ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

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Classic Heavy Hitters: Tricky Diagnoses That Recurrently Lead to Large Malpractice Payouts

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Certain diagnoses have recurrently and consistently been the bane of emergency department (ED) physicians, with regard to malpractice payouts year after year. They continue to be missed, and lead to some of the larger awards. Below we present several recent typical cases to raise awareness and avoid liability.

Case 1: Encephalitis in an Infant

A 7-month-old male was taken by his father to the defendant hospital's ED due to two days of diarrhea. The infant had a fever ranging from 102-104 degrees and had not been sitting up for several days. The fever had not responded to Tylenol. In triage, the nurse noted a rectal temperature of 104.7, pulse of 130/minute, respiratory rate 28/minute, blood pressure 98/47, and liquid yellow stool. When the infant was examined by physicians, the infant resisted movement of his thighs and knees bilaterally. Blood studies revealed a white blood count of 14.4. The infant was diagnosed with a "febrile illness" and bilateral hip dysplasia following an X-ray. The infant was discharged home with instructions to take Tylenol and follow-up. Blood cultures were found to be positive the following day. The hospital attempted to contact the family via phone, and when this was not successful, a mailgram was sent advising the family to return to the hospital.

The following day, the infant

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returned to the ED with fever, right-arm and right-sided trembling, and eyes that rolled back. Evaluation included a lumbar puncture, which confirmed group A Streptococcus central nervous system infection. An enhanced CT scan of the brain demonstrated infarction and cerebritis of the temporal, parietal, and occipital lobes. MRI confirmed extensive infarction of the cerebrum and extensive encephalitis. The infant suffered global, massive, and irreversible brain injury, and will require round-the-clock care for the remainder of life. The plaintiff maintained lumbar puncture should have been performed at the time of first ED visit. The defendant claimed that the child was not ill-appearing enough to require lumbar puncture on the first visit. A $3.75 million settlement was reached.[1]

Case 2: Meningitis in an Infant

A 3-month-old girl was taken to the ED of Reading Hospital and Medical Center. She had a fever of 103 degrees. The physician diagnosed a middle ear infection and discharged the patient with a prescription of amoxicillin. There was no documentation of which ear was infected, or what was seen in the ear. The next day, the infant was pale, cool to touch, and lethargic. She was taken to her pediatrician's office and immediately transferred to Lehigh Valley Medical Center. After arrival, she was diagnosed with Pneumococcal meningitis, hypoxic brain injury, and hydrocephalus. She was hospitalized for almost a month. The child died two years later from respiratory complications related to the infection. During the interim, the infant had been taken to the hospital 10 times and had been seen by several medical specialists. The plaintiffs claimed that the ED physician should have ordered blood cultures and urinalysis to exclude bacteremia and meningitis. They also claimed the physician should have scheduled a follow-up visit within 24-48 hours of the first visit. The defendant claimed that the bacteremia and meningitis developed after the patient left the hospital, and the strain of pneumococcus responsible for the problems was resistant to amoxicillin. A $1.72 million verdict was returned.[2]

Lawsuits arguing that medical negligence contributed to an adverse patient outcome with regard to the diagnosis of bacterial meningitis are some of the most common claims filed against emergency medicine as well as pediatric physicians.[3] In a retrospective review of closed pediatric cases over a 16-year period, meningitis was found to be the most common diagnosis involved in pediatric malpractice lawsuits, as well as one of the top two diagnoses seen in cases in which the child died.[4] In another systematic review of malpractice lawsuits involving pediatric patients, the most severe and frequent errors were seen in the infant age group, again with meningitis being commonly seen.[5] Meningitis is more frequent in the first month of life than any other period and, at times, the clinical presentation of infants and neonates with meningitis may be difficult to discern from neonatal sepsis without meningitis. It is one of the most serious of the common pediatric infections, with a fatality rate of 5-10%. Thirty percent of neonates will have long-term neurological sequelae.[8]

It is imperative to consider this diagnosis in any febrile child, and a lumbar puncture can be invaluable in excluding or confirming the diagnosis.

