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INSIDE

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Patients' Easy Access to Records Means Complaints — and Chance to Avoid Litigation

EDs are bracing for a surge of complaints — not that patients are suddenly receiving terrible care. Rather, it is because patients are about to enjoy easier electronic access to their medical records, as required by the HHS Office of the National Coordinator for Health Information Technology's Cures Act.[1-3]

Although the enactment date was pushed to April 2021, some EDs are in compliance already. "In the first few days after we enabled patients to have immediate access, our patient complaints within 24 hours of their visits jumped," says **Jonnathan Busko**, MD, MPH, FACEP, ED medical director at St. Joseph Hospital in Bangor, ME.

Previously, the vast majority of complaints came in 60 to 90 days after an ED visit, right after patients received their bill. "Now that it's so easy, more patients are immediately accessing their notes," Busko reports.

People no longer have to go through the discovery process during litigation to find out everything ED providers charted. "If a nursing note throws a physician under the bus or vice versa, or if the notes appear to contradict each other, patients will have immediate access to that," Busko explains.

With patients reviewing all the clinical documentation, plenty of misunderstandings can happen.

"Even if great care was delivered, immediate access to the full range of notes can undermine patients' perception of their care," Busko observes. This is a sample of patient complaints:

• ED providers seemingly disagreed as to whether their child was "lethargic." For emergency physicians (EPs), "lethargic" is a red flag term that identifies a critically ill child. For many patients, and even many ED nurses, the term is used to describe increased sleepiness.

A parent may have described their child as "lethargic," and the ED nurse may have documented the child as "lethargic," but the EP documented

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the opposite, that the arousable, interactive child was "not lethargic."

• The history of present illness was documented incorrectly.

• The provider never mentioned lab results that were flagged as abnormal. Patients did not realize the results were just barely outside normal limits, or that the provider likely believed they were not clinically relevant.

• The template note in the EHR included the word "obese" as a checkbox in the physical exam portion. "'Obese' has a very specific definition in medicine, but a negative connotation to most patients," Busko notes.

In each case, ED leaders and members of the hospital's patient experience team contacted the patients to address the concerns.

The Cures Act requires EHRs to be accessed without special effort on the part of the user, and specifically prohibits "information blocking," says **Cynthia A. Haines**, JD, principal in the Harrisburg, PA office of Post & Schell.

Haines offers these examples of ED practices that could be considered "information-blocking" as defined in the Cures Act:

• If an ED refused to share core clinical information with a rival hospital, or shares information only by a way that is expensive or inefficient (e.g., fax only);

• If the ED refuses to share treatment records without a patient's consent, despite the fact HIPAA does not require consent to share treatment records;

• If the ED refuses to share mental health records across state lines, even if the patient has consented and no law prohibits it.

"Information-sharing in EDs is important because individuals don't have relationships with the doctors treating them, and they cannot request who they want to see," Haines says.

It is more difficult for patients to obtain their records from EDs than from physicians they see regularly. "Real-time access to health records could immediately end controversies over how soon a patient was seen, by whom, the initial impression, and whether treatment protocol was followed," Haines offers.

Patients are discovering answers that previously would have been available only after attorneys obtained them through discovery requests. Thus, says Haines, "this should alleviate some lawsuits that are brought because of a lack of transparency." ■

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ED Nurses Also Face Liability for Misdiagnosis

EPs diagnose patients, but ED nurses are held legally responsible for their role in the process, according to an analysis of malpractice claims.[1]

"The idea that it is not within the nurses' scope of practice to contribute to diagnosis is both dangerous and wrong," says **Kelly Gleason**, PhD, RN, the study's lead author.

Gleason and colleagues analyzed a database of malpractice claims from 2007 to 2016 related to diagnosis (139 claims) and physiological monitoring (647 claims) that named nurses as the primary responsible party. The claims involved various settings, including the ED.

"The contributing factors were similar across all settings, with communication with providers listed as a contributing factor for over half of cases," says Gleason, an assistant professor at Johns Hopkins School of Nursing.

• In the 139 claims related to diagnosis, there was a much higher likelihood of death if communication among providers was a contributing factor;

• In the 647 cases involving physiologic monitoring, there was a greater likelihood of death, and also higher expenses and indemnity, if communication among providers was a contributing factor.

In some claims involving communication breakdowns, the plaintiff's chief complaint was a fall injury. The patient sustained only minor lacerations. However, at triage, the patient mentions feeling dizzy before the fall. The patient assumes that since the triage nurse knew about the dizziness, the rest of the clinical team is aware.

