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Apology Laws: The Complexities of Apologies and Error Disclosure

By Kevin Klauer, DO, EJD, Chief Medical Officer — Emergency Medicine Chief Risk Officer, Executive Director, Patient Safety Organization, TeamHealth

Showing compassion and expressing remorse is a humanistic attribute that most patients would expect of their providers. However, due to concerns of medical legal risk, such sentiments are rarely, if ever, expressed.

In 1986, Massachusetts enacted the nation's first apology law in.[1] As many other states followed suit, this fundamental shift in philosophy served as a signal to providers that it was now safe to apologize to patients, without the possibility of retribution by way of admissibility of their statements in professional liability claims filed against them. Unfortunately, many did not read the fine print. Just like other terms used in daily communication, "apology" has a specific meaning in a legal context and varies from state to state; all apologies are not created equal. Most importantly, many statutes do not offer protection from admission of fault, but merely expressions of sympathy (i.e., expressions, gestures, actions, general sense of benevolence). The Massachusetts statute only protects expressions of sympathy. It was not until 2004 that Colorado adopted a statute prohibiting admissibility of admissions of fault.[2]

> APOLOGY HAS A SPECIFIC MEANING IN A LEGAL CONTEXT AND VARIES FROM STATE TO STATE — ALL APOLOGIES ARE NOT CREATED EQUAL.

The National Conference of State Legislatures published a list of the

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About This Month's Featured Author

Dr. Kevin Klauer has a long and diverse background in the field of emergency medicine, serving in various capacities, becoming chief medical officer of emergency medicine at Knoxville, TN-based TeamHealth in January. In the April issue of ED Legal Letter, Dr. Klauer weighed in on the challenges of peer reviews in the emergency medicine setting. He is a frequent AHC Media contributor.

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nation's apology statutes in 2014.

"Thirty-six states, the District of Columbia, and Guam have provisions regarding medical professionals making apologies or sympathetic gestures. Of these states, six have provisions that specifically relate to accidents."[3]

Presumptions? Avoid Them

The only thing worse than not having protections for apologies is the presumption of protection that you do not have, which is the situation the imcomplete protection of most apology laws create, covering only expressions of sympathy.

However, protection of expressions of sympathy still provides valuable medical legal protection, provided the practitioner understands the details and limitations of the statute in their state.

For example, the Ohio State Supreme Court upheld a trial court's determination that such an expression of sympathy was inadmissible, despite the fact that Ohio's statue was enacted three years after the patient's date of service.

"In *Estate of Johnson et al. v. Smith et al.*, a patient claimed that her surgeon's comments after a bile duct surgical injury were an admission of guilt and should be admissible in her medical liability lawsuit. But the state high court ruled that the doctor's sentiments were precluded from becoming evidence by the state's apology statute, even though the incident happened before the law took effect."[4]

Despite the variability of different states' statutes and the limitations of most, there is great value in expressing compassion to patients.

We should do so carefully, and in states not protecting admission of fault, limit our individual statements to expressions of sympathy and not create new liability exposure by expanding to an admission of fault.

Regardless of whether your state considers admission of fault inadmissible, it is recommended that admissions of fault be carried out by trained personnel in a structured fashion, outlined in hospital policy.[5] As such disclosures are associated with significant medical legal implications, cost implications, and potential hospital operational changes, a decision to admit fault should be guided by carefully crafted policy and not left to the individual practitioner to decide.

Furthermore, the content of such an apology has to be carefully considered and that message carefully delivered. Per Gallagher, and a patient survey he published in 2006, the elements that were most important to patients and families were[6]:

- Disclosure of all harmful errors;
- An explanation as to why the error occurred;
- How the error's effects will be minimized;
- Steps the physician (and organization) will take to prevent recurrences.

Determining Errors to Disclose

Also of importance, and noted in Gallagher's body of work, is which errors should be disclosed. From the medical ethics perspective, the provider should not determine which errors to disclose.

Rather, if an error has occurred, it should be disclosed. Just because the patient may not otherwise know

of the error or even if no harm has occurred, it is not the provider's right to limit the information to which the patient is entitled.