Case 3: Missed Appendicitis

A male patient came to the Biloxi Regional Medical Center ED with abdominal pain and recurrent vomiting. He was evaluated by the emergency physician. The patient had normal bowel sounds and a soft abdomen. The physician suspected simple nausea, but, nevertheless, tests were ordered. Blood tests were normal. A CT scan of the abdomen was obtained and was read by the radiologist as showing a normal appendix. The plaintiff was discharged home with the diagnosis of acute gastritis and instructed to return if his condition changed.

Two days later, the patient's appendix ruptured, leading to a complex and difficult recovery, which included several surgeries. The plaintiff claimed negligence in failure to diagnose appendicitis at the first presentation. He also claimed that the radiologist misread the CT scan, which actually showed an abnormal appendix that was double the typical size. The radiologist settled with the plaintiff for an undisclosed amount prior to trial. The emergency physician argued that he had reasonably relied on the radiology report, and there was nothing else in his examination or other test results that indicated that the CT scan report was in error. He also claimed that the plaintiff should have returned earlier if the condition had worsened. A defense verdict was returned.[6]

Case 4: Missed Appendicitis

A patient, age 16, was taken to an ED suffering from abdominal pain. The patient was diagnosed with a urinary tract infection. No X-rays were taken. A surgery consultation was not obtained. The patient suffered a ruptured appendix within 6-10 hours after discharge from the emergency department. The plaintiff became septic prior to surgery being performed. The patient fully recovered after an extended hospital stay. A $325,000 settlement was reached.[7]

Abdominal pain is one of the most common complaints seen in the ED, and up to 50% of patients seen for the chief complaint of abdominal pain will leave the emergency department without a clear or specific diagnosis.[9] Lawsuits and claims in regard to abdominal pain in the emergency department are very dependent on the age of the patient as well as the sex of the patient being evaluated.[9] With regard to appendicitis, there are a few keys that may help avoid lawsuits and improve clinical judgment. CT scans of the abdomen are regularly used by physicians to discern whether a patient is suffering from appendicitis, but it is important to remember that there is a 5-8% error rate in diagnosing appendicitis. If there is continued clinical concern for the diagnosis, despite a negative CT scan, then proper follow up or consultation should be obtained.[9] Urinalysis can also cloud the picture with regard to the diagnosis of appendicitis. White blood cells or red blood cells in the urine may lead to misdiagnosis as urinary infection in appendicitis patients. The key to diagnosis is high clinical suspicion and realization that presentation may be atypical. In a successfully litigated appendicitis cases, the discharge diagnosis is frequently listed as "gastroenteritis." Cautious consideration of potential appendicitis should be done before listing this as the diagnosis on the chart.

Case 5: Missed Aortic Dissection

A patient presented with chest pain and sweating and was brought by ambulance to St. Francis Hospital. She had a history of tobacco use and hypertension. The ED physician began a work up for myocardial infarction and called for a cardiology consultation. Cardiology consultation was obtained and the evaluation revealed that the chest pain radiated toward the shoulder and down the upper abdomen. An echocardiogram demonstrated moderate to severe aortic regurgitation and a widened aortic root. An initial chest X-ray showed a tortuous aorta. The plaintiffs claimed that the findings on the testing should have led to the inclusion of aortic dissection as a possible diagnosis and that a CT scan of the chest would have definitively made the correct diagnosis. A CT scan was never ordered.