But the ED nurse did not share this concerning piece of information, which suggests the fall might have happened because the patient suffered a stroke. After finding no significant injuries, the EP discharges the patient home. "The patient is later readmitted with a stroke, which potentially could have been caught had the clinical team realized that dizziness led to the fall," Gleason offers.

Viewing ED nurses as key members of the diagnostic team "is essential to optimizing patient outcomes," Gleason adds. ED nurses communicate patient information to the clinical team. They also ensure the patient understands and agrees with the diagnosis. "Ensuring that nurses are aware that it is not just within their scope of practice to participate in the diagnostic process, but also expected of them as part of their job, is important," Gleason stresses.

John C. West, JD, MHA, DFASHRM, CPHRM, has seen multiple ED misdiagnosis claims that started with premature closure (the EP decides what something is without running all the necessary diagnostic tests) or anchoring (the EP hits on a diagnosis and sticks to it despite conflicting test results or symptoms).

"My feeling is that nurses set the stage, or point to a path for the physician to go down," says West, principal at West Consulting Services, a Signal Mountain, TN-based risk management and patient safety consulting firm.

If an ED nurse tells an EP that a patient with "back pain" is ready to be seen, this conveys that the problem is back pain as opposed to something else. "The physician works the patient up for musculoskeletal issues, when the patient has a dissecting aortic aneurysm," West notes.

Often, there is no legal recourse taken against the ED nurse in most misdiagnosis cases. The nurse's attorney will try to paint the EP or the hospital as the real culprit. From a legal standpoint, says West, "the ultimate responsibility to make a proper medical diagnosis is the sole responsibility of the physician."

Compared to EPs, nurses spend a great deal of time with patients, and often obtain history and physical findings that were missed. "Data discovered by nurses can be combined with physician assessment and lab or imaging data to solve the potential mystery of what is wrong with a patient," says **Martin Huecker**, MD, an associate professor and research director in the department of emergency medicine at the University of Louisville.

ED nurses learn about a new medication the patient is on, an obscure symptom nobody mentioned to the EP, or a mild mechanism of trauma the EP did not factor in during the assessment. Information like that can save a patient from a missed diagnosis, but EHRs make it difficult to find. "Nursing notes are comprised of default information that is often not relevant to the diagnosis. Each iteration of medical record systems seems to bury the crucial, unique patient information," Huecker laments.

Since the EP is not seeing the whole picture, it is easier to make the wrong diagnosis. "Face-to-face communication remains valuable in the ED setting," Huecker adds. ■

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Incomplete Medication Lists Can Lead to Allegations of Negligence

Just 23% of older adults in the ED gave a medication list that mirrored pharmacy records, according to the results of an analysis.[1]

More than half the patients omitted antibiotics they were taking at the time of the visit. "Not knowing about a medicine can lead to dangerous therapy or misdiagnosis," says **Daniel Pallin**, MD, MPH, a Cambridge, MA-based EP and legal consultant. These are some examples of how knowing a patient's medications can prevent bad outcomes:

• **The medication list reveals most of the patient's chronic medical conditions.** "For example, a patient on a high dose of a diuretic, a beta-blocker, and an ACE inhibitor should be presumed to have congestive heart failure, and caution is warranted with fluid boluses," Pallin explains.

• **A medication can be the cause of the emergency.** If a patient taking an ACE inhibitor presents with angioedema, there is a strong likelihood the ACE inhibitor is the cause. In that case, the patient should receive no treatment at all other than intubation, if needed.

"Many emergency providers may not know that lamotrigine, a very widely used drug, can cause a dangerous, progressive, allergic reaction, and must be stopped if the patient presents with a rash soon after starting to take it," Pallin adds.

• **The medication list can indicate necessary emergency treatments.** "Consider the millions of patients taking factor Xa inhibitors," Pallin says.

Most of those patients exhibit nothing abnormal on coagulation studies, so ED providers might never know they are anticoagulated without looking at the medication list.

"Right when they hit the door, if there's hemorrhage, you need to get the andexanet or prothrombin complex concentrate ordered," Pallin explains.

• **A complete medication list can shed light on the patient's presenting symptoms and prevent misdiagnosis.** An example is a patient who was treated with a checkpoint inhibitor, either currently or in the past year.

"If you don't know about that therapy, you won't make the diagnosis," Pallin observes. "These agents are widely used, and the numerous side effects are very common."

