ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

JULY 2017 Vol. 28, No. 7; p. 73-84

INSIDE

AHC Media
A RELIAS LEARNING COMPANY

Deconstructing the Duty to Warn Doctrine

By Hon. Nathaniel Schlicher, MD, JD, MBA, FACEP, Associate Director, TeamHealth Patient Safety Organization; Regional Director of Quality, TeamHealth Northwest; Emergency Physician, St. Joseph's Medical Center, Tacoma, WA

The enigma of the rights of the individual vs. the rights of society has confounded ethicists, philosophers, lawmakers, and artists for millennia. In medicine, the duty to warn in the setting of the care for mental health patients is our professional personification of this societal tension. The duty to warn doctrine, often referred to by the foundational *Tarasoff* case,[1] is a classic ethical quandary presented to every medical student in their training. The fundamental dilemma posed in these cases is the intersection between the individual right to privacy as expressed by the confidentiality of the physician-patient relationship and the physician's duty to warn the broader public of potential danger and harm.

> A PROVIDER MUST WARN A THIRD PARTY OF THE POTENTIAL HARM FROM A PATIENT WHEN THERE IS SIGNIFICANT THREAT OF HARM TOWARD A REASONABLY IDENTIFIABLE PERSON.

It has been the generally accepted standard that a provider must warn a third party of the potential harm from a patient when there is significant threat of harm toward a reasonably identifiable person. The delicate balance of these ethical

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** (Author); **Jonathan Springston** (Editor); **Kay Ball**, RN, PhD, CNOR, FAAN (Nurse Planner); **Nathaniel Schlicher**, MD, JD, MBA, FACEP (Author); **Shelly Morrow Mark** (Executive Editor), and **Terrey L. Hatcher** (AHC Media Editorial Group Manager).

ED LEGAL LETTER

ED Legal Letter™,
ISSN 1087-7347, is published monthly by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
AHC Media
PO Box 74008694
Chicago, IL 60674-8694

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421
Customer.Service@AHCMedia.com
AHCMedia.com

EDITORIAL EMAIL ADDRESS:
jspringston@reliaslearning.com

SUBSCRIPTION PRICES:
Print: 1 year with free *AMA PRA Category 1 Credits™*: $519.
Add $19.99 for shipping & handling.
Online only: 1 year (Single user) with free *AMA PRA Category 1 Credits™*: $469

Back issues: $83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

ACCREDITATION: Relias Learning is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Relias Learning designates this enduring material for a maximum of 1.5 *AMA PRA Category 1 Credits™*. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Approved by the American College of Emergency Physicians for a maximum of 1.5 hour(s) of ACEP Category I credit.

Relias Learning LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

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

Opinions expressed are not necessarily those of this publication, the executive editor, or the editorial board. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought in specific situations.

AUTHOR: Stacey Kusterbeck
EDITOR: Jonathan Springston
EXECUTIVE EDITOR: Shelly Morrow Mark
AHC MEDIA EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

challenges has come under recent assault in Washington in the case of *Volk v. Demeerleer*.[2] The court effectively disemboweled the sacredness of the physician-patient relationship in the name of the greater hypothetical good, no matter how vague, unforeseeable, and remote it may be. How shall we care for patients and uphold our Hippocratic oath in these trying times?

The Facts

The *Volk* case, like so many involving mental health patients, arises out of a tragedy that cannot be dismissed easily. A psychiatrist accused of malpractice started caring for a patient in 2001 for bipolar depression. He treated the patient intermittently when the patient sought care for his disorder, helping him manage his depression through a difficult divorce, family estrangement, work instability, and other life stressors. Like many with bipolar depression, the patient was somewhat compliant with his medications and sometimes would go for long stretches without regular care.

The patient expressed suicidal and homicidal thoughts to his psychiatrist intermittently, but he never acted on them. The patient last expressed homicidal thoughts about his ex-wife and her new boyfriend to his psychiatrist in 2005. The patient never attempted to harm his ex-wife or her boyfriend, and went on to enter into a new and successful relationship that resulted in an engagement, pregnancy, and shared living arrangement with his partner and her three children.

Tragically, in July 2010, the patient murdered his recently estranged fiancée and one of her sons and seriously injured another. He had not seen his psychiatrist since April 2010, at which time he was working on his relationship with his significant other and managing some mildly intrusive suicidal thoughts. At no time had the patient expressed homicidal thoughts toward the victims. The court record reflected that "family members, friends, and acquaintances who visited [the patient] shortly before the incident gleaned no indication of any plan to kill someone or to commit suicide. Many expressed shock at the deaths."[2] The families of the victims sued the psychiatrist for medical malpractice despite not being his patients, claiming that the homicidal and suicidal behavior was foreseeable and preventable.