On the third day of admission, a CT scan of the abdomen was obtained demonstrating the presence of an intramural aortic hematoma that was not recognized by the radiologist. The patient then underwent an esophagogastroduodenoscopy procedure. After the procedure

was complete, the patient began to complain of severe pain in her legs and soon lost feeling in the legs. A CT scan of the chest was performed that revealed an ascending aortic dissection. She was taken for emergent surgery but died on the operating table. A $3 million settlement was reached.[9]

Aortic dissection is a relatively uncommon but potentially catastrophic illness. Early and accurate diagnosis in a patient with chest pain is key to survival. The survival rate decreases quickly, so timely diagnosis is essential. The missed diagnosis is often successfully litigated since a readily available test definitively makes the diagnosis (CT scan of the chest). In a recent analysis of 33 legal cases involving thoracic aortic aneurysm and dissection, 90% of cases that prompted legal action ended with the death of the patient, while the other 10% involved stroke or paraplegia.[11]

Aortic dissection is a diagnosis that should be a part of every physician's differential when evaluating a complaint of chest or abdominal pain. Diagnosis of an aortic dissection is not always clear. Additionally, a D-dimer blood test has been advocated as a screening test. What becomes tricky in regard to its diagnosis is that dissection can occur at any level of the aorta, leading to occlusions and ischemia of any or multiple organs. This can cause a dissection to mimic a presentation similar to a primary problem of another organ.[11] Another confusing factor is that about 20% of patients with diagnosed aortic pathology will not present with typical complaints usually seen in a dissection.[11] Having a high clinical suspicion and keeping the diagnosis of dissection on the differential diagnosis of chest and abdominal pain patients is key. Neurologic symptoms may be present, and chest pain accompanied by neurologic complaints or findings should immediately raise the suspicion of this diagnosis.

Case 6: Missed Myocardial Infarction

A 56-year-old man went to a private emergency facility with a complaint of chest pain. He had reported two separate episodes of chest pain, with the most recent being that day. An electrocardiogram was taken at that time, which was abnormal with ST depressions in multiple leads. He was advised to go to a hospital ED for a cardiac evaluation and intervention. The patient went directly to an ED and complained of two separate episodes of substernal chest pain while en route. Two EKGs were obtained in the ED and were interpreted as a normal sinus rhythm with a septo-myocardial infarct of undetermined age. The patient had the previous EKG taken at the private facility with him. He was discharged home with an appointment to return for a stress test the next week.

The patient suffered a myocardial infarction and died three days later. A lawsuit claimed that a cardiology consult should have been obtained and the decedent should have been admitted for observation and cardiac evaluation. The plaintiff claimed that if he had been admitted, further testing would have shown abnormalities that would have led to life-saving treatment. A $750,000 settlement was reached.[11]

Chest pain is a common complaint seen by ED physicians. There are approximately 6 million visits per year to EDs across the country with this chief complaint.[12] A missed or delayed diagnosis of a myocardial infarction can lead to significant morbidity and mortality and actually represents the greatest malpractice risk to emergency medicine physicians, making up 10-12% of all lawsuits filed and 30-35% of all monetary awards.[12] It can be difficult at times to diagnose coronary artery disease and MI, particularly in those populations in which presentations are not typical. These populations tend to include young males younger than the age of 40, women younger than the age of 45, ethnic or minority groups, and the elderly population.[13] Up to 25-40% of patients who are diagnosed with an MI do not have chest pain as their presenting complaint.[14] Instead, in some of these trickier populations, the patient may complain of nausea/vomiting, dyspnea, abdominal pain, back pain, jaw or shoulder pain, or overall generalized weakness.[14] To better care for any chest pain patient, whether elderly or young, follow American Heart Association guidelines with regard to chest pain, use clinical tools and scores to help determine who is at higher and lower risk, and be conservative with obtaining EKGs and admitting those with EKG changes, especially in a higher-risk population. It is important to take into consideration the atypical presentations of chest pain, especially in our female, elderly, and ethnic populations, and make sure to obtain an EKG and biomarkers in order to help with disposition.