There are additional reasons to consider disclosing an error, providing an apology, and even admitting fault. Perhaps most compelling is the impact this may have on professional liability exposure. *American Medical News* cited case examples of programs that reduced the average indemnity paid and frequency of claims.[7] "From 1990 to 1996, the Lexington VA had 88 claims and paid an average $15,622 per claim, compared with a $98,000 average at VA hospitals without 'I'm sorry' policies.

"Medical centers affiliated with the University of Illinois at Chicago, Stanford University, Johns Hopkins University, and Harvard University also have adopted 'I'm sorry' policies. So have Kaiser Permanente's medical centers, the Catholic Healthcare West system, and the Children's Hospitals and Clinics of Minnesota. COPIC Insurance Co., a medical liability carrier in Colorado, started openly communicating about medical errors in 2000 and reimburses patients for costs of up to $30,000."[7]

In 2002, the University of Michigan implemented a procedure to disclose errors, apologize for them, and to compensate the patient. They reported a $2 million annual reduction in litigation expenses and a 40% reduction in new claims. Their average cost of a claim dropped from $405,921 to $228,308.[8]

In addition to the humanistic benefits to the patient, their family, and the providers, as well as the potential positive impact on claims severity and frequency, regulatory agency requirements for disclosure provide another strong incentive to implement such programs. In 2002, The Joint Commission announced the requirement to disclose medical errors to patients (e.g., Sentinel events).

Despite the challenges associated with the variability of state statutes addressing apologies, providers should be encouraged to show compassion and express concern and sympathy toward their patients.

JUST BECAUSE THE PATIENT MAY NOT OTHERWISE KNOW OF THE ERROR, OR EVEN IF NO HARM HAS OCCURRED, IT IS NOT THE PROVIDER'S RIGHT TO LIMIT THE INFORMATION TO WHICH THE PATIENT IS ENTITLED.

Although providers must be aware of the details of the statutes in the states in which they practice, a carefully worded show of concern or expression of sympathy does not necessarily result in significant risks for liability exposure to the provider, particularly when such humanistic behaviors may improve the relationship with the patient and their family, lowering the risk of a claim or lawsuit. However, when it comes to an admission of fault, this should be performed carefully and in conjunction with the hospital and physician group risk managers and in accordance with established hospital and/or group policy.

[*Editor's note: To learn more about which states have apology laws, please visit http://www.ncsl.org/research/financial-services-and-commerce/medical-professional-apologies-statutes.aspx.*] ■

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Is EP 'Over-documenting' with EMRs? Malpractice Defense Will Be Difficult

Otherwise defensible claims against EPs are being settled

In some malpractice litigation against emergency physicians (EPs), electronic medical record (EMR) charting is making the plaintiff attorney's job much easier.

EPs are "documenting significantly less because they're relying too much on checkboxes," according to **Joan Cerniglia-Lowensen**, JD, an attorney at Pessin Katz Law in Towson, MD.

"You get 'yes,' 'no,' or half answers instead of narratives and a complete H&P."

Cerniglia-Lowensen says EMRs are making it more difficult to defend malpractice claims because "the way EPs are charting has gotten significantly sloppier." Here are some ways EMR charting is complicating EPs' malpractice defense:

• The EP checks the wrong box, and their own notes contradict the box they checked.

With EMRs, "it's very easy to be inconsistent," Cerniglia-Lowensen says. The EP's narrative may refer to the patient's history of cardiac problems, for instance, but a box is checked stating "no past medical history of any type of cardiovascular disease."

"That causes problems when you are trying to defend the chart," she says. "The EP will be asked, 'Were you treating the patient as though you believed there was a history, or not?'"

In a recent malpractice case, inconsistency in the EMR charting became a central issue. The EP's notes stated that crackles were heard in the patient's lung, but the box "Breath sounds normal" was checked. The patient died from an allergic reaction to the antibiotic ordered by the EP.

"The plaintiff used the inconsistency in the record to claim there was no pneumonia; therefore, the patient's death was caused directly by the provider ordering an unnecessary medication," Cerniglia-Lowensen says. The case against the EP was settled.

"It is very difficult to defend sloppy charting," Cerniglia-Lowensen adds. "It looks as though your own doctors didn't believe in the treatment they were giving."

• There is nothing in the EMR to explain the EP's decision-making.

