Patient Ombudsman
Ombudsman des patients

Investigation completed: February 2025

Investigation Summary

Poor communication contributed to pregnant patient leaving against medical advice

This investigation summary allows Patient Ombudsman to publicly share the outcome of a formal investigation to raise awareness of important issues and specific circumstances negatively impacting health care experiences in Ontario. More importantly, the resulting recommendations are intended to be a catalyst for systemic change and improvement.

Patient Ombudsman has decided not to share identifying information so that the focus remains on the complaint, the issues, and the resulting recommendations. Only those individuals and organizations directly involved with the investigation were provided with the full investigation report. Patient Ombudsman continues to follow-up with the health sector organization on its efforts to implement these recommendations.

Complaint

On July 8, 2023, in the early hours of the morning, a 40-year-old woman woke up with the onset of abdominal pain. The woman was pregnant and because the pain was intense, she attempted to drive herself to hospital #2, where she had an obstetrical history. On the way to hospital #2, the pain became overwhelming, and the woman decided to change direction, driving herself to the emergency department at hospital #1, which was closer. Her husband remained at home to look after their three-year-old child.

On arrival to the emergency department at hospital #1, the woman was in both physical and emotional distress. She informed the staff that she thought she was having an ectopic pregnancy. The woman was immediately triaged and taken to a room in the subacute zone for assessment. Another patient, who was vomiting, was in the room with the woman. The woman asked to be moved elsewhere and was placed on a stretcher in the hallway of the subacute zone, where she stayed for just under three hours.

Clinical information provided to the woman was poorly communicated, her distress was ignored, and repeated requests for help yielded rude and unkind comments from the staff. The woman thought that she was not receiving the care that she needed and with the still significant pain, she decided to leave and seek care elsewhere. The woman's intravenous catheter was removed by a nurse before she left. The emergency staff at hospital #1 did not follow the policy for patients who choose to leave against medical advice (AMA). This includes speaking to the patient about the risks of leaving and having the patient sign a form to acknowledge that they are leaving despite the risk.

The woman drove to hospital #2, where she was assessed, her pain was treated, she received an ultrasound, and she felt heard. Clinicians at hospital #2 reviewed the ultrasound but because the

pregnancy was early (seven to eight weeks), they could not see if or where the embryo was located. The woman was given appointments for a computerized tomography scan and the early pregnancy clinic, as well as discharge instructions before she left.

Two days later (July 11, 2023) at hospital #2, the woman was seen at the early pregnancy clinic and was placed on the "urgent surgery list." The woman underwent laparoscopic surgery for an ectopic pregnancy and the removal of a partially ruptured fallopian tube.

Investigation

Patient Ombudsman explored the following questions:

- How does hospital #1 monitor, review and follow-up on incidents where patients leave without physician clearance?
- What is hospital #1's obligation regarding patient safety when patients leave the emergency department without being cleared by a physician?

Evidence for this investigation was gathered through formal interviews with the complainant and hospital staff, a review of documents including policies and health records, and a review of closed-circuit television footage. In addition, Patient Ombudsman reviewed scholarly articles related to the subject matter.

Findings

Finding 1: The quality of the medical care at hospital #1 met expected standards.

Finding 2: Poor communication from the physician to the complainant contributed to the complainant's decision to leave the emergency department of hospital #1 without medical clearance.

Finding 3: Patient-centred communication was not evident or exhibited in the electronic medical record or security video footage respectively at hospital #1.

Finding 4: The clinical staff at hospital #1 did not adhere to the *Patients Leaving Against Medical Advice* policy when the complainant said she was going to leave to seek care elsewhere.

Finding 5: The internal complaints process for this case was not followed at hospital #1.

Finding 6: Hospital #1 and hospital #2 are addressing capacity pressures, each with a different model of care. These different models contributed to the complainant's differing experiences in the two emergency departments.

Finding 7: Quality improvement initiatives after significant events are approached differently by hospitals #1 and #2 and this impacted the complainant's experience.

Conclusion

Staff communication and behaviour at hospital #1 created an experience for the complainant that recognized neither the emotional trauma of miscarriage or the loss of a child. Instead, the

complainant was subjected to a harsh and humiliating environment where communication was terse and task centred.

No attempt was made to understand why the complainant wanted to leave AMA or to deter her by explaining the risks and benefits of leaving versus staying. The physician was notified of the complainant's departure after she left, but no follow-up was attempted.

Hospital #1 did not follow the investigation process set out in its complaint policy. The hospital's investigation was limited to a chart review instead of a more in-depth approach in keeping with the categorization of the complaint, which would have required the engagement of all parties.

Recommendations

Patient Ombudsman makes the following five recommendations to hospital #1:

POLICIES AND PROCEDURES

1) Patient Ombudsman recommends that the *Patients Leaving Against Medical Advice* policy at hospital #1 be reviewed and updated to reflect findings in recent literature that highlight why patients leave AMA, as well as the impact on mortality, morbidity, readmission rates and health care costs.[1] Patient Ombudsman believes that incorporating best practices and recommendations into this policy will help address the stigmatization of patients who leave AMA and a reduction in readmission rates. Once the policy has been updated, leaders should engage and monitor staff to ensure that the new policy is consistently followed.

2) Patient Ombudsman believes that practices and record keeping in hospital #1's emergency department are inconsistent with the hospital policies and procedures that focus on transferring and documenting care. Patient Ombudsman recommends that hospital #1 audit for gaps in practice and future lapses.

EDUCATION

3) Patient Ombudsman recommends that the patient relations department be retrained on the management of complaints so that all requests are addressed in a timely fashion. The hospital leadership should ensure that any knowledge gaps regarding when to escalate a complaint are closed and that there are clear guidelines developed for patient relations staff to reference.

4) Patient Ombudsman recommends that department managers should be formally trained in how to conduct complaint-based investigations that are thorough and result in resolutions and solutions that benefit staff, patients and families.

5) Patient Ombudsman recommends that hospital #1 use theoretical knowledge and simulation training to educate the emergency department staff on how to actively incorporate patient-centred communication into their interactions with patients and families. The interactions should include engaging patients or their substitute decision-makers in the plan of care, confirming their understanding and providing regular updates.