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Original article

Factors associated with early discharge against medical advice among trauma patients

Facteurs associés aux sorties précoces contre avis médical chez les patients traumatisés

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Abstract

Introduction: Discharge against medical advice (DAMA) undermines both continuity and safety of care. Little is known about the factors that determine how early trauma patients leave hospital once they have decided to do so. This study aimed to identify the factors independently associated with early DAMA, defined as discharge within the first 24 hours after admission.

Methods: We conducted a single-centre, retrospective, observational and analytical study at the Regional Hospital of Ziniaré, Burkina Faso, from 1 December 2021 to 31 December 2025. All records of trauma patients discharged against medical advice were included consecutively. Sociodemographic characteristics, time from injury to hospital admission, mechanism of injury, time from admission to DAMA, the person who made the decision and the reasons for DAMA were analysed. Bivariate associations were tested with the chi-square test or Fisher's exact test. Because late DAMA was infrequent, Firth's penalised logistic regression was used for multivariable analysis.

Results: Among the 291 patients included, the mean age was 32.21 ± 16.60 years and 224 (77.0%) were male. The admission-to-DAMA interval was documented for 288 patients: 258 (89.6%) left within the first 24 hours and 30 (10.4%) after 24 hours or more. In bivariate analysis, early DAMA was associated with age per 10-year increment (OR = 0.79; 95% CI: 0.64–0.97), male sex (OR = 4.06; 95% CI: 1.86–8.84), residence in Boussé (OR = 0.19; 95% CI: 0.07–0.53), being a housewife (OR = 0.30; 95% CI: 0.10–0.88), admission within 24 hours of injury (OR = 24.00; 95% CI: 9.23–62.38), domestic accidents (OR = 0.21; 95% CI: 0.07–0.63) and leaving to consult a traditional bone setter (OR = 3.16; 95% CI: 1.42–7.03). After adjustment with Firth regression, only admission within 24 hours of injury remained independently associated with early DAMA (aOR = 5.28; 95% CI: 1.05–26.61; p = 0.044).

Conclusion: In this population of trauma patients who left against medical advice, admission within 24 hours of injury was the only factor independently associated with early DAMA. Informing patients and their relatives from the very first hours, and involving the family early in decision-making, may help to limit early departures.

Keywords: Discharge against medical advice; early discharge; trauma; associated factors.

Résumé

Introduction : Les sorties contre avis médical (SCAM) constituent un problème de continuité et de sécurité des soins. Les données concernant les facteurs associés à leur précocité chez les patients traumatisés restent limitées. Cette étude avait pour objectif d'identifier les facteurs indépendamment associés à une SCAM précoce, définie comme survenant dans les 24 premières heures suivant l'admission.

Méthodes : Il s'agissait d'une étude rétrospective, observationnelle et analytique, monocentrique, réalisée au Centre Hospitalier Régional de Ziniaré, au Burkina Faso, du 1er décembre 2021 au 31 décembre 2025. Les dossiers de patients traumatisés ayant effectué une SCAM ont été inclus de manière

exhaustive. Les caractéristiques sociodémographiques, le délai entre le traumatisme et l'admission hospitalière, l'étiologie, le délai admission–SCAM, le décideur et les raisons de la SCAM ont été analysés. Les associations bivariées ont été étudiées par le test du χ^2 ou le test exact de Fisher. Une régression logistique pénalisée de Firth a été utilisée en raison du faible nombre de SCAM tardives.

Résultats : Parmi les 291 patients inclus, l'âge moyen était de 32,21 ± 16,60 ans et 224 (77,0 %) étaient de sexe masculin. Le délai admission–SCAM était renseigné chez 288 patients ; 258 (89,6 %) avaient effectué une SCAM dans les 24 premières heures et 30 (10,4 %) à partir de la 24e heure. En analyse bivariée, la SCAM précoce était associée à l'âge exprimé par tranche de 10 ans (OR = 0,79 ; IC95 % : 0,64–0,97), au sexe masculin (OR = 4,06 ; IC95 % : 1,86–8,84), à la résidence à Boussé (OR = 0,19 ; IC95 % : 0,07–0,53), au statut de femme au foyer (OR = 0,30 ; IC95 % : 0,10–0,88), à une admission dans les 24 heures suivant le traumatisme (OR = 24,00 ; IC95 % : 9,23–62,38), à l'accident domestique (OR = 0,21 ; IC95 % : 0,07–0,63) et au recours au rebouteux comme raison de SCAM (OR = 3,16 ; IC95 % : 1,42–7,03). Après ajustement par régression de Firth, seul le délai entre le traumatisme et l'admission hospitalière inférieur à 24 heures demeurait statistiquement associé à une SCAM précoce (ORa = 5,28 ; IC95 % : 1,05–26,61 ; p = 0,044).

