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Research Paper

Refusal of Hospital Admission and Discharge Against Medical Advice in Children and Adolescents: A Retrospective Study in the Independent Public Provincial Specialist Hospital in Chelm, 2013–2018

Paweł Kamiński[1], Mateusz Kaczmarski[2], Laura Maria Surdacka-Barańska[3], Marta Żerebiec[4], Paula Katarzyna Jankowska[5], Krzysztof Jacek Jankowski[6], Magdalena Grzegorczyk-Dyzma[5], Karolina Iwanicka[7], Adam Jakubas[8], Karolina Pawelec[9]

[1] *Independent Public Healthcare, General Hospital in Puławy, Poland*
[2] *Independent Public Healthcare, General Hospital in Łęczna, Poland*
[3] *The 1st Military Clinical Hospital with Polyclinic in Lublin, Independent Public Healthcare Institution, Poland*
[4] *Student Scientific Association at the Department of Rehabilitation, Medical University of Lublin, Poland*
[5] *Pediatric Department, Independent Public Regional Specialist Hospital in Chełm, Poland*
[6] *Chair and Department of Family Medicine, Medical University of Lublin, Poland*
[7] *Independent Public Complex of Health Care Facilities in Pruszków, Poland*
[8] *J. Popiełuszko Bielanski Hospital in Warsaw, Poland*
[9] *Międzylesie Specialist Hospital in Warsaw, Poland*

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Abstract

Introduction: Refusal of hospitalisation and DAMA in paediatric patients are insufficiently studied, especially in Poland and Central and Eastern Europe. These decisions may affect safety and care continuity and are shaped by medical and non-medical factors.

Aim: To analyse the frequency, circumstances, and selected determinants of refusal of hospitalisation and DAMA among patients in the Pediatric Ward of the Independent Public Provincial Specialist Hospital in Chelm in 2013–2018.

Material and methods: This retrospective study analysed records of patients under 18 presenting to the Emergency Department, Admission Rooms, and Pediatric Ward. Patients recorded during the first 10 days of each month in 2013–2018 were included. Variables were age, sex, ICD-10 diagnosis, mode of admission, length of stay, and discharge type. Analysis used Microsoft Excel and R 4.0.5, with $\alpha = 0.05$.

Results and discussion: Among 6,525 cases, refusal of hospitalisation occurred in 4.9% (n = 320). Among 2,315 hospitalised patients, discharge at a legal guardian's request occurred in 11.4% (n = 263). DAMA patients were more often admitted by Emergency Medical Services than all cases (46.6% vs. 21.5%). Gastrointestinal disorders and infections were the most common diagnoses.

Conclusions: Refusal of admission and DAMA were not rare in this paediatric population. Further prospective studies are needed to identify causes and support interventions reducing these events.

Corresponding author: Paweł Kamiński; Independent Public Healthcare, General Hospital in Puławy, ul. Bema 1, 24-100 Puławy, Poland.
E-mail address: kamien0604@gmail.com

1. INTRODUCTION

Every patient has the right to consent or refuse medical treatment.[1] With regard to patients under 16 years of age, consent for hospitalization is provided by a legal guardian. For patients 16–18 years of age, consent must be obtained from both the patient and the legal guardian. If the patient's and guardian's decisions contradict, the final decision is made by the guardianship court.[2] The Regulation of the Minister of Health of 26 June 2019 provides two main admission pathways to hospital wards: elective and emergency. The first requires a valid referral from the primary healthcare provider. In emergency situations, a patient may be transported to the hospital by Emergency Medical Services or may present independently without a referral.[3]

Discharge against medical advice (DAMA) is defined as a situation in which a patient decides to leave the hospital prior to the time recommended by the attending physician. DAMA may increase the risk of adverse events, the need for readmission and mortality, highlighting its importance in terms of patient safety.[4,5] In minors, discharge from the hospital may occur at the request of the legal guardian, provided that discontinuation of the diagnostic and therapeutic process does not pose an immediate threat to the child's health or life. If discontinuation of treatment poses a risk to the child's health, the case may be referred to the guardianship court.[6] Physicians are required to inform guardians about the consequences of DAMA and a formal refusal must be documented. Failure to provide adequate information may result in legal consequences.[7,8] In the case of a direct threat to life or health, healthcare professionals are authorised to provide the necessary medical assistance without the consent of the legal guardian ensuring the wellbeing of the child.[9,10]

Despite existing regulations, refusal of hospitalization and discharge against medical advice remain insufficiently studied, especially in Central and Eastern European countries, including Poland. The reasons behind these decisions and their clinical consequences remain understudied.

