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Halting Inappropriate Expert Witness Testimony — Part II: Efforts of State Medical Boards and State Medical Societies to Police 'Experts'

by Robert A. Bitterman, MD, JD, FACEP

Introduction

Last month we explored State Medical Society actions to rein in unethical or fraudulent testimony by medical experts in malpractice litigation.[1] Civil defamation actions brought against the 'experts' by aggrieved physician defendants were largely unsuccessful, and professional discipline depended upon the state courts holding that expert witness testimony constituted the 'practice of medicine'.

This month we will address attempts by State Medical Boards to use their licensure powers to censure or fine physicians, suspend their medical license, or outright revoke their ability to practice medicine for providing unprofessional testimony. We'll also see, as the cases discussed will demonstrate, that it's a fractious task to pursue perceived unscrupulous experts and if the attack process isn't squeaky clean it can boomerang on the complaining physicians.

Dr. Lustgarten v. The North Carolina Medical Board

Dr. Gary Lustgarten, a Neurosurgeon from North Miami Beach, testified for the plaintiffs in the North Carolina case of Hardin v. Carolina Neurological Services, et al. At the time, he held both a Florida and North Carolina medical license. The North Carolina Board of Medicine, one of the more active medical boards in the country, revoked Dr. Lustgarten's state license for what it considered unprofessional conduct on the witness stand in the case. The Board concluded that he misrepresented the applicable standard of care and testified without a good faith basis that one of the neurosurgeon defendants had intentionally falsified the medical records.

Dr. Lustgarten appealed the Board's ruling in North Carolina state court. [2,3] The judge overturned the Board's decision on the misrepresentation of the standard of care, holding that Dr. Lustgarten was merely providing his opinions on the care provided by the defendants. However, the court affirmed the Board's ruling on the charge that the neurosurgeon engaged in unprofessional conduct when he repeatedly made factual assertions without any evidentiary or good faith basis regarding falsification of

the medical records. Consequently, the Board retracted its revocation of the physician's medical license and instead suspended his license for one year. Dr. Lustgarten challenged the suspension to the North Carolina Court of Appeals.[4]

The appellate court first noted that NC legislature granted the Medical Board the authority regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina; and it agreed that the Board has the power to suspend or revoke the license of a physician who was reasonably found by the Board to have committed unprofessional conduct.[5] The NC statute defines unprofessional conduct as failure to conform to the standards of prevailing medical practice, but also as "failure to conform to the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina."[6]

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Vice President/Publisher: Brenda Mooney
Editorial Group Head: Glen Harris
Managing Editor: Martha Jo Dendinger
Contributing Editors: Robert Bitterman, MD, JD, FACEP, Staci Kusterbeck, William Sullivan, DO, JD, FACEP, FCLM.

Questions & Comments

Please contact **Lee Landenberger,** Associate Publisher, at lee.landenberger@ahcmedia.com or (404) 262-5483.

Thus, in North Carolina expert witness testimony constituted a form of the practice of medicine for which the physician could be subjected to peer-review and discipline, such as suspension or loss of licensure.

The court next scrutinized the Board's findings of fact and conclusions, as well as those of the lower court, to determine if they were reasonable under the circumstances and should be upheld by the appellate court.

The Board had concluded that Dr. Lustgarten engaged in unprofessional conduct because he had levied a groundless accusation when he testified that another doctor had falsified medical records to protect his associate. The specific misconduct charges against the expert witness included:

"Dr. Lustgarten testified in the absence of any corroborating evidence and in spite of evidence to the contrary, that a physician [the defendant] falsified medical records to protect his associate."

"Dr. Lustgarten testified under oath that Dr. X [the defendant], in order to somehow protect Dr. Y [his partner], falsified the procedure note … . Dr. Lustgarten had absolutely no direct evidence to support this extremely serious accusation."

The lower court upheld the Board's conclusion that Dr. Lustgarten had committed unprofessional conduct because "he repeatedly testified without an evidentiary or good faith basis that Dr. X [the defendant] had falsified medical records", and ruled that the suspension of Dr. Lustgarten's license was appropriate discipline for "testifying that Dr. X [the defendant] falsified medical records."[2]

Dr. Lustgarten's primary argument on appeal tracked the language of NC's governing statute, contending that the lower court should not have affirmed the Board's discipline order because there was no substantial record evidence that he accused the defendant physician of falsifying a medical record without a good faith evidentiary basis.[6]

The appellate court reviewed the physician's testimony and the record as a whole and agreed with Dr. Lustgarten. It first noted that "Dr. Lustgarten did not actually state that the defendant had "falsified" a medical record or use the terms "liar" or "lying" to describe the other physician or his conduct. Rather, these terms were introduced by the attorneys representing the defendant." On the contrary, Dr. Lustgarten had stated he had "difficulty believing" the defendant's notation in the records (that a shunt-dependent patient's intracranial pressure was not elevated at the time a second shunt catheter was inserted), and cited a host of clinical reasons for his skepticism concerning the notation, such as the CT scan results, mood changes in the patient, pain-medication-resistant headaches being experienced by the patient, and the lack of ventricular flow.[4]

The court stated the record was also clear that Dr. Lustgarten was content to state no more than his opinion that the defendant's note was faulty. The defense attorney, however, repeatedly asked Dr. Lustgarten whether the defendant was lying. Dr. Lustgarten didn't wish to answer this question, but he eventually stated that he was "not going to call [the defendant] a liar" but that, in his opinion, he had "tried to temporize his findings and write a note that was benevolent." Also, when the defense attorney persisted by asking whether Dr. Lustgarten was "accusing . . . [the defendant] of falsifying medical records," Dr. Lustgarten responded that the issue would have to be decided by a jury and again indicated that he had difficulty believing the physician's note.[4]