In 25% of litigated cases, the ED physician failed to recognize historical and physical findings related to ischemic cardiac disease. In another 25% of litigated missed

MI cases, the EKG was misread. Some of these misinterpretations were obvious, while others were subtle. Sometimes the physician failed to recognize significant changes by failing to compare the EKG with an available prior EKG.[13]

Summary

A few key diseases that present to EDs are responsible for the majority of money awarded in malpractice cases. These lawsuits usually involve a claim of "failure to diagnose." We have shared several typical recent cases to raise awareness. By considering these entities frequently, physician liability may be reduced. ■

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Social Media Can Lead to Suits Against EP for Malpractice, Civil Defamation

Posts are one of plaintiff's "best tools"

In 2013, an emergency department (ED) director was terminated after commenting on a patient's photo, which had been posted on Facebook by an ED nurse.[1] In a similar case the same year, an emergency physician (EP) was sued after posting a photo of an intoxicated patient that included comments.[2]

"Consider a Facebook post like you 'just took care of a 99-year-old drunk driver in the ER,'" says **Tom Scaletta**, MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL.

This post would violate the Health Insurance Portability and Accountability Act (HIPAA) even though the patient isn't named, he explains. This is because the patient's advanced age creates a small enough cohort in the geographical area the poster resides in to determine the patient's identity. "Moreover, the civil defamation suit, assuming the post was discovered by an angry family, could be steep," warns Scaletta.

Since most professional liability policies don't cover such an occurrence, EPs would have to retain

their own defense counsel, adds Scaletta. "The ED is a high-risk area, since this is where socially interesting things happen," he says. "For some, social media posting is a stress reliever, especially after a grueling shift."

However, a post such as "Heroin shooter last night begged for admission to treat his low back pain and nothing but IV Dilaudid works. Conveniently had 'fever and chills' at home. I guess he knows how to surf the Internet. Not fooled!" can also be a career-ending mistake.

"If you see any colleagues beginning to cross the line, do them a favor and suggest they stop," advises Scaletta. "Remind them that web crawlers and other permanent archiving tools make years-old comments very easy to find."

EPs should remember that what they post on the Internet is going to be there permanently, warns **Andrew Wong**, MD, assistant clinical professor of emergency medicine at University of California Irvine School of Medicine and associate medical director of the ED at UC Irvine Health.

"If there is anything that you would want to post regarding a patient case, which should almost never be the case on social media, make sure to ask permission from the patient," he advises. "Some experts say you can obtain it verbally, but written authorization is even better."

All Data Likely Discoverable

"Just like in divorce cases, where electronic data and social media postings are Exhibit A, the same is now true in medical malpractice actions," says **John W. Miller II**, principal at Sterling Risk Advisors in Atlanta, GA.

An EP's social media posts are all potentially discoverable, says Scaletta, depending on the situation and state rules.

"Where once we only had to worry about the medicine and what the experts said relative to the documentation of care, plaintiff attorneys now use electronic information, be it social media or otherwise, to discredit the defendant," says Miller.

Any information in the public realm, including social media posts, are "fair game" for plaintiff attorneys, says Miller. "The subpoena of electronic information has become one of the best tools in the plaintiff attorney's arsenal for creating traps in the defendant's testimony," he adds.

When physicians use a phone for both business and personal communication, typically the plaintiff attorney gets access to all the data, not just that which is pertinent to the case. "There is an argument that some malpractice insurers are making for physicians to keep two different cell phones — one for business and one for personal use," says Miller.

This has been successful to an extent, says Miller, in keeping data from the phone used for personal matters from being subpoenaed. "But to the extent a physician uses his or her business phone for personal reasons, usually all the data in that phone become discoverable," he says.

Posts Can Help or Harm Defense

Depending on the facts of a medical negligence case, social media posts can complicate both the prosecution or defense. A recent lawsuit alleged a patient was harmed because an on-call surgeon failed to return to the hospital to attend to a patient he performed a procedure on earlier that day.

"He contended that he never got the pages, the cell phone calls, or the text messages from the hospital," says Miller. During the litigation, a Facebook post was revealed showing the physician and his wife celebrating their anniversary on the night in question, with an open bottle of wine between them. "Needless to say, this compromised the defense of his case," says Miller.

Another recent case was won by an orthopedist after the jury was shown a video posted to social media depicting the patient using the arm that, under oath, he had claimed was incapable of lifting more than 10 pounds, subsequent to a procedure he alleged was a violation of the standard of care.