2. AIM

The aim of the study was to analyse the frequency, circumstances and selected determinants of refusal of hospitalisation and discharge against medical advice in a population of the Pediatric Ward of the Independent Public Provincial Specialist Hospital in Chełm in the years 2013–2018.

3. MATERIAL AND METHODS

The study was based on a retrospective analysis of the medical records of patients under 18 years of age presenting to the Emergency Department, Admission Rooms, and the Pediatric Ward of the Independent Public Provincial Specialist Hospital in Chełm.

The study included pediatric patients recorded during the first 10 days of each month between 2013 and 2018. This sampling strategy was adopted to ensure feasibility while maintaining seasonal and temporal variability. Patients with incomplete medical records or administrative entries lacking clinical data were excluded. The extracted variables included age, sex, ICD-10 diagnosis, mode of admission, length of stay, and discharge type.

The statistical analysis was conducted using Microsoft Excel and the R statistical package version 4.0.5. The normality of distributions was assessed using the Shapiro–Wilk test. Comparisons between groups were performed using the Student's t-test for normally distributed variables and the Mann–Whitney or Kruskal–Wallis tests for non-normally distributed variables, as appropriate. Nominal variables were presented as counts (n) and percentages. Associations between categorical variables were evaluated using Pearson's chi-square test or the chi-square goodness-of-fit test. A p-value < 0.05 was considered to be statistically significant.

4. RESULTS

4.1. Refusal of hospitalization

A total of 6,525 cases were analysed. Legal guardians refused consent for hospitalisation in 4.9% of all patients (n = 320). Among these cases, 53.9% of these patients were male. The median time spent in the hospital before refusal of admission was 1 hour and 1 minute (IQR: 25 minutes to 2 hours and 50 minutes), with a range from 5 minutes to 17 hours and 58 minutes. The median age of these patients was 6.6 years (IQR: 2.1–12.8), ranging from 19 days to 17 years and 11 months.

The most common final diagnoses, classified according to the International Classification of Diseases, 10th Revision (ICD-10), among patients whose guardians refused hospitalisation were abdominal and pelvic pain (ICD-10: R10–R10.9; 14.1%), fever of other or unknown origin (ICD-10: R50–R50.9; 7.8%), infectious gastroenteritis and colitis, unspecified (ICD-10: A09; 5.3%), functional dyspepsia (ICD-10: K30; 5.3%), acute upper respiratory infections of multiple and unspecified sites (ICD-10: J06–J06.9; 4.4%), superficial injury of the head (ICD-10: S00–S00.9; 4.4%), syncope and collapse (ICD-10: R55; 4.1%), and encounter for medical observation for suspected diseases and conditions ruled out (ICD-10: Z03–Z03.9; 4.1%).

4.2. Discharge against medical advice

The analysis of discharge against medical advice included 2,315 admissions to the Pediatric Ward. Discharge from the Pediatric Ward at the request of a legal guardian was recorded in 11.4% of the analysed patients (n = 263). Males accounted for 55.3% of these cases. The median length of stay was 1,3 days (IQR: 0.6–3.4 days), with a range from 53 minutes to 10.5 days. The median age of the patients was 11.7 years (IQR: 5.8–16.7), with a range from 8 days to 17 years and 9 months.

Table 1. Final diagnoses in patients whose guardians refused hospitalization.

No.	ICD-10 code	Diagnosis	n	%
1	R10-R10.9	abdominal and pelvic pain	45	14.1
2	R50-R50.9	fever of other or unknown origin	25	7.8
3	A09	infectious gastroenteritis and colitis, unspecified	17	5.3
4	K30	functional dyspepsia	17	5.3
5	J06-J06.9	acute upper respiratory infections of multiple and unspecified sites	14	4.4
6	S00-S00.9	superficial injury of the head	14	4.4
7	R55	syncope and collapse	13	4.1
8	Z03-Z03.9	encounter for medical observation for suspected diseases and conditions ruled out	13	4.1

Modes of admission to the Pediatric Ward were evaluated for all patients who were later discharged at the request of a legal guardian (Figure 1). Compared with the overall study population, this group was significantly ($p < 0.001$) more frequently admitted via Emergency Medical Services (46.6% vs. 21.5%).

