be trained to recognize the patients with a tendency to LAMA. Restraining of patients coming from distant villages through eye camp is not an option unlike in psychotic and pediatric ward which can follow Lock ward door policy.

From our experience, camp patients admitted for medical management with poor or nil visual prognosis and uncontrolled systemic co-morbidities should be preferably segregated, creating a graded in-patient care system. Ophthalmic Public Relation officers (PRO) is the most vital main link between rural camp patients and hospital-based ophthalmology team in our practice, the PRO must develop a healthy rapport with the camp patients and constantly communicate regarding the inpatient management plan. This can alleviate fears and insecurities. PRO can also identify impending LAMA patients by continued interaction even after admission. As a follow-up, the Ophthalmic PRO must go back to the community center and interact with LAMA patients and try to get their feedback on the exact reasons of LAMA.

Orienting the hospital policy to facilitate comprehensive eye care delivery to camp patients will go a long way in reducing LAMA. The use of patient education material, displays, counselors, and empathetic ward attendants can help in enhancing the camp patients' confidence in the hospital services and reduce the incidence of LAMA [19].

Limitations

Limitations of the study were as there was no similar literature, making it one of the first among Ophthalmology eye camp patients. Multicentric studies with a broader database can help in better understanding the cause of LAMA. Information such as educational status, socio-economic status, marital status, and psychological assessment may be included in future studies.

Conclusion

LAMA is an indicator of the effectiveness of the community health care delivery system. It is a well-recognized vexing issue world over with regional and specialty differences. It reflects poorly on the utility of the national programs specifically targeted for the underprivileged rural population, more so in the setting of free comprehensive eye care provided at a tertiary care medical college hospital.

It may also add to the incidence of blindness. The reasons are many and the solution is in educating the patients regarding their disease, the adverse effects of refusing treatment in an empathetic manner, respecting their rights as a patient. Better insight into the reason requires understanding their social, economic, cultural, and educational status. Reducing the number of LAMA patients can have a positive impact on the optimal utilization of resources and improve the health status of the community.

What does the study add to the existing knowledge

The present study can help us understand the profile of LAMA patients and thus improve community health care service since it is a very poorly understood and less studied aspect of the health care delivery system.

Author's contribution

Dr. Apurva Shivaji Navale: Data collection, Search for review of literature, Manuscript preparation.

Dr. Sandhya Ramachandra: Study design, Search for review of literature, Manuscript preparation, and correction.

Dr. Rashmi G.: Search for review of literature, manuscript correction.

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