"The video showed the plaintiff picking up a relative at a family reunion and twirling them around his body with said arm," says Miller. Here are important considerations for EPs involving liability risks of social media:

• EPs might face defamation lawsuits if they respond to others' social media posts.

"Emergency physicians need to be careful about associating on Facebook with coworkers," says Scaletta. In a widely publicized case, an ED technician was suspended for posting patient information to her Twitter account.[3]

"If a 19-year-old technician cannot resist the urge to post something that is inappropriate, and the emergency physician clicks 'Like,' this could end a job, and possibly a career," he warns.

EPs might also be tempted to respond to negative posts by patients on social media that criticize the EP. "There is legal risk related to inappropriate, in-kind responses to patients' opinions," says Scaletta.

"These might instigate a defamation lawsuit."

Sometimes colleagues defend the EP or the ED against derogatory things said in a social media post. "It just becomes a firestorm," says Miller. "Now you've really upset the patient and, potentially, violated HIPAA by discussing the patient's treatment online."

EPs at Edward Hospital were tempted to respond to a recent negative post on the hospital's Facebook page that named a specific EP and ED nurse. "Many staff knew about the posting, as they follow the hospital site. They were upset because they knew that the remarks were completely baseless," says Scaletta. He counseled staff not to reply to the posting, since this could be construed as a HIPAA violation.

"While it's tempting to set the record straight, particularly to something in the public realm, our advice is to leave it be," says Miller.

Miller has seen such responses inflame situations into a lawsuit or a state board complaint. "Generally, responding only makes it worse, as you're not going to win. The poster will always have the last word," says Miller.

• If EPs post risk-management questions, these can be discoverable during litigation.

"These may be temporally related to a particular case that converts to a claim," says Scaletta.

• EPs should proceed with caution before using Facebook to learn more about patients.

"In general, we would advise against physicians using social media as a regular part of their work," says Miller. "We would tend to avoid researching patients beyond how they presented clinically."

However, Miller knows of a provider who received a lab report with a diagnosis of metastatic cancer, and discovered the patient had moved out of state with no forwarding information. "The physician felt so compelled to make sure that this person knew of their diagnosis that he actually resorted to social media," he says. By posting on social media, the physician was able to track down the patient.

"Using the Internet to look up a patient needs some forethought, but it may be a helpful source that may uncover a safety issue," Miller concludes.

In some cases, EDs have used social media posts in a patient's phone to find next of kin, when the patient presented with no contact information. "These exceptions need to be carefully thought through, with counsel engaged to be sure no laws or regulations are violated," cautions Miller.

Scaletta once suspected that a patient was misrepresenting her condition. He found a website the patient was apparently using to raise money for what appeared to be a fictitious disorder. "We flagged her in the system to alert other providers of this fact," he says.

Scaletta also used Facebook to show that a patient was sending messages that suggested suicidal ideation. This resulted in the decision to admit the patient to a psychiatric facility. ■

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These Suits Against EPs Became Indefensible: Medical Records Were Altered

"Virtually impossible" to go undetected during litigation

In a case related to the alleged delay in providing care to a patient, an emergency physician (EP) was accused of altering the time that he ordered certain treatments for the patient.

"The handwriting in the chart was difficult to read," says **Marcie A. Courtney**, JD, an associate at Post & Schell in Philadelphia, PA. The plaintiff's attorney suggested that the EP had originally documented the time that he wrote the order, then later tried to change that time by writing another time over it.

"Plaintiff's counsel suggested that this was done in an effort to show that the patient received treatment earlier than he really had," she says. The EP denied altering the record, but a handwriting expert determined that there were, in fact, two times entered in the chart, one placed over the other. While these times were written with two separate pens, the expert concluded, they were written by the same individual.

"In addition, this expert was able to comment as to which time was written first and which was written second," says Courtney. These conclusions supported the plaintiff's argument that there was a two-hour delay in providing care to the patient, and that this delay resulted in harm.