Among patients discharged at the request of a legal guardian, the most frequently reported final diagnoses according to ICD-10, were infectious gastroenteritis and colitis, unspecified (ICD-10: A09; 16.0%), functional dyspepsia (ICD-10: K30; 12.6%), pneumonia caused by an unspecified infectious agent (ICD-10: J18.8; 7.6%), acute bronchitis, unspecified (ICD-10: J20.9; 7.6%), other symptoms and signs involving the nervous and musculoskeletal systems (ICD-10: R29.8; 6.9%), and acute upper respiratory infections of multiple and unspecified sites (ICD-10: J06.8–J06.9; 6.1%).

4.3. Diagnoses in patients who remained hospitalized

Among hospitalized patients, the most common primary diagnoses at admission were infectious gastroenteritis and colitis,

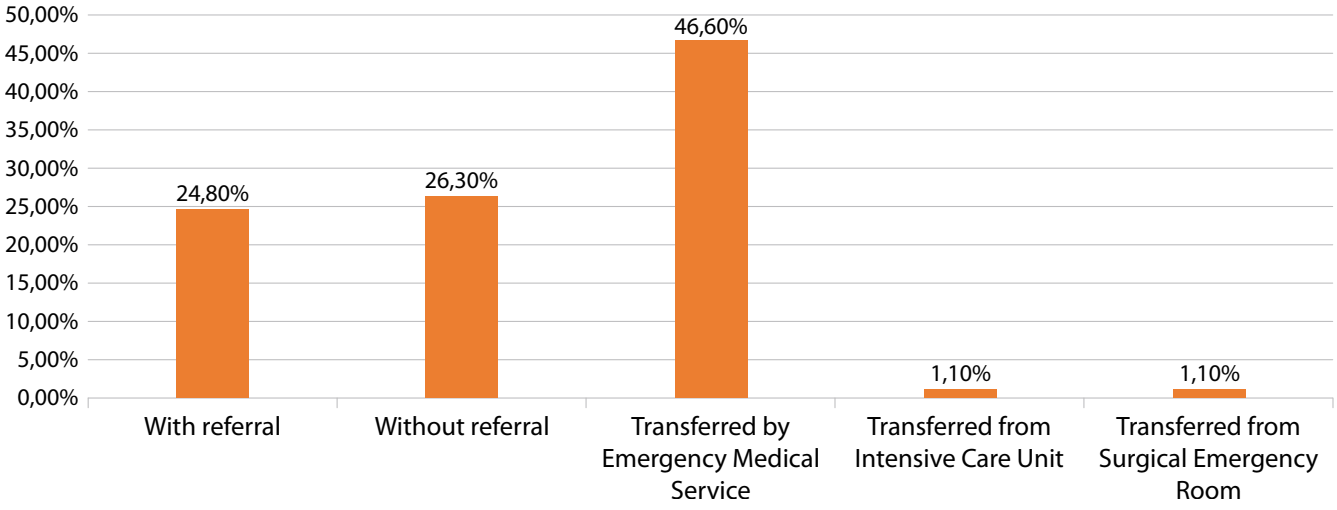

Figure 1. Modes of admission among patients discharged against medical advice.

Table 2. Final diagnoses in patients discharged against medical advice.

No.	ICD-10 code	Diagnosis	n	%
1	A09	gastroenteritis and colitis, unspecified	42	16.0
2	K30	functional dyspepsia	33	12.6
3	J18.8	pneumonia caused by an unspecified infectious agent	20	7.6
4	J20.9	acute bronchitis, unspecified	20	7.6
5	R29.8	other symptoms and signs involving the nervous and musculoskeletal systems	18	6.9
6	J06.8-J06.9	acute upper respiratory infections of multiple and unspecified sites	16	6.1

Table 3. Primary diagnoses at admission in patients who remained hospitalized.