Crystal Ball Required Foreseeability

The court found that the duty to warn extended to any foreseeable victims, not just those readily identifiable. The court relied on the prior case of *Petersen v. State*,[3] decided shortly after *Tarasoff*, which expanded the duty to warn to any foreseeably endangered patient, holding that the issue of foreseeability was an issue of fact for a jury to decide.[4] This is in spite of the fact that the court acknowledges that commentators and most other courts have criticized the decision for its overly broad duty implications. Furthermore, the court acknowledges that the legislature, by statute, narrowed this duty for involuntary commitment patients to warn those that the "patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims."[5] The *Volk* decision instead holds that the duty for voluntary outpatient treatment extends

more broadly than in the setting of involuntary treatment to include all foreseeable victims.

This is a truly astonishing standard and wholly impractical in the real world. Arguably, a clinician must warn anyone with a nexus to the patient who could become a victim at any time in the future. Herein, the patient had not expressed homicidal thoughts in five years, never to this victim, and had no imminent threat of harm, according to those in his life. How would the psychiatrist meet the standard? Notify any new significant other in a patient's life that the patient had made previous statements of homicidal thoughts to an ex-spouse and her new boyfriend? Maybe post a comment on their Tinder, Facebook, or Snapchat accounts for all to see of their homicidal flights of fancy? Or possibly take out a newspaper ad if their thoughts are more of a general societal nature? One cannot think of a more destructive standard to undermine the physician-patient relationship.

HIPAA Problems

The supremacy clause of the U.S. Constitution provides that HIPAA overrules any conflicting statute or court finding regarding the protection of patient privacy in medical care. HIPAA specifically allows for the disclosure of patient information in the setting of "serious and imminent threat."[6] In fact, a three-part test is required for disclosure (45 CFR 164.512(j)(1):

1. "Necessary to prevent or lessen";

2. "A serious and imminent threat to the safety of a person or the public";

3. "Disclosure is only to a person(s) reasonably able to prevent or lessen the threat, including the target of the threat."

This standard appears to be significantly narrower than the application made by the court to the foreseeable threat standard created by the court. When applied to the case at hand, it is hard to imagine that a patient without homicidal ideation in five years and no imminent threat to a specific target would meet the requirements of HIPAA for disclosure. As such, the supremacy clause would require that the court comply with the HIPAA standard and bar disclosure, not demand it.

IT CAN BE REASONABLY RECOMMENDED THAT PROVIDERS SHOULD DOCUMENT THEIR DETERMINATION OF THE RISK ASSOCIATED WITH ANY COMPLAINTS OF HOMICIDAL IDEATION.

Hope on the Horizon

While the *Volk* case is concerning, it is not alone. In the past, other courts have ruled similarly with a broad duty to warn any foreseeable victims.[7] Yet, most of these cases have been overturned by subsequent case law and statute. Of 44 jurisdictions with cases on point, 41 have come down on the side of the narrowed duty of imminent, foreseeable, and specifically identifiable victims, with the exceptions of Tennessee, Wisconsin, and Vermont.[8] As a result, most clinicians will be subjected to the traditional medical school teaching of the balanced duty to warn. Motions for reconsideration and legislative efforts are underway in Washington to overturn the *Volk* decision to bring the state in line with the overwhelming majority of states. Yet, that future remains uncertain and underscores the importance of understanding your state's duty to warn doctrine and engaging in the process to address overly broad and harmful standards that pose existential crises to the physician-patient relationship.

Protecting Yourself

If a provider resides within one of the states that now has a "foreseeability" standard that may violate HIPAA standards, guidance is speculative at best. But, as with most evolving areas of health law, it can be reasonably recommended that providers should document their determination of the risk associated with any complaints of homicidal ideation. Furthermore, documentation of the lack of identifiable victims and foreseeable harm potentially could help a provider in their defense of a patient with vague suicidal and homicidal ideation. Arguably, the only definitive protection would be to refer all cases of threatened harm to others for involuntary commitment to qualify for the higher protections afforded them under statute. This would overburden an already-taxed system and, in the

aggregate, possibly do more harm to the whole of the psychiatric population than good. Thus, thorough documentation should be the target of providers in these challenging states.