"Due to the fact that a jury would likely agree that the physician altered the records, and since the jury could conclude that the physician's deposition testimony in this regard was not accurate, this matter was ultimately resolved out of court," Courtney says.

In another malpractice case, the plaintiff alleged that certain recommendations were written after the patient had been discharged from the ED and, therefore, were never disclosed to the patient. The handwriting expert determined that different writing instruments were used to document the recommendations, and that they could have been written at different times.

This allowed plaintiff's counsel to argue that the recommendations were never made to the patient, and this caused the patient harm. "This matter was ultimately resolved out of court, in part due to this potentially scandalous issue," says Courtney.

Otherwise Defensible Cases Settled

"Physicians may be tempted, following a bad outcome, to alter records," acknowledges **James Scibilia**, MD, a member of the American Academy of Pediatrics' Committee on Medical Liability and Risk Management.

During a recent malpractice trial, the plaintiff's attorney showed the jury the original medical chart, which had been altered by the physician in a later version.

"The appearance to the jury was that the physician was being deceptive and had missed something initially," says Scibilia. "This case, which would have been quite defensible, was settled with a sub-stantial reward to the plaintiffs."

It is virtually impossible for an EP to alter records and go undetected during litigation, emphasizes Courtney. "Due to the implications associated with altering the records, cases which are otherwise defensible may be settled," she says.

The audit trail, which is maintained for all electronic medical records, documents the exact date and time that an EP enters information into a patient's chart. "A plaintiff's lawyer will be aware that this alter-ation occurred, and will pursue this aggressively during the physician's deposition and throughout the litigation," says Courtney.

In Pennsylvania, if the plaintiff's lawyer suspects that medical records have been altered or destroyed, he or she can request that the Court give the jury a spoilation of evidence charge. "This charge allows the jury to infer that the altered or destroyed evidence would have been unfavorable to the person who altered or destroyed it," Courtney says.

Further, a lawyer can use the altered medical records to convince the jury that the physician cannot be trusted. "If a jury does not trust or like the physician, the chances of a defense verdict diminish," Courtney says.

Plaintiff Will Ask Why Change Was Made

If a physician feels a need to add to a chart following a bad patient experience, this should be written as a new note, advises Scibilia. "These entries should be factual and clarifying, not emotional treatises on the physician's own feelings," he says.

An EP might want to document that a patient was told to return to the ED immediately if certain symptoms worsened, but waited several hours to do so, for example, or the EP might wish to clarify history or exam findings. "The sooner this note is written the better, since it will appear that the note was placed prior to litigation being initiated," says Scibilia.

Writing an appropriately dated and timed addendum in the chart is acceptable if the EP feels that it is

absolutely necessary, says Courtney. "However, during the physician's deposition, plaintiff counsel will most certainly inquire as to why such an addendum was made," she warns. ■

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EMTALA Lawsuits Involving Psychiatric Patients Held in ED Rarely Successful

Liability for suicide, harm to third parties are legal risks

The risk of an Emergency Medical Treatment & Labor Act (EMTALA) lawsuit involving a patient with psychiatric illness is low, according to a recent study.[1] If emergency physicians (EPs) perform appropriate medical screening examinations, the lawsuit is rarely successful.

"We anticipated that the decline in inpatient psychiatric bed capacity would have resulted in an increasing number of EMTALA cases, as fewer beds would likely pressure emergency providers to dismiss, or board, patients with psychiatric illness," says **Annie T. Sadosty**, MD, one of the study's authors. Sadosty is chair of the Department of Emergency Medicine and associate professor of emergency medicine at Mayo Clinic in Rochester, MN.

"While the trend line of EMTALA cases involving patients with psychiatric illness since 1986 — the year EMTALA was enacted — is positive, it did not reach statistical significance," she reports.