• **The patient's current medication list can contraindicate certain therapies.** "The drug most commonly implicated in adverse outcomes is warfarin," Pallin reports.

Many drugs increase or decrease warfarin's effects. These include trimethoprim-sulfamethoxazole and fluoroquinolones, which are commonly administered in the ED.

Sometimes, patients cannot give the information because they cannot recall all their medications, and there are no records in the system. Talking about the patient's complaint, or asking about broader categories of medications, might elicit more specific details, says **Daniel LaLonde**, MD, medical director of the ED at Ascension Providence in Southfield, MI.

If someone presents with head trauma, asking about "blood thinners" can elicit a history of antiplatelets or anticoagulants.

"A focused medication history may expand your differential," LaLonde says. If a patient with back pain is taking warfarin, the EP considers the possibility of retroperitoneal hemorrhage.

Documentation of pertinent negatives is important for the defense of a malpractice claim. For a young woman with pleuritic chest pain, LaLonde says to specifically note the patient is not on birth control (if that is the case).

Blood tests might be the only way to definitively confirm whether patients are taking a particular drug. For instance, if a patient presents with refractory atrial fibrillation and a questionable history of taking digoxin, the level can be checked in this manner.

"Most anti-epileptics can also be checked in terms of their therapeutic levels, as well as drugs related to toxic metabolites, such as salicylates and acetaminophen," LaLonde says.

Medication history becomes extremely important when using alteplase is considered for patients with acute ischemic cerebrovascular accident. "There are plenty of contraindications to this drug, including the use of novel anticoagulants," LaLonde notes.

If the patient arrives with a significant aphasia, the EP should ensure the patient is not on a novel anticoagulant before giving alteplase over concerns about increased risk of hemorrhage.

Incomplete medication lists also are dangerous for anyone discharged with pain medications. "There is a black box warning regarding the concomitant use of benzodiazepines and opioids," LaLonde says. If no one obtains a complete medication history, "you might be sending someone home with the potential for sedation or respiratory depression," he adds.

How far are providers legally obligated to go to be sure the medication history is correct and complete? If a patient has known atrial fibrillation but no available medication list, it is incumbent on the provider to find out what anticoagulant the patient is taking for the atrial fibrillation before prescribing a contraindicated drug, according to Pallin. If the patient arrives alone with altered mental status and the medications are readily available in the EHR, a plaintiff attorney would argue a reasonable EP would have accessed the medication history. In that kind of case, says Pallin, "it's harder to defend against negligence if there's a medication side effect or a medication-related diagnosis."

Generally speaking, ED providers are legally obligated to investigate and act on information that is reasonably accessible to them. "If the information about medication history is available with the click of a mouse, then there is a duty of care to review that information and use it in a treatment plan," says **Kenneth N. Rashbaum**, JD, a partner at New York City-based Barton. "Too busy to check" is not much of a defense for providers. "Of course, that presumes the information is in fact in the EMR," Rashbaum observes.

If the patient was never seen at the ED or hospital, there may be no medication history in the system. Juries are going to expect that ED providers tried to obtain the information from other sources. If there is no evidence providers tried, says Rashbaum, "it is extremely difficult for the defense to overcome if that failure leads to adverse reactions to medications given in the ED, or on the floor, or other medical issues with the patient."

Documented efforts to secure a complete medication history helps the defense — providers asked the patient, friends, or family; they contacted the patient's other doctors or pharmacy. As for the EP's legal obligations, "this is a complex issue, and one that has not been well-litigated at the trial or appellate court levels," Rashbaum says.

ED clinicians are expected to review information that is reasonably accessible to them. "This was the standard of care in the paper chart days, too, but then 'reasonably accessible' was more important," Rashbaum recalls.

That is because the patient may have been seen at disparate locations, and it was not practical to gather all those paper charts. If the patient's entire medical history is available electronically, then the standard of care requires ED providers to review it, says Rashbaum, unless there are compelling reasons not to (e.g., a code or some other urgent or emergent event).

Sometimes, the problem is the medication history is not accessible because it is contained in a different system. "Defense counsel, then, should be prepared to defend the failure to review the EMR on the basis of exigent circumstances, lack of interoperability, or causation, that nothing in the EMR would have changed the treatment or outcome," Rashbaum says. ■

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- What successful missed MI lawsuits have in common
- "Drug-seeking" patients pose unique legal challenges
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Better Patient Experience Mitigates Malpractice Risk

An abdominal pain patient is sent home from the ED with a flu diagnosis. Staff speak to the patient rudely and dismissively. Hours later, the patient returns to the ED and receives an appendicitis diagnosis. It was too early to diagnose the appendicitis during the first visit, but the patient is immediately suspicious malpractice occurred — not because of care delivered, but because of negative engagement with staff.