Conclusion

The care of psychiatric patients is one of the most challenging parts of emergency medicine. With no good risk stratification tools, limited mental health resources in many of our states, and exploding need, decisions like this can seem to turn the difficult into the impossible. Yet, even in these difficult times, we can take some solace in the fact that these are the ethical dilemmas that philosophers have wrestled with for much of our history. We must remain engaged not only in the care of our patients but the education of lawyers, judges, and the greater society on the cost and benefits of these types of decisions. On their surface, they advance the idea of protecting society, but deep down they erode the trust between patients and their providers. We can only hope that cooler heads will prevail and reasonable solutions can be found. ■

REFERENCES

1. *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal.3d 425, 551 P.2d 334, 131 Cal.Rptr. 14 (1976).
2. *Volk v. Demeerler*, 184 Wash. App. 389 (2014).
3. *Petersen v. State*, 100 Wash.2d 421, 671 P.2d 230 (1983).
4. *Bernethy v. Walt Failor's, Inc.*, 97 Wash.2d 929, 933, 653 P.2d 280 (1982).
5. Washington State Legislature. RCW 71.05.120. Available at: http://bit.ly/2rtozer. Accessed May 22, 2017.
6. U.S. Department of Health and Human Services. Disclosures for Public Health Activities, HIPAA, 45 CFR 164.512(b). Available at: http://bit.ly/2q8X1Hh. Accessed May 22, 2017.
7. *Schuster v. Altenberg*, 144 Wis. 2d 223 (1998), *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185 (D. Neb., 1980).
8. *Turner v. Jordan*, 957 S.W.2d 815 (Tenn., 1997), *Schuster v. Altenberg*, 144 Wis.2d 223,233, 424 N.W.2d 159 (1988), *Kuligoski v. Brattleboro*, 216 WL 5793088 (Sept 2016).

ED Patients in Observation Status Are Focus of Recent Med/Mal Cases

Patients deteriorated suddenly

A man who presented to an ED with abdominal and chest pain was placed in observation where he rapidly deteriorated. "He expired despite emergency measures to address what was later discovered to be an aortic dissection," says **Katharine C. Koob**, Esq., an attorney at Post & Schell in Philadelphia.

Another claim against an EP involved a leukemia patient undergoing chemotherapy who was placed on observation status after presenting to the ED with eye irritation. "It was alleged that while being observed, his medical providers failed to timely administer antibiotics and address the patient's volume depletion, resulting in sepsis and requiring amputation of multiple limbs," Koob says.

A third case involved a young girl who was placed under observation after presenting to an ED with headache, nausea, and vomiting. Over the course of the day, she became lethargic and disoriented. Eventually, she was admitted to the hospital as an inpatient, where it was discovered that tumor-related fluid had caused irreversible brain injury.

"Subsequently, she was removed from life support and expired," Koob says. "The brain damage was likely incurred during the course of her observation."

These cases vary in jurisdiction and fact pattern, but all involved ED patients placed in observation status for an extended period. "EPs remain

EXECUTIVE SUMMARY

Several recent malpractice cases have involved ED patients who deteriorated rapidly after being placed in observation status.

- Keeping patients in observation status for lengthy periods exposes EPs legally.
- EPs remain responsible for patients sent to the hospital's observation unit, even if these patients no longer are physically in the ED.
- A recent court ruling establishes that the decision to send a patient to observation does not end obligations under EMTALA.

responsible for patients sent to the hospital's observation unit, even if these patients are no longer physically in the ED," Koob emphasizes. This is because sending a patient to an observation unit is not legally analogous to admitting a patient to the hospital.

"EPs who are under the mistaken belief that their obligation to their patient ends when the patient is placed in observation status expose themselves and the hospital to potential liability," Koob warns.

In fact, permitting patients to remain in observation status for lengthy periods exposes EPs legally. "It inherently creates more opportunity for a patient to experience an adverse event," Koob explains.

Koob names these other common risk-prone practices with ED patients under observation:

- an inadequate staff-to-patient ratio;
- failure to order tests or imaging studies;
- failure to administer appropriate medications;
- inappropriate administration of medications;
- failure to appreciate the effect of medications patients have taken, or regularly take, as an outpatient.
- failure to follow up. This is the primary issue EPs face in sending a patient to an observation unit, according to Koob. "In the fast-paced ED, a practice must be established to ensure close observation and adequate follow-up for these patients," she underscores.

Care and diagnostic testing should not be delayed by the patient's placement in observation. "There is no one-size-fits-all solution," Koob says. "Part of addressing this concern may relate to the location of the patients being observed." Patients might be observed in the ED or in a separate unit. "Adequate staffing is a necessary component to ensure the ability to appropriately monitor patients," Koob adds.

EMTALA Obligations Continue

Sending a patient to the observation unit doesn't end a hospital's obligations under the Emergency Medical Treatment and Labor Act (EMTALA), according to a recent federal court ruling.[1]

The case involved a chest pain patient who died of cardiac arrest shortly after being discharged from the hospital. The plaintiff filed a negligence action against two physicians and the hospital, and also asserted an EMTALA failure-to-stabilize claim against the hospital. The defense argued that EMTALA obligations couldn't have been violated because the patient was admitted for observation.

