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OCTOBER 2014 Vol. 25, No. 10; p. 109-120

INSIDE

Washington State Supreme Court Bans Boarding of Psychiatric Patients in Hospital EDs

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On August 7, 2014, the Washington high court held that the state may not board committed psychiatric patients in emergency departments (EDs) as a remedy for lack of treatment beds at certified facilities, and failure of the legislature to appropriate adequate funding for mental health services was not an excuse to allow such boarding.

Prolonged "boarding" of psychiatric patients in emergency departments is a pervasive problem nationwide, but it is particularly pernicious in the state of Washington.[1] Across the country, 85% of hospitals report boarding psychiatric patients for more than 24 hours; 50% report boarding for longer than two days; and 10% have boarded patients for longer than a week. Furthermore, well over two-thirds of hospitals provide absolutely no psychiatric care to the patients while they are boarded in the ED.[2,3]

In Washington, boarding has reportedly quintupled in the past few years. Nearly two out of every three committed psychiatric patients spend some time warehoused in an ED — the average wait time for placement is three days, although some patients are held for weeks.[4]

Duing the past six years, the state decommissioned 250 psychiatric beds, about 36% of its stock, even as the state's population grew by 14% and involuntary commitments rose by 27%. During the period of great recession, the legislature in Olympia,WA, cut nearly $100 million from its funding for mental health services.[5] Washington now ranks 47th in the nation in its provision of behavioral health services and availability of inpatient psychiatric beds.[4,6]

Like all states, Washington has a

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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.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
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Print: 1 year with free *AMA PRA Category 1 Credits™*: $519.
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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.
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Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 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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statutory civil commitment process — set out in its Involuntary Treatment Act (ITA).[7] If a hospital ED determines that patients, as a result of a mental disorder, present an imminent risk of harm to themselves or others,[8] the ITA authorizes the hospital to briefly hold these patients against their will. This detention period, limited to six hours, is provided to allow the ED staff to notify a county "designated mental health professional" who is authorized to order the involuntary custody and transport of the patient to a psychiatric "certified evaluation and treatment facility," as defined by the ITA.[9,10,11]

The county-certified psychiatric facilities routinely lack sufficient space/beds for all those patients the designated mental health professionals involuntarily detain under the ITA. Consequently, the counties resort to temporarily holding persons they involuntarily detain in EDs (and other acute care centers) via what's termed "single bed certifications."[12] The "single bed certification" is a regulatory exception to the ITA that the Department of Social and Health Services (DSHS) contends allows a county to place an individual on a 72-hour detention or 14-day commitment in a facility that is not certified under the state's statute/regulations. The purpose of the "single bed certifications" is, paradoxically, to avoid overcrowding the certified psychiatric facilities.[12]

Facts Leading to Supreme Court Involvement

Against this backdrop, in February of 2013, Pierce County in Washington had detained 10 patients on 72-hour holds under the state's ITA in local hospitals, primarily in their EDs. Unable to procure beds at a psychiatric "certified evaluation and treatment center" within 72 hours, the county petitioned the Mental Health Commissioner to hold the patients for up to another 14 days in the ED (or other non-certified facility) via "single bed certifications."[13] Several of the involuntarily detained patients engaged attorneys and challenged the county's petition, arguing that they had not been, and believed they would not be, detained in a "certified evaluation and treatment facility" as required by law. Furthermore, the patients claimed they were being denied their right to "adequate care and individualized treatment," which was also explicitly mandated by the ITA.[14]

The commissioner held an evidentiary hearing that included the state DSHS and several hospitals that housed the involuntarily detained patients. After the hearing, he ruled that a patient involuntarily detained under a "single bed certification" "gets no psychiatric care or other therapeutic care for their mental illness," and that using single bed certifications to avoid overcrowding certified evaluation and treatment facilities is illegal. A trial court judge who reviewed the matter reached the same conclusion, which Pierce County and DSHS appealed. The appeals court, without publishing its rationale, simply punted the case directly to the Washington Supreme Court.[13]

In the Matter of the Detention of D.W., et al. v. Pierce County and the DSHS

As one could imagine, the case drew enormous interest in the state from hospitals, emergency physicians, nurses, and civil rights groups, and many of their respective advocacy organizations

filed "friend of the court" briefs urging the Supreme Court to uphold the trial court's ruling.[5]