Successful Defense Strategies

Researchers analyzed jury verdicts, settlements, and other litigation from three legal databases involving alleged EMTALA violations related to psychiatric patients between 1986 and the end of 2012, and identified 33 relevant cases. Here are key findings:

- Two cases were decided in favor of the plaintiffs, four were settled, 10 had an unknown outcomes, and 17 were decided in favor of the defendants.
- Most of the plaintiffs were men, had past psychiatric diagnoses, were not evaluated by a psychiatrist, and eventually committed or attempted suicide.
- The most frequently successful defense used was to demonstrate that providers used a standard screening examination, and did not detect an emergency medical condition that required stabilization.

The study is limited to lawsuits pertaining to alleged EMTALA violations, and should not be generalized more broadly, cautions Sadosty.

"Most providers defended themselves by arguing that they never identified a medical condition that needed stabilization and, therefore, had no further obligation to the patient under EMTALA," says **Rachel Lindor**, MD, JD, the study's lead author. Lindor is former research director of the Center for Law, Science & Innovation at Arizona State University's Sandra Day O'Connor College of Law.

To satisfy EMTALA, providers must apply a standard screening exam to all patients, says Lindor, and as long as that exam doesn't detect an emergency medical condition, the EMTALA obligations are satisfied.

"That said, if providers or institutions develop a screening exam that is terrible, they may not face EMTALA liability when it misses ill patients, but they are still at risk for general medical malpractice lawsuits," says Lindor.

Only two cases in the study were deemed to be EMTALA violations. One involved a man in his 20s with a history of depression and several past suicide attempts. "He was brought to the ED by family after inflicting several shallow cuts on his wrist," says Lindor. In the ED, he was evaluated by a psychiatric nurse, who eventually discharged him home after having him sign a safety contract agreeing to stay

with family until an outpatient appointment could be scheduled. "An emergency physician cosigned the paperwork, but never evaluated the patient," says Lindor. "The day after discharge, the patient walked away from a family gathering and hanged himself."

The other successful case occurred in 2000 and involved a female with a history of depression and alcohol abuse who presented to the ED intoxicated and with suicidal ideation. She was seen by an EP, who suggested that the woman speak to an ED-based guidance counselor. "The woman refused and after doing so, the emergency physician committed her to police custody," says Lindor. "She filed an EMTALA lawsuit after she was detained for a night in jail with no psychiatric care."

Improve Evaluation of Patients

According to an online survey conducted in April 2014 by the American College of Emergency Physicians, 84% of EPs reported that psychiatric patients are boarded in their ED, and 91% indicated that this practice has led to violent behavior by distressed psychiatric patients, distracted staff, or bed shortages.

"Boarding of psychiatric patients is a complex problem," says **Jon Mark Hirshon**, MD, PhD, MPH, FACEP, associate professor in the Department of Emergency Medicine and an attending EP at the University of Maryland Medical Center and Baltimore VA Medical Center. In March 2014, Hirshon testified before Congress about the issue of psychiatric boarding.

"Many individuals who need psychiatric care cannot adequately access either inpatient or outpatient services. They often end up in the ED seeking care," he says. EPs are supposed to take care of patients to the best of their ability, notes Hirshon, "but what can I do if there is no location for a patient who needs to be admitted?"

Hirshon suggests forming a committee to identify best practices involving ED care of psychiatric patients. "This might be an ongoing discussion where you meet on a monthly or quarterly basis with psychiatric professionals to discuss cases," he says. "Be proactive in terms of improving the care delivered."

Boarding Ruled Unconstitutional

In August 2014, the Washington State Supreme Court determined that boarding of psychiatric patients in the ED is unconstitutional and violates the state's Involuntary Treatment Act. "The ruling should reduce the burden of dealing with long-stay psychiatric patients for most EDs in the state," says **Paul S. Appelbaum**, MD, Dollard Professor of Psychiatry, Medicine, & Law and director of the Division of Law, Ethics, and Psychiatry at Columbia University College of Physicians & Surgeons in New York, NY.

