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.

“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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