The court noted that the state's current involuntary commitment system has been "regularly overwhelmed" since it was first enacted by the legislature in 1979.[13] It then proceeded to agree unanimously with the trial judge that boarding psychiatric patients in the ED was illegal in Washington state, basing its decision solely on the statutory language of the ITA and not on any due process or other constitutional grounds.[13]

First, the court determined that when involuntary commitment patients are boarded under a "single bed certification" at a non-certified facility, they are indeed not provided any substantive psychiatric medical care as required by the ITA. The law plainly states that once an individual is involuntarily detained or committed, he or she "shall have the right to adequate care and individualized treatment."[15]

EDs simply do not have the qualified staff, training, pharmaceutical skills, or resources to deal with the mental health needs and security and safety of psychiatric patients. The ED basically functions as a holding tank, warehousing the patient instead of providing counseling and/or therapeutic intervention, administering medications to control agitation rather than treating underlying psychiatric conditions, and undertaking a good faith effort to prevent the patient from eloping while waiting for the state to find a proper treatment bed for the patient.[16] The \ commissioner and trial judge both found that a patient involuntarily detained under a "single bed certification" "gets no psychiatric care or other therapeutic care for their mental illness."[13] The DSHS itself testified that these patients "are getting less care than they would if they were in an [certified] evaluation and treatment center."[13]

Second, the court noted that the ITA specifically and repeatedly requires persons involuntarily detained for evaluation, stabilization, and treatment to be held in certified evaluation and treatment facilities (i.e., facilities that the state has previously certified meet requirements set out in the ITA that ensure they are competent and capable of addressing the patient's psychiatric emergency conditions).[17]

The ITA defines "evaluation and treatment facilities" as any facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is certified as such by the department [DSHS].[18]

Among other things, a certified evaluation and treatment facility must be able to provide a timely psychosocial evaluation by a mental health professional,[19] an individualized plan of care, and treatment with daily contact by a qualified mental health professional,[20] supervision by mental health professionals or specialists who meet specific necessary qualifications (including background checks by the Washington state patrol),[21] and appropriate safety and security systems for both the patients and the staff.

The court stated that the statutory definition of an "evaluation and treatment facility" does not include hospital EDs or other acute care centers unless they are specifically certified as evaluation and treatment centers (and no one in this case contended that they were certified). It also noted that the ITA prohibits any correctional institution or facility, or jail, from being certified as an evaluation and treatment facility.[7]

Finally, the DSHS argued that utilizing the "single bed certification" to board psychiatric patients in an ED to avoid overcrowding certified facilities was allowed by both the ITA and its implementing regulations.[22] The court stated flatly that the act itself does not authorize single bed certifications to avoid overcrowding certified evaluation and treatment facilities. It did agree that the regulations allow single bed certifications, but only under specific circumstances, and only after a properly qualified agent of the mental health division, in the exercise of professional judgment, determines that those circumstances have been satisfied in each individual case.[23]

The request for single bed certification must describe why the patient requires medical services that are not available at a certified facility, such as dialysis or chemical dependency treatment, or why being at a non-certified facility would facilitate continuity of care in the patient's best interest.[23]

In the cases before the court, it was evident that the requests for the single bed certifications were not medically justified or the result of an exercise of professional judgment about the needs of the individual patient. Instead, they were based solely on the fact that there were no beds at the certified facilities, and they were routinely approved by the state without knowledge or inquiry concerning whether there was a medical justification for involuntarily detaining that particular patient outside of a certified facility.[13]

Thus, the court found that the ITA authorizes single bed certifications only for reasons individual to the patient that are delineated in the law, but not because there is a generalized lack of space at certified facilities.[13]

Court's Conclusion

Accordingly, the court therefore affirmed the trial judge's ruling that "the Involuntary Treatment Act does

not authorize psychiatric boarding as a method to avoid overcrowding certified evaluation and treatment facilities."[13]

Aftermath from the Court's Decision

The next day DSHS and its designated mental health professionals planned to begin releasing committable patients from EDs if there were no beds available in certified facilities, instead of boarding them involuntarily on 72-hour stays in the ED as they had been doing. Fortunately, the Attorney General and the Governor's office convinced them to hold off as the stakeholders negotiated a solution. Within two weeks afterwards a broad coalition, including DSHS, the state attorney general, hospitals and physician groups, the legislature, and the governor packaged a plan together to beseech the court for more time to comply.[24] The court granted their request, deferring the effective date from August 27 to December 26, 2014.[25]

It offered no reasons why it allowed the delay, but the immediate concrete actions taken by DSHS and the state must have factored favorably in the decision. These efforts included:

- DSHS immediately funded 10 new beds at the state psychiatric hospitals;
- DSHS amended its regulations on an expedited basis to authorize single bed certifications in residential treatment facilities (which, unlike EDs, could provide appropriate psychiatric intervention);
- Governor Jay Inslee and DSHS collaborated to identify and arrange funding for an additional 125 beds to be made available over the next 120 days (the governor authorized an additional $30 million for mental health services, although still more funding will be needed through the normal legislative process).