"The downside of that is when you are facing a courtroom, you won't remember what your thought process was, and your EMR is not going to reflect that," Cerniglia-Lowensen says.

John Davenport, MD, JD, physician risk manager of a California-based HMO, recommends EPs explain their decision-making in the chart, including the reason why certain diagnoses are not suspected.

"It's important to put down the reason that you don't think it's certain things," he says. If a patient presents with chest pain or shortness of breath and the EP determines it's pleurisy or bronchitis, the EP can document, "I do not think it's a pulmonary embolism" and state a reason why.

"Making some effort to show your decision-making really goes a long way to convincing somebody that you were seriously thinking about the patient and doing your best to help them," Davenport notes.

• The patient is discharged with abnormal vital signs, and there is nothing in the EMR that says the EP was aware of it.

Cerniglia-Lowenson has defended several cases in which abnormal vital signs were clearly documented in the EMR — but not by the EP.

"It isn't always a nurse assessing vital signs. It could be a CNA [certified nursing assistant], and they don't bring it to the attention of anyone. But they do chart it in the EMR," she says.

This allows the plaintiff's attorney to convincingly argue that the EP inappropriately discharged the patient, and that the patient's outcome would have been different if the EP had acted on the abnormal vital signs.

• The chart indicates the EP did an extensive evaluation, when it is clear that this never occurred.

"With a few short keystrokes, a note will pop up with additional information, saying that you did things that you did not do," Davenport says.

When EPs do not edit EMR charting carefully, "that exposes you to the accusation that you are essentially lying," he warns.

"I've seen this come up in several trials." Juries will likely infer the EP is falsely charting for billing purposes.

EPs face legal risks if they allow inaccurate information to be populated in the chart, warns **Jonathan E. Siff**, MD, MBA, FACEP, associate chief medical informatics officer at The MetroHealth System. Siff is also assistant operations director for the Department of Emergency Medicine at MetroHealth Medical Center in Cleveland.

"An example is the patient with a history of leg amputation where the

charting macro documents 'normal dorsalis pedis and posterior tibial pulses bilaterally,' despite the fact the patient only has one leg," Siff says.

Davenport has reviewed several ED charts in which timestamping revealed the EP spent only a few minutes with the patient. Yet the EMR indicated an extensive examination occurred.

"We see constantly the plaintiff say, 'The doctor wasn't in the room with me for five minutes and he barely touched me,' but the chart looks like a medical school history and physical," Davenport says.

In many ED charts, a complete physical examination is documented for a patient with a minor complaint.

"It strains credibility that somebody would do a full neuro and abdominal exam if you come in with a sore throat," Davenport notes.

During deposition, the plaintiff's attorney asks about the care of the patient, the amount of time the EP took, and what the EP examined. Then, an expert medical reviewer compares the EP's testimony with the ED chart. "If the expert shows that what the EP said was not true, it might not have a direct impact on the theory of the case," Davenport says.

"Regardless, it has an effect on the credibility of the physician."

The plaintiff attorney is trying to show the EP failed to meet the standard of care, but at the same time, is also trying to show the EP's testimony isn't trustworthy.

"Once a witness is found to be untruthful in one part of the testimony, the whole testimony can be disregarded," Davenport explains. "The plaintiff attorney can ask how many patients the EP sees in a day, how long it takes to perform a neuro exam, and start adding up the time."

The inference is that the EP is falsely claiming to have performed the examinations.

"If you get caught doing that, it affects your believability at trial. It makes it a much more difficult case to win," Davenport notes. "With overwhelming evidence that the EP was not truthful, these cases are typically settled."

EMR charts containing personal notes, on the other hand, can help the EP's defense.

EXAMINATIONS THAT WERE INACCURATELY DOCUMENTED DON'T HAVE TO AFFECT THE PATIENT'S OUTCOME TO HARM THE DEFENSE.

"These indicate actual, personal discussions with the patient and others in the room," says **Amy Evans**, executive vice president in the Bellevue, WA, office of Western Litigation, a professional liability claims and risk management company.

EPs might note, for example, "Patient just returned from a shopping trip with sister and felt ill" or "Wife reports that the patient was not feeling well all week."

To counter claims the EP spent almost no time with the patient, the EP can document detailed discussions or that he or she rechecked the patient several times.