> ED STAFF MUST BE AWARE THAT SENDING A PATIENT TO THE OBSERVATION UNIT DOES NOT END THE HOSPITAL'S EMTALA OBLIGATIONS.

The court said applicable Centers for Medicare & Medicaid Services (CMS) regulations and guidance make clear that observation status isn't the same as being formally admitted as an inpatient, which the agency has acknowledged ends a hospital's potential EMTALA liability.

"The opinion correctly recites the CMS position on 'admission,'" says **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney. The plaintiff in the case alleged that:

- there was an improper medical screening process prior to putting the patient in observation;
- there was a failure to meet EMTALA discharge criteria prior to the patient's release.

"Anyone who understands the billing status of observation vs. admission would have anticipated this ruling," Frew says.

Ongoing Monitoring Needed

Timothy C. Gutwald, JD, an attorney at Miller Johnson in Grand Rapids, MI, wasn't surprised that the court rejected the hospital's argument that placing the patient in observation automatically terminated the hospital's EMTALA obligations. "CMS has repeatedly said patients in the ED and observation are not inpatients, so EMTALA obligations still apply," he notes.

ED staff must be aware that sending a patient to the observation unit does not end the hospital's EMTALA obligations, according to Gutwald. "Patients must be admitted or stabilized before their EMTALA obligations end," he says.

Frew stresses that appropriate monitoring and stabilization must be ongoing during observation of ED patients. "At the conclusion of the observation process, the patient would have to meet the same discharge requirements as any

other EMTALA patient in the ED," he notes. One of two things must happen:

• An emergency medical condition must have been ruled out definitively, and documented as such;

• The condition must be resolved, and documented as such.

Koob concludes, "A clear delineation between an 'inpatient' and a patient placed in 'observation status' has been created by this decision." The ruling establishes that the decision to send a patient to observation does not end obligations under EMTALA, even when the patient is provided a hospital bed and kept overnight or for an extended period within the hospital.

"The differentiation is based on the theory that observation status is used to determine whether a patient requires admission for further treatment, or should be discharged," Koob explains. In practice, there may be little to no difference in the way these patients are treated medically. "However, as a result of this legal development, it is important for EPs to understand their EMTALA obligations," Koob says. Transferring the patient to the observation unit is insufficient to satisfy those obligations.

"Where a patient is admitted for treatment as an inpatient in good faith, an exception to EMTALA likely applies," Koob adds. The EP's EMTALA obligations then are satisfied. The same is true if a patient is stabilized properly and discharged.

Koob says this is a "vital" consideration for EPs making the clinical judgment regarding the need to admit patients or place them in observation.

"It is critical that physicians do not allow a patient to remain in 'limbo,'" she underscores. "Patients in observation must be actively progressing towards the point of discharge, or considered for admission." ■

REFERENCE

1. *Dicioccio v. Chung*, No. 14-1772 (E.D. Pa., Jan. 20, 2017).

SOURCES

- **Stephen A. Frew**, JD, Vice President, Risk Consulting, Johnson Insurance Services, Loves Park, IL. Phone: (608) 658-5035. Fax: (815) 654-2162. Email: sfrew@medlaw.com.
- **Timothy C. Gutwald**, JD, Miller Johnson, Grand Rapids, MI. Phone: (616) 831-1727. Fax: (616) 988-1727. Email: gutwaldt@millerjohnson.com.
- **Katharine C. Koob**, Esq., Post & Schell, Philadelphia. Phone: (215) 587-1020. Fax: (215) 320-4787. Email: KKoob@PostSchell.com.

Recent Cases Spotlight Pressure to Admit ED Patients

Anything not in patient's best interest 'unacceptable'

Recent lawsuits have alleged that hospitals billed for medically unnecessary inpatient admissions from EDs, and that hospital administrators pressured EPs to admit patients when the patients could have been discharged or observed.[1]

Whether an admission is "unnecessary" is easy to determine in retrospect, but that's not always true at the time of the ED visit. "The entire admit/observe disposition is a chaotic mess that is often fueled by third-party payers," says **Robert B. Takla**, MD, MBA, FACEP, medical director and chief of the emergency center at St. John Hospital and Medical Center in Detroit.

Often, it is not clear at the time of disposition that an ED patient doesn't meet criteria for admission. This might become evident only after additional testing and/or treatment have been rendered.

"Chest pain that resembles unstable angina, with an equivocal [ECG] and negative biomarkers, may result in an admission with IV heparin and other standard of care treatment," Takla says.

It may not be clear that this pa-

EXECUTIVE SUMMARY

Pressure on EPs to admit patients unnecessarily has led to litigation in some cases. EPs can protect themselves legally by:

- seeking clarification, and asking for requests in writing;
- ensuring they can see what's billed in their names;
- determining if they can be fired without peer review and due process.

tient's presentation was not of a serious cardiac etiology until additional diagnostic testing is performed.