Comment

In reading press releases, media reports, pundit comments, and hospital/physician briefs to the court, it seems there may be a massive misunderstanding of the court's ruling. It does not mean, as reported in the press or as stated in one brief asking the court to delay is ruling, "Without a stay, patients in need of court ordered psychiatric care will be released without treatment;" or "Persons who present a likelihood of serious harm to themselves or others … will be required to be released immediately, regardless of whether they have a safe place to go."[5,24] Hogwash!

Note the court's conclusion very carefully: "The Involuntary Treatment Act does not authorize psychiatric boarding as a method to avoid overcrowding certified evaluation and treatment facilities." The ruling means that the state is prohibited from boarding involuntarily detained psychiatric patients in EDs, and instead it must move those patients into its certified evaluation and treatment facilities, regardless of whether those facilities are overcrowded. In other words, instead of boarding and overcrowding hospital EDs, the state must board and overcrowd its state certified psychiatric facilities.

The Washington Supreme Court decided this very issue years ago in the case of *Pierce County v. Western State Hospital*.[26] Western was then, and is today, a Washington state psychiatric hospital. It was in danger of losing its Medicare certification due to staffing issues, so the hospital established an admissions control policy and refused to admit patients beyond its bed capacity until ordered to do so by the high court.

The court in the Pierce County case cited the same two ITA provisions discussed above — the duty to provide "adequate care and individualized treatment" and the duty to do so in "certified" facilities — plus one more that directly governed the issue:

Whenever the designated county mental health professional petitions for detention of a person whose actions constitute a likelihood of serious harm to him- or herself or others … the facility providing 72-hour evaluation and treatment must immediately accept, on a provisional basis, the petition and the person. The facility shall then evaluate the person's condition and admit or release such person in accordance with RCW 71.05.210 (which defines the evaluation, treatment, and disposition duties of the facility).[27]

Based on the statute, the court ruled the state hospital was required to immediately accept all petitions for detention, as well as the persons on whose behalf the petitions are submitted, regardless of "whether or not such acceptance will overtax the institution's facilities."[28]

The court acknowledged that "admission of persons beyond the stated capacity of any of the wards jeopardizes the physical safety of patients and staff and adversely affects the hospital's ability to adequately treat its patients."[26] (The same can certainly be said of boarding and overcrowding the emergency department.) Nonetheless, it determined that the only result dictated by the statute was to overcrowd the certified psychiatric institutions, commenting that "treatment delayed and inadequate must surely be better than no treatment at all."[26]

Does federal law, the Emergency Medical Treatment and Labor Act (EMTALA), impact enforcement of the ITA? Absolutely. The claim that involuntarily detained psychiatric patients would have to be released immediately when there were no beds in certified facilities if the court didn't delay implementation of its ruling is a canard.[29] These patients were involuntarily committed because they were a danger to themselves or others, which is an emergency medical condition as defined

by EMTALA. Thus, the hospital EDs have a legal duty to stabilize that emergency condition, which essentially means preventing the patient from harming him- or herself or others.[30] Federal law trumps state law, so even if the ITA or the Washington Supreme Court required hospitals to release patients if there was no room at certified facilities, EMTALA's duty to stabilize would override the state mandates and require the hospitals to keep the patients until appropriate placement could be arranged.

However, the duty to stabilize does not mean an ED can't transfer a stable patient to an overcrowded state psychiatric hospital. The briefs state that, "Before a hospital can transfer a patient under EMTALA, the receiving facility must have available space and qualified personnel for the treatment of the patient and have agreed to accept the transfer. If this cannot be arranged because there are no beds available at a certified evaluation and treatment facility, then the hospital must keep the patient until an appropriate transfer can be arranged."[5,24] There is a *big* word missing from this statement: the word "unstable" should be inserted before the word "patient" everywhere in the statement. EMTALA's "appropriate transfer" provisions only apply to the transfer of unstable patients; they do not apply to the transfer of stable patients.[31] So the elements of an "appropriate transfer" — that the receiving facility have available space, qualified personnel, and advance acceptance — are not required for stable patients by EMTALA (may be good medicine, but they are not legally mandated by federal law).