"This indicates the physician spent good time with the patient and family," Evans says.

• Normal findings are mistakenly entered into the chart, which don't reflect the patient's clinical condition.

"A template note might automatically put 'regular sinus rhythm, no gallop heard,' for instance, when this is clearly not the case," Davenport says.

A patient's ECG might show premature atrial or ventricular contractions, or a patient may present with a known history of rate-controlled atrial fibrillation, both of which would also contradict the template note.

"Sometimes, the EP just forgets to review the notes," Davenport notes. "I've seen a fair number of normal findings entered into the chart that didn't correlate to the patient."

If EPs document something in one part of the chart that is abnormal and click an "all normal" button elsewhere, it creates an inconsistency in the chart.

"For example, the EP might document vomiting in the HPI [history of present illness], but use the 'all normal' button on review of systems, thereby setting GI to 'normal,' despite having documented the presence of vomiting elsewhere," Siff explains.

If the EMR includes a long list of physical findings that are listed as "normal" by default, the onus is on the EP to correct any findings that were inadvertently listed as normal.

"To leave that in there is not good for the EP," Davenport warns. "It exposes the EP to allegations that he was careless in his charting or even lying."

Examinations that were inaccurately documented don't have to affect the patient's outcome to harm the EP's defense.

"If a chest pain patient sues for

misdiagnosis of myocardial infarction [MI], and you've got a neuro exam stuck in there, it's not really pertinent to the case," Davenport says.

Whether the EP actually performed the neurological exam makes no difference to the patient's outcome.

"But if you can prove the EP didn't do it, that affects the EP's credibility," Davenport adds. The judge or jury will be asked to believe that the EP was untruthful in the chart, but is truthful in all of his or her other testimony.

"The defense is left to argue, 'My client is guilty of careless charting,'" Davenport continues. "That is a hard defense when you have to rely on that."

• To save time, the EP completes the template in advance, with the intention of correcting it based on what is found during the examination.

"This is a poisonous practice," Davenport says. In one malpractice case, the EMR time-stamping showed the patient was actually at the nursing station at the time the EP was documenting a physical exam. "The EP is claiming to have done a full physical on a patient who was still having their vital signs checked by a nurse," Davenport says. "That does not look good for the EP."

• Nursing EMR charting conflicts with the EP's.

Some EMRs make it difficult for EPs to view the nursing documentation.

"But having a clunky chart doesn't excuse you," Davenport warns. "It's not enough to say, 'This chart is not designed well and I had to go through three or four steps to find it.'"

The plaintiff attorney will likely take full advantage of the fact the EP failed to review the nursing notes.

"The EP will be asked, 'So you didn't have an extra 45 seconds to look at that nursing note and prevent the patient from having an MI?'" Davenport explains.

The EP must note any discrepancy in the chart, and clarify that the patient's condition changed between exams, Evans advises. In one case Evans reviewed, the ED nurse noted guarding, rebound, and tenderness, yet the EP indicated the abdominal exam was benign.

"The patient went on to experience a ruptured appendix with abscess, and sued the doctor for failure to diagnose," Evans says.

The defense tried to argue that the symptoms noted by the nurses had resolved by the time the EP examined the patient. "But the patient testified that our EP spent no time with her and did not examine her abdomen," Evans notes. "The jury believed the patient, because her testimony was consistent with the nurses' notes."

• Time stamping shows that something happened at a substantially different time than the EP documented, that the EP spent minimal time with the patient, or that the EP altered the documentation.

"Clearly identify any modifications to the chart as late entry or addendums to prevent the appearance of trying to 'change history,'" Siff advises. ■

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Bad Outcome in 'Boarded' ED Patient? Reduce Likelihood of EP's Liability

Poor communication is often root of claims

A recent malpractice case involved a 38-year-old female with chest pain and low blood pressure who was held in the ED until an ICU bed became available.

"A CT of the chest revealed a moderate pericardial effusion. The patient had previously been hospitalized a month earlier for a small pericardial effusion," says **Jordan S. Powell**, JD, an attorney at Levin & Perconti in Chicago.

The EP and the hospitalist who were going to take the case reviewed the CT result. Shortly thereafter, an ICU bed became available. Before the patient was transferred out of the ED, a new hospitalist took over in the ICU.