"Most medical malpractice lawsuits are initiated because the patient feels that the emergency physician didn't care, or disrespected them in some way," says **John Tafuri**, MD, FAAEM, regional director of emergency medicine at the Cleveland Clinic.

If that same patient perceived a terrific experience, a lawsuit might be much less likely. Many hospitals are investing heavily in "The Patient Experience." In the ED, "there is a lot of potential for return," says Tafuri, chief of staff at Fairview Hospital, also in Cleveland. "If you treat the patient with respect, if you are courteous and not condescending, that makes a big difference in how they perceive you."

Even a fantastic patient experience cannot prevent all litigation. Malpractice lawsuits are likely whenever there is a catastrophic outcome for an ED patient and the standard of care was clearly not met.

"But I think with most lawsuits, that applies. If the patient is angry at something, they are looking to get back at the provider in some way," Tafuri offers.

Patients who are angry about the way they were treated sometimes report substandard care to convince a lawyer to pursue a claim. "People are not always honest with attorneys. The attorney may look at the ED record and see that the case is not supported even at the most basic level," Tafuri observes.

Even if no malpractice happened, unscrupulous attorneys might pursue a claim anyway. "Sometimes, lawyers make a mountain out of a molehill. In some cases, that could lead to a settlement," Tafuri explains.

> "IF YOU TREAT THE PATIENT WITH RESPECT, THAT MAKES A BIG DIFFERENCE IN HOW THEY PERCEIVE YOU."

Tafuri says any ED would benefit from teaching EPs to be more aware of how patients perceive them. Engaging in role-playing exercises are helpful. Record the exercises so they can be viewed and critiqued. Fairview Hospital's ED used the scenario of telling someone an error was made. "Being honest and forward with the patients can make a difference in a lawsuit not being filed," Tafuri suggests.

Some EPs' personality traits rub patients the wrong way. "We all have had times where we don't come off well to a patient," Tafuri laments. "But physicians who do this repeatedly have a mannerism or habit which should be corrected."

It is not always easy to ascertain which EPs fall into this category. Patient satisfaction survey ratings can be misleading because of tiny sample sizes. Tafuri has been rated anywhere from 50% to 99% on patient satisfaction scores in various years, despite the fact the way he practiced was unchanged.

"Any EP can get a complaint about being rude. Even the best EPs come off that way from time to time," Tafuri says. "The key is to work with someone who is consistently having problems."

One approach is to ask another provider to work with the problematic EP. Some EPs stand over the patient instead of sitting, look away when the patient is speaking, or appear rushed and dismissive. Colleagues may catch these behaviors and help correct them. "Beyond just reducing your malpractice risk, treating patients with respect is the right thing to do," says Tafuri.

Excellent communication and perceived empathy can mitigate dissatisfaction from long waits and crowding in EDs, according to the authors of a paper.[1] "There is a clear link between malpractice risk and poor patient experience," says **Benjamin A. White**, MD, a paper co-author and an attending physician at Massachusetts General Hospital.

Nearly all jurors will have been an ED patient at some point in their lives, or a visitor anxiously waiting with a family member. "A juror is more likely to identify with the plaintiff's ED experience than the medical decision-making of the EP," says **Ryan M. Shuirman**, an attorney at Raleigh, NC-based Yates, McLamb & Weyher. In Shuirman's experience, two factors are particularly likely to inflame jurors:

- The plaintiff waited a long time to be seen. In reality, most EPs have little control over how quickly

patients are seen. Still, jurors are likely to hold the EPs accountable.

"The longer a plaintiff waits to be treated in an ED, the more likely it is that a juror is going to favor the plaintiff," Shuirman cautions.

If wait time is a central issue in a malpractice case, defense attorneys will want to talk to potential jurors about their own experiences waiting in EDs.

• Providers did not really listen to the patient or family. "While the facts are different in every case, almost all malpractice cases involve some communication issue," Shuirman reports.

Plaintiffs often claim the ED team did not listen, that the EP failed to address a less-than-desired outcome or express any compassion about it, or that the EP failed to answer lingering questions about why a poor outcome happened.