Therefore, once the patient is stable, EMTALA no longer applies, and from that point forward, state law (i.e., the ITA) then governs the care of the involuntarily detained psychiatric patient.[32] Accordingly, these stable psychiatric patients can be transferred to overcrowded certified facilities exactly as ordered by the Washington Supreme Court.

The actual statutory definition of "stabilized" under EMTALA reads:

"'Stabilized' means, with respect to an emergency medical condition … that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility."[33]

Is it reasonably probable that a suicidal patient will materially deteriorate if sent by secure transport to a nearby certified psychiatric evaluation and treatment center, even one that is somewhat overcrowded? Don't think so. Would it be better for the patient to be in an overcrowded, chaotic ED with no psychiatric expertise, no therapeutic intervention, and shaky security, or in an overcrowded specialized psychiatric facility with trained mental health professionals, pharmacologic expertise, and specifically tailored safety and security systems that has been certified by the state mental health division as competent to provide psychiatric care?

It's true that a certain degree of overcrowding at a receiving certified facility would cause an emergency physician to delay transferring a patient to that facility, just as the time/distance of transport to even an uncrowded facility might also give the emergency physician pause. All these issues, as well as the patient's current medical condition, are factors the emergency physician must take into account in determining if/when an involuntarily detained psychiatric patient is stable under EMTALA, since stability is defined in terms of transfer. But would overcrowding the 14 or so certified hospitals and approximately 10 freestanding certified evaluation and treatment centers in the state by a few patients each really harm patients, render them too unstable to transfer from boarded emergency departments? Don't think so.

Therefore, EDs could, before the recent Washington Supreme Court ruling, and can right now, before that ruling goes into effect the day after Christmas, require by law that certified psychiatric facilities in the state accept involuntarily detained patients in excess of their stated bed capacity on an immediate basis under the right circumstances. Boarding these patients in the ED has always been illegal in Washington, and it's entirely reasonable to use the full force of the law to require the state to step up to its responsibilities.

In summary, the state has a legal duty to provide "adequate care and individualized treatment" to anyone it detains involuntarily under the ITA, and must provide that care without delay in a facility that the state has "certified" as capable, competent, and properly staffed to provide the indicated psychiatric care the patient needs.

Conclusion

The problem of providing care to psychiatric patients discussed here can be summed up in a quote from the Washington Supreme Court, not from this 2014 case, but from its original case back in 1982: "Much as the courts may sympathize with the institutions which have to bear the frustration and discomforts of overcrowding, and the patients who go untreated or poorly treated, the problem is one which can be solved only by the Legislature, as it is one of providing for the creation and funding of adequate facilities."[26]

Unquestionably, this decision by the Washington court will reverberate in the many other states where demand for psychiatric treatment exceeds capacity and ED boarding of psychiatric patients is rampant. Lawyers are no doubt already scouring state constitutions and civil commitment statutes, and implementing regulations to find the machinery that may finally force states to fulfill their duty to provide

medically appropriate, compassionate, and timely mental health services to their denizens. ■

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6. ACEP. America's emergency care environment: A state-by-state report card 2014. http://www.emreportcard.org/. The report card specific to Washington State is at http://www.emreportcard.org/Washington/. The state ranks third worst in the nation for the number of psychiatric care beds with 8.3 per 100,000 people. Nationally, there is an average of 26.1 psychiatric beds per 100,000 people. The Treatment Advocacy Center recommends that each state should have 50 public inpatient psychiatric beds for every 100,000 people in a state's population. See Torrey EF, Entsminger K, Geller J, et al. The shortage of public hospital beds for mentally ill persons. Arlington, Va: Treatment Advocacy Center; 2008.
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31. See 42 USC 1395dd(c); and 42 USC 1395dd(c) (2) — definition of an appropriate transfer under EMTALA.
32. EMTALA is a limited law. It requires hospitals only to stabilize emergency conditions; it does not require them to treat the emergency conditions. EMTALA leaves to the province of state legislatures to govern health care beyond the immediate crisis related to emergency conditions.
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ED Medical Directors Face Some Unique Legal Risks

Suits may claim policies, training are negligent

When emergency physicians (EPs) are promoted to a medical director position, they often fail to consider the additional liability risks they face in their new role, says **John W. Miller II**, a malpractice insurance broker and principal of Sterling Risk Advisors in Marietta, GA.