Conclusion : Dans cette population de patients traumatisés ayant effectué une SCAM, une admission hospitalière dans les 24 heures suivant le traumatisme était le seul facteur indépendamment associé à une SCAM précoce. Une information précoce du patient et de son entourage, ainsi qu'une implication rapide de la famille dans la prise de décision, pourraient contribuer à limiter les départs précoces.

Mots-clés : Sortie contre avis médical ; sortie précoce ; traumatologie ; facteurs associés.

Introduction

Discharge against medical advice (DAMA) refers to a patient leaving a healthcare facility before the care recommended by the medical team has been completed [1]. It raises concerns about quality, safety and continuity of care, and is associated with a higher risk of readmission and poor outcomes [1–3].

Trauma patients are particularly vulnerable to the consequences of interrupted care. Their management may require clinical monitoring, further investigations, and medical or surgical treatment [4,5]. In resource-limited countries, the decision to leave hospital may also be shaped by financial constraints, family obligations, the perceived severity of the injury and the use of alternative care pathways [6].

In African settings, the coexistence of conventional and traditional medicine can strongly influence the therapeutic itinerary [7]. In a previous analysis of this cohort at Ziniaré Regional Hospital, consulting traditional bone setters and financial constraints were among the main reasons for DAMA [8]. In that series, the decision to leave was made by a relative in 80.4% of cases, a degree of family involvement also reported in other African settings [9].

However, most available studies have examined the factors associated with leaving hospital against medical advice, rather than the timing of discharge among patients who have already chosen to leave [9–11]. Identifying the factors associated with particularly early discharge could help target information, communication and support interventions from the very first hours of care.

The aim of this study was therefore to identify, among trauma patients discharged against medical advice, the factors independently associated with early discharge, defined as discharge within the first 24 hours after admission.

Materials and methods

Study design, setting and period

This was a single-centre, retrospective, observational and analytical study conducted at Ziniaré Regional Hospital, Burkina Faso. The study period ran from 1 December 2021 to 31 December 2025.

Study population

The study population consisted of trauma patients who left hospital against medical advice during the study period. All eligible patients were included. Patients were eligible if their medical record and/or the DAMA register allowed the interval between admission and discharge to be documented. Patients admitted for non-traumatic conditions and those who died before DAMA were excluded.

Variables and outcome definition

Data were extracted from medical records and DAMA registers and entered into KoboToolbox. The variables studied included sociodemographic characteristics, time from injury to admission, injury characteristics, mechanism of injury, time from admission to DAMA, the person who made the decision and the stated reason for DAMA.

The primary outcome was early DAMA, defined as discharge occurring within the first 24 hours after admission; discharge at or after the 24th hour was considered late.

The 24-hour threshold was chosen because it covers the initial phase of hospital care, including initial clinical assessment, diagnostic investigations and the start of first-line treatment. The definition was therefore not based solely on the observed distribution of the data.

Statistical analysis

Data were analysed with Stata version 17. Categorical variables were expressed as counts and percentages, and quantitative variables as mean ± standard deviation or median with range, depending on their distribution.

Early and late DAMA were compared using the chi-square test or Fisher's exact test. Bivariate associations were expressed as crude odds ratios (OR) with 95% confidence intervals (CI) and p-values. Variables with $p < 0.20$ in bivariate analysis, together with those considered clinically relevant, were candidates for the multivariable model.

Given the small number of late DAMA cases, Firth's penalised logistic regression was used to reduce estimation bias and the problems associated with complete or quasi-complete separation. Results were expressed as adjusted odds ratios (aOR) with 95% CI and p-values. Statistical significance was set at $p < 0.05$.

Missing data were not imputed. Analyses were performed on available data, and the number of missing values is reported for each variable concerned. Because of small numbers, some occupational categories were grouped in the multivariable model.

Ethical considerations

The study was conducted retrospectively using hospital records. Personal identifiers were not included in the analysis database, and all information was handled confidentially and anonymously. Ethical approval was obtained before the start of the study. In line with the ethics committee's decision, individual consent was not required for this retrospective record-based study.

Relationship with a previous publication

A previous publication by the same authors, conducted at Ziniaré Regional Hospital, focused on patients who left against medical advice in order to continue their treatment with a traditional bone setter [8]. That descriptive study included the same 291 patients. It mainly described patient characteristics, reasons for DAMA and the therapeutic pathway.