"Attempting to address a dissatisfied patient before he or she leaves the ED is often the best risk management strategy to reduce claims by patients who feel their questions were not answered," Shuirman offers.

Many states passed laws that prevent a plaintiff from using the fact that an EP apologized for an outcome to prove negligence. "While it seems so simple, showing some compassion to a patient or family whose outcome was suboptimal can be the best means to prevent a legal claim later," Shuirman adds. ■

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Discharge of Psychiatric Patients Is Legal Landmine for EDs

When someone visits an ED with psychiatric symptoms, providers have to consider multiple legal requirements before discharging the person.

"Medical liability may be significant under this circumstance," says **Todd B. Taylor**, MD, FACEP, a Phoenix-based EMTALA compliance consultant.

If a patient with psychiatric symptoms experiences a poor outcome shortly after discharge from an ED, allegations of inadequate medical screening are possible. Good documentation is the best protection against these allegations. "Post-discharge events are subject to the proverbial Monday morning quarterbacking," says **Mary C. Malone**, JD, a partner at Hancock Daniel in Richmond, VA.

One central consideration is EMTALA, which requires the hospital to provide an appropriate medical screening exam (MSE). "Documentation of the examination, thought process, and medical judgment can help from both EMTALA compliance as well as

professional liability perspectives," Malone offers. For psychiatric patients, the MSE includes two components:

• A medical portion to determine whether there is an organic cause for psychiatric symptoms.

Malone gives this example of good charting to show there was no apparent organic cause for the patient's psychiatric symptoms: "The patient is diabetic and presents with slightly elevated blood sugar. Otherwise, seems generally medically healthy. There is no indication a physical process is causing psychiatric symptoms."

• A psychiatric portion to determine whether there is a psychiatric emergency condition that requires stabilizing treatment and/or transfer.

During this part, note any relevant history of behavioral health disorders and anything relevant the patient or family discussed (e.g., as the patient is anxious, the patient indicated she cannot eat or sleep, or the patient is hearing voices).

"In simple terms, a patient has a psychiatric emergency if he or she has a behavioral health condition that renders the patient a threat to self or others," Malone explains.

Determining this is can be difficult. The chart should specifically indicate whether the patient is considered a threat to self or others:

• "Patient expresses active suicidal ideations."

• "Patient has no psychiatric history, recently separated from his wife. Indicates that while he is experiencing periodic anxiety attacks, he is not actively suicidal or otherwise a potential harm to himself."

Even if the chart indicates there is no apparent threat at the time of the visit, "it is best to ensure, in addition to a psychiatric screening assessment, that there is some period of observation of the patient prior to discharge," Malone suggests.

A patient with a psychiatric complaint can be discharged from the ED with instructions for follow-up outpatient care under these circumstances:

• The screening evaluation does not reveal a psychiatric emergency condition, and there is no concomitant medical emergency medical condition;

• The psychiatric emergency condition resolves itself, or intervention is taken to alleviate these symptoms, and the patient is no longer considered a threat to self or others. "This requires very careful consideration, and should not be done quickly," Malone cautions.

Providers must determine whether an emergency medical condition (EMC) exists as defined by EMTALA. "For mental health conditions, this usually means [patients] may be a danger to self or others, or perhaps are gravely disabled, such that they cannot care for themselves safely," Taylor explains.

Other conditions could cause an EMC, such as an acute overdose, chronic medication toxicity, or other medical condition resulting from the underlying mental health illness. If a provider determines the patient exhibited no EMC or the EMC was stabilized before discharge, the EMTALA obligation ends, according to Taylor. That does not mean there will not be an investigation.

"It may be determined by the CMS physician reviewer that these were not reasonably determined, resulting in possible citation and sanctions," Taylor says.

Mental health is particularly difficult in this regard. Many patients are chronically ill, with sometimes rapidly changing symptoms. "A patient prone to suicidal ideation may seem perfectly fine at discharge. Then, shortly afterward, some unanticipated event triggers a suicide attempt," Taylor observes.

If an EMC is identified, the hospital must provide stabilizing treatment within their capability to stabilize. If the facility lacks the capability or capacity, staff must transfer the patient to a hospital that does. That hospital is obligated to accept the patient. "If the patient is able to be stabilized, they may be discharged home or to another appropriate setting," Taylor adds.

A psychiatric consult is not required, so long as the physician performing the MSE is qualified to assess for a mental health EMC. "However, as with any other EMC, if the examining physician requires assistance from a specialist, the on-call specialist is required to respond appropriately to complete the medical screening exam and/or provide stabilizing treatment," Taylor says.