The court determined that the Dr. Lustgarten's observations and testimony demonstrated substantial evidence that Dr. Lustgarten had a good faith basis for his opinion that the defendant's notation was not credible, and for making the statements at trial for which the Medical Board seeks to impose discipline. The court could find no other evidence in the record to support the Board's decision.[4]

Thus, the appellate court held that the lower court judge erroneously affirmed the Board's determination, finding that the record as a whole did not permit an inference that Dr. Lustgarten made an entirely unfounded statement concerning the defendant's notes in the medical record. The court dismissed the charges against Dr. Lustgarten, reinstating his medical license in the state of North Carolina.[4]

Dr. Fullerton v. Florida Medical Association, et al

Dr. Fullerton was a California physician who testified against three Tampa area physicians in a Florida medical malpractice case. After winning the case, the defendants sent a complaint letter to the Florida Medical Association's (FMA) Expert Witness Committee (EWC), a part of the FMA's Council on Ethical and Judicial Affairs (CEJA)). In their letter they complained that Dr. Fullerton's testimony fell below reasonable professional standards, that it was made "for the sole purpose of propagating a frivolous lawsuit for financial gain," and that he specifically "presented false testimony and false theories about stroke." They asked the FMA to opine whether Dr. Fullerton's testimony was substandard, and, if so, to report its findings to the Florida Board of Medicine for appropriate disciplinary action in order "to prevent the Medical profession from being terrorized by similar experts."[7]

After publication of the letter Dr. Fullerton countered swiftly by suing the physicians and the FMA for defamation, tortious interference with an advantageous business relationship, conspiracy through abuse of economic power, witness intimidation, and violation of Florida's Racketeer Influenced and Corrupt Organizations Act (RICO).[7]

He claimed that the statements in the physician's letter were false and that the Expert Witness Committee was organized for the purpose "of intimidating, hindering, and deterring persons, including himself, from appearing as expert witnesses on behalf of plaintiffs in cases involving medical malpractice," thereby depriving injured plaintiffs of the ability to pursue medical-malpractice lawsuits.[7]

Importantly, he pointed out that while he was licensed to practice medicine in both California and Florida, he was not a member of the FMA and it had no jurisdiction over him.

The defendants asked the court to dismiss Dr. Fullerton's suit on the grounds that it was barred by Florida and federal peer-review immunity statutes.[8,9]

Dr. Fullerton agreed that the FMA was a statutorily designated professional-review committee, but argued that the immunity statutes were enacted for the purpose of addressing the quality of health care provided by physicians when treating patients, and not designed to apply to expert-witness testimony.

The trial court sided with the defendants, ruling that the statutory immunity privileges provided in both Florida's law and the federal Health Care Quality Improvement Act (HCQIA) barred Dr. Fullerton's claims unless he could prove the defendants engaged in intentional fraud.[7]

However, the Florida appeals court overturned the trial court and reinstated Dr. Fullerton's lawsuit against the three physicians and the FMA. It held first, that testimony in a medical malpractice action was not the "practice of medicine", citing Florida's statutes which defines the practice of medicine as the "rendering of health services" including the "diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition".[10] Dr. Fullerton didn't 'render' such services to a patient, and since his testimony wasn't considered the practice of medicine Dr. Fullerton was entitled to the long recognized common privilege of absolute civil immunity for testimony provided in connection in the course of a judicial proceeding.[7]

Second, since the appeals court judged that neither Florida's peer-review statutes nor the HCQIA clearly and unambiguously expressed legislative intent that such testimony should be scrutinized by peer review, it concluded the statutes provide no immunity to the three physicians. It also held that HCQIA provided "no immunity to the FMA in its role as an examiner of the quality of a non-member physician's judicial testimony".[7]

The courts ruling on the HCQIA was directly opposite that of the Kansas court in the case of Bundren v.

Parriott[11] (discussed last month), and also that of the Seventh Circuit Court of Appeals in Austin v. American Association of Neurological Surgeons, which did believe HCQIA authorized professional peer-review bodies to assess the quality of a physician's testimony given in a malpractice action.[12] The court dismissed the Austin holding, noting particularly that "Dr. Fullerton, unlike Dr. Austin, was not a member of the professional association that entertained a complaint to discipline him". Thus, the court opined that "even if the immunity statues permitted peer-review of a member physician's malpractice testimony, the FMA had no cause under the circumstances to subject Dr. Fullerton to its discipline."[7]

Therefore, as warned in Part I of this article, if a physician makes defamatory comments against another physician outside the confines of the legal proceeding, where judicial privileges do not apply, that physician can be civilly liable for defamation.[1]

Testimony as the Practice of Medicine.

A physician can practice medicine without belonging to a State Medical Society or Professional Association, but not without a license from a State Board of Medicine. That's why the real fight on the tempering of expert witnesses is over whether or not providing testimony in malpractice cases is a form of the practice of medicine, and hence subject to peer-review by the state Board.[13]

The American Medical Association (AMA) is on record declaring that medical expert witness testimony constitutes the practice of medicine and should be subject to peer review.[14] Furthermore, the Association actively encourages peer review and discipline for unprofessional or fraudulent testimony, and warns that it will assist professional bodies in punishing physicians who provide such testimony.[15]

The American College of Emergency Physicians (ACEP) also holds that medical expert witness testimony falls within the realm of the practice of emergency medicine, because it has demonstrated the potential to set standards of medical care, and would therefore be subject to accountability by appropriate licensing authorities.[16]

Most courts have agreed that expert witness testimony is a type of the practice of medicine.

