Discharge instructions frequently play an important role as evidence in medical malpractice cases, says John J. Barton, JD, a partner in the Providence, RI, office of Barton Gilman.

“Most often, such instructions are helpful to the defense,” says Barton — as in cases in which the patient is told to return to the ED if symptoms persist or if new symptoms develop, and the patient fails to do so.

In such cases, the patient’s own failure to act can give rise to a comparative negligence defense, a break in causation, or a failure to mitigate damages. “However, there are also many cases when discharge instructions are cited as evidence of a physician’s allegedly callous and careless attitude,” says Barton.

**Give “crystal clear” instructions**

Many times, patients are discharged from the ED with instructions to follow up with a primary care physician or specialist. If a bad outcome occurs, the patient may later claim the instructions were unclear.

In this scenario, several factors can determine whether the EP is held liable. “The patient might not end up being seen by the subsequent physician for any number of reasons,” says David P. Sousa, JD, senior vice president and general counsel at Medical Mutual Insurance Co. of North Carolina in Raleigh. Even if the patient is seen, the subsequent physician isn’t necessarily made aware of what occurred in the ED that would be relevant to subsequent care decisions.

“If the patient chooses not to go, then arguably that’s the patient’s fault and their problem,” says Sousa — and perhaps even contributory negligence in those states that recognize and allow such a defense.

“But if the patient does go, and there were significant findings in the ED that then were not communicated well to the subsequent treating doctor, that can be a problem for the EP,” says Sousa.
Here are common allegations in claims involving this communication breakdown:

- that the EP failed to follow up with either a patient’s primary care physician or cardiologist concerning heart issues;
- that the EP failed to recommend that the patient see an orthopedist for worsening pain, loss of function, numbness, or bluish color or redness following a traumatic injury with non-specific ED findings;
- that the EP failed to consider poly-pharmaceutical issues for a patient already taking various medications prior to drugs being prescribed in the ED.

“If the potential harm to the patient for failure to follow up is significant enough, then many ED physicians are coordinating the follow-up appointment with the community physician before discharge of the patient from the ED,” says Sousa.

In the absence of such a process, Sousa recommends these practices:

- giving the patient clear written instructions as to the needed follow up, why, and the dangers in not doing so;
- making a follow-up call to confirm with the patient that the follow-up appointment was, in fact, scheduled, and then charting that conversation;
- taking extra care to ensure patients who are under the influence of drugs or alcohol, who are unconscious at the time of arrival, and who are non-English speaking are aware of what needs to happen next.

“Handing that patient very clear written discharge instructions can go a long way toward getting the monkey off the ED doc’s back if something goes wrong,” he says.

Sousa has seen cases in which the patient was discharged with a set of instructions, but the EP failed to keep a verbatim copy of what the patient was given. The EP is then in the position of claiming the patient was told exactly what to do, while the patient insists otherwise. This complicates the EP’s defense.

“Another area where we see deficiencies in ED discharge summaries is assuring that the patient is crystal clear about meds that need to be taken, or that need to be started or stopped, as a result of treatment that occurred in the ED,” says Sousa.

A common example of this would be a patient who comes to the ED on an anticoagulant, is stopped from any further dosages due to the EP anticipating the patient’s possible need for surgery, but no surgery takes place. “The patient is not told to restart their anticoagulant at discharge,” says Sousa. “The patient leaves the ED and then later dies from a stroke.”
Likewise, responsibility for educating the patient on potentially dangerous drug interactions with medications given in the ED “is going to fall back on the EP,” warns Sousa.

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