If the hospital does not provide psychiatric services, or they are unavailable, and providers determine the patient needs those services, then the patient must be transferred to a setting that can provide a similar level of care. If no appropriate mental health services are available within a reasonable distance, the patient may need to be boarded in the ED or placed in a monitored observation or inpatient setting until transfer is possible.

In addition to the typical ED history and physical exam, Taylor says mental health patients also require an assessment of mental status, social situation, substance abuse, and safety. "Lab and radiology are often unnecessary without specific indication," Taylor notes.

As with any test, the EP should ask, "What am I going to do

with the resulting information?" Sometimes, there is no clear answer. "Drug screens and ethanol levels are particularly unhelpful, yet almost routinely obtained," Taylor says. "However, in this age of COVID, it may be reasonable to obtain a COVID screen, especially if transfer is anticipated."

Follow-up arrangements for discharged patients are particularly important. "Most mental health patents have chronic symptoms which can easily deteriorate," Taylor says. Social support, or lack thereof, is an important factor. A patient with chronic suicidality with a good support system may never come to an ED or be admitted.

"The same patient, without a good support system, may be a revolving door of ED visits and admissions," Taylor laments.

Many patients who present with suicidal ideation can be discharged after effective ED treatment, says **Kimberly Nordstrom**, MD, JD, an emergency psychiatrist at the University of Colorado Anschutz Medical Campus. Stabilization may occur through sobering from alcohol or drugs, a brief family meeting/therapy session, or quick, individual, supportive, or solution-focused therapy. Nordstrom says it is problematic when an EP documents "schizophrenia" in the chart when the sole evidence is current psychosis. The problem is many issues could be causing the psychosis — drug intoxication, delirium, or dementia — not just schizophrenia.

"Once in an electronic medical record, it is difficult to get rid of an incorrect diagnosis," Nordstrom says.

The diagnosis is removed from the problem list, but stays in the notes, on which future providers rely. "It affects next steps in treatment when providers rely on false information," Nordstrom adds. ■

Some Psychiatric Patients Can Bypass ED Altogether

ED providers in Alameda County, CA, noticed they were seeing the same patients on involuntary holds repeatedly. To learn more about these patients, they analyzed 541,731 EMS encounters from 2011 to 2016.[1]

- About 10% of patients brought by EMS to the ED were experiencing psychiatric emergencies.
- Involuntary hold patients were more likely to be men, were substantially younger, and less likely to be insured.
- A small subset of individuals who had been on five or more holds during the five-year study period made up about 40% of involuntary hold cases.
- Most patients experienced only one involuntary hold during the study period. "People with severe mental health emergencies use ambulance services frequently," says **Tarak Trivedi**, MD, the study's lead author, an EP at Ronald Reagan UCLA Medical Center, and research fellow at UCLA Health.

Many times, though, those individuals do not specify a psychiatric complaint. For example, a patient with chronic untreated schizophrenia might call an ambulance repeatedly for chest pain. "If you were to randomly pull over any ambulance in Alameda County, there's a one out of four chance there's a patient on board who was at one point on a psychiatric hold in the previous four years," Trivedi offers.

For some, there is no underlying psychiatric diagnosis, but they are going through a traumatic event. They call 911 because they do not know what else to do. "Who arrives? Police arrives, as well as EMTs," Trivedi observes. "Race and socioeconomic status may play a major role in how police operate when they arrive on the scene."

Some individuals believe they were placed on an involuntary hold unfairly, but still are not allowed to leave the ED. "We have a system that doesn't do justice to psychiatric emergencies," Trivedi says. Many patients with psychiatric complaints do not belong in the ED in the first place. "Often times, we end up seeing patients experiencing a psychiatric crisis who are in front of us because police have no other place to take them," Trivedi notes.

EPs are trained to identify life-threatening conditions from a physiologic perspective as opposed to a psychiatric perspective. Trivedi and colleagues considered protocols that bypass the ED by allowing EMS to directly transport patients to a specialized regional center for evaluation of psychiatric emergencies. The protocols are somewhat controversial. "One reason this is not taking off around the country is there is some fear that acute medical emergencies could be missed," Trivedi says.

The concern is police or EMS could mistake a medically life-threatening condition for a psychiatric crisis, or vice versa. "We

wanted to look at that model and see how effective it was," Trivedi explains.