No.	ICD-10 code	Diagnosis	n	%
1	A09	infectious gastroenteritis and colitis, unspecified	433	18.7
2	J18	pneumonia, organism unspecified	168	7.3
3	R50	fever of other and unknown origin	166	7.2
4	R10	abdominal and pelvic pain	119	5.1
5	K30	functional dyspepsia	117	5.1
6	R55	syncope and collapse	99	4.3
7	R11	nausea and vomiting	97	4.2
8	J18.8	other pneumonia, unspecified organism	77	3.3

Table 4. Final diagnoses in patients who remained hospitalized.

No.	ICD-10 code	Diagnosis	n	%
1	J18.8	other pneumonia, unspecified organism	356	15.4
2	A09.9	infectious gastroenteritis and colitis, unspecified	347	15.0
3	R29.8	other symptoms and signs involving the nervous and musculoskeletal systems	148	6.4
4	K30	functional dyspepsia	142	6.1
5	A08.0	rotavirus enteritis	127	5.5
6	J20.9	acute bronchitis, unspecified	99	4.3
7	J06.9	acute upper respiratory infection, unspecified	82	3.5
8	N39.0	urinary tract infection, site not specified	61	2.6

unspecified (ICD-10: A09; 18.7%), pneumonia, organism unspecified (ICD-10: J18; 7.3%), fever of other and unknown origin (ICD-10: R50; 7.2%), abdominal and pelvic pain (ICD-10: R10; 5.1%), functional dyspepsia (ICD-10: K30; 5.1%), syncope and collapse (ICD-10: R55; 4.3%), nausea and vomiting (ICD-10: R11; 4.2%), and other pneumonia, unspecified organism (ICD-10: J18.8; 3.3%).

By contrast, the most common final diagnoses among patients who remained hospitalized were other pneumonia, unspecified organism (ICD-10: J18.8; 15.4%), infectious gastroenteritis and colitis, unspecified (ICD-10: A09; 15.0%), other symptoms and signs involving the nervous and musculoskeletal systems (ICD-10: R29.8; 6.4%), functional dyspepsia (ICD-10: K30; 6.1%), rotavirus enteritis (ICD-10: A08.0; 5.5%), acute bronchitis, unspecified (ICD-10: J20.9; 4.3%), acute upper respiratory infection, unspecified (ICD-10: J06.9; 3.5%), and urinary tract infection, site not specified (ICD-10: N39.0; 2.6%).

5. DISCUSSION

The current study focused on the characteristics and prevalence of DAMA and refusal of hospitalization in patients under 18 years of age in Poland. The observed rates, 11.4% for DAMA and 4.9% for refusal of hospitalisation, indicate that they are not uncommon and may represent a significant clinical and organizational challenge.

Reported rates vary widely in the literature. The highest rate of DAMA (50%) was reported in a study conducted in Iran.[11] Much lower rates were observed in studies from Australia (1.34%) and Nigeria (1.5%).[12,13] The lowest rate (0.4%) was reported in a study from Saudi Arabia.[14] Differences between countries may reflect variation in healthcare system structure and organisation, access to primary care, and cultural factors.[15,16] The limited data available from Central and Eastern Europe highlight the importance and relevance of the present study.

The present study showed a slight male predominance among children discharged against medical advice, with boys accounting for 55.3%. A similar pattern was observed in a Nigerian study conducted by Chika Duru et al., where boys accounted for 57.5% of DAMA cases.[17] This suggests a modest male predominance, although no causal interpretation can be made. It may reflect demographic or epidemiological differences.

The median age in the present sample (11.7 years) was higher than in other studies; Manijeh Khalili et al. reported 2.73 years,[11] while Mohammed Albalawi et al. reported 4.4 years.[14] Differences in the organization of healthcare systems and in admission characteristics between centers may have contributed to this finding.

The median duration of hospitalisation before DAMA in this study was 1.3 days (IQR: 0,6–3,4 days), which is comparable with findings from the literature, where reported values range from 1.67 to 3.8 days.[11,14,15] This suggests that

caregivers may reconsider the need for continued hospitalization after a similar period of inpatient care, despite ethnic, cultural, and social differences.