"There was never any communication between the ER

physician and either hospitalist," Powell says.

The claim has not yet been resolved and is set for trial at the end of the year.

"With adequate communication by the EP to the other physicians, and documentation of such communication, potential liability could have been avoided," Powell notes.

Both hospitalists are taking the position that they do not see patients in the ED and are only responsible once the patient gets to the floor.

"The ER physician claims the hospitalist is responsible for providing the admitting orders," Powell says. "As a result of this dispute and lack of communication, an initial set of admitting orders was never performed."

There was no communication to the hospitalists that the pericardial effusion had increased from the previous month. The patient ultimately died of a cardiac tamponade.

"Since there is finger pointing between the EP and the hospitalists, the EP will not be dismissed," Powell says. "The jury will be required to make the determination."

Powell says these practices can be legally protective for EPs when admitted patients are boarded in the ED:

• Document all assessments, findings, and communication with other practitioners.

"Without documentation, it is difficult to remember any communications," Powell notes. "At the time of a lawsuit or a deposition, there will be no proof that any such communication was had."

• When patients are being held in the ED waiting for a bed to open, have a discussion with the admitting physician and develop a plan related to any orders.

"This fosters continuity of care," Powell says. "It helps to reduce the risk that orders will not be properly followed."

Who Is Responsible?

When claims against EPs involve admitted patients held in the ED, "the question becomes, on the back end, 'Whose responsibility is it to provide care for that patient?'" says **Brandon K. Stelly**, corporate director of enterprise risk management, legal division, and internal counsel for the Lafayette, LA-based Schumacher Group.

> THE RESPONSIBILITY TO CARE FOR PATIENTS HELD IN THE ED GENERALLY FALLS TO BOTH THE EMERGENCY PHYSCIAN AND THE ADMITTING PHYSICIAN.

Once a disposition has been made on a patient, and an admitting physician has accepted the patient into their care, the EP typically moves on to other patients, Stelly says. During the time the patient is in the ED, nursing staff are expected to monitor the patient and notify the nearest physician — likely, the EP — of any change in the patient's condition or need that the patient may have.

"But who has the duty to that patient?" Stelly asks. "Cases show the answer to that question varies."

Some courts have found the duty was with the EP because the patient was still physically in the ED, Stelly notes.

"But most likely, it would be the responsibility of both the EP and the admitting physician."

If the attending physician has come to the ED and seen the patient, the responsibility is much more likely to fall with the attending physician instead of the EP, according to Stelly. This is not the case if the patient is admitted on paper, but the attending has not come to the ED and will not see that patient until the following day.

In this scenario, Stelly says, "I would strongly urge EPs to not take the mindset of that patient being the responsibility of the attending physician, at least while the patient is still physically in the ED."

One malpractice claim Stelly reviewed involved a patient whose blood pressure changed significantly while he was held in the ED.

"According to the plaintiff's attorney, it had changed to a point where it would have been an emergent finding," he says. "The ED nurses were documenting it, but the EP was not advised of those blood pressures."

The patient deteriorated before arriving on the inpatient floor.

"Even the nursing staff were of the mindset that the patient was admitted, and was therefore no longer under the care of the ED," Stelly says.

The nurses failed to inform either the EP or the admitting physician of the patient's blood pressure.

"It's a fine line to walk when the patient is housed in the ED," Stelly explains. "From the EP's standpoint, it really is a double-edged sword."

If the EP is notified of a change in the patient's status and the EP takes action to correct it, via orders or any other intervention, it will be very hard for the EP to take the position that it wasn't his or her patient anymore.

If a change in the patient's status requires immediate intervention, Stelly advises, then the nursing staff should notify the closest physician — likely the EP.

"However, if the patient's change in status is something that is not emergent, then I would suggest the nursing staff notify the admitting physician," he says. "The problem lies within making the determination of which category the patient belongs."

Stelly cautions EPs to "never ignore a notification from a nurse."

"You may have moved on to the next patient, or the next four patients," he says. "But when the nurse taps you on the shoulder and says, 'We've got a problem,' you need to take action."

The EP must also document the subsequent action.

