ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

FEBRUARY 2016 Vol. 27, No. 2; p. 13-24

INSIDE

Editor's Note: This is a special issue dedicated to insight on the legal risks of treating psychiatric patients. Our cover story reports on how EDs can defend against allegations of inadequate psychiatric evaluation. Inside, we cover legal risks of boarding psychiatric patients for extended periods, report on malpractice suits involving frequent ED users with psychiatric complaints, and explore EMTALA requirements involving psychiatric patients.

AHC Media

Did Your ED Examine a Mass Shooter?

Lawsuit could allege inadequate evaluation; EPs could be liable for violent acts of patients

Shortly after treating a patient at your ED, you hear news reports that he committed a mass shooting. What are the liability risks for the emergency physician (EP) who cared for this patient?

"In this era of violence and terrible mass shooting incidents, EDs are vulnerable as being a point of contact for dangerous psychiatric patients," says **Jonathan D. Rubin**, JD, an attorney at Kaufman Borgeest & Ryan in New York City.

Eric J. Neiman, JD, an attorney in the Portland, OR, office of Lewis Brisbois, says there is currently a "troubling" case before the Washington Supreme Court.[1] The case involves a man who murdered his former girlfriend and one of her children. He had not indicated violent intent toward a specific victim to his psychiatrist.

"Nevertheless, the Washington Court of Appeals decided there was enough evidence to send the case to trial against the psychiatrist," says Neiman. If the court upholds this decision, he warns, it could expand the potential liability of many mental health and medical professionals, including EPs.

"There could be a new wave of litigation around the country regarding medical professionals' liability for violent acts of their patients," Neiman says.

The challenges of psychiatric assessment in EDs typically reflect system problems, says **Richard J. Bonnie**, director of the University of Virginia School of Law's Institute of Law, Psychiatry, and Public Policy.

"That is clearly true of psychiatric boarding due to delays in obtaining the necessary psychiatric assessment or in locating an acute care bed or alternative placement for stabilizing the patient's psychiatric condition," Bonnie says.

For a patient whose main presentation is a psychiatric crisis, Bonnie says an ED often is a clinically unsuitable location and exacerbates the patient's

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: **Arthur R. Derse**, MD, JD, FACEP (Physician Editor); **Stacey Kusterbeck** (Contributing Editor); **Shelly Morrow Mark** (Executive Editor); **Jonathan Springston** (Associate Managing Editor), and **Kay Ball**, RN, PhD, CNOR, FAAN, (Nurse Planner).

ED LEGAL LETTER

ED Legal Letter™,
ISSN 1087-7347, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
ED Legal Letter
P.O. Box 550669
Atlanta, GA 30355.

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GST Registration Number: R128870672.

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This activity has been approved for 18 nursing contact hours using a 60-minute contact hour. Provider approved by the California Board of Registered Nursing, Provider #CEP14749, for 18 Contact Hours.

This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

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psychiatric problems. The challenge is to facilitate access to alternative locations for such assessments, he says, such as separate facilities for psychiatric emergency services and crisis stabilization units.

"A very high policy priority, especially in a state with large rural areas, is removing impediments to tele-psychiatric assessments," Bonnie says.

From a professional liability standpoint, Bonnie explains, "one of the complicating factors is the interaction between professional liability law, including EMTALA [the Emergency Medical Treatment and Labor Act], and the state statutes that govern involuntary detention and hospitalization of patients experiencing psychiatric emergencies."

Inadequate Assessment

The most common allegation Neiman sees in claims involving psychiatric patients is that the EP failed to adequately assess the patient for a mental disorder, making the patient unstable and dangerous, and failed to detain the patient for treatment.

"This allegation results in the most serious claims, in which the patient harms self or harms others. The harm can occur in the ED or in the community after discharge," Neiman says.

If an ED prematurely or improperly discharges a patient who goes on to commit violence, "liability would definitely boomerang back to the ED and the hospital," Rubin warns. A plaintiff attorney would likely allege that the EP performed an inadequate mental health evaluation, or that the EP should have kept the patient involuntarily.

"[Plaintiff attorneys] would look at how the workup is done, who did it, if the patient refused treatment, and if there were grounds to keep [the patient]," Rubin says.

If a patient reports recent psychiatric care, whether inpatient or outpatient, Rubin says it can be legally protective for EPs to consult with the psychiatrist.

Mitigating many liability issues boils down to obtaining a consult from a mental health professional such as a psychiatrist, psychiatric nurse practitioner, psychologist, or social worker, Neiman says.

"Unfortunately, this resource is not available in many hospitals, especially smaller and rural ones," he says.