The present study is based on the same cohort of 291 patients, and some sociodemographic and clinical variables are common to both works. The scientific question, however, is different. The earlier publication described the characteristics and pathway of patients who left hospital to consult a bone setter, whereas the present study analyses the factors associated with the timing of DAMA, distinguishing early discharges (< 24 h) from discharges at ≥ 24 h. It therefore includes a bivariate analysis and multivariable modelling with Firth regression, neither of which was performed in the earlier work, and no association between the factors studied and DAMA timing was reported previously. The present study is thus not a repetition of the previous analysis but a re-analysis of the cohort using a different outcome, focused on the timing of DAMA and relying on specific multivariable modelling.

Results

General characteristics

A total of 291 patients were included (Table I). The mean age was 32.21 ± 16.60 years (range: 4–86 years). Males accounted for 77.0% of the population, giving a sex ratio of 3.34.

The main occupational groups were farmers/livestock breeders (33.7%) and self-employed workers (32.6%). Most patients lived in Ziniaré (64.6%).

Time from injury to admission was less than 24 hours in 257 patients (88.3%) and 24 hours or more in 26 patients (8.9%); data were missing for eight patients. Road traffic accidents accounted for 76.6% of injury mechanisms.

Consulting a traditional bone setter was the main stated reason for DAMA (58.1%), followed by financial difficulties (29.9%). The decision to leave was made by a relative in 80.4% of cases.

The admission-to-DAMA interval was available for 288 patients (99.0%). Of these, 258 (89.6%) left within the first 24 hours and 30 (10.4%) at or after the 24th hour.

Time from injury to admission was available for 283 patients. Among patients who presented within 24 hours of injury, 240/255 (94.1%) left early, compared with 10/25 (40.0%) of those who presented after 24 hours. This association was statistically significant (OR = 24.00; 95% CI: 9.23–62.38; $p < 0.001$).

Table I: Characteristics of trauma patients discharged against medical advice (N = 291)

Variable	Category	n	%
Age, years	mean ± SD	32.21 ± 16.60	—
	median [min–max]	29 [4–86]	—
Sex	Male	224	77.0
	Female	67	23.0
Occupation	Farmer/livestock breeder	98	33.7
	Self-employed worker	95	32.6
	Pupil/student	40	13.7
	Housewife	36	12.4
	Civil servant	14	4.8
	Unemployed	4	1.4
	Other	4	1.4
Residence	Ziniaré	188	64.6
	Zorgho	42	14.4
	Boussé	23	7.9
	Other towns	38	13.1
Injury-to-admission time	< 24 h	257	88.3
	≥ 24 h	26	8.9
	Missing	8	2.7
Type of injury	Closed injury	204	70.1
	Open injury	81	27.8
	Missing	6	2.1
Mechanism of injury	Road traffic accident	223	76.6
	Domestic accident	33	11.3
	Occupational accident	12	4.1
	Other causes	7	2.4
	Missing	16	5.5
Admission-to-DAMA time	< 24 h	258	88.7
	≥ 24 h	30	10.3
	Missing	3	1.0
Decision-maker	Relative	234	80.4
	Patient	57	19.6
Sex of the deciding relative	Male	223	95.3
	Female	11	4.7
Reason for DAMA	Traditional bone setter	169	58.1
	Financial difficulties	87	29.9
	Transfer to another health facility	21	7.2
	Refusal of care	8	2.7
	Other	4	1.4
	Refusal of surgery	2	0.7

DAMA: discharge against medical advice; SD: standard deviation. Percentages are calculated on the 291 patients (the percentage of the deciding relative's sex is calculated on the 234 decisions made by a relative).

Factors associated with early DAMA: bivariate analysis

Bivariate analyses were performed on the 288 patients for whom the admission-to-DAMA interval was documented (Table II).

Age was inversely associated with early DAMA when expressed per 10-year increment (OR = 0.79; 95% CI: 0.64–0.97; p = 0.026). Male sex was associated with a higher frequency of early DAMA (OR = 4.06; 95% CI: 1.86–8.84; p < 0.001).

Patients living in Boussé were less likely to leave early than those living in Ziniaré (OR = 0.19; 95% CI: 0.07–0.53; p = 0.003). Among occupational groups, housewives left early less often than farmers/livestock breeders (OR = 0.30; 95% CI: 0.10–0.88; p = 0.034).

Time from injury to hospital admission was strongly associated with early DAMA: admission within 24 hours of injury was associated with higher odds of early DAMA (OR = 24.00; 95% CI: 9.23–62.38; p < 0.001).