Holding a patient indefinitely in an ED does not help his or her psychiatric condition. "Because they are on involuntary holds, they can't leave. EPs can't just release them because they would be negligent if something were to happen to them," Trivedi says.

Yet EDs do not have the resources to provide that patient with immediate psychiatric help. "It's bad for patients, bad for EDs, and bad for society," Trivedi laments.

Trivedi and colleagues found paramedics could safely rule out the vast majority of medical crises. "They did a good job of sorting out who needs to go to the ER and who doesn't," Trivedi reports.

Of the patients who bypassed medical clearance in the ED, only 0.3% required re-transport to a medical ED in the 12 hours after they arrived at the psychiatric emergency services. "The lesson to be learned is we need to invest heavily in prehospital psychiatric infrastructure, with first responders trained in psychiatric emergencies, to take people places other than the ER," Trivedi offers. The common belief is there is no way to distinguish medical crises from psychiatric crises in the field, so EMS needs to take everyone to the ED to sort it out. "We have proven that it is possible to do this safely without having to spend hours waiting in a regular ER," Trivedi explains. ■

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Alleviate Risks if Patients Leave Without Being Seen

Every ED leader can attest there are a certain number of patients who present for care but leave without being seen (LWBS). "It's a big issue for quality reasons, and it's a big issue for financial reasons. But most importantly, it's a risk management issue," says **Niels Rathlev**, MD, a professor of emergency medicine at Tufts University School of Medicine in Medford, MA.

Baseline LWBS rates were 7% at Baystate Medical Center's ED in Springfield MA, according to an analysis by Rathlev and colleagues.[1] They examined the characteristics of patients who LWBS. "This is a little different than patients who are seen by the provider and leave without completing treatment," Rathlev observes. A few factors were linked to higher LWBS rates:

- The number of arrivals in the ED per hour;
- The door-to-provider time;
- The numbers of ED boarders;
- The number of patients in the ED waiting room.

Younger adults with low-acuity visits were more likely to leave than older adults with higher-acuity visits. "There can be a sense that it's just people who aren't very sick who are leaving," Rathlev notes. "But that's not universally true. There are plenty of older patients who walk out and really should have been seen earlier."

Surprisingly, Rathlev and colleagues found no link between staffing levels (of doctors, residents, nurses, or technicians) and LWBS rates. "We have always assumed that staffing with nurses is critically important. If we don't have enough nurses scheduled, it really affects these throughput measures and process times," Rathlev explained.

The authors analyzed staffing based on the number of nurses scheduled, not those who actually were working. Thus, it is possible staffing levels really do affect LWBS rates. "Providers are important for decision-making. But it's the nurses who do the majority of the work, and certainly have the most face time with patients," Rathlev says. Hospital administrators might be unaware of the adverse effects of ED boarding, which Rathlev says was one of the reasons for conducting this analysis. Placing an EP at triage is one way to reduce risks of boarding and packed waiting rooms.

"If all you are doing is taking an EP who was working inside the ED and seeing patients, and are now repurposing that role in working at triage, you probably don't accomplish very much," Rathlev cautions.

Door-to-doctor time probably will decrease. Yet on the back end, things take longer because there are not enough EPs to evaluate and discharge patients. Adding an additional EP to work with the triage nurse requires a financial investment. "But not only will that decrease walkouts, it will also negate the negative impact on the back end," Rathlev offers.

Putting an EP up front also can stop some bad outcomes from happening to people in the waiting room. "Certainly, that happens. People show

up with shortness of breath and look relatively OK, but things can change in a hurry," Rathlev says.

Asking someone to continually assess each person who is waiting is important for this reason. "It doesn't have to be a nurse or a doctor. It could be a social worker who is checking in just to make sure patients know they are not being forgotten. That's an important piece," Rathlev adds.

There is a tendency to assume that if someone left the ED, he or she probably was not that sick. That is a dangerous assumption, according to **Purva Grover**, MD, MBA. "It's very well-known that patients who leave without a complete assessment are one of the highest-risk groups that we see in the department," she reports.

Long waits are the most common reason why patients leave, caused by staffing, boarding, or crowding. "For patients who are in the waiting room, if you were there an hour after triage or two hours after first vital signs got done, and have not been seen, the chances of leaving the department are very, very high," says Grover, medical director of the Cleveland Clinic Health System's pediatric ED.