Here are some risk-reducing approaches for EPs caring for psychiatric patients:

• Utilize telepsychiatry if consults are unavailable.

"This is rapidly becoming more available, and will make a big difference in both diagnosis and treatment, especially medication decisions," Neiman says.

• Consider a physician hold, authorized by most states' civil commitment laws, and request an assessment by the court investigator.

EPs often worry about a claim of false imprisonment when assessing whether to involuntarily detain a patient.

"Depriving a patient of liberty is a serious matter, with ethical and licensing concerns in addition to liability risk," Neiman says. However, statutory immunity generally protects decisions pursuant to civil commitment laws.

In addition, EMTALA requires stabilization before discharge of a patient who is dangerous to self or others because of a psychiatric disorder. In terms of legal risk, Neiman emphasizes, "the most important consideration in the moment is 'safety first.'"

• When the decision is made to discharge a psychiatric patient, verify that there is a strong safety plan in place.

This includes involving family, friends, and outside providers to the extent possible.

"The plan should include directions about what to do if the patient's condition worsens," Neiman says. "As always, good documentation must be emphasized." He says these items can help the EP's defense:

• Detailed discharge instructions, both in the ED chart and the written plan given to the patient;

• Documentation of the last assessment before the patient leaves;

• Documentation that the patient was asked about suicidal and homicidal ideation and that someone followed up on positive responses.

"It's important to ask about access to firearms and have an action plan for follow-up when [the patient is] present, but this is a topic of much discussion," Neiman says.

Evaluations Outsourced

Some EPs believe that outsourcing psychiatric evaluations insulates them from liability, but this isn't the case, according to **Leslie Zun**, MD, MBA, chair of the Department of Emergency Medicine at Mount Sinai Hospital in Chicago.

"How is the psychiatric patient different from any other patient?" Zun asks. "Are you going to say, 'I don't do stroke evaluations,' and wait for somebody else to come in and do that?"

Zun says it's legally risky for an EP to allow an outside service to assume responsibility for determining if the patient requires admission or finding an appropriate transfer location.

"I've seen a lot of EPs basically wash their hands and say, 'I don't evaluate the patient.' That just opens up huge risks for the EP," Zun warns.

If an ED discharges a suicidal or

Common Allegations in Psych Med/Mal Suits

Here are some common allegations in suits involving psychiatric patients seen in EDs, according to **Eric J. Neiman**, JD, an attorney in the Portland, OR, office of Lewis Brisbois.

• Misdiagnosis or failure to diagnose the patient's medical condition;

• False imprisonment for detaining a patient in the ED due to the danger posed to self or others;

• Failure to detain the patient per civil commitment laws, resulting in self-harm or harm to others;

• Failure to warn a potential victim of risk of harm from a patient;

• Patient harmed self or others in the ED due to inadequate safety plan;

• Patient eloped from the ED while waiting for assessment or admission to treatment bed, resulting in harm to patient or others;

• Unreasonable delays in admission or transfer.

"This claim really is directed to the hospital and is a function of a lack of community resources and inpatient treatment beds," Neiman says. "But often, the emergency physician is pulled in."

Paul S. Appelbaum, MD, Dollard Professor of Psychiatry, Medicine, & Law at Columbia University College of Physicians & Surgeons in New York City, is unaware of emergency physicians (EPs) being targeted by lawsuits arising out of any of the recent highly publicized mass shootings.

"In general, should such a case arise in the future, EPs will be held to a standard of care related to their specialty," Appelbaum says. He adds that the likely focus of such a lawsuit would center on:

• whether the EP obtained or performed an adequate mental health evaluation;

• if the EP failed to do so, whether the performance of such an evaluation would more likely than not have led to actions, such as involuntary hospitalization, that would have avoided the subsequent harm the patient caused.

"In general, specialists are held to the standards of care of their specialty," Appelbaum says. If something went wrong with the care of an ED patient, the question would become: "Was the care rendered by this EP within the standard of care for EPs in similar situations?"

"Framed in this way, the standard takes into account the constraints of the setting, which are outside the control of the physician," Appelbaum notes. For instance, prompt psychiatric consultation may not be available.

"The major exception to this rule is that specialists who hold themselves out as providing the services of another specialty, such as an EP who undertook a course of psychotherapy with a patient, will be held to the standards of the second specialty," Appelbaum says.

Such claims would be unlikely to arise during a short-term ED visit, when it's clear that only urgent evaluation and care are being provided. "However, when patients are boarded in EDs for extended periods of time, ongoing treatment may be held to a higher standard, and should involve consultation from a psychiatrist or other mental health professionals," Appelbaum says. ■

homicidal patient who goes on to commit violence, the question is, "Who is liable?"