"Just as I advise my EPs to document well, I'm quite sure nurses are also documenting well and will document that the EP was informed," he says. "The question then boils down to, 'What did the EP do with it?'"

The EP should also notify, advise, and consult with the admitting physician and document those interactions, Stelly urges.

"That will allow the EP to say, 'I took the appropriate action that was needed, and I did so with the involvement of the attending physician under whose care the patient belonged,'" he says.

EPs Can't 'Wash Hands' of Patient

When malpractice claims involve an ED patient who was boarded, allegations against EPs can include failure to stabilize the patient, failure to monitor and manage a decompensating patient, and failure to appropriately admit or transfer the patient to an inpatient care location, says **Nathaniel Schlicher**, MD, JD, FACEP, associate director of the Patient Safety Organization at TeamHealth. Schlicher is also attorney of counsel in the Seattle office of Johnson, Graffe, Keay, Moniz & Wick.

"Providers can get in trouble when they believe they have transferred care and thus can 'wash their hands' of the patient regardless of their condition and location," Schlicher warns.

Without clear delineation of the timeline of the transfer of care and when responsibility shifts to the inpatient service, there is a risk the EP can get swept into a malpractice case.

"From the public's perspective, the ED doc that is 10 feet away is still responsible when the patient is declining — even if they have been admitted for four hours to a provider that has never seen them," Schlicher stresses.

Schlicher recommends EPs work with hospitalists and administrators to clearly delineate responsibility for boarding patients, timelines for when the transition of care occurs, and who is writing the orders. In some institutions, EPs write admission or transition orders that can last up to 24 to 48 hours.

"These extend the provider's risk and liability far beyond the initial care and stabilization," Schlicher says. "It is important to limit the duration and also ensure the inpatient provider is assuming care in a timely manner."

During malpractice litigation, inpatient providers frequently claim the ED failed to communicate an important fact that would have changed their evaluation or timeliness of care.

"This is the reality in almost all cases involving transition of care," Schlicher says. "Thus, it is important the ED providers clearly document what information was communicated." ■

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Length-of-Stay Benchmarks Linked to Fewer Adverse Events

EDs with a higher percentage of patients meeting length-of-stay benchmarks on a given shift had lower rates of adverse events, according to a recent study.[1] "This suggests that setting, and meeting, performance targets for ED length of stay is an important intervention to reduce the risk for patients associated

with crowding," says **Michael Schull**, MSc, MD, the study's lead author. Schull is an emergency physician and president and CEO of the Institute for Clinical Evaluative Sciences in Toronto, Ontario, Canada.

Researchers found that the risk to patients varied, depending on how crowded a particular shift was. "It wasn't that there were 'good' EDs and 'bad' EDs in terms of the risk from crowding," Schull explains. "We statistically compared patient outcomes from more and less crowded shifts from the same ED."

If EDs choose a length-of-stay benchmark that's too short, it could compromise patient safety due to rushed care, Schull notes. "If you pick a benchmark that's too long, you might not really be reducing crowding enough to reduce the risk it poses to patient care," he adds.

In a previous study of 122 EDs, the researchers showed that death or hospital admission within seven days of ED discharge was more likely to occur when patients were seen during ED shifts with worse crowding, measured by average ED length of stay of all ED patients seen on the shift.[2] Better performance on length-of-stay benchmarks was associated with a 10-45% reduction in the odds of death or admission seven days after ED discharge.

"However, from that study, we could not say whether achieving a particular ED length-of-stay benchmark — such as discharging patients within a certain timeframe — would reduce that risk," Schull says. To reduce risks, he suggests EPs work with ED and hospital leaders to reduce average ED length of stay on each shift, using benchmarks and targets.

> IF LENGTH-OF-STAY BENCHMARKS ARE TOO SHORT, IT COULD COMPROMISE PATIENT SAFETY DUE TO RUSHED CARE.

"Efforts to improve quality of care for specific high-risk patients — acute myocardial infarction, stroke, and sepsis — are also important," Schull notes. "But this may do little to reduce the risks we identified, since those higher-risk patients are rarely discharged." ■

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SOURCE

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Did ED Patient Refuse Admission? This Documentation Is Essential

A 63-year-old ED patient with mid-back pain that radiated to her chest explained that she'd experienced it many times previously as a result of gastroesophageal reflux disease.