One issue that emergency department (ED) medical directors must consider is that their physician-patient relationship is of an indirect nature. "Traditionally, medical malpractice policies will cover a physician for their direct patient care responsibilities, or when they are directing a nurse or someone else to provide such care to a patient," Miller notes.

A malpractice suit may allege that the ED medical director's indirect patient care responsibilities were negligent. These include setting policies, procedures, and protocols within the department. "Medical directors need to be concerned about the liabilities inherent in these indirect patient care responsibilities," says Miller.

Medical Directors Also Named

When EPs are sued for medical malpractice, plaintiff attorneys often name the ED medical director who set the policies and procedures or protocols, alleging that these were inappropriate and don't meet the standard of care within the community. "There are other exposures that medical directors have for their duties in managing the employee population," adds Miller. "To the extent they do hiring and firing, there might be allegations of wrongful termination, discrimination, or harassment."

A 2012 Georgia case illustrates the types of liability faced by ED medical directors. In this case, a 64-year-old woman died in an ED of cardiac arrest. "The lawsuit filed by the family included the doctors and staff who treated the woman and the medical director of the ER, even though he was not physically present at the time," says Miller.

The lawsuit stated that the ED medical director "was negligent in failing to take adequate steps to ensure that emergency room staff were properly trained on the existence of and proper implementation of ED policies and protocols, including the Chest Pain Standing Orders."[1]

Here are some ways in which ED medical directors can protect themselves from this type of exposure:

• Ensure that professional liability coverage covers ED medical director duties.

"Hospital systems or large hospitals typically have a directors and officers professional liability policy that will also extend to cover an individual medical director for their duties on behalf of the hospital," says Miller.

If the facility does not allow ED medical directors to be covered by the facility's policy, says Miller, they can obtain an individual medical director's liability policy. "This will cover the medical director for any duties that they have to that facility and to the patients of that facility," he explains.

• Routinely update policies and procedures.

"This is one of the most common mistakes that medical directors make," says Miller. "They'll initially go in and review those policies and procedures and say, 'Yes, these meet what I consider to be the standard of care in my community.'"

However, ED medical directors often fail to routinely evaluate whether those policies and procedures are still up to date, Miller says.

• Ensure that ED policies and procedures are being followed.

"It is one thing to set the policies and procedures on the front end," says Miller.

The ED medical director also has a duty to the facility and its patients to ensure that its policies are indeed being followed.

"Many times, plaintiff attorneys will be critical of medical directors if they don't fulfill that duty," Miller says. ■

REFERENCE

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SOURCE

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Will Supervising EP Be Named in Claim Against PA?

Suits allege improper supervision

Matt Mitcham, senior vice president claims for MagMutual, an Atlanta-based provider of medical professional liability insurance, sees many claims against emergency physicians (EPs) alleging improper supervision of physician assistants (PAs), resulting in a clear misdiagnosis of the patient's medical condition.

"With the increase in patient workload in the emergency room, we are seeing the need for more physician's assistants involved in patient care," says Mitcham. "Unfortunately, if you are the supervising physician, you are not immune from litigation if the PA should make a mistake."

In some cases, EPs don't look closely at the charts of physician assistants, and "simply rubber stamp them," says Mitcham. "As their supervisor, you are legally responsible for their actions, and if they are sued, you will be in the litigation."

An example of such a case involves a 34-year-old post-partum female who presented to an ED with back pain and a blood pressure of 175/92. "She was treated by a PA with pain medication and dismissed," says Mitcham. The supervising EP did not see the patient, and the patient returned 12 hours later with a subarachnoid hemorrhage.

"The allegations are that the PA missed the diagnosis, and that if the supervising EP had seen the patient or the medical record, this might have been avoided," says Mitcham.

A 2006 case involving an EP supervising a PA resulted in a jury verdict of $217 million, and later settled for an undisclosed amount. "This case involved several unique factors," says **Stephen A. Frew**, JD, vice president of risk consulting at Johnson Insurance Services and a Rockford, IL-based attorney. First, the EP allowed a PA to perform a medical screening examination on a patient whose presenting complaint should have received an examination by the EP, says Frew.

