Outcome of Discharged Patients a 'Concerning Blind Spot'

Did a terrible outcome occur minutes, hours, or days after an ED visit? The timing complicates the defense of a subsequent malpractice claim for multiple reasons.

"A common plaintiff's argument is the physician did not rule out the most dangerous possibilities on the differential diagnosis, even if they were less likely to be at play," says **Jason Newton**, JD, senior vice president and associate general counsel at Medical Mutual Insurance Group of North Carolina. This scenario creates a circumstantial inference that something was missed in the ED, even if the standard of care was met. "Although it is not rare, it is a difficult scenario to explain to a jury," says **W. Bradley Gilmer**, JD, an attorney at Baker Donelson.

Brent Reece, JD, director of risk management and advocacy at Sterling Seacrest Partners, says plaintiff attorneys "relish fact patterns that are easy to explain and easy for a jury to understand." Most jurors enter the courtroom with a general understanding that one visits an ED for a medical emergency. Further, one should not be discharged until that medical emergency has been resolved. "Therefore, when a patient is discharged from the ED and has a bad outcome shortly thereafter, the plaintiff attorney can easily connect the dots for the jury," Reece explains. Any documentation of what ED providers observed and what they considered becomes important. "The more detailed the record, the easier to remember and explain the provider's decisions," Reece notes. Depending on where the lawsuit is filed, the statute of limitation on these cases can be several years.

"This means it may be several years after the care at issue was rendered before the provider is first asked to recount the patient's presentation to the ED," Reece adds.

Newton says to mitigate risks, EDs can take several steps:

• Ensure and document a clear understanding of discharge instructions. "The ED patient should be able to verbally repeat back the EP's instructions," Newton offers. Specifics on expectations for follow-up treatment also are important. These specific details should address two questions: "*Exactly what circumstances merit returning to the ED?"* and *"Exactly when should the patient see his or her primary care physician?"* If the EP says this should happen the "next day" or "in two days," that may not be good enough. It is better to institute a process whereby someone can make an appointment for the patient at the primary care physician's office.

"Can the ED arrange that [appointment]? Has that [appointment] been communicated to the patient and contemporaneously documented in the chart?" Newton asks.

• Be mindful of obstacles to recommended follow-up care. Newton says EPs should consider whether the patient has transportation to make it to the follow-up appointment. If not, how does that affect the treatment plan? Did the EP document this discussion? Other considerations include:

- a patient's financial concerns, such as a high-deductible plan or lack of insurance;

- confidence the patient will follow up as prescribed;

- whether to admit a patient if the EP believes the patient is unlikely to follow up as prescribed.

"Emergency physicians who find themselves defendants in medical malpractice litigation sometimes ask the question, *'What are we, babysitters?'*" Newton notes. "Yes, you kind of are."

Charting how someone arrived at a treatment decision curtails the plaintiff's ability to engage in "Monday morning quarterbacking."

"Documenting the thought process of how a particular treatment decision is arrived at, even if it turns out to be the wrong one, in lieu of other options can be as important as arriving at the 'correct' decision," Newton adds.

• Designate a person to call and follow up with patients. Of particular concern: Patients with reported chest pain, preliminary culture results, closed head injury, abdominal pain, pediatric fever. Also: Patients on prednisone tapers. "The call, the discussion, and the results of the discussion should all be documented," Newton recommends. Gilmer agrees that follow-up contact is "certainly an added layer of protection" for EDs. This is particularly important for any symptoms that possibly could correlate with a myocardial infarction, stroke, or pulmonary embolus, where treatments are time-dependent.

Newton gives these examples of good charting: *"Follow-up call with patient on (date) at (time) who was in ED c/o chest pain yesterday. Spoke with patient who denied chest pain today and is feeling better. Reviewed discharge instructions. Patient reports she made appointment with cardiologist for (date/time) and understands to return to ED if worse."* If the patient reports feeling worse, the documentation might state, *"Patient instructed to immediately return to ED without delay, confirms she has transportation to do so and does not need EMS. She expects to be here within X minutes. Triage alerted so processing can be expedited to treatment area upon arrival."* If no one answers: *"Follow-up call made to patient at (insert phone number) on (date) at (time), no answer, left voicemail message to call ED at (insert phone number) as soon as possible and return if condition worsens."* In the ED at Edward Hospital in Naperville, IL, a next-day follow-up program has been in place for several years.

"Contacting discharged ED patients by phone or an automatic discharge follow-up program are ways of getting timely well-being or service feedback," says **Tom Scaletta**, MD, CPPS, chair of the ED. Scaletta helped develop an automated discharge follow-up program that reaches ED patients by email or text message.

"Next-day status-checking corrects a concerning blind spot that has always existed for the specialty," Scaletta reports. A recent case involved a man who presented with low back pain after yard work. He was sent home with a diagnosis of lumbar strain and prescribed an opiate and muscle relaxant. The following day, the man received an e-survey about his ED visit that asked him, *"Are you feeling better, the same, or worse?"* The man indicated that his legs were becoming numb. He was instructed to immediately return to the ED. The diagnosis of epidural abscess was made. After surgical drainage, the man exhibited no neurologic deficits.

Even if ED patients are given "return if worse" aftercare instructions, some with serious problems do not return. "Patient feedback mitigates medical-legal risk by catching misdiagnoses early in the process," Scaletta explains. Two common examples: appendicitis misdiagnosed as gastroenteritis and coronary artery ischemia misdiagnosed as gastroesophageal reflux disease. Even if patients are diagnosed correctly, they may worsen shortly after leaving the ED. "Development of a procedure complication or adverse medication reaction may be both uncommon and not immediately obvious to the patient," Scaletta adds.

About one-third of Edward Hospital's ED patients complete the survey. "That can be doubled if providers or nurses share a compelling request before discharge," Scaletta shares. For instance, ED nurses can state, *"I really want to hear how you are doing tomorrow. You'll receive a text message with a link to a quick survey. Please use that to tell me if you are getting better or not."*

Five percent of those who complete the survey report feeling "worse" and are called back by an ED nurse, according to estimates based on four years' experience with 500,000 ED patients surveyed at Edward-Elmhurst Health. Of these, one in 25 are asked to immediately return for a repeat evaluation. Of this group, another one in 25 are diagnosed with a serious medical condition.

"Of these, perhaps one in eight will file a claim," Scaletta adds.

Based on these numbers, for every 20,000 patients who come to the ED, one malpractice claim is prevented by routine postdischarge contact. "While the ROI is substantial due to defense costs and payouts, the process requires careful sifting through a big haystack to find a small needle," Scaletta notes.

Sometimes, the follow-up system detects misunderstandings instead of misdiagnosis. This allows ED staff to apologize, if warranted.

"By addressing complaints, a strained patient-provider relationship can be reconciled before any anger intensifies," Scaletta notes. ■