In the case of Joseph v. District of Columbia Board of Medicine, the District of Columbia Court of Appeals affirmed the D.C. Board of Medicine's defining the "practice of medicine" to include the offering of expert witness testimony.[17]

Dr. Joseph, who specialized in emergency medicine and trauma, appeared as a plaintiff's expert in a South Carolina medical malpractice case and testified falsely that he was board-certified in thoracic surgery. He also provided other false information about his academic credentials. The Maryland Commission on Medical Discipline charged him with "immoral conduct" and with willfully making false reports or records in the practice of medicine.[18] It reprimand and levied a civil fine against Dr. Joseph, which were upheld by a Court of Appeals.[17]

Key Points

Two Elements Required to Peer Review Expert Witness Testimony

1. Define testiomony as the practice of medicine; and
2. Provide State Medical Boards jurisdiction over out-of-state experts.

Dr. Joseph attempted to define the practice of medicine solely in terms of patient care. However, the Commission stated that it is the practice of medicine in Maryland when a "medical expert in a malpractice case is retained to give his/her opinion based on the patient's records as to the standard of care required, the standard of care given, and the damage caused to the patient by the medical care rendered by another physician."[17] It equated such testimony given by a non-treating physician to be in the nature of giving a second opinion, and also requires that the witness be licensed to practice medicine in order to testify as an expert. The court noted that Dr. Joseph lied under oath in his capacity as a medical expert, about his own medical qualifications, in order to have his diagnosis accepted by the jury.[17]

In the case of Deatherage v. State v. Washington Examining Board of Psychology,[19] Dr. Deatherage argued that his expert witness testimony fell within the scope of absolute witness immunity under state law. The Supreme Court of Washington agreed that he could not be held civilly liable for his unethical testimony, but that professional discipline was entirely appropriate, stating:

"Permitting a professional to be subject to discipline for unprofessional conduct...serves to advance the Court's goal of accurate testimony from expert witnesses, and further the disciplinary board's goal of protecting the public."19

Similarly, as mentioned in last month's article, the Seventh Circuit Court of Appeals in the case of Austin v. American Association of Neurological Surgeons also determined that physician testimony is a type of medical service subject to peer-review and discipline if found to be unethical or unprofessional.[12]

Jurisdiction

Assuming state and federal courts accept that expert witness testimony is the practice of medicine and subject to peer-review and sanctions by the state medical

board, it is irrelevant if the expert is from out-of-state and doesn't have an in-state license subject to the jurisdiction of the board. In a number of states, most notably Florida, that is precisely the problem: the state medical board has no jurisdiction over physicians who testify in the state if they don't maintain a Florida license.

The Florida Medical Association has repeatedly lobbied the Florida legislature for a bill that would bring out-of-state physicians who testify in Florida under the jurisdiction of the Florida Board of Medicine. It has been equally repeatedly rebuffed by the legislature, most recently just late last year.

Other states have been more successful, such as Ohio, which recently enacted legislation which deems expert witnesses temporary licensed in Ohio and subject to the authority of the state medical board. Expert testimony determined by the State Medical Board to be false or completely without medical foundation would be considered "unprofessional conduct" and subject to discipline by the board."[20]

The American Medical Association encourages state medical societies to collaborate with their state licensing boards to provide out-of-state expert witnesses a temporary license (at no cost or for a nominal fee) for the express purpose of subjecting the expert's testimony to the Board's peer-review process.[21]

References

1. Bitterman RA. Halting Inappropriate Expert Witness Testimony — Part I: Professional Associations Efforts to Police 'Experts'. *Emerg Depart Legal Letter*. 2007;18(1):1-4.
2. Lustgarten v. North Carolina Medical Board, Wake County Superior Court (North Carolina) No. 02 CVS 12218, April 18, 2005.
3. N.C. Gen. Stat. § 150B-51(b) (2005).
4. In RE: Gary James Lustgarten, MD, 629 S.E.2d 886 (N.C. App. June 6, 2006).
5. N.C. Gen. Stat. § 90-2 (2005).
6. N.C. Gen. Stat. § 90-14(a)(6) (2005).
7. Fullerton v. Florida Medical Association, Fla. 1st District Court of Appeal, (July 2006).
8. Florida Statutes, Section 766.101 (2003).
9. The Health Care Quality Improvement Act (HCQIA), 42 U.S.C. §§ 11101-11152.
10. Florida Statutes, Sections 458.305(3) and Section 766.101; emphasis in the original.
11. Bundren v. Parriott, US District Court for the District of Kansas, (June 2006).
12. Austin v. American Association of Neurological Surgeons, 253 F.3d 967 (7th Cir. 2001).
13. See for example, Feld AD & Carey WD. Expert Witness Malfeasance: How Should Specialty Societies Respond? *The American Journal of Gastroenterology*. 2005;100(5):991.; McHenry CR, Biffl WL, Chapman WC, & Spain DA.. Expert witness testimony: The problem and recommendations for oversight and reform. *Surgery*. 2005;137:274-278. (Position Paper of the Society of University Surgeons); Sullivan W. Expert Opinions: Defendants aren't the only ones on trial. *Emergency Department Legal Letter*. 2004;15(9):97-108.; Sacopulos MJ. Addressing False Expert Witness Testimony in Medical Malpractice Litigation. *American Health Lawyers News*. 2005;9(5):24-29.
14. AMA Policy H-265.993.
15. AMA Policies H-265.992 & H-265.994.
16. ACEP Policy Statement, Expert Witness Guidelines for the Specialty of Emergency Medicine, Policy #400114; Approved August 2000.
17. Joseph v District of Columbia Board of Medicine, 587 A2d 1085 (D.C. App. 1991).
18. See Maryland Health Occ. Code Ann. §§ 14-504(3) & (4) (1981).
19. Deatherage v State of Washington Examining Board of Psychology, 948 P2d 828 (Wash. 1997).
20. Ohio Statute R.C. 2323.421 (2004); See also Chapter 4731 of the Revised Code.
21. AMA Policy H-265.992.