"The EP is always going to be liable," Zun says. "It's the same issue as when you call a consultant in the ED — who is ultimately responsible? The EP has the ultimate responsibility."

If the outside service determines that the patient can go home, and the patient later commits a mass shooting, "there is a huge liability in that for EPs," Zun says. "Is there a blanket immunity clause in the contract that says, 'When a patient presents with a psychiatric complaint, we take on all liability?'"

In some EDs that lack proper resources, patients are sent home without any psychiatric evaluation or follow-up at all.

"I'm surprised that anyone could think that is good practice," Zun says. "There is no other patient type ... that it's OK to send home without seeing a consult."

Many EPs lack training and experience in psychiatric assessments.

"There aren't great tools, like we have to assess STEMI [ST-elevation myocardial infarction] or PE [pulmonary embolism] risk," Zun says. "But that doesn't mean we shouldn't do our best, with a well-defined protocol. If you are not comfortable evaluating the patient, then get the knowledge to do that."

While EPs don't have an obligation to admit the patient, there is an obligation to conduct a thorough psychiatric assessment, Zun says, "and the EP then needs to document how he or she came to his or her decision."

The ED chart should document recommended follow-up care, such as an appointment with a primary care physician or admittance to a substance abuse treatment center, to address the patient's underlying disorder.

If the ED discharges the patient, Zun advises telling the patient who to contact if they're feeling worse.

"In the ED, we tend to say, 'come back if your condition worsens,' but for psychiatric patients, it's better to say, 'here is a safety plan,'" Zun says. "It's not just assessing them, but also providing them with appropriate follow-up as needed, and a good plan." ■

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Psych Patients Held in ED for Days Create Legal Risks for EPs

Some patients discharged without evaluation

Emergency physicians (EPs) face significant legal risks if psychiatric patients are boarded for long periods due to a lack of inpatient beds, warns **Scott L. Zeller**, MD, chief of psychiatric emergency services at the John George Psychiatric Hospital of the Alameda Health System in Oakland, CA. "This is a major issue around the country," he says.

The average boarding time for patients with mental health issues ranges from seven to 34 hours, according to recent studies.[1,2]

Most EDs are not suited to handle psychiatric emergencies, according to Zeller.

"Unfortunately, too often the most common options for treatment are to either restrain and sedate the patient, or have the patient wait with a sitter until the patient can be sent to an inpatient hospital," he says.

Zeller recommends creating a dedicated psychiatric ED or a separate section of the ED with a psychiatric focus.

"It's much better for patients if you actually get them the care they need immediately," he says. "Otherwise, quite frequently, by the time actual definitive treatment begins, it's often three or four days from the emergency."

Zeller and colleagues reported that psychiatric patient boarding times were reduced with a system allowing mental health services to be accessed either by ambulance or direct transfers from EDs.[3]

"It's really time to look at an alternative approach and make sure

the patient is receiving an evaluation that's consistent with community standards," he says.

EPs also face legal exposure due to the possibility of a psychiatric patient's symptoms worsening during long waits.

"Patients can become aggressive and that can lead to injuries," says Zeller. "If it's deemed that the ER staff was not doing enough to treat that patient's symptoms, they could probably be held liable for whatever happens."

An ED chart showing no evidence that the patient's vital signs were reassessed can quickly complicate the EP's defense.

"There is a risk to assuming that somebody is 'all done' and just waiting for a bed," Zeller says.

Patients with serious psychiatric illnesses often have medical comorbidities and have higher levels of asthma, diabetes, and seizure disorders than the general population, he notes.

"As long as the patient is in your ER, they are still your responsibility," Zeller says. "It's easy to forget that, if you think your part has been completed."

Discharge Without Consult

Zeller once testified as an expert witness in a case against an EP who discharged a patient waiting for a psychiatric consult.

"The EP was waiting so long, he finally got frustrated and discharged the patient. The patient ended up in a skirmish with police and got killed," he says. The family sued, claiming the EP breached the standard of care by failing to perform a proper psychiatric evaluation.

"It's not uncommon for EPs to discharge emergency psychiatric patients without a psychiatry consult, typically because of the difficulty accessing such consults in a timely fashion," Zeller says. "That's where the risks come in."

Telepsychiatry is one possible solution.

"Anything we can do to actually get a psychiatrist to the patient, whether in a special section of the ER or by videoconferencing, will alleviate a lot of legal concerns," Zeller says.

Some EPs, frustrated with long wait times for psychiatric consults, argue that they should be allowed to discontinue involuntary psychiatric holds and create space in the ED.