Domestic accidents were less often associated with early DAMA than road traffic accidents (OR = 0.21; 95% CI: 0.07–0.63; p = 0.009). Leaving to consult a traditional bone setter was associated with a higher frequency of early discharge than all other reasons combined (OR = 3.16; 95% CI: 1.42–7.03; p = 0.005).

Factors associated with early DAMA: multivariable analysis using Firth's penalised logistic regression

Firth regression was performed on the 265 patients with complete data for the variables in the model (Table III). After adjustment, only admission within 24 hours of injury remained statistically associated with early DAMA (aOR = 5.28; 95% CI: 1.05–26.61; p = 0.044).

Male sex (aOR = 3.01; 95% CI: 0.76–12.03; p = 0.118), age per 10-year increment (aOR = 0.80; 95% CI: 0.59–1.07; p = 0.134), residence in Boussé (aOR = 0.52; 95% CI: 0.10–2.60; p = 0.425), domestic accidents (aOR = 0.51; 95% CI: 0.14–1.84; p = 0.300) and consulting a bone setter (aOR = 2.06; 95% CI: 0.72–5.85; p = 0.176) were no longer significantly associated with the outcome. Housewives did not show an independent association with early DAMA either.

Table II: Factors associated with early discharge against medical advice among trauma patients: bivariate analysis in the 288 patients with a documented admission-to-DAMA interval

Variable	Category	DAMA < 24 h	DAMA ≥ 24 h	Crude OR	95% CI	p
Age, per 10 years	—	258	30	0.79	0.64–0.97	0.026
Sex	Female	51	15	1.00	Ref.	
	Male	207	15	4.06	1.86–8.84	< 0.001
Occupation	Farmer/livestock breeder	89	8	1.00	Ref.	0.021
	Self-employed worker	87	7	1.12	0.39–3.21	1.000
	Pupil/student	37	3	1.11	0.28–4.41	1.000
	Housewife	27	8	0.30	0.10–0.88	0.034
	Civil servant	12	2	0.54	0.10–2.84	0.612
	Unemployed/other	6	2	0.27	0.05–1.56	0.168
Residence	Ziniaré	171	14	1.00	Ref.	0.008
	Zorgho	38	4	0.78	0.24–2.49	0.751
	Boussé	16	7	0.19	0.07–0.53	0.003
	Other towns	33	5	0.54	0.18–1.60	0.333
Injury-to-admission time	≥ 24 h	10	15	1.00	Ref.	
	< 24 h	240	15	24.00	9.23–62.38	< 0.001
Mechanism of injury	Road traffic accident	211	10	1.00	Ref.	< 0.001
	Domestic accident	27	6	0.21	0.07–0.63	0.009
	Occupational/other	17	1	0.81	0.10–6.67	0.585
Decision-maker	Patient	52	4	1.00	Ref.	0.470
	Relative	206	26	0.61	0.20–1.82	
Reason for DAMA	Other reasons*	100	20	1.00	Ref.	

Variable	Category	DAMA < 24 h	DAMA ≥ 24 h	Crude OR	95% CI	p
	Traditional bone setter	158	10	3.16	1.42–7.03	0.005

*DAMA: discharge against medical advice; OR: odds ratio; CI: confidence interval; Ref.: reference category. Crude OR, 95% CI (Woolf method) and p-values (Fisher's exact test) are computed from the counts shown. *Financial difficulties, transfer to another health facility, refusal of care or surgery, and other reasons.*

Table III: Factors associated with early discharge against medical advice: multivariable analysis using Firth's penalised logistic regression (n = 265)

Variable	Category	aOR	95% CI	p
Age, per 10 years	—	0.80	0.59–1.07	0.134
Sex	Female	1.00	Ref.	
	Male	3.01	0.76–12.03	0.118
Occupation	Farmer/livestock breeder	1.00	Ref.	
	Self-employed worker	1.26	0.33–4.82	0.736
	Pupil/student	0.88	0.13–5.97	0.898
	Housewife	1.70	0.26–11.28	0.583
	Other	0.82	0.11–6.19	0.845
Residence	Ziniaré	1.00	Ref.	
	Zorgho	0.64	0.18–2.25	0.484
	Boussé	0.52	0.10–2.60	0.425
	Other towns	0.67	0.14–3.12	0.607
Injury-to-admission time	≥ 24 h	1.00	Ref.	
	< 24 h	**5.28**	**1.05–26.61**	**0.044**
Mechanism of injury	Road traffic accident	1.00	Ref.	
	Domestic accident	0.51	0.14–1.84	0.300
	Occupational/other	0.49	0.09–2.85	0.431
Reason for DAMA	Financial difficulties	1.00	Ref.	
	Other reasons	1.84	0.35–9.72	0.472
	Traditional bone setter	2.06	0.72–5.85	0.176

aOR: adjusted odds ratio; CI: confidence interval; Ref.: reference category.