"The patient stated that she was only in the ED because her primary care physician, concerned that she might be having a cardiac event, would not see her in the office," says **Jeanie Taylor**, RN, BSN, MS, vice president of risk services for Emergency Physicians Insurance Company in Auburn, CA.

The physician's assistant (PA) told the patient she needed to be admitted to rule out pulmonary embolism (PE).

"The patient was surprised that admission was required; she had not previously been told that PE was being considered," says Taylor. The PA abruptly responded, "You can leave AMA [against medical advice], but we cannot discharge you."

"No doubt this ill-informed PA thought that an AMA discharge would protect her from exposure to liability," says Taylor.

The patient was admitted and had a good outcome, but the scenario highlights a dangerous misconception held by many ED providers — that they aren't legally responsible if patients refuse admission.

"Many believe that if a patient leaves AMA, they are not liable for what happens to the patient. Think

again," says Taylor.

If the patient refused admission and a bad outcome occurs, the plaintiff's attorney will likely allege the EP was negligent for failing to insist on the patient being admitted, and that the EP should have protected the patient against the patient's own bad judgment, says **John W. Miller II**, principal at Sterling Risk Advisors in Atlanta.

"The most common allegation against physicians and nurses is that they didn't properly inform the patient of the seriousness of their condition," says Miller.

ED patients sign out AMA for any number of reasons, including responsibilities for children, parents, and even pets; some patients without insurance or with high co-pays and deductibles think they cannot afford to be admitted.

"Regardless of the reason, it is not in the provider's best interest for patients to leave AMA," says Taylor.

Form Is Never Enough

Miller says EPs can protect themselves by clearly documenting in the record, and perhaps through an informed refusal form, the discussion with the patient of all the risks and benefits and potential outcomes that might affect that patient as a result of that decision. However, "it is never enough to have patients sign a generic form that says they are aware of the risks," warns Miller.

The form is representative of the dialogue that must take place between the EP and the patient, he explains, "but it's only a partial proof that the conversation took place." It must be further supported by the ED medical record, in which the details of the conversation are recorded.

"The emergency physician must be able to demonstrate that the patient was taken through the process, and record the patient's response, and, ideally, the patient's acknowledgment of their understanding of the potential consequences," says Miller.

The more detailed the medical record is on the substance of the informed refusal conversation, the better, he stresses. This is because allegations of misdiagnosis are best defended through a clear story in the medical record where the EP rules out and/or contemplates all potential diagnoses.

IF THE PATIENT REFUSED ADMISSION AND A BAD OUTCOME OCCURS, THE PLAINTIFF'S ATTORNEY WILL LIKELY ALLEGE THE EP WAS NEGLIGENT FOR FAILING TO INSIST ON THE PATIENT BEING ADMITTED.

"Since that is where the allegations will begin, informed refusal must be outlined in the medical record where the emergency physician records all potential outcomes associated with their decision not to be admitted," says Miller.

When it is written down at the time of refusal, the burden of proof is on the plaintiff to prove that it is false.

"This is extremely difficult," notes Miller. "It is helpful to have a second person there to document the discussion, but writing it down is paramount." He advises that EPs document:

- All the EP's objections to the patient leaving;
- The patient's actual responses.

"This adds to the veracity of the record," says Miller. "Making this a firm habit with all patients who leave against medical advice is a smart practice."

Try to Deter Patient From Leaving

ED providers should do all they can to deter a patient from leaving AMA, advises Taylor.

"Never offer AMA as a solution to a patient," she warns. "Do not be quick to execute an AMA discharge."

Instead, says Taylor, EPs can tell patients who are refusing admission the following:

- That you would like them to stay in the hospital because you are concerned for their safety;
- That you want to know the reason for their decision.

One ED nurse offered to care for an elderly patient's dog so the patient could be admitted.

"If the patient is concerned about co-pays, deductibles, or is uninsured, call the business office to work with them on managing the cost of hospital," recommends Taylor.

- That you will have to ask them to sign a form releasing the hospital from any liability in case something bad happens to them.

"Often, that is enough to make them reconsider their decision," says Taylor.

She says to make sure the risks specific to the patient's condition are

well-documented.