Frequent ED visitors = High risk of EMTALA violations

Always do an appropriate MSE

If an ED physician refuses to examine and treat a patient suspected of "drug seeking," this is an automatic violation of the Emergency Medical Treatment and Labor Act (EMTALA), warns Stephen A. Frew, JD, vice president and risk consultant with Johnson Insurance Services, a Madison, WI-based company specializing in risk management for health care professionals. Treatment does not necessarily mean that pain medications must be given, but it does mean that a complete assessment, work-up, and necessary consultations must be provided, he says.

"An inadequate or openly hostile record and an adverse outcome are likely to lead to a lawsuit or EMTALA complaint," says Frew. "Physicians who consider themselves 'narcs' by lecturing patients, calling them names, having them arrested in the ED and similar conduct greatly increase the risk of lawsuit or complaint for both the hospital and the physician."

In one such instance, a hospital received a Type One deficiency from the Joint Commission on Accreditation of Healthcare Organizations, as a result of failing to properly treat an out-of-town patient who came to the ED with clear documentation of an existing serious pain condition.

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SPECIAL REPORT

Psychiatric Emergencies: A Medical-Legal Minefield

by Gregory P. Moore and James A. Pfaff

There is no area of Emergency Medicine that incorporates as many associated unique legal issues as that of psychiatric emergencies. Not only is there responsibility for medical care and diagnosis but also specific legal concepts. This occurs in a setting which lacks optimal patient/physician communication. The following is a brief presentation of ED cases that illustrate these concepts.

Medical Management Issues:

a) Medical Clearance:

Case: A 43-year-old male with paranoid schizophrenia and diabetes presented to the ED. Before his examination, he disrobed. The police were called, and the patient was arrested for indecent exposure. A mental health evaluation was set up for two days later. The patient did not inform staff about his history of diabetes. He was found dead on the floor during his second day of incarceration. The cause of death was diabetic ketoacidosis. A verdict of $28 million was returned.[1]

Case: A 37-year-old woman was brought to the ED by ambulance after taking a reported 20 Darvon and 12 Vicodin. The patient was allowed to leave the ED on two occasions unsupervised. Her belongings were not checked. While on these breaks, it was alleged that she took 10 more Darvon tablets. No charcoal or lavage was done. The patient was transferred to the psychiatric ward. Forty minutes after arrival, she became comatose and died. Autopsy revealed death due to propoxyphene overdose. A settlement was reached via mediation for $475,000.[2]

When psychiatric patients present to the ED, they are frequently disruptive and consume an inordinate amount of staff resources. Thus, the physician is often pressured to superficially evaluate and prematurely dispose the patient. However, the incidence of organic disease in patients presenting with psychiatric complaints has been cited in the literature as varying from 19% to as high as 80%.[3,4,5] Disastrous outcomes, with resultant liability may ensue if organic disease is missed. In the emergency department setting, drug and alcohol intoxication and withdrawal are the most common diagnoses in combative patients.[6] Infectious disease, especially of the CNS, must be considered as well.

A thorough physical examination should be performed to search for an organic cause of violent behavior and uncover any resulting injury. Patients with persistently abnormal vital signs, a clouding of consciousness, disorientation, or focal neurologic findings are more likely to suffer from organic disease and require further diagnostic evaluation.

The ordering of diagnostic studies is controversial. Some recommend a variety of panels of lab and x-ray studies for psychiatric patients. Most recommend an individual approach, with diagnostic ordering dependent on suspicion of particular illness. A check of blood sugar and pulse oximetry should be obtained for all combative patients. Patients younger than 40 years with a prior psychiatric history and normal physical examination, including vital signs, who are also oriented and regain a calm demeanor without medical management, are unlikely to require further diagnostic testing.[7]

b) Appropriate Dispositions to avoid "Practicing Psychiatry"-

Case: A psychiatric patient with a history of schizophrenia and psychotic symptoms, moved to Los Angeles. He presented to the ED, relating that he was suffering from auditory hallucinations and depression and had prior suicide attempts. The patient was almost out of his medication, Zyprexa, and asked for a refill of his usual dose of 20mg taken daily. The ED physician decided to refill it at half of the previous dose. The physician noted it was his policy to only refill medication at typical doses when he was unfamiliar with the medication. Eight days later, the patient hanged himself. He now requires 24-hour care due to anoxic brain damage. The physician was sued for decreasing the dose of medication without a careful examination or psychiatric consultation. The ED physician settled for $1 million.[8]