"It turns out that the PA was not licensed. The physician perjured himself and testified that he had provided the exam rather than the PA," says Frew. The EP's defense attorney found out about the perjury and withdrew from the case. "The patient's attorney smelled a rat, and got additional depositions to explore what the defense was hiding," says Frew. "The physician confessed in the second deposition. In the interim, the PA had died."

Despite the unique factors in the case, the claim stemmed from common issues in the use of PAs in some EDs, says Frew. Here are some common practices that can result in malpractice litigation against supervising EPs:

• PAs are often allowed to over-extend the scope of patients they see based on state scope of practice rules or on hospital protocols.

"This exposes the hospital to EMTALA [Emergency Medical Treatment and Labor Act] liability, and the supervising physician to malpractice claims," says Frew.

• Some hospitals and groups commit fraud by billing for a physician visit when the PA examined the patient.

In some cases, the EP never saw the patient or evaluated the patient's condition before discharge. "Obviously, this puts the physician supervising the PA as the target in a fraud investigation, which has much more serious potential than a mere malpractice suit," says Frew.

• Sloppy credentialing is an issue in some facilities, which often results in lapses in licensing.

"Allowing services by an improperly licensed individual could add fire to a malpractice claim against a supervising physician if a mistake allegedly occurs on the theory of negligent supervision," says Frew.

Allegations of Negligent Supervision

Justin S. Greenfelder, JD, Buckingham, Doolittle & Burroughs, Canton, OH, recently represented the medical director of anesthesiology in a community hospital who was sued for the allegedly negligent acts of his certified registered nurse anesthetist (CRNA).

"The claim involved a micro-laryngoscopy surgery, during which the patient was deprived of oxygen for several minutes and passed away,"

he says. The patient's family claimed that the CRNA was negligent in the performance of her duties in preserving the patient's airway during surgery.

"My client, the medical director of anesthesiology, was not present in the hospital on the day of surgery," says Greenfelder. "The other anesthesiologist was present and observing the CRNA."

The patient sued the CRNA, the anesthesiologist, the surgeon, and the hospital on claims of direct negligence. The medical director was sued on a theory that he negligently supervised the CRNA and should have known that the CRNA had a pattern of substandard conduct in previous surgeries.

"Basically, the plaintiff claimed that the medical director had an independent duty to prevent the CRNA from acting negligently," says Greenfelder. He filed a summary judgment motion asking the court to dismiss the claims against the medical director, on the grounds they were not cognizable under Ohio law.

"The prerequisite to any claim for medical malpractice is the existence of a physician-patient relationship," notes Greenfelder. "The only exception under Ohio law is when a physician is under contract to supervise residents at a teaching hospital."

The plaintiff argued that the services agreement between the medical director's group and the hospital created a physician-patient relationship. Greenfelder argued that such an interpretation would create such a relationship between a medical director and every anesthesiology patient in the hospital, and the medical director did not consent to such a relationship.

Before the trial court could rule on the motion for summary judgment, the case went up on appeal on an unrelated issue. "While the appeal was pending, the hospital and CRNA settled and the plaintiff agreed to dismiss all claims against my client," says Greenfelder. The case is continuing against the surgeon and anesthesiologist.

"I felt very confident that the court would have granted my summary judgment motion. This is a likely reason why the plaintiff agreed to dismiss his claims against the medical director," says Greenfelder. As in Ohio, most states require that a physician-patient relationship exist before any physician can be held liable for malpractice.

"This is no different in the ED," says Greenfelder. "ED policies should be clear as to the scope of a PA's practice and the degree of supervision required."

The potential liability of the EP depends on the degree of supervision over the PA, he explains. If the EP is required to sign off on the patient's chart, there is a much greater opportunity for the EP to be liable if something goes wrong.

If the EP also generally supervises the PA's conduct but has no direct responsibility for a particular patient/plaintiff, an argument can be made regarding potential liability for negligent supervision. "But it is by no means a sure thing," says Greenfelder. "If the EP has no supervisory responsibility and the PA acts autonomously, the same argument regarding the lack of a physician-patient relationship can be made."

In general, an ED medical director should not be liable for the conduct of a PA unless the medical director takes a direct supervisory role over the PA's care of the particular patient making the claim, he adds.

"ED medical directors should be cautious, though," says Greenfelder. "Take note of any troubling conduct by PAs to avoid any claim that the medical director 'should have known' that the PA had a pattern of negligent conduct and was in a position to prevent it." ■

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Missed MIs Still "Loss Leaders" for EDs — and Atypical Presentations Aren't Always to Blame

Many malpractice claims involve chief complaint of chest pain

In one case, a 45-year-old mother of four who spoke limited English was awakened by severe chest pain. Her teenage son, who acted as the interpreter, told the emergency physician (EP) that his mother had fainted when she tried to get up that morning, and that she had complained of chest pain prior to going to bed.