"Initially, the history and exam warrant an admission to a telemetry bed with intensity of service and severity of illness consistent with an admission," Takla says.

If pressured to admit patients inappropriately, even subtly, Takla says EPs should "always try to do what is best for the patient and involve them in decision-making. Anything else is unacceptable."

EPs should not change their recommendation based on finances or third-party interference, he emphasizes.

"If the EP believes they are being asked to do something that is inconsistent with the patient's best interest, there is an obligation to go to their chief and seek clarification," Takla says.

If indeed the EP is under pressure or asked to commit fraud, Takla says that "every EP should genuinely and honestly respond that they will 100% do what they believe is in the best interest of their patients. Requests to do anything else can be asked for in writing, and I will bet you no one will provide such a request."

EPs Face Pressure

Andy Walker, MD, FAAEM, a Signal Mountain, TN-based EP who offers legal consultation on the defense of EPs, says unnecessary admissions are just one of the improper things EPs can find themselves pressured to do.

"Others include avoiding the necessary admission of undesirable patients, making inappropriate transfers, ordering unnecessary tests, overlooking inadequate staffing, and ignoring coding and billing fraud," he says. Walker says there are two ways to make EPs more resistant to such pressures and cut down on fraud and abuse:

- Ensure EPs can see what is billed and collected in their names, so they can recognize if fraudulent coding and billing are going on;
- Make sure no EP can be fired without peer review and due process.

> "IF THE EP BELIEVES THEY ARE BEING ASKED TO DO SOMETHING THAT IS INCONSISTENT WITH THE PATIENT'S BEST INTEREST, THERE IS AN OBLIGATION TO GO TO THEIR CHIEF AND SEEK CLARIFICATION," TAKLA SAYS.

"Only those EPs who own their own practice as partners in an equitable, democratic, wholly physician-owned group are guaranteed peer review and due process, and are able to see what is billed and collected on their behalf," Walker notes.

Academic EPs typically are guaranteed peer review and some kind of due process, such as a hearing, before being fired. But as employees, they usually have no idea what is billed and collected for their professional fees.

"Nevertheless, with so many eyes watching and a commitment to evidence-based medicine, fraud and improper pressures are rare in academia," says Walker, adding that the same is not true for publicly traded staffing corporations.

Some employment contracts stipulate that EPs can be stripped of their medical staff privileges and fired without due process or peer review.

"Their contracts require them to waive all rights to due process," Walker says. "So, while federal law says EPs must be shown what has been billed and collected in their names, any EP who works for a staffing company and asks for that information may be quickly fired without cause."

EPs in such situations may find it difficult to resist pressures to make inappropriate admissions and transfers, or to report inadequate staffing or unresponsive on-call specialists.

"They are forced to choose between their jobs and doing the right thing, because they can be fired on a whim and have no recourse," Walker says. "Being a partner in a physician-owned, democratic emergency medicine group is a completely different story."

This is because a partner in such a group cannot be fired and ejected from the group without a majority or super-majority vote of fellow physician-partners. Thus, EPs get to make their case to peers and defend themselves against allegations of wrongdoing.

"EPs are far less likely to fire 'one of their own' for illegitimate reasons," Walker adds. This gives EPs some insulation from improper pressures from hospital administration.

"This is one reason why it is better for both EPs and patients if EPs own and control their own practices, rather than being employed

by corporations beholden to shareholders," Walker argues. ■

REFERENCE

1. FalseClaimsAct.com. The United States District Court has unsealed a whistleblower lawsuit filed by North Carolina emergency room physicians against Health Management Associates And Emergency Medical Services Corporation, Jan. 3, 2014. Available at: http://bit.ly/2rCX67L. Accessed June 5, 2017.

SOURCES

- **Robert B. Takla**, MD, MDA, FACEP, Medical Director/Chief, Emergency Center, St. John Hospital and Medical Center, Detroit. Phone: (313) 343-7398. Email: rtakla@comcast.net.
- **Andy Walker**, MD, FAAEM, Signal Mountain, TN. Email: awalkermd@comcast.net.

Psych Patients Awaiting Transfer From ED Are High Legal Risks

EP is the doctor who is present physically

All transfers of ED psychiatric patients must occur in compliance with EMTALA, with a receiving physician and properly completed transfer forms, stresses **Laura Pimentel**, MD, vice president/chief medical officer at Maryland Emergency Medicine Network. Other requirements:

• Like all transfers, psychiatric patients must be stabilized;

• The benefits of transfer must outweigh the risks;

• Psychiatric patients should be cleared medically to the degree necessary to establish that the presenting symptoms are not from an organic cause.