"EPs should be able to determine if an involuntary psychiatric hold is inappropriate and discontinue those, such as a psychiatric hold placed on a patient whose behavior was due solely to delirium or head trauma," Zeller says. But for true psychiatric emergencies, he says, "there needs to be a much greater degree of trepidation."

Some EPs believe they should be able to release involuntary holds when they see a drunk patient is sober and no longer suicidal.

"Those are the ones that are going to get you," Zeller warns. "You may have been lucky so far, but a suicidal threat should always be explored further."

If the patient does harm himself or others and the EP was the one to release the involuntary psychiatric hold, Zeller adds, the EP could be held to a higher standard of care.

"One of the ideas has been, 'Why don't we get a law passed where we can get legal authority to discontinue these holds?'" Zeller says. "Board-certified EPs feel they should be considered qualified to do this, which does make a lot of sense."

The question is whether the EP has the time and ability to conduct a comprehensive psychiatric evaluation that meets the community standard of what a mental health provider's evaluation would be.

"Discontinuation of a psychiatric hold requires a comprehensive evaluation, including making phone calls to obtain collateral history," Zeller notes. "It can be a difficult and intricate process."

An EP might take the view that a patient appears to be doing well, discontinue the involuntary hold, and discharge the patient. If a bad outcome occurs, the EP will likely be compared against what a psychiatrist would have done in that situation.

"If the EP did nothing more than a cursory evaluation and documentation, he or she could be accused of an inadequate exam, and could be liable for malpractice," Zeller says. ■

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Assuming Patient's Symptoms 'Just Psychiatric' Is Legally Risky

A 50-year-old male with a history of schizophrenia presented to an ED with a chief complaint of "needing medical clearance for psychiatric placement." The patient reported gradual onset of agitation and depression and "aching pain in the body," including the chest. The physical exam showed a blood pressure of 205/105; the EKG revealed Q-waves in leads V1 and V2 with nonspecific lateral T-wave changes.

"He was diagnosed with psychosis, medically cleared, and sent to the psychiatric facility. Within 24 hours, he was found unresponsive in cardiopulmonary arrest and failed resuscitation attempts," says **Mark F. Olivier**, MD, FACEP, FAAFP, an EP at Lafayette, LA-based Schumacher Group & Hospital Physician Partners.

The subsequent malpractice litigation alleged the EP failed to address the hypertension and EKG findings.

"There was no medical decision-making documentation by the ED provider addressing why they did not feel these EKG findings could potentially be due to acute coronary syndrome," Olivier says. The case was settled on behalf of the hospital and the ED provider.

In this case, Olivier says, "a period of medical observation for blood pressure and glucose control, along with a cardiac evaluation, may have proved beneficial prior to transfer to the psychiatric facility."

The term "medically cleared" may be outdated, says **Michael Wilson**, MD, PhD, director of UC San Diego Health's Department of Emergency Medicine Behavioral Emergencies Research Lab, pointing to the medical screening examination required by EMTALA for all patients who present to the ED.

"If during the medical screening no physical signs or symptoms are noted to explain the chief complaint, then EPs are expected to focus on the chief complaint," Wilson says.

If, on the other hand, the EP notes other symptoms or signs that may be causing the patient's symptoms, then the current standard of care is to order further testing as needed for workup of this condition, Wilson says.

If the patient has an unrelated medical condition that is not detected on a reasonable screening exam, he adds, EPs are not necessarily expected to treat these.

"However, many of these, like diabetes, may still need treatment after the emergency department," Wilson says, adding that risk-reducing practices include a careful history and physical exam, including the review of systems.

"Potential pitfalls include focusing too early on the psychiatric complaint or assuming that the patient is 'just psych,'" Wilson notes. "This may happen if the EP is uncomfortable working with psychiatric patients."

Dangerous Assumptions

EPs sometimes assume that delusions, hallucinations, agitation, and other psychiatric complaints are due to a psychiatric illness without performing a complete history and physical examination.

"Sometimes psychiatric patients are unwilling or unable to give a complete history," Olivier says. In this case, he suggests these approaches:

• Try to obtain and document additional history from family, friends, emergency medical services personnel, and possibly the patient's local healthcare provider or psychiatrist.

"This additional history may provide further insight on whether the symptoms may be due to a medical cause," Olivier says.

• Obtain an accurate medication list to rule out medication-induced side effects, which can mimic psychiatric symptoms.

"Are any of the medications new, which could be a potential precipitant of the problem?" Olivier asks.

• Perform and document a complete physical examination, including a neurological and mental status exam, looking for medical causes for the patient's psychiatric complaints.

"Based on your history and examination, decide whether further ancillary studies are needed to rule out organic causes of the patient's presentation," Olivier says.