Case: A husband noticed his wife Donna was acting depressed and lethargic just prior to his leaving on a two-week National Guard deployment. He asked his commander for permission to stay home. The commander told him he would have to get a doctor's statement, so the couple went to the ED on a Friday. The ED doctor diagnosed her with delusional psychosis and recommended admission. They refused this advice. So the ED physician arranged psychiatric follow-up 3 days later and prescribed vistaril. Two days later, Donna attacked her husband with a closet rod, threatening to kill him. As he went into another room to call 911, Donna beat and killed their 16-month-old son. At trial, she was not guilty by reason of insanity. The couple filed suit against the ED physician. A lower court granted summary judgement (Note: Summary Judgement is when a judge takes

all of the evidence, and reviews it in the most favorable way for the plaintiff, but still decides that there is no case to pursue.) for the defendants but an appeals court over-ruled this decision and ordered a new trial. Expert testimony noted the standard of care is to get a psychiatry consult or admit a newly delusional patient, and that vistaril is not standard treatment for psychosis.[9]

It is well known that violence is very difficult to predict and assess, even in the psychiatric literature. The consequences of misdiagnosis may be catastrophic, as these cases illustrate. A low threshold for consultation should be maintained. Admission should be considered for violent patients who state specific intentions to hurt themselves or others, refuse to answer questions, are under the influence of drugs or alcohol, are psychotic, have an organic brain syndrome, or refuse to cooperate. A violent psychiatric patient should not be discharged without psychiatric consultation and documented agreement with discharge.[10]

Duty to Warn:

Case: A paranoid schizophrenic was admitted to a day hospital. During group meetings he voiced fears of hurting himself or others. He later shared that he was having thoughts of stabbing his mother. Later that day he was released to home, where he stabbed his father to death and stabbed his mother, with serious injuries resulting. The plaintiffs sued for failure to warn them of the threat from their son. The defense claimed that the family was aware of the patient's violent potential via prior events and there was no further duty to warn. The jury awarded $2 million to the patient's mother.[11]

Previously, physicians had a duty to care for and protect only the patient they had an established relationship with. This was dramatically changed by the famous court case of Tarasoff v Regents of California in 1976. In that case, a man confided his intent to kill a woman to his psychologist. The psychologist called the police, who briefly detained the man and then released him. Two months later, he killed the woman, and her parents successfully sued the psychologist for not warning her of the danger. From this case, a "duty to warn" arose. The court stated that if a provider is aware of a "foreseeable" harm, the provider must either control the conduct of the potential offender or warn the intended victim. The courts have held that this duty to warn supersedes physician-patient confidentiality.[12]

If a violent patient communicates intent to harm a foreseeable victim, the emergency physician should notify both law enforcement officials and the intended victim. For example, if the patient states, "I'm going to kill Sally Jones," or "I'm going to kill someone in the psychiatry clinic," a duty to warn is established. On the other hand, if the patient states, "I'm going to kill someone in the army," this does not represent an identifiable or foreseeable victim; thus, there is not a duty to warn.[13]

Not all states recognize the duty to warn. It is important to know what the courts require in the state of practice to comply with the law but it is very simple to warn those who are in danger and completely avoid the issue.

False Imprisonment and Battery:

Case: A 34-year-old homemaker presented to a community mental health center for counseling after being violently raped that same day. The staff felt she should stay at the facility but she decided to leave. Thus, she was held there by force, put in restraints, medicated and held by a physician's order over the phone. There was no physician on site to examine the patient. The next day, a physician examined the patient and she was released. She litigated and claimed that she was falsely imprisoned without mandatory state commitment proceedings as provided by law. The defendants claimed they had the legal and ethical right to hold the patient. The jury awarded $100,000 of punitive damages and $50,000 of general damages.[14]

Case: A 45-year-old woman voluntarily admitted herself to a psychiatric hospital for treatment of depression due to the trauma of a hot air balloon crash. Later that day, she asked to be released but was refused. Seven days later she asked again and was released. The patient sued, claiming she was falsely imprisoned. A jury awarded her $50,000.[15]

False imprisonment is when an actor intends to confine another person within fixed boundaries and accomplishes it with resultant awareness of the other party that they are confined and to their harm.[16] Damages may be awarded, even in the absence of physical harm, for inconvenience, mental suffering, and humiliation. A standard medical malpractice insurance policy may not cover this area, leaving a physician personally liable. All states have laws defining the procedure for holding patients against their will, and the emergency physician should become familiar with the statutes of the state in which he or she practices. When physicians comply with state law and procedural paperwork, they are given great latitude in holding someone for a period of time to evaluate further and assess the danger. It is imperative to complete required forms when restraining or involuntarily committing a violent patient. Documentation should include that 1) an emergency existed, 2) there was inability to obtain consent, and 3) the treatment was for the patient's benefit.[10,13]

Battery is a closely related issue to false imprisonment when psychiatric emergencies occur, and when patients litigate in one area, they usually include the other. Battery is the intentional infliction of a harmful or offensive bodily contact. Victims of battery do not necessarily have to be physically injured and may merely suffer damage to their dignity. "Intentional" simply implies that the actor wanted to do the action, regardless of whether they were trying to help the patient. (For example: a surgeon who operates without consent and is trying to actually help the patient can be sued for battery.) Courts are very protective of the "sanctity of the person," "bodily integrity," and "personal autonomy" as a fundamental personal right. A competent patient should never be touched or have a procedure done without their consent, or liability for battery may follow. Damages awarded may include, "general," such as compensation for the harm done, and "special," such as compensation for medical charges, lost wages, and other expenses. These damages, like false imprisonment, may not be covered by standard medical malpractice insurance.[14]

Battery may be legally allowed when a patient is in an emergency situation and incompetent or represents a danger. In 1982, the Supreme Court supported the use of restraints to protect patients and others if it was in the best interest according to reasonable medical judgment.[17] In this case; a young, mentally handicapped male with repeated episodes of violence was restrained and involuntarily committed. The court stated, "We have established that the patient retains liberty interests in safety and freedom from bodily restraint. Yet these interests are not absolute, there are occasions in which it is necessary for the state to restrain the movement of residents — for example, to protect them, as well as others from violence." The Model Penal Code allows "an exception from the assault statute for physicians . . . who act in good faith in accordance with accepted medical therapy."[18]

Table 1

Guideline for Patient Restraint

1. Protection and preservation of patient rights, dignity, and well being.
2. Use based on patient's assessed needs.
3. Use of least restrictive methods.
4. Safe application and removal by competent staff.
5. Monitoring and reassessment of the patients during use.
6. Meet patient needs during use.
7. Time limitation of orders that are provided by licensed practitioners.
8. Documentation of the medical record.