Pimentel says the period while the patient is still in the ED, awaiting transfer, is particularly high risk. This is true both for patients and EPs.

"An initial decision is the proper security status for boarded patients," Pimentel says. If actively suicidal, patients require one-on-one observation. If agitated or combative, patients may require sedation, restraints, or seclusion.

"All associated hospital policies must be followed," Pimentel stresses. She offers these risk-reducing practices:

• Provide the patient with ongoing care from psychiatric and social work services while in the ED, if possible.

• Consider ordering antidepressant or antipsychotic medication in consultation with a psychiatrist, so that treatment can begin in the ED.

"It is prudent to consider continuing the patient's usual medications, if known," Pimentel offers.

• Address the patient's co-existing medical problems.

"In my experience, the deterioration of co-existing medical problems is common in this population if not explicitly addressed," Pimentel says.

Conditions to specifically consider are withdrawal syndromes from alcohol and narcotics.

"Initiating protocols for the nursing staff to regularly assess and treat these conditions should be done," Pimentel notes. Similarly, if mental health patients have chronic diseases such as hypertension, diabetes, or seizure disorders, orders for their regular medications should be completed. "Regular vital signs and glucose checks should be ordered," Pimentel adds.

• Create a psychiatric observation order set.

"Some of our practices have done this, with good success," Pimentel reports. The order sets include all diagnoses, certification status, vital signs, neurological checks, diet, medications, psychiatry and social work consults, and security status.

• Follow safe handoff practices within the ED.

EXECUTIVE SUMMARY

Psychiatric patients awaiting transfer in the ED pose multiple legal risks involving security, deterioration of the patient's condition, and unsafe handoffs. To reduce risks:

- provide ongoing care with psychiatric and social work services;
- direct oncoming EPs to review the patient's progress and condition;
- consider ordering medications in consultation with psychiatry.

Psychiatric patients often spend hours to days in the ED waiting to be transferred, spanning several EP shifts.

"Each EP caring for the patient should place an assumption of care note on the chart, updating the patient's condition and progress during that shift," Pimentel advises.

Oncoming and outgoing EPs should review all diagnoses, vital signs, lab results, and recommendations from the consulting psychiatrist or mental health provider, Pimentel adds.

Michael Jay Bresler, MD, clinical professor of emergency medicine at Stanford University School of Medicine, recommends EPs include this documentation in the transfer note and the ED chart, if a psychiatric patient is being transferred: "At this point in time, there is no evidence of a non-behavioral medical emergency that would preclude transfer, but the patient should have a medical as well as psychiatric evaluation after arrival at the receiving hospital."

"That's important, because some psychiatric hospitals view the ED workup as an admission history and physical, which it is not," Bresler explains.

For instance, a patient's overdose might not become apparent until after ED discharge. In one such case, a patient presented to an ED and was transferred to a psychiatric facility, and later suffered a seizure, which resulted in brain damage.

"It turned out that the patient overdosed on lithium," Bresler says. "The EP was sued for not finding the overdose." ■

SOURCES

- **Michael Jay Bresler**, MD, Clinical Professor, Emergency Medicine, Stanford University School of Medicine. Email: bruzl@aol.com.
- **Laura Pimentel**, MD, Vice President/ Chief Medical Officer, Maryland Emergency Medicine Network. Email: lpimentel@umem.org.

Unexpected Legal Risks of ED Patients With 'Do Not Resuscitate' Orders

Patients or families could sue for unwanted interventions or for withholding resuscitative efforts

Did an ED patient present with a "Do Not Resuscitate" (DNR) order?

"This important question helps guide healthcare providers to provide care that the patients want," says **Catherine A. Marco**, MD, FACEP, a professor in the division of emergency medicine at The University of Toledo (OH).

Patients or families potentially could sue EPs either for unwanted interventions or for withholding resuscitative efforts.

"Most important is whether the EP acted in good faith based on information available regarding the patient's wishes," Marco stresses.

It's important to document the patient's or family's decisions regarding end-of-life care in the medical record, which may include a DNR order.

"Otherwise, when the patient has a heart attack, and the nurse does not call a code, and the patient dies, the plaintiff could argue that this was neglect," explains **Dean Sittig**, PhD, professor in the School of Biomedical Informatics at the University of Texas Health Sciences Center at Houston.

State Laws Vary

State laws vary significantly regarding DNR orders. Some specifically confer legal protection to providers who follow state-approved advance directives.

"Many states confer immunity to providers who in good faith follow Physicians Orders for Life Sustaining Treatment [POLST] orders," Marco adds. States vary in the specific implementation of POLST; some have enacted statutory legislation, while others have authorized their use through regulations. Still others have developed consensus guidelines without specific legislative or administrative authorization. "Best practices should include reviewing documentation of the patient's wishes, including any advance directive or POLST," Marco says.