All abnormal vital signs should be explained and not assumed to be due to a psychiatric problem, Olivier advises. Persistent tachycardia, for instance, can be caused by multiple medical conditions, including pulmonary embolism (PE). A recent malpractice case involved a patient with a history of anxiety who presented with mild shortness of breath and was diagnosed with anxiety attack and discharged — only to return days later in cardiac arrest due to a PE. The ED provider failed to obtain pertinent history of a recent hip surgery.

"Repeat vital signs to make sure they normalize prior to medically

clearing the patient," Olivier says. "If they do not normalize, document your medical decision making as to why you don't feel the abnormality is due to a medical problem."

Olivier cautions EPs to "be careful with fever in psychiatric patients. Fever can be a sign of infection and may present as delirium, especially in an elderly patient."

EPs also should be particularly careful with their evaluation when diagnosing a new psychiatric illness.

"In these patients, it is especially important to make sure you attempt to rule out medical etiologies," Olivier says.

The ED chart should reflect repeat assessments of the patient, especially prior to discharge or transfer.

"Repeat evaluations should support that the patient is 'medically cleared,'" Olivier explains. He says this is especially important for patients who remain in the ED for extended periods of time prior to transferring to a psychiatric facility, who may get put aside while care continues for other high-acuity patients.

"Before final disposition, make it your practice to reevaluate the psychiatric patient, making sure medical issues have not developed and that he or she remains stable," Olivier says.

The EP is responsible for determining if the patient has a medical problem as well as the psychiatric problem he or she presented with, underscores **Bruce Janiak**, MD, a professor in the Department of Emergency Medicine at Medical College of Georgia. If a patient reports hallucinations with a history of schizophrenia and says he or she hasn't been taking their medication, this calls for a different approach than a patient with new onset of psychosis.

"The history is problematic, and the answers may not be as accurate as you would like, but the patient may be the only source," Janiak says. Severe hypertension or altered mental status could end up being hypertensive encephalopathy, tachycardia could be a drug reaction, and a high temperature could be a drug reaction or infection. "Those must be ruled out, or the patient cannot be sent to psychiatry," Janiak warns.

Once the EP has ruled out a medical condition, another legally risky scenario presents itself: the lengthy delay for the psychiatric consult, during which time the patient could worsen. "When psychiatry says, 'We'll be there in 24 hours to see the patient," there isn't a lot we can do at that point," Janiak says. "The patient is in limbo." ■

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Complacency Is Risky for Frequent ED Users with Psychiatric History

Assumptions of "same old" symptoms are dangerous

A recent malpractice case involved a woman with a known psychiatric history who presented with a panic attack, reporting chest pain for the previous three months.

"The patient was well-known to ED staff," says **Jeanie Taylor**, RN, BSN, MS, vice president of risk services for Emergency Physicians Insurance Company in Auburn, CA.

The patient remained in the ED waiting for a psychiatric evaluation for several hours. The EP did not evaluate or reassess the patient during this time. Eventually, a social worker deemed the patient safe for discharge, and the ED nurse began the discharge process.

"The patient's condition started to decline before the discharge could be executed," Taylor says. The EP, who received the patient from a mid-level provider, had not viewed the chest X-ray up to this point, but now noted the patient had pneumonia.

"Unfortunately, the patient continued to deteriorate and died of MRSA pneumonia several hours after admission to the ED," Taylor says. The case settled for an undisclosed amount.

The patient's status as a frequent ED user contributed to the bad outcome and lawsuit, Taylor adds.

"The providers assumed that she was, once again, in for her psychiatric issues and dismissed her other symptoms," she says.

Another malpractice case involved

a homeless man who was well-known to the ED.

"He was drug-seeking and non-compliant in terms of follow-up or seeking outpatient care," says **Dan Groszkruger**, JD, MPH, principal of Solana Beach, CA-based rskmgmt. inc. The patient presented to the ED intoxicated, and was discharged with standard discharge instructions and without a cardiac examination.

"He was found dead within hours of the ED visit, still on the hospital's grounds, apparently having suffered an acute MI [myocardial infarction]," Groszkruger says. The case settled for an undisclosed sum. "The dilemma is that busy ED physicians are tempted to cut corners, assuming that the frequent flyer is back with the 'same old' symptoms," Groszkruger explains.

Such assumptions are risky — medically for the patient and legally for the EP.

"This time, the patient may actually have a serious non-psychiatric or non-substance abuse medical problem," Groszkruger says. "This type of patient presents a difficult dilemma for the ED physician."

Even when the patient presents for the first time, symptoms may be wrongly attributed to substance abuse or mental illness, Groszkruger says. Normal diagnostic testing may not be considered necessary or justified.