4) Duty to Protect:

Case: A 32-year-old homeless man was taken to the ED after he threatened to kill his psychologist. It took six police officers to confine him on a gurney in four-point restraints on a back board. He continued his aggressive behavior and was seen by the ED physician. The patient was given a sedative to control his behavior. He was turned on his stomach with the backboard on top of him. He complained of inability to breath. A towel was loosely placed in front of his mouth to prevent him from further spitting on personnel. A sheet was placed over top of him to prevent further stimulation. When the patient was wheeled down the hall for placement in an ambulance, it was noted that his hand was blue. He was noted to be in respiratory and cardiac arrest, and was unable to be resuscitated. Autopsy revealed death due to positional asphyxia. A verdict for $2 million was returned.[19]

The taking of one's liberty via restraints is considered significant, according to the courts. However, once an authority has taken another's liberty, then they become responsible for their health and well-being. An analogy would be a person sent to prison. The jail is now responsible for the nutrition and health of that person via the fiduciary relationship created. There have been a number of complications that have been reported with the use of restraints. These include aspiration pneumonia, circulatory obstruction, cardiac stress, skin breakdown, poor appetite, dehydration and accidental death.[20] Most sudden death occurs when a patient is restrained in the prone position, with their hands behind their back. This should be avoided. *Table 1* summarizes key points in restraint usage, and follows federal guidelines.

References

1. Estate of Reverend Ronel Huggins v Eastern Health Care Medical Malpractice: Verdicts, Settlements, and Experts. V 22, N 6, p 24, July 2006
2. Anonymous v Anonymous Hospital, Anonymous Emergency Room Physician, Anonymous Nurse and Anonymous Psychologist. Medical Malpractice: Verdicts, Settlements, and Experts. V 21, N 6, p18, June 2005
3. Tintinalli JE, Peacock FW, Wright MA: Emergency medical evaluation of psychiatric inpatients. *Ann Emerg Med*. 23:859 (1994)
4. Hall RCW, et al: Physical illness manifesting as psychiatric dis-

ease: Analysis of a state hospital inpatient population. *Arch Gen Psychiatry*. 37:989 (1980)
5. Zun LS, Leiken JB,Stotland N, et al: A tool for the emergency medicine evaluation of psychiatric patients. *Am J Emerg Med*. 1994; 24:672-677.
6. Dubin WR, Weiss KJ: Emergency psychiatry. In Michels R, et al (eds): Psychiatry, vol 2. Philadelphia, Lippincott-Raven, 1997, pp 1-15
7. Korn CS, Currier GW, Henderson SO: "Medical clearance" of psychiatric patients without medical complaints in the emergency department. *J Emerg Med*. 18:173 (2000).
8. Doe Patient v Roe Hospital, Roe Emergency Physician and Roe Psychiatrist. Medical Malpractice: Verdicts, Settlements, and Experts V 20, N 5, May 2004
9. Brown v Carolina Emergency Physicians, P.A. No.97-CP-23-1347, Dec 17, 2001
10. Rice MM, Moore GP: Management of the violent patient: Therapeutic and legal considerations. *Emerg Med Clin North Am*. 9:13 (1991)
11. Dorothy Mcgrath, Judith Guthrie, Estate of Robert B. McGrath v. Barnes Hospital, Washinton University, Washington University Medical Center, Micaheal R. Jarvis, John Zempel, H. Ying, Kent Greenberg, E. Nelson, MD et al. Missouri Circuit Court Case No. 992-00130
12. Tarasoff v Regents of University of California 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14; 1976.
13. Louis Kao, Gregory P. Moore. The Combative Patient in Rosen's Emergency Medicine: Concepts and Clinical Practice MOSBY ELSEVIER, Philadelphia, PA 2006 p 2969
14. Janice Barker v. Netcare Corporation, Liberato Dasobas MD, Ruby Scott, and Patrick Jones, RN Franklin County Court of Common Pleas Ohio 98 CV-09-7239
15. Lynn G. Lenfestey vRobert T. Held Broward County FL Circuit Court Case No. 96-10332 05
16. Restatement (Second) of Torts
17. Youngberg v Romeo 457 U.S. 307; 1982
18. Wexler DB: Seclusion and restraint: Lessons from law, psychiatry, and psychology. *Int J Law Psychiatry*. 5:285 (1982).
19. Estate of Doe v ABC Ambulance Co. et al. Medical Malpractice: Verdicts, Settlements, and Experts V 17, N 3, March 2001, p 20
20. Zun LS: A prospective study of complication rate of use of patient restraint in the emergency department. *J Emerg Med*. 2003;24: 119-124. ■

The physician on duty is alleged to have accused the woman of "drug seeking" and refusing to evaluate the patient or contact the treating physician. "The complaint alleged that the physician told the patient that she was a "drug addict" and needed to "go cold turkey,"' says Frew. "It is alleged that his conduct was rude and abusive and failed to comply with Joint Commission standards for medical assessment and the patient's right to pain control."