"The pain was worse with inspiration, movement, and palpation," says **Jeanie Taylor**, RN, BSN, MS, vice president of risk services for Emergency Physicians Insurance Company in Auburn, CA. The patient rated her

pain as 10, but the EP's documentation described "histrionics" in relation to the patient's reaction to the pain.

The patient's heart rate was 116, and vital signs were otherwise within normal range. The family history and past medical history were benign, and illicit drug use was denied.

"The patient was overweight and a smoker. The initial — and only — EKG showed some subtle ST wave changes which were attributed to the tachycardia," says Taylor. "Her pain resolved after a single dose of IV morphine."

The patient was diagnosed with "rib pain" and discharged with instructions to follow up with her primary care physician in two or three days if the pain continued, and to return to the ED if the pain worsened.

"Her pain continued at home, but the family did not return to the ED, as they felt reassured by the ED evaluation and trusted that the pain was not cardiac or significant," says Taylor. When the pain became very severe, emergency medical services was called. "The woman experienced a cardiac arrest en route, and could not be resuscitated," says Taylor.

In the resulting malpractice case, the plaintiff's experts opined that even though the patient's EKG changes were subtle, they indicated the need for a further evaluation. They also argued that while the symptoms were not typical for an acute myocardial infarction (AMI), they were not typical for costochondritis either; observation and a more thorough work-up was indicated.[3] "The case settled for a large undisclosed amount," says Taylor.

Chest Pain: Cardiac Until Ruled Out

Missed AMI and chest pain cases "have been the loss leaders in medical malpractice claims for years — no, make that decades," says Taylor. "They account for approximately 25% of indemnity dollars paid."[1]

Even though patients who present with "crushing chest pain" are not likely to be missed, patients who attribute their pain to reflux or heartburn might be, says Taylor. EPs need to be diligent in not allowing patients to lead them to a non-cardiac diagnosis without an appropriate work-up.

"We often hear physicians lamenting about atypical presentations, which, of course, is a concern," says Taylor. "But many of the claims and incidents the Emergency Physicians Insurance Company reviews involve a chief complaint of chest pain."

EDs are challenged with throughput and patient wait times, says Taylor, and at some facilities, patients with chest pain wait for care once they perform an EKG and show it to an EP, who reads the EKG as normal.

"However, a single EKG on arrival is only a snapshot," says Taylor. A 2010 study reported that it is safe, in some circumstances, to have a stable patient with chest pain and a normal EKG remain in the waiting room, as long as an evaluation is taking place while they wait.[2]

"Chest pain is cardiac until ruled out," emphasizes Taylor. "The chest pain bundle — serial biomarkers, serial EKGs, and provocative testing — remains constant," she says. She says that another "constant" involves these risks associated with treatment of patients with chest pain:

- Mistaking acute coronary syndrome (ACS) for a gastrointestinal problem or chest wall pain.
- Ruling out AMI but failing to rule out ACS.
- Overlooking other life-threatening conditions, such as pulmonary embolism, esophageal rupture, cocaine use, or aortic aneurysm. "Sometimes providers anchor on AMI and CAD [coronary artery disease], and fail to consider these potentially deadly diagnoses," says Taylor.[3]

EDs should collaborate with radiology, cardiology, and internal medicine providers to facilitate agreement on treatment protocols, she advises.

"Emergency departments that do not employ CT imaging to evaluate coronary arteries must arrange for same or next day testing for intermediate- or high-risk patients and outpatient testing of low-risk patients," adds Taylor.

Failure to Consider Diagnosis

The most common allegation in missed MI cases is failure to consider the diagnosis, says **Terrence W. Brown**, MD, JD, FACEP, chairman of the Department of Emergency Medicine at Banner Estrella Medical Center in Phoenix, AZ. Brown is also counsel for the Emergency Physician Insurance Program.

Most cases of missed AMI result from atypical presentations, according to Brown. "As EPs, I think we are getting better at risk stratifying patients appropriately who present with chest pain, sending low-risk patients home, and bringing in higher risk patients for observations or provocative testing," he says.