"The patient may be uncooperative or combative and unwilling to submit to such procedures as blood draws, imaging, or even sitting still for a physical exam," Groszkruger adds.

Taylor recommends asking these three important questions up front when evaluating an ED patient with behavioral issues:

- Is the patient extremely agitated or threatening?
- Is the patient suicidal or in danger of harming himself or herself or the staff?
- Is there an underlying medical condition?

"Psychiatric and intoxicated patients with underlying medical issues can be overlooked, as they are often unable to articulate, or even recognize, their symptoms," Taylor says.

TO OVERCOME THE RISK OF MAKING ASSUMPTIONS ABOUT PSYCHIATRIC PATIENTS WHO ARE FREQUENT ED USERS, ASK WHAT ELSE COULD ACCOUNT FOR THE PATIENT'S PRESENTATION.

Swift Disposition Is Focus

If a patient claims he or she is perfectly fine and demands to be discharged immediately, some EPs simply hand the patient an against medical advice (AMA) form to sign.

"But the risk of liability, or even EMTALA violations, is manifest if other circumstances, such as the report of bizarre behavior from a family member or an EMT, suggest that the patient is lying to avoid unwanted attention," Groszkruger says.

To overcome the risk of making assumptions about psychiatric patients who are frequent ED users, Groszkruger suggests asking the question, "What else could account for this patient's presentation?" Careful EPs generally will ask this question as a routine part of arriving at a differential diagnosis.

"But the usual human factors — time pressure, stress, fatigue, and distraction — often tempt clinicians to cut corners in order to cope with heavy patient demand," Groszkruger says.

Psychiatric patients who present frequently to EDs often are non-compliant with medications and follow-up care, Groszkruger notes, making them more susceptible to medical emergencies than other ED patients.

"The busy ED demands swift disposition, rather than taking the time to inquire about past medical history and on-going treatment," he says.

Thus, EPs are often tempted to make a quick assessment and to discharge or transfer a psychiatric patient prematurely.

"Some EDs recognize this common understanding and require a longer, more detailed interview and examination of such patients, specifically to allow identification and treatment of any medical conditions associated with non-compliance," Groszkruger says. ■

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EPs Often Unaware of Psychiatric Patients' EMTALA Risks

Screening must cover both medical and mental health

Some emergency physicians (EPs) do not fully understand how the Emergency Medical Treatment and Labor Act (EMTALA) applies to psychiatric patients, according to **Mary C. Malone**, JD, a partner in the healthcare law firm of Hancock, Daniel, Johnson & Nagle in Richmond, VA.

In Virginia, this is likely the result of the civil commitment system, whereby the community services boards are taking control of the disposition of behavioral health patients in the ED.

"CMS [Centers for Medicare & Medicaid Services] generally considers emergency department physicians qualified to perform the psychiatric portion of the medical screening examination," Malone says. "Federal EMTALA law preempts state civil commitment law."

Consequently, CMS will not consider attempts by a hospital to comply with the state commitment process as an excuse for non-compliance with EMTALA.

There may be a disagreement between the EP and the state representative who is evaluating the patient for a legal hold regarding the need for involuntary treatment, the facility where the patient will be admitted, or the court order regarding how the patient will be transported to another facility under a legal hold.

"The EP must make reasonable attempts to obtain legal reconsideration of the patient's needs and not simply let the civil commitment process take over," Malone says.

Because payers often have separate coverage and reimbursement protocols for patients with mental illness, EPs are at a disadvantage when screening psychiatric patients, says **Thomas Barker**, JD, a partner and co-chair of healthcare practice at Foley Hoag in Washington, DC.

"Even after the EP successfully completes the screening exam, for patients who must be admitted and who are covered by public health insurance programs such as Medicare and Medicaid, the physician must grapple with programs that impose limitations on coverage for mental illness," he says.

These limitations, which were common in the commercial insurance marketplace in 1965 when Medicare and Medicaid were created, remain to this day, Barker says, even though the private insurance marketplace has advanced through the enactment of mental health parity laws.[1]

"At least one court has observed that 'EMTALA … aims at disparate treatment,'" Barker says.[2] "Quite simply, each similarly situated emergency patient should be treated the same regardless of their payment source."

Because of the way many payers manage their care, Barker says, psychiatric patients pose the potential for disparate treatment.

"Many payers, including, at this point, most Medicaid state plans, carve out the behavioral health benefit from the standard benefit package," he says.