There have been a number of EMTALA citations for inadequate assessment where the ED staff claimed this was because the patient was a "drug seeker," with the chart totally lacking evidence of compliance or justification for the patient being discharged, says Frew.

In one case, adverse and judgmental comments in the medical record about the patient resulted in a lawsuit against an ED physician, but the physician's comments in that case referred to malingering and not drug-seeking conduct. The case was dismissed because of the claimant being unable to establish specific damages, but that would probably not be the case with a "drug seeking" label, adds Frew. "In many states, an allegation of drug seeking conduct would be considered sufficiently defamatory that no specific damages would have to be proven."

The worst mistake is to assume the patient is "just a drug seeker" and fail to do a thorough evaluation, says Mary Jean Geroulo, JD, a health care attorney with Dallas, TX-based Stewart Stimmel. "It is absolutely essential to do a normal evaluation of that patient, to find out what is going on, and make sure that there is no emergency medical condition for what EMTALA would apply," she says.

The fact that a patient has been seen on prior or multiple occasions does not change the obligation for complete assessment on each and every visit, Frew emphasizes.

"I am reminded of a frequent visitor to my ED in the past. The patient had a chronic pain syndrome and frequently needed pain relief," says Sandra Schneider, MD, ED physician at the hospital and professor of emergency medicine at University of Rochester (NY). "One day she had a new complaint. Workup of that new complaint led to a diagnosis of cancer."

The ED physician may refer to prior visits and reference them as a part of a repeat visit, but if specific symptoms have changed or test results are of a type that may have changed since the prior visits, they may have to be repeated to comply with EMTALA, says Frew.

Repeat visits within a 48 hour period are sufficient by themselves to cause investigators from the Centers for Medicare & Medicaid Services (CMS) to conduct a complete review of all patient visits for an individual that often result in citations for inadequate assessment on multiple visits, he says.

"From a medical-legal perspective, repeat visits the same day raise ominous red flags," adds Frew. "An adverse outcome after repeat visits typically results in a greater chance of litigation or CMS investigations."

However, once a patient has had a medical screening examination (MSE) and it is determined that no emergency medical condition exists, the hospital has no obligation

under EMTALA to treat them or to give pain medications, and you can refer the patient to other health care providers, says Geroulo. "CMS says no, there is no obligation to provide pain medications at that point. So even Medicare backs that up," she says.

The point is, EDs don't have to do anything more than they normally would, says Linda M. Stimmel, JD, a partner with Stewart Stimmel. "As long as the patient is stable and has a medical screening examination, I'm not worried about them getting sued if they don't give them pain medication," she says.

Document the MSE adequately, to show that no current conditions constitute an emergency medical condition, Frew advises. However, under EMTALA, symptoms of substance abuse are within the class of emergency medical conditions requiring further evaluation, testing, and stabilizing care, he says.

Where there is suspicion of drug dependency, the MSE should include necessary testing, a pain consult and psychological evaluation if available, and assessment for risks of withdrawal if discharge is considered, says Frew.

The patient must be adequately evaluated for risk of withdrawal, which is considered an emergency medical condition under EMTALA, says Frew. If the patient is at risk for withdrawal following discharge, discharge may be prohibited by EMTALA, as the patient's emergency medical condition makes it likely that the patient would deteriorate following discharge, he explains.

Where the patient is under the treatment of a physician who has prescribed drugs, contact with the treating physician should be made before making a disposition decision, Frew recommends.

If the hospital and physician fail to provide the same evaluation and care to a potential "drug seeker" as they would provide to anyone with a similar presenting complaint, an automatic EMTALA violation has occurred that could lead to malpractice or EMTALA lawsuits for any adverse outcome, or CMS citations for violations — whether or not any harm occurs to the patient, says Frew.

"CMS, however, can be expected to issue more citation elements, be harder to please with a plan of correction, and OIG will be harder to settle on fines if the patient actually has a missed condition or untreated condition," says Frew. "I mention the untreated condition because advanced drug seekers have been known to physically injure themselves to get drugs. Refusing to see or treat these injuries would have a high risk of adverse outcome."

The bottom line is that all presenting patients are entitled to proper triage, medical screening, testing, on-call assessment, and stabilization regardless of whether they are "frequent fliers" or drug seekers, says Frew. "Judgmental attitudes, potentially offensive or insulting comments or behavior, including body language or gestures, should be prohibited," he stresses. "ED nurses and physicians who treat these patients with any less professionalism than others are a risk to themselves, to the hospital, and to patients in general." ■

Key Points

To comply with the Emergency Medical Treatment and labor Act, give patients a complete medical screening examination every visit, regardless of how many times the patient has been seen previously.

- If no emergency medical condition exists, the ED has no further obligation to treat or give pain medications.
- Suspected substance abuse requires further evaluation, testing, and stabilizing care.
- Assess suspected drug abusers for risk of withdrawal because of the risk of deterioration after discharge.

Reduce risks with credentialing for rare, high-risk ED procedures

Being too specific will increase legal risks

Credentialing requirements for specific numbers of procedures performed may be suitable for most hospital units, but these may be difficult or impossible to meet in the ED. For instance, if three cricothyrotomy procedures are required per time period, this is not realistic, since this procedure is very rarely done in the ED.