• That asking them to sign out AMA merely documents the EP's belief that admission is the best treatment option, but that the AMA discharge in no way prevents the patient from changing their mind at any time and returning to be admitted.

EPs might tell patients, "Should you change your mind at any time, even as you are leaving, we will arrange for you to be admitted."

Taylor adds that EPs should never let nursing staff handle a patient refusing admission. "An emergency physician should be involved in all AMA discharges and refusals of care," she says.

Obligation to Patient

If the patient remains unwilling to be admitted, the EP's obligation to provide care for the patient does not end.

"You must provide the best possible care you can in light of the AMA decision," underscores Taylor. "It should not result in an argument or be a source of conflict."

She recommends these practices:

• Provide the highest level of care the patient will accept.

Is a chest pain patient refusing admission?

"Make sure your documentation states that you not only recommended admission, but also recommended an alternative plan of care," says Taylor.

This might include observation, serial enzymes, a stress test, outpatient cardiac medications, or follow-up.

"If an alternate plan of care is negotiated with the patient, great. But make sure the record clearly reflects your original treatment recommendation for admission," warns Taylor.

• Provide prescriptions.

Some EPs hesitate to do this, fearing that it encourages patients not to seek follow-up care or implies that the EP agreed to provide substandard care.

"This is not true," says Taylor.

For example, a patient with pneumonia refusing admission can be given a dose of IV antibiotics in the ED, with a prescription for oral antibiotics and an appointment scheduled with their physician early the next morning.

"All patients should be prescribed appropriate antibiotics, analgesics, and other medications indicated by their clinical condition, even if they leave AMA," underscores Taylor.

• Contact the patient's primary care physician and inform him or her that the patient refused admission.

"Enlist their assistance in ensuring the patient gets follow-up care, and document the conversation," says Taylor.

• At the time of discharge, invite the patient to come back to complete their treatment at any time.

• Ensure the patient has the capacity to understand the implications of refusing admission and document this.

"This is especially important in patients who have been drinking, have altered mental status and/or have psychiatric symptoms," says Taylor.

• Call patients who left after refusing admission the next day, and document the conversation.

"Let the patient know you are concerned about them. Invite them back to complete their treatment," Taylor says. ■

SOURCES

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CME/CNE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

COMING IN FUTURE MONTHS

- Allegations in med/mal lawsuits involving ED change of shift handoffs
- The biggest EMTALA risks posed by obstetric patients presenting to EDs
- Simple changes that can make ED policies much more legally protective
- Malpractice attorneys explain how wait time guarantees can get EPs sued

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CME/CNE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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2. Scan the QR code to the right, or log onto **AHCMedia.com** and click on My Account. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.

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CME/CNE QUESTIONS

1. **Which is true regarding liability risks for EPs involving EMR documentation?**

   A. An explanation of why certain diagnoses are not suspected can help the EP's defense.
   B. The EP has no obligation to correct findings inadvertently listed as normal in the EMR.
   C. Incorrect charting must be relevant to allegations made in the claim in order to be introduced as evidence.
   D. If a neurological exam was charted but not performed, it is not admissible unless the exam would have prevented the patient's bad outcome.

2. **Which can harm the EP's defense?**

   A. personal notes regarding discussions the EP had with patients
   B. a detailed explanation of medical decision-making
   C. documentation of extensive examinations that conflict with EMR time-stamping on time spent with the patient
   D. documentation that the EP rechecked the patient several times

3. **Which is true regarding admitted patients held in the ED?**

   A. Admitting physicians are legally responsible even if they do not see the patient until the following day.
   B. The EP's duty to the patient does not end even after the patient is admitted and arrives to the inpatient unit.
   C. If the attending physician sees the patient in the ED, he or she is much less likely to be held legally responsible.
   D. EPs should not assume the patient is the attending's responsibility while the patient is physically in the ED.

4. **Which is recommended to reduce risks of boarded ED patients?**

   A. Admission or transition orders written by EPs should last a minimum of 48 hours.
   B. EPs should clearly document what information was communicated to inpatient providers.
   C. ED protocols need not clearly delineate timelines for when the transition of care occurs since it occurs automatically when the accepting physician documents in the EMR.
   D. Lack of clarity over when responsibility shifts to the inpatient service is legally protective for EPs.