However, it will not alleviate the flow of acute psychiatric patients into EDs. "Unless new beds are created, the end result is likely to be diverting more people with serious psychiatric disorders to jails and prisons," says Appelbaum.

Liability for suicide and harm to third parties is among the most important liability risks likely to arise from the treatment of psychiatric patients in the ED, warns Appelbaum.

Busy EDs may be ill-suited to provide the kind of close observation and containment that some psychiatric patients require. "The arrival of cases needing emergent medical or surgical interventions can offer opportunities for a suicidal patient to slip past distracted staff, or for an assaultive patient to grab a dangerous implement left unattended," says Appelbaum. Here are some practices that may reduce liability risks:

• Create special areas for the evaluation of patients presenting with psychiatric emergencies.

EDs that see large numbers of such patients often have separate "psych EDs." "At my institution, which is an academic medical center, we send them to a psychiatric ED which is just down the hall from our main ED," says Hirshon. "This allows us a separate place for psychiatric patients."

In smaller EDs without this resource, obtaining an evaluation from a psychiatrist via telemedicine is one good option, he suggests. "When these issues happen, you need to show that you are doing the best you can, given the limitations," says Hirshon.

"For smaller EDs that see psychiatric patients less frequently, designated evaluation rooms can be created with design features that minimize risk for psychiatric evaluations, but can 'swing' to accommodate med-surg patients as well," says Appelbaum. Such features include recessed fixtures, closed circuit observation cameras, and secure storage spaces.

• Develop procedures

for continuous observation of patients likely to pose a substantial risk to themselves.

"Coordination with security is essential in planning to deal with patients who present an escape risk or pose risk to other people," says Appelbaum.

• Get psychiatric patients out of the ED as quickly as possible.

"This is perhaps the best approach to minimizing ED liability risk," says Appelbaum. To do so, efficient procedures are needed for calling in mental health personnel to perform evaluations, and for prioritizing arrangements for transfer to inpatient units when patients require hospitalization.

Widespread shortages of inpatient psychiatric beds complicate this process. "But EDs are not the best places to hold psychiatric patients for prolonged periods," says Appelbaum. "Moving them rapidly to appropriate facilities remains key." ■

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SOURCES

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CNE/CME QUESTIONS

1. **Which is true regarding social media posts and malpractice litigation, according to John W. Miller II?**

   A. Posts do not violate patient privacy laws unless the patient is named.
   B. Professional liability policies typically cover the defense for a civil defamation lawsuit stemming from a physician's social media post.
   C. EPs cannot be successfully sued for defamation by merely responding to a colleague's social media post.
   D. A social media post can be used to discredit the EP's credibility.

2. **Which is true regarding discoverability of social media posts, according to Tom Scaletta, MD, FAAEM?**

   A. An EP's response to others' posts is not admissible in court.
   B. An EP's social media posts are not discoverable unless they directly pertain to the care rendered in the ED.
   C. An EP's social media posts are all potentially discoverable, depending on the situation and state rules.
   D. A patient's social media posts cannot be used to help the defense.

3. **Which is true regarding EMTALA lawsuits involving psychiatric patients held in EDs, according to a 2014 study?**

   A. Most of the cases were dismissed or unsuccessful.
   B. Virtually all cases were decided in favor of the plaintiffs.
   C. None of the suits involved patients who committed or attempted suicide.
   D. Demonstrating that providers did not detect an emergency medical condition after using a standard screening examination was never a successful defense.

4. **Which is true regarding altered ED medical records, according to Marcie A. Courtney, JD?**

   A. Late entries to charts involving a bad outcome are ideally made several days after the incident.
   B. A spoilation of evidence charge allows the jury to infer that altered evidence would have been unfavorable to the person who altered it.
   C. If a physician wishes to add additional documentation after a bad patient experience, this should be written as though it was part of the original entry.
   D. Making an addendum to the chart is never acceptable, even if it is appropriately dated and timed.

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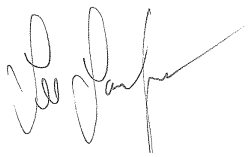

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