Discussion

The main finding of this study is that admission within 24 hours of injury was the only factor independently associated with early DAMA after multivariable adjustment. Patients admitted within the first 24 hours after their injury had roughly five-fold higher odds of leaving against medical advice within 24 hours of admission.

This finding should be interpreted with caution. Time to admission should not be regarded as a direct cause of early DAMA. It is more likely a marker of other, unmeasured features of the care pathway, such as the perceived severity of the injury, the expectations of the patient or family, advice received before admission, or the availability of an alternative source of treatment.

Previous studies of DAMA in trauma care have mainly identified sociodemographic, clinical and organisational factors associated with leaving hospital, without specifically examining the timing of discharge [12,13]. In our study, several of these factors were associated with early discharge in bivariate analysis, but none remained independent after adjustment. This difference may reflect the particular nature of our outcome, which concerns not whether DAMA occurs but when it occurs among patients who have already decided to leave.

The association between early admission after injury and early DAMA may have several explanations. The first relates to perceived severity. When a patient presents soon after an injury and no immediate procedure is offered after the initial assessment, the patient or relatives may interpret this as a sign that the injury is minor or that hospital admission is

unnecessary. This perception could encourage departure before investigations or the treatment plan have been completed.

The second explanation concerns the therapeutic pathway. In a context of medical pluralism, the hospital may be seen as a place for assessment before turning to other forms of treatment. This is particularly relevant in our population, in which consulting a traditional bone setter was the main stated reason for DAMA [8,12,14].

Finally, family decision-making may influence the timing of discharge. In our series, the decision was made by a relative in 80.4% of cases. Rapid admission may leave little time to explain the diagnosis, the investigations required, the risk of complications and the benefits of continuing care to the patient and family. Early, structured communication could therefore be a useful target for intervention.

Several variables associated with the outcome in bivariate analysis lost their association after adjustment. Age was associated with early discharge in the crude analysis, but this association disappeared once the other variables were taken into account. This is in keeping with studies reporting more frequent DAMA among younger patients in orthopaedic and trauma populations [9–11].

Male sex was also strongly associated with the outcome in bivariate analysis, but the association was no longer significant after adjustment. Male sex therefore cannot be regarded as an independent factor for early DAMA in this population.

The associations observed for housewives and residence in Boussé also disappeared after adjustment. They may reflect interrelated socioeconomic, geographical or organisational differences. Economic constraints are indeed frequently reported among the reasons for DAMA in resource-limited settings [6,12].

Domestic accidents were associated with a lower frequency of early DAMA in bivariate analysis, but this association did not persist in the multivariable model. Similarly, consulting a bone setter, although it was the main stated reason for DAMA and was associated with early discharge in the crude analysis, showed no independent association. This indicates that recourse to traditional treatment remains an important component of DAMA as a whole, but that its link with early discharge may be explained by other patient and pathway characteristics [12,14].

The distinction between crude and adjusted associations is therefore essential. Our results do not allow us to conclude that sex, age, occupation, residence, mechanism of injury or consulting a bone setter independently determine how early DAMA occurs. Once the model variables were considered simultaneously, only admission within 24 hours of injury remained statistically significant.

Limitations

This study has several limitations. Its retrospective design exposes it to selection and information bias, and its single-centre setting limits the generalisability of the findings. Because there was no group of trauma patients who did not leave against medical advice, the study cannot identify the factors associated with DAMA itself, only those associated with its timing among the patients concerned. The small number of discharges occurring at or after 24 hours and the small size of some occupational and injury-mechanism categories may also reduce the precision of the estimates. Despite the use of Firth regression, some estimates have wide confidence intervals and should be interpreted with caution. Finally, several factors that may explain the decision to leave, notably perceived severity, the quality of communication between staff and families, the costs actually incurred and advice received before admission, were not available in the records.

Conclusion

Most DAMA among trauma patients in this series occurred within the first 24 hours after admission. After adjustment using Firth's penalised logistic regression, admission within 24 hours of injury was the only factor statistically and independently associated with early DAMA.

The associations observed in bivariate analysis for age, sex, occupation, residence, mechanism of injury and consulting a bone setter did not persist after adjustment. These results suggest that interventions aimed at preventing very early discharge should begin in the first hours of care, in particular by providing clear information about the potential severity of the injury, the investigations required, the treatment plan and the risks of interrupting care.

Prospective, multicentre studies are needed to confirm this association and to clarify the respective roles of clinical, economic, family and sociocultural factors in early DAMA.

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