A payer that specializes in psychiatric care then manages behavioral healthcare; that payer often contracts only with a handful of hospitals with inpatient psychiatric units. Barker gives this scenario to illustrate the dilemma this poses for EPs: The decision to admit a patient who presents to an ED with an emergency medical condition was made, but the hospital does not have a contract with the patient's behavioral health carve-out provider, even though it has an open bed in its locked psychiatric unit.

"It is possible the hospital risks an EMTALA violation if it transfers the patient at that point, especially where the transfer is made only for payment purposes," Barker says.

Mental Health Unaddressed

The EP must ensure that the medical screening examination is appropriate, Malone says. This requires medical screening to rule out any organic origin of the patient's behavioral health symptoms, followed by psychiatric screening to determine whether the patient is a threat to himself or others.

Nathan A. Kottkamp, JD, a partner in the Richmond, VA office of McGuireWoods, has handled cases in which the EP conducted a medical screening but didn't address mental health issues.

"Mental health issues are part of the required screening for EMTALA," he emphasizes.

EMTALA does not create a different standard of care, he explains. If the evaluation and treatment provided to a particular patient is reasonable under the circumstances and consistent with the standard of

care, Kottkamp says, "it's going to meet the EMTALA rules. But there is often a mindset of focusing on the obvious problem in front of the provider."

When dealing with EMTALA screenings, Kottkamp says a mental health evaluation should be routine, regardless of any other clinical issues.

"Of course, it may be very easy to rule out a mental health issue, but the key is that it is specifically addressed and documented," he explains.

If a patient presents with acute behavioral distress, the tendency is for the EP to focus on the behavioral health issue. "But you also need to conduct a comprehensive screening to figure out if there is some type of physical issue," Kottkamp says.

Even after performing the evaluation properly, EPs run into problems if they fail to indicate in their documentation that, in addition to screening for behavioral health issues, they also screened for physical distress and other healthcare issues.

"You need to indicate clearly in the record, in case there is any challenge at a later date, that you screened for both," Kottkamp says.

Kottkamp often sees poor, sparse documentation in ED charts indicating what the EP evaluated and considered.

"The more complicated the case, the better the note ought to be," he says. "We've seen cases where it's just the opposite." Kottkamp says that contemporaneous notes are the "very best defense the EP has. You wrote it right then, not because you're being investigated but because you are making a clear record of what you are doing."

Here are some challenges involving EMTALA and psychiatric patients:

• It can be difficult to determine at what point a patient is no longer a threat to self or others.

"This is a tricky scenario," Malone says. A patient may present with suicidal ideations but after a couple of hours in the ED, indicates that he is no longer actively suicidal.

"Does that mean the patient is stable? Not necessarily," Malone says. Patients may falsely claim that suicidal ideations have passed in order to avoid further screening or treatment. "The physician has to take into account the patient's psychiatric history and other factors," Malone says. "Beware of discharging too quickly before stability is achieved and maintained for a safe period of time."

The need to retain psychiatric patients in the ED for an appropriate period of observation prior to release, however, can be challenging.

"A traditional ED is not necessarily set up to handle these patients," Malone notes.

• Patients with emergency medical conditions who need psychiatric admission often cannot get beds in a timely manner.

"This is an emerging problem, as access to behavioral health becomes more challenging," Malone says. "Many hospitals do not have behavioral health units." This requires patients to be transferred to an appropriate facility, utilizing

Psych-related EMTALA Violations

Mary C. Malone, JD, a partner in the Richmond, VA-based healthcare law firm of Hancock, Daniel, Johnson & Nagle, has represented hospitals cited for these EMTALA violations involving psychiatric patients:

• Labeling behavioral health patients who are repeat visitors to the ED as "frequent fliers," and failing to provide a full and appropriate medical screening examination as a result.

• Inappropriate delay in treatment for behavioral health patients who remained in the ED for days awaiting admission to a psychiatric facility, receiving no stabilizing treatment in the interim.

"Consider whether your hospital could benefit from creating a psychiatric ED, which is designed in a manner that helps to better manage behavioral health patients — particularly for purposes of short-term observation," Malone says.

• Failure to provide appropriate transportation for the patient, such as allowing transport by private car for a patient with assaultive behaviors.

• Arranging inappropriate transfers to other facilities for psychiatric admission, such as sending a patient with a concurrent complex medical condition to a psychiatric facility that does not have the resources to manage the medical condition.

• Refusal to accept transfers of psychiatric patients based on inappropriate admissions limitations, such as refusal to accept transfer of patient more than 50 miles from the receiving facility.

If your facility has behavioral health inpatient services and capacity to treat the patient, Malone says, do not refuse to accept the patient based on criteria such as geographic proximity of the sending and receiving facilities.