If the patient can communicate, the patient's wishes should be clarified. With the patient's permission, families should be involved in such discussions. "In some circumstances, this may take significant time," Marco notes.

EPs may need to obtain documents, and possibly involve an institutional ethics committee or obtain a legal opinion. "If patient wishes are

uncertain, resuscitative efforts may be appropriate while attempting to clarify patients' wishes," Marco adds. ■

SOURCES

- **Catherine A. Marco**, MD, FACEP, Professor, Division of Emergency Medicine, The University of Toledo (OH). Phone: (419) 383-6343. Email: catherine.marco@utoledo.edu.
- **Dean Sittig**, PhD, Professor, School of Biomedical Informatics, The University of Texas Health Sciences Center, Houston. Phone: (713) 299-2692. Email: Dean.F.Sittig@uth.tmc.edu.

Excessive Wait Times Common Issue in ED Malpractice Litigation

Attorneys allege patient should have been seen immediately

Delay in treatment is one of the most frequent allegations in ED malpractice claims, says **Marc E. Levsky**, MD, a board member of the Walnut Creek, CA-based The Mutual Risk Retention Group.

"EPs are charged with the duty to not only provide appropriate and timely care for any given patient, but to provide the same care for many patients at once, never knowing at the time which is destined to have a bad outcome," says Levsky, who also serves as an EP at Marin General Hospital in Greenbrae, CA.

The time the patient was seen by the EP and times of each intervention usually are documented clearly in the ED medical record, which plaintiff attorneys scrutinize in retrospect.

"It is impossible to act at the earliest possible moment on every finding on every patient when caring for 10 or more patients at a time, which is often the case," Levsky explains.

Inevitably, care will be delayed for some ED patients. "These delays are easy to criticize in retrospect, when the focus is only on a single patient," Levsky offers.

The plaintiff's attorney and expert reviewing the ED chart inevitably ignore the time expended by the EP providing care to other patients, while the patient in question had something that ultimately proved to be significant and in need of intervention.

"To an audience unfamiliar with the ED, it would seem that the EP had been doing nothing as the condition of the patient in question deteriorated, though this is generally not the case," Levsky says.

Wait Times Available

Some data on ED wait times are available publicly. "It is easy to compare a wait time to a published average," Levsky says. "The challenge for the plaintiff's attorney is to demonstrate that this was somehow negligent on the part of the defendant."

Some EDs openly advertise their current wait times. "If a patient waits significantly longer than average at a facility which advertises short wait times, it could reflect poorly on the care providers, regardless of circumstance," Levsky notes.

Frequently, plaintiff attorneys make an issue of wait times by drawing attention to an error in triage. Malpractice claims often allege that the severity of a patient's condition was underestimated. "This could serve to place additional liability on the hospital, which usually employs the triage nurse, and is often thought of by the plaintiff's attorney as having deeper pockets than the physician," Levsky says.

A plaintiff's attorney could ask if it is standard of care to allow a non-ST-elevation myocardial infarction patient to sit in the waiting room for three hours without labs, reevaluation, examination, or repeat ECG, says **Jennifer L'Hommedieu Stankus**, MD, JD, FACEP, attending physician at Madigan Army Medical Center's

EXECUTIVE SUMMARY

Plaintiff attorneys often allege an ED patient should have been seen immediately. Malpractice cases involving a patient who deteriorates while waiting are difficult to defend for these reasons:

- Inevitably, care will be delayed for some patients;
- Lawsuits focus on a single patient without regard to other ED patients;
- The patient's severity may have been underestimated at triage.

department of emergency medicine and founder of Gig Harbor, WA-based Comprehensive Medical Legal Consultants.

If the ED patient's wait time was longer compared to other EDs in the area and it potentially caused an injury, "I could see this as a problem," Stankus says. "And where there is one win on this basis, you can bet that others will follow."

Such cases often end up settled, especially if it appears the EP didn't take the patient's care seriously. Levsky explains, "Deterioration of a patient's condition in the waiting room never looks good when trying to defend a case." Stankus says successful lawsuits against EPs are possible under these scenarios:

• A delay in diagnosis causes an injury because the patient didn't get care immediately.

A 36-year-old male presents with atypical chest pain and a normal ECG, and waits for three hours before anyone takes him to a bed. No labs were drawn at triage, but a troponin level now comes back positive, and staff perform another ECG, which is abnormal. The patient suffers non-reversible myocardial ischemia.

• A bad triage decision leaves the patient in the waiting room, and there is a missed chance for treatment.