In the current study, legal guardians refused hospital admission for their child in almost 5% of cases. In the Emergency Department of the Bielanski Hospital in Warsaw, this rate was 2% in 2014.[18]

The most common diagnoses were gastrointestinal disorders and infections across all patient groups. Final diagnoses in the group of patients whose guardians refused hospitalization were generally less specific. Caregivers and patients may underestimate these symptoms and, as a result, refuse hospitalization or decide on premature discharge. Patients discharged against medical advice were more likely to receive specific diagnoses, including conditions that may be perceived as more severe by caregivers. After admission and following further diagnostics, the initial diagnosis may be refined. Overall, decisions regarding hospitalization depend on medical factors, such as the clinical condition of the patient and the level of diagnostic confidence, as well as non-medical factors.

Research to date suggests that social factors may significantly affect the rate of DAMA. Parental anxiety, dissatisfaction with medical care, and socio-economic factors may lead caregivers to withdraw from further inpatient treatment.[13]

The high proportion of admissions via Emergency Medical Services may have increased parental anxiety and impatience. This might have led them to reconsider the need for hospitalization and to refuse treatment prematurely. However, this interpretation remains speculative as the reasons for refusal of hospitalisation or DAMA were not recorded.

Southern et al. reported that DAMA and refusal of hospitalization are associated with increased mortality and more frequent readmissions.[19] Although follow-up data were not available in the present study, these findings emphasise the need for further investigation of this issue in the pediatric population to support the development of strategies aimed at reducing its occurrence. These findings also have important clinical implications. Effective communication between caregivers and healthcare professionals is essential. A clear and careful explanation of the diagnosis, the expected course of the illness, and the possible consequences of premature discharge may help reduce the number of DAMA cases.

Patient safety and clinical outcomes may be improved by implementing protocols for active, standardised discharge counselling and by identifying patients at higher risk of DAMA or refusal of hospitalization.

The current study has several limitations. Due to its retrospective observational design, causal relationships between patient characteristics, admission pathway, diagnosis, and refusal of hospitalization or discharge against medical advice could not be established. The findings should therefore be interpreted as descriptive associations rather than causal effects. Additionally, the sampling strategy included only patients recorded during the first 10 days of each month. Although this approach was adopted to preserve temporal and seasonal variability while maintaining feasibility, it may have introduced selection bias and may not fully reflect the case mix, admission patterns, caregiver decisions, or organisational factors observed during the remaining days of the month. Although descriptive data were available for patients who remained hospitalized, the study did not include a separate predefined comparison group for adjusted analytical comparison. This limits the ability to identify independent factors associated with refusal of hospitalization or discharge against medical advice. Moreover, the study did not include the reasons for refusing hospitalization or requesting discharge, which may have influenced the final conclusions. Assessment of readmissions was not possible because such data were not available within the hospital records. As the study was based on a single-center design, the findings cannot be generalised to other hospitals or to the national level.

Future studies should be based on prospective data collection to obtain more accurate and comprehensive information. Additional factors and possible determinants should be considered, including follow-up records and caregivers' reasons for refusing hospitalization or requesting discharge against medical advice. A multicenter study would be particularly valuable, as it could provide more generalisable results.

6. CONCLUSIONS

This study provides important information regarding refusal of admission and DAMA in the pediatric population. The findings indicate that such discharges against medical advice are not rare. However, due to the lack of follow-up data, their clinical consequences could not be assessed. Further prospective studies are required to identify underlying causes and to develop interventions aimed at reducing these events. Physicians should be aware of the legal framework of their place of work and the importance of effective communication with caregivers of their patients to minimise potentially harmful decisions.

Ethics approval

The study protocol was approved by the local Bioethics Committee of the Medical University of Lublin – approval no. KE-0254/301/2018, November 29, 2018.

Informed consent

Due to the retrospective nature of the study and the use of fully anonymised data, obtaining informed consent from individual participants was not required. The dataset contained no sensitive or personally identifiable information, and therefore the requirement for participant consent was waived.

Conflict of interest

None declared.

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Author contributions
Study design: PK, MK, LMS-B, KJJ, KI
Data collection: MŻ, PKJ, AJ
Statistical analysis: MŻ, KJJ, KP
Data interpretation: PKJ, MG-D
Manuscript preparation: PK, MK, LMS-B, MG-D, KI
Literature search: PK, MK, LMS-B, PKJ, AJ, KP

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