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REVIEW ARTICLE

Review article: Patients who leave before care is completed: What does the legal duty to warn mean for emergency department clinicians?

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Abstract

Patients leave ED for a variety of reasons and at all stages of care. In Australian law, clinicians and health services owe a duty of care to people presenting to the ED for care, even if they have not yet entered a treatment space. There is also a positive duty to warn patients of material risks associated with their condition, proposed treatment(s), reasonable alternative treatment options and the likely effect of their healthcare decisions, including refusing treatment. This extends to a decision to leave the ED before care is completed. The form of that warning may vary based on what is known about the patient's condition and the associated risks at the time. Specific documentation of warnings given is essential.

Key words: *duty to warn, emergency department, health law.*

Introduction

Patients leave ED for a variety of reasons and at all stages of care. Most undergo assessment and management and are discharged home, but some choose to leave either before being seen by a health professional, or during the care process. Not all notify staff that they are leaving.

For emergency clinicians this raises a number of questions:

- Does the duty to warn differ if patients leave at various stages of care (and therefore with various amounts of diagnostic information)?
- Does a healthcare service have a duty to warn patients who leave without being assessed by a clinician?
- How specific do warnings need to be? Is a statement 'to return to ED if any concerns', or 'safety netting' or similar, enough?

General principles and case law

In Australian law, it is well established that doctors owe a duty to exercise reasonable care and skill in the provision of professional advice and treatment. This '*extends to the examination, diagnosis and treatment of the patient and the*

Key findings

- In Australian law, clinicians and health services owe a duty of care to people presenting to the ED for care, even if they have not yet entered a treatment space.
- There is a positive duty to warn patients of material risks associated with their condition, proposed treatment(s), reasonable alternative treatment options and the likely effect of their healthcare decisions, including refusing treatment. This extends to a decision to leave ED before care is completed.
- The duty extends to giving appropriate, and not inaccurate or misleading information and advice. The nature, extent and specificity of the warning will be limited by the information available at the time and the role of the ED staff member (clinician *vs.* non-clinician).
- Specific documentation is required to provide evidence that reasonable warnings were given in the particular circumstances. Use of shorthand terms like 'safety netting' is likely to be insufficient.
- Technology such as SMS may fulfil the duty to warn when patients leave without informing staff.

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provision of information in an appropriate case'.[1]

A doctor, and a health service, owe a duty of care to their patients and to people presenting to the ED even if they have not yet entered a treatment space.[2–5] The duty is a duty to provide reasonable care by assigning patients appropriate priority through the triage system and observing them in the waiting area in case their condition deteriorates.[4,5] However, there is generally no duty to provide medical services until a person can be accommodated in the treatment area.[4] What is reasonable depends on all the circumstances, including the number of staff on duty, the needs of other patients and the assessments made by the triage nurse to assign relative treatment priorities. It follows that there is no general duty to see people in the order that they present to the ED or in a timeframe that the patient may think is reasonable.[4]

Clinicians also have a duty to warn patients of material risks.[1] A risk is material if a reasonable person in similar circumstances would attach significance to the risk, or if the doctor is, or should be, aware that the particular patient would likely attach significance to it.[1]

People are free to exercise their autonomy and the hospital staff generally have no power to restrain them.[4] However, where a person leaves the ED they may be at risk of serious injury or complications of their illness, including death. Where a person has been examined and a provisional diagnosis has been made, a clinician may think the patient is at serious and identifiable risk if they leave without definitive treatment. Where the person has not yet been seen, there is a general risk that whatever brought them to the ED may be serious, but that risk cannot be quantified.

Accordingly, the duty of warn extends to taking reasonable care to furnish the patient with appropriate advice and information in relation to leaving the ED. Clinicians and hospitals have a duty to warn patients of the general risks of leaving and the specific known risks related to their presenting condition and observations that staff may make, even if those observations are based on brief and incomplete assessment, including a triage assessment.[3,4] This duty also requires that staff (including non-clinical staff) take reasonable care not to provide misleading or inaccurate information as to the availability of medical assistance, such as inflated waiting times, that may discourage a patient from staying in the ED.[3] The estimated waiting time does not need to be precisely accurate to the minute or hour, but it must not be obviously incorrect or absent altogether. What is required is that staff act reasonably in the circumstances taking into account their training, expertise and responsibilities, and the information available. For example, a clerk will be assessed by the standard of an averagely competent and well-informed person performing the function of a clerk at a department providing emergency medical care.[4]

The risk for a patient leaving ED will vary and what is known of that risk will also vary depending on the circumstances of each case. Therefore, simply warning everyone who arrives at ED for any complaint that they must or should wait to be seen by a doctor in the ED and there is a risk if they leave is likely to be considered meaningless and unprofessional. The standard required is what is reasonable in the particular circumstances. For example, a patient who has 'rolled' their ankle may have a fracture, but they would not necessarily need to be seen in the ED. They might validly choose to seek care elsewhere. Alternatively, a patient presenting with asthma and low oxygen saturation or covered in blood with a severely deformed limb is at greater risk if they leave and should be advised of this risk.

If a patient does not have decision-making capacity, clinicians or health services are not absolved from providing appropriate advice. In such cases, in the absence of an emergency, advice should be provided to the relevant substitute decision maker, such as a guardian or statutory health attorney.