An elderly patient reports feeling off balance, difficulty walking, and burning urination. The triage nurse decides that a urinary tract infection is causing all the symptoms, and the patient waits for several hours. The EP recognizes that ataxia can be evidence of a stroke, and neuroimaging is obtained that demonstrates acute ischemic stroke. Now, the patient is outside the window for tPA, and suffers permanent neurologic injury, without a chance for a better outcome.

• There is a decompensation of a patient in the waiting room that goes unrecognized.

A 26-year old male is rear-ended in a motor vehicle collision with the complaint of headache, neck pain, and vertigo. It was a low-speed collision that happened hours ago, and there is no outward evidence of injury. The patient's wife tells the triage nurse the patient is vomiting with worsening neck pain. The patient receives anti-nausea medication and continues to wait for two hours. The wife keeps asking for the patient to be brought back, but is told that there are more serious cases ahead of this and to please be patient. The patient continues to vomit, and experiences a seizure. Staff bring in the patient immediately and perform a CT scan. Based on the history of neck pain, headache, and vertigo after trauma, staff also perform a CT angiogram of the head and neck. These exams reveal a vertebral artery dissection, stroke, and, now, hemorrhagic transformation. The patient is transferred to a center with neurosurgical care, but this takes several hours, and the patient suffers a brainstem herniation and dies.

"The moral of the story is that the ED, and the physicians in the ED, are responsible for the patients who check in," Stankus says. If someone relays a concerning story or troubling vital signs, the EP should alert the charge nurse to get that patient to the back as quickly as possible for a rapid assessment, Stankus underscores.

Proper triage is critical to avoiding catastrophic outcomes and lawsuits. "The most experienced nurse or an actual provider should be in triage," Stankus says. "Even then, the EPs should be constantly scanning the waiting room, 'looking for badness' to prevent bad outcomes."

Regular reassessment on all patients who experience a significant ED wait is the best way to decrease risk, says Stankus, "in what is an impossible situation for most EDs in this country, most of which have, at least occasionally, long wait times." ■

SOURCES

- **Marc E. Levsky**, MD, The Mutual Risk Retention Group, Walnut Creek, CA. Phone: (925) 949-0100. Fax: (925) 262-1763. Email: levskym@tmrrg.com.
- **Jennifer L'Hommedieu Stankus**, MD, JD, FACEP, Attending Physician, Madigan Army Medical Center Department of Emergency Medicine; Founder, Comprehensive Medical Legal Consultants, Gig Harbor, WA. Phone: (253) 857-2652. Email: JLStankus@cmlc-llc.com.

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.

ED LEGAL LETTER™

CME/CE QUESTIONS

1. **Which is true regarding ED patients in observation status?**

   a. Permitting patients to remain in observation status for lengthy periods is an effective way to reduce legal exposure because the patient can be observed over time.
   b. EPs remain responsible for patients sent to the hospital's observation unit, even if these patients are no longer physically in the ED.
   c. Sending a patient to an ED observation unit is legally analogous to admitting a patient to the hospital.
   d. Plaintiff attorneys cannot allege inadequate staff-to-patient ratio in hospital observation units in claims against EPs because the patient is no longer in the ED.

2. **Which is true regarding ED observation and EMTALA?**

   a. Under EMTALA, observation status is the same as being formally admitted as an inpatient.
   b. The decision to send a patient to observation does not end obligations under EMTALA.
   c. The Centers for Medicare & Medicaid Services (CMS) regulations and guidance do not specifically address the issue of whether there is a distinction between inpatients and patients in observation status.
   d. EMTALA obligations end for patients in observation status only if the patient is kept overnight.

3. **Which is true regarding legal risks and ED admissions?**

   a. If it's unclear whether an ED patient meets criteria for admission at the time of disposition and the patient is discharged home, this constitutes a violation of the standard of care.
   b. To protect themselves legally, EPs should change their recommendation based on finances or third-party interference only if it means the patient will receive a higher level of care.
   c. EPs should be aware of what is billed and collected in their names, so they can recognize if fraud is occurring.
   d. State laws require employment contracts to guarantee EPs peer review and some type of due process before being fired, specifically to protect EPs from pressure to admit patients unnecessarily.

4. **Which is true regarding psychiatric patients waiting for transfer?**

   a. Patients must be stabilized, and the benefits of transfer must outweigh the risks.
   b. Unlike other ED patients, psychiatric patients do not require medical clearance since their problem is related to mental health.
   c. Providing the patient with ongoing care from the psychiatric and social work services while in the ED increases legal exposure because it means the patient remains the legal responsibility of the EP for a longer period.
   d. Once any medications are ordered in consultation with a psychiatrist, the EP's legal obligations end, even if the patient remains in the ED physically, , since the psychiatrist has effectively assumed responsibility.