Some of those people will experience a bad outcome and come back to the ED in worse shape. Others will go to a different ED. "Both of those groups pose great risk," Grover says. "The fact of the matter is once the patient is on your property, the patient is yours in every way." To reduce risks of LWBS patients, Grover offers some recommendations:

• EDs can use LWBS rates as a major quality indicator.

• EDs can do everything possible to ensure patients are seen in a timely matter. "That is easier said than done," Grover acknowledges.

• If a patient tells someone they are leaving, ED providers can intervene to see if there is a way to accommodate that person immediately. "If we identify a patient who is leaving, it's such a big deal to us that the triage nurse calls the EP to ask what can be done," Grover reports.

Many times, the patient is seen right away, but not always. "You can reduce the number, but it will never be zero," Grover says.

If the patient leaves anyway, staff ask him or her to sign a form stating they are leaving against medical advice and are aware of the risks. Staff might hesitate to make this kind of request. The patient is angry already. "The last thing you want is more confrontation," Grover says. "There's a tendency to forgo the form, which could really help the ED if things go badly."

• ED providers can document all conversations with the patient. If the patient says something like, "I'm leaving if you don't see me in two minutes," EPs can document those words and also how they responded to the patient. Providers can show they cared enough to offer a phone number to reach the on-call nurse. That nurse can provide good follow-up instructions and encourage the person to come back to the ED any time.

• If the patient left without telling anyone, providers can document that staff tried to find the patient. An ED chart that suddenly goes blank appears suspicious to anyone reviewing it after the fact. Documentation of "no answer at 9:00" and "no answer at 9:10" is better because it brings closure to the case.

"If an outside entity reviews the chart, even that piece of information shows that you were following protocol but that the patient had left," Grover says.

Grover recommends that for all patients who LWBS, the nurse manager calls within 24 hours. This gives the nurse manager a chance to state, "We are really concerned about you. We are so sorry you left. We hope you are doing better. What can we do for you?"

"It gives you some degree of protection if you document that you reached out to the patient," Grover adds. It also gives the nurse manager the chance to instruct the patient to return to the ED if necessary. Grover makes a practice of calling patients who were discharged, or patients who left during her shift. It is a way to provide closure, but sometimes emergencies are identified.

One mother had left the previous night without being seen. During the follow-up call, she reported her child was still having diarrhea and was now seeking care at urgent care center. Grover urged her to go to the ED instead.

There, the child was seen immediately and was sick enough to be admitted to the ICU. Grover expected the mother to be angry, but the opposite was true. Shortly after the ED visit, the mother sent a thank you note to Grover for preventing a possible terrible outcome by calling back. "To me, this was reinforcement that this was the right thing to do, and we should absolutely do it," Grover says.

Over the past several years, the practice of calling discharged patients has become standard at the health system's EDs. During the follow-up calls, people remain angry about the long wait. Nevertheless, virtually all of them appreciate the chance to be heard. "We have seen a documented decrease in our complaints, which hopefully leads to a decrease in litigation," Grover says. ■

REFERENCE

1. Rathlev NK, Visintainer P, Schmidt J, et al. Patient characteristics and clinical process predictors of patients leaving without being seen from the emergency department. *West J Emerg Med* 2020;21:1218-1226.

ED LEGAL LETTER™

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CME/CE QUESTIONS

1. **Which is true regarding the Cures Act and ED patients?**

   a. Fewer patients are disputing their hospital bill.
   b. Patients still must go through the legal discovery process to view nursing notes.
   c. More lab results are flagged as abnormal.
   d. More patients are complaining within 24 hours of the ED visit.

2. **Which is true regarding EMTALA requirements and discharge of psychiatric patients?**

   a. A psychiatric screening exam is sufficient unless there is an apparent organic cause for the psychiatric symptoms.
   b. If ED providers do identify an apparent threat, prolonging the visit with an additional period of observation is not in the patient's best interest.
   c. The ED chart should specifically indicate whether the patient is considered a threat to self or others.
   d. Drug screens and ethanol levels are particularly helpful for this group of patients, but are rarely obtained.

3. **Which group of patients in Alameda County, CA, were more likely to be on an involuntary hold?**

   a. Women
   b. Patients older than age 65 years
   c. Uninsured patients
   d. Individuals with Medicaid coverage

4. **Which factor was not linked to higher leave without being seen rates for ED patients?**

   a. Staffing
   b. Door-to-provider time
   c. The numbers of ED boarders
   d. The number of patients in the ED waiting room

CME/CE 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;
3. Integrate practical solutions to reduce risk into daily practice.