In all cases, liability will only arise where the relevant standard of care is not met, and this breach of duty has caused harm to the patient. In cases relating to the provision of information, advice or warning, causation requires establishing that the patient would have followed the advice if it had been provided.[1,4]

Scenarios

1. A soccer player presents with a painful foot. Another player landed on her foot when she was taking off after the ball. On examination, the midfoot is a bit swollen and is tender especially over the medial side. Plain X-rays are reported as normal. The most likely diagnosis is bruising or a minor ligament strain but there is the possibility of a more serious injury such as a Lisfranc injury. This possibility will become clearer over the following few days.

   In this case, the doctor has examined the patient and there are investigations and other evidence upon which to base a provisional diagnosis. It is not reasonable for this patient to be admitted to hospital to determine if there is a more serious injury. On discharge, the doctor should give advice on how to manage the injury at home, that there is a small risk of a more serious injury and what signs and symptoms would indicate this, and what follow up should be sought (including an approximate time frame).

2. A 35-year-old man presents with an episode of chest pain that has now resolved. He has been seen by the triage nurse and has no pain currently. Vital signs are normal. After waiting 45 min he decides to leave the ED.
   a. He tells a clerk that he is leaving. He is advised to talk to the triage nurse before going but does not do so.

   The duty to warn extends to non-clinical ED staff.[3,5] The standard required is that of an averagely competent and well-informed person performing the function of a clerk in an ED. The clerk has no duty to examine the patient or give medical advice. The advice to wait to talk to the triage nurse is probably reasonable advice in the circumstances. The

clerk should make sure the advice is recorded in the clinical notes.

b. He tells the triage nurse. The nurse advises him to stay for assessment, but he declines and leaves. No formal assessment or investigations have been undertaken at this time.

The duty is to give 'appropriate' advice as to the risk. That would depend on the nurse's albeit limited assessment. It will vary depending on the information obtained. For example, if the patient told the nurse they had Marfan's syndrome (raising the possibility of aortic dissection) the advice might be quite different from a patient who had no risk factors or other features suggesting a serious diagnosis.

c. He tells no-one.

Assuming that reasonable steps in the circumstances have been taken to determine whether or not the patient has actually left (and is not, e.g. lying on the floor unconscious), that begs the question of whether there is the capacity to warn him. If the hospital has contact details (noting that usually telephone and not email details are recorded) it may be appropriate to try to warn the person of the risks, if those risks can be identified. Technology, such as an SMS message alert, which is used by some hospitals, to the effect that the patient's condition may be because of a serious illness and advising them to seek medical treatment, may discharge this duty.

3. A 50-year-old woman is in an ED treatment room being assessed for severe headache. The doctor is concerned about the possibility of subarachnoid haemorrhage and advises imaging. They inform the patient that to do the scan and get a report will likely take about 3 h. The patient says they cannot wait that long and wants to leave.

In this case, the doctor can be quite specific about the risks – what it means if there is a subarachnoid haemorrhage, what it will mean for the patient if that is undiagnosed, why the diagnosis cannot be made without a scan and what can be done for her in hospital if her condition deteriorates. The patient is thinking of making a choice between staying or going and it is incumbent upon the clinician to inform her of the risks that are or should be material in her decision making. Further inquiries about why she wants to leave may be helpful and assist in addressing her concerns.

4. A 61-year-old man has been brought in by ambulance with chest pain. An ECG shows an ST elevation myocardial infarction and percutaneous coronary intervention is advised. After the procedure is explained, the patient says they are not consenting to it and in fact want to leave the ED to seek alternative treatment.

Leaving the ED is of course their right, subject to the patient having decision-making capacity. Any doctor making a diagnosis and treatment recommendation should advise the patient of the risks and benefits of treatment and whether the treatment should be considered urgent or something that can be delayed. There are two risks here, the risk of the procedure and the risks of discharge from hospital. Both sets of risk and alternative treatments available must be explained and attempts made to negotiate the safest course of action that is acceptable to the patient.

5. A 70-year-old patient has been assessed and treated for abdominal pain. The clinical summary includes the words '*safety netting*' without any details about advice regarding risk provided. The discharge advice provided to the patient simply says '*return to ED if any concerns*'. Is this enough?

Research informs clinicians that older patients have a higher risk of surgical and life-threatening causes for abdominal pain and that not all diagnoses are obvious at first ED visit.[6,7] In circumstances where risks are known, general advice to return to the ED '*if any concerns*' is likely not enough. The patient should be advised of specific features that should prompt them to seek urgent medical review (such as increased abdominal pain, vomiting, fever, not passing flatus/stool, etc).

Summary

In Australian law, the duty to warn varies depending on the stage of care, the amount of information available to provide reasonable advice as to the risks involved and whether the advice is being provided by clinical or non-clinical staff. The advice must be appropriate and not inaccurate or misleading. To interpret that the duty is in all circumstances to advise that a patient should wait in the ED until they have been seen by a doctor is both meaningless and unprofessional. Good clinical practice requires consideration of the actual risks to the particular patient, not a statement that is intended to tick the box that a warning was given. Warnings should differ case to case. They should fit the specific circumstances of a presentation and be based on the information available. That does not mean the nature of the duty changes, but the content of the warning does. The duty is to provide appropriate and accurate information based on what can reasonably be known and observed in the circumstances. The present paper discusses Australian law and may not be applicable in other jurisdictions.

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