"Remember: If you have the capacity and capability, you must agree to receive the transfer," Malone says. ■

appropriate means of transport and equipment or personnel.

"This means that in most cases, the patient should not be transported by private car," Malone says. "It may require that staff accompany the patient during an ambulance transport."

• Certain state civil commitment laws conflict with federal EMTALA requirements.

In some cases, the patient has a psychiatric emergency medical condition but is not willing to agree to a psychiatric admission. In such cases, a court order must be obtained to hold and evaluate the patient.

"It is easy for hospitals to relinquish control over the patient in these situations, allowing the civil commitment process to drive the patient care and transfer," Malone says. "But CMS is not concerned with state civil commitment laws."

This means that in cases in which there may be an inappropriate transfer or discharge of a psychiatric patient with an emergency medical condition due to state civil commitment processes, CMS will still hold the hospital responsible for any resulting EMTALA violations.

EPs should not allow persons involved in the civil commitment process to perform the psychiatric screening portion of the EMTALA medical screening exam, Malone warns.

"This is not allowed," she says, adding that only members of the hospital's medical staff or employees who are either physicians or who have been designated as "qualified medical personnel" may perform those exams.

Malone says EPs should understand the hospital's obligations regarding psychiatric patients with respect to all three major EMTALA obligations: screening, stabilization, and transfer.

"Do not delegate these obligations to others in cases where patients are involuntary and there is a need to institute the state civil commitment process," she underscores.

Kottkamp has seen EPs get into trouble when outside entities assist with mental health screening for detention orders and involuntary admissions.

"Where there is a complete and utter handoff to those entities, that creates a real risk for EPs," Kottkamp says.

The EP is required to maintain ultimate control over the entire case until such time as that patient leaves the ED, he explains. If a patient is being worked up for possible involuntary admission to the court in the state of Virginia, community service boards perform the evaluation and determine whether or not to proceed with the court process.

"But as long as that patient is still in the ED, the EP needs to retain control of the case and reassess that patient," Kottkamp says. "You can't have somebody waiting for the screener to come along and not show that you are checking on the patient and making sure there is no change in status."

EPs often feel they are handing the case to the screener, and that the patient is no longer their responsibility.

"But EMTALA doesn't defer to state law in this case," Kottkamp explains. "It says the EP has control of the case until there's a discharge." ■

REFERENCES

1. 42 U.S.C. § 300gg-26.
2. *Brooks v. Maryland General Hospital*, 996 F.2d 708 (4th Cir. 1993).

SOURCES

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CME/CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify legal issues related to emergency medicine practice;
2. Explain how the legal issues related to emergency medicine practice affect nurses, physicians, legal counsel, management, and patients; and
3. Integrate practical solutions to reduce risk into daily practice.

COMING IN FUTURE MONTHS

- Educate other hospital departments on legal risks involving ED care
- Effective defenses against allegations of misdiagnosed abdominal pain
- Common fact patterns in malpractice claims alleging missed sepsis
- Med/mal suits involving delayed time-dependent ED treatments

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CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right, or log onto **AHCMedia.com** and click on My Account. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

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CME/CE QUESTIONS

1. **Which is true regarding allegations of inadequate evaluation for ED psychiatric patients?**

   A. The fact that a consult was not available in a timely fashion protects the EP legally if the patient is discharged without a psychiatric evaluation.
   B. There is no reason for EPs to document unsuccessful attempts to obtain permission to consult with the patient's psychiatrist, since there was no consultation.
   C. EPs are generally insulated from liability risks if psychiatric evaluations are outsourced.
   D. It's legally risky for EPs to allow an outside service to assume responsibility for determining if the patient requires admission.

2. **Which is true regarding the standard of care the EP will be held to when caring for psychiatric patients?**

   A. EPs are held to a standard of care related only to emergency medicine if the patient presented to the ED, even if the EP held himself or herself out as providing services such as psychotherapy.
   B. There is a risk of EPs being held to a higher standard of care if patients are boarded and receive ongoing treatment in the ED.
   C. EPs are generally held to a higher standard if psychiatric consults are unavailable.
   D. EPs are held to the same standard as a psychiatrist for assessment and evaluation that occurs in the ED setting.

3. **Which of the following reduces risks if psychiatric patients are boarded for long periods?**

   A. Creating a separate section of the ED with a psychiatric focus
   B. Discharging the patient if the psychiatric consultant fails to show up in the ED in a reasonable timeframe
   C. Allowing EPs to discontinue involuntary psychiatric holds based on their clinical judgment, even if the required comprehensive evaluation is incomplete
   D. Postponing all but emergent interventions while the patient is in the ED in order to clarify that the EP is not legally responsible for the patient