However, the challenge is for EPs to do the same kind of risk stratification on patients who present without chest pain. Patients may present with indigestion, nausea, trouble breathing, dizziness, and other vague or nonspecific symptoms.

"This is particularly important in patients with diabetes, the elderly, and women," says Brown. "There is a good amount of literature at a plaintiff's attorney's disposal to show that consideration of a cardiac cause is

required when they present with atypical symptoms."

Most of these patients — and many who present with chest pain as a chief complaint — can be safely sent home, however, says Brown, assuming that an appropriate initial ED workup is done which matches the patients' risk of a cardiac event.

"I don't think we have reached a point where juries expect EPs to catch every atypical presentation for impending MI," says Brown.

Some Missed MIs Are Defensible

There is a lot of room to defend a missed MI that was discharged from the ED, says Brown, if the EP can show that the diagnosis was considered, and that the patient was advised of the possibility.

"What makes these cases hard to defend is where the EP anchored on a non-cardiac etiology, or the chart seems to read in retrospect like blind reassurance was given to a patient that his/her symptoms were benign," says Brown.

Sending a patient home with discharge instructions for "GERD" after successful treatment of indigestion with a GI cocktail is not unreasonable, says Brown, if the EP can show that the possible diagnosis of MI was entertained by the EP in the initial workup, discussed with the patient, and return precautions given.

"The alternative is to risk an allegation that the EP failed to act with the care expected — not just to diagnose a benign condition, but to carefully consider life threats — which plaintiff's attorneys and juries feel is the particular duty of the emergency room," says Brown.

Equally challenging are cases in which the EP did, in fact, entertain a cardiac etiology, but failed in the initial workup. "These are equally attractive to plaintiff's attorneys," says Brown. "They can take advantage of the EP's ability to think of the diagnosis as a way to focus criticism on the evaluation or treatment." He says these factors make cases difficult to defend:

- Sending one set of troponins;
- Discharging patients with abnormal EKGs without cardiology consultation;
- Discharging patients with inappropriate follow-up timeframes.

"In these cases, the argument is not about the potential diagnosis, but how to engage in a basic workup once the 'right' diagnosis is entertained, which is harder to sympathize with in the eyes of the jury," explains Brown.

It's easier for juries to sympathize with the complexities of making a difficult diagnosis, says Brown.

"They are less likely to let off the practitioner for not doing what the plaintiff will argue is the 'basics' of treating a known condition," he says. "These cases are very hard to settle." ■

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CNE/CME 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

- Misleading info during litigation may make case indefensible
- Will EP be named in suit along with negligent colleague?
- When nursing staff are stretched too thin, malpractice may result
- EPs caught in the middle of pressure to reduce testing

ED LEGAL LETTER™

CNE/CME 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 on to www.cmecity.com to take a post-test; tests are taken after each issue. 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%.

4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

CNE/CME QUESTIONS

1. **Which is true regarding liability risks faced by ED medical directors, according to John W. Miller II?**

   A. ED medical directors will not be named in a malpractice suit if they can prove that their physician-patient relationship is of an indirect nature.
   B. A malpractice suit may allege that the ED medical director negligently set policies, procedures, and protocols.
   C. ED medical directors are not obligated to routinely evaluate whether policies and procedures are still up to date.
   D. The ED medical director has no duty to ensure that policies are being followed.

2. **Which is true regarding liability risks of emergency physicians (EPs) supervising physician assistants (PAs), according to Stephen A. Frew, JD?**

   A. Supervising EPs will not be held liable for the PA's actions.
   B. If the hospital fraudulently bills for a physician visit when the PA examined the patient, the supervising EP cannot be held responsible.
   C. The fact that the hospital allowed services by an improperly licensed individual cannot be introduced during malpractice litigation against the EP.
   D. If PAs are allowed to over-extend the scope of patients they see, this exposes the supervising EP to malpractice claims.

3. **Which is true regarding malpractice claims alleging missed myocardial infarction, says Jeanie Taylor, RN, BSN, MS?**

   A. Evidence clearly shows it is safe to have patients with chest pain wait for an evaluation once a single EKG is performed.
   B. It is always inappropriate to have a stable patient with chest pain and a normal EKG remain in the waiting room while an evaluation is taking place.
   C. It is not necessary for EDs to arrange for same or next day testing for intermediate risk patients if the ED does not employ CT imaging to evaluate coronary arteries.
   D. EDs must arrange for same or next day testing for intermediate or high-risk patients if the ED does not employ CT imaging to evaluate coronary arteries.