If the practitioner does this procedure and is not successful in saving the patient, a lawsuit may be filed alleging negligent credentialing due to the failure of the hospital to prevent the practitioner from performing a procedure that he or she was not qualified to perform, based on their own criteria, says Vicki L. Searcy, CPMSM, practice director of credentialing and privileging for the Greeley Company, a Marblehead, MA-based consulting firm specializing in healthcare regulation and compliance.

For this reason, organizations should not set clinical activity requirements for emergency procedures that are performed in the ED, says Searcy. "ED physicians have to be able to handle the emergencies that present to the ED," she says. "Numbers should not be attached to procedures that are performed in the ED in order to save patient lives."

If a clinical activity requirement is established for a procedure that is infrequently performed in an ED, an ED practitioner may perform the procedure in an emergency situation without having met the clinical activity requirement, says Searcy.

If requirements are difficult or impossible to meet, then medical staff has to reconsider their criteria and base it on the typical patient load and procedures performed over the past two years, says Christina W. Giles, CPMSM, MS, president of Nashua, NH-based Medical Staff Solutions. "If it is a rare occurrence, then requiring three isn't appropriate," she says.

Some specialties have recommended numbers to be achieved with certain procedures, but each hospital also has to take into account their own community standards and patient population, says Giles.

"They may need to set the numbers lower based on the type of patients they see," Giles says. "If all physicians achieve the number except one, then I would expect that that one physician would lose the privilege."

If an organization does require a certain number of procedures, they're making a big mistake, according to Bruce David Janiak, MD, FACEP, FAAP, vice chair of the department of emergency medicine at Medical College of Georgia in Augusta. "It doesn't make any sense because it's never going to happen-these are unrealistic targets and antiquated expectations," he says. "If you haven't made arrangements for an alternative like an animal lab experience, then that's another big mistake."

Each hospital needs to define whether or not they will accept simulation or animal lab procedures, or procedures done at other hospitals, says Giles. "But again, if many physicians are not achieving the number, then the number has to be changed," she says. "And if you do use numbers, these have to be based realistically on the number of types of patients and procedures performed in the past. You can't just adopt a number from a professional society without looking at what will realistically occur in their organization."

Address emergencies in bylaws

Many hospitals have gone to core privileging for physicians to avoid the long laundry list of procedures with specific numbers requirements, says Nancy J. Auer, MD, FACEP, chief medical officer at Swedish Health Services in Seattle, WA. The primary goal is to assure the practitioner has the education and experience to perform the procedures requested.

"Certainly if there are rarely performed procedures so that the physician has a difficult time achieving the numbers, proficiency can by demonstrated by simulation labs or animal labs," says Auer. "However, hospitals should not have to pay for physicians to achieve these criteria any more than they are expected to pay for medical school, residency training or continuing medical education."

By going to a core privilege sheet, the emergency physician can perform rarely used procedures if the clinical situation dictates, advises Auer. Language should be added to the privileging form indicating that the physician may be called upon to do seldom performed procedures in the attempt to save a patient's life, she adds.

"While such language will not protect the physician totally from lawsuit or peer review, it does recognize that an emergent situation may dictate treatment that is rarely utilized," says Auer.

For example, even if a specific procedure is not listed on the ED privileging form, this could be covered under emergency provisions stated in the bylaws or other documents, with wording such as "In an emergency, defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger, any physician, dentist or podiatrist shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary or desirable to do so."

This wording protects the emergency physician to a large extent, says Janiak. "Let's say you perform a cricothyrotomy but botch it completely and cause significant harm. The case would be reviewed and in most cases they would probably say this was a last ditch effort, and the physician can't be faulted for doing anything wrong," he says.

However, there would be liability exposure if the physician attempted to do a cricothyrotomy without attempting to intubate and the patient died. "If the patient has normal neck anatomy but you cut into the esophagus, you'd be in trouble," he says. "But if you did one on a swollen neck and got into the wrong place, you probably wouldn't be faulted for that."

ED leaders: Get involved

Credentialing requirements are primarily set by physicians in a peer setting, notes Auer. "Emergency physicians should be involved in the credentialing process so that other specialties do not set unrealistic expectations for proficiency," Auer recommends.

In order to ensure competency in the provision of emergency procedures, many hospitals require ED physicians to maintain board certification in emergency medicine, be certified in Advanced Cardiac Life Support

CNE/CME objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

CNE/CME *Questions*

5. Which one of the following is recommended to reduce risks of patients with frequent visits to the ED?
   A. No medical screening examination is required if the patient came to the ED within 24 hours with the same complaint.
   B. Physicians must administer the specific narcotics requested if patients claim to be in severe pain.
   C. The patient must be adequately evaluated for risk of withdrawal.
   D. If it's determined that no emergency medical condition exists, the ED is still obligated to treat and provide pain relief.

6. Which is recommended to reduce legal risks pertaining to credentialing for ED procedures?
   A. Requirements should be based on specific numbers of procedures recommended by specialty societies, without regard to the hospital's own patient population.
   B. Criteria should be based on the typical patient load and procedures performed over the past two years.
   C. If a specific procedure is not listed on the ED privileging form, then that procedure should not be performed even in emergent situations.
   D. ED physicians should be required perform periocardiocentesis only in conjunction with cardiologists.

7. Under what circumstances may an ED physician refer a patient to other health care providers?
   A. If the patient had a medical screening examination (MSE) within the previous 24 hours
   B. If the patient came to the ED within 48 hours with the same chief complaint.
   C. If a patient comes in specifically requesting narcotics
   D. Only after a patient has had a MSE and it is determined that no emergency medical condition exists

Answers: 5. C; 6. B; 7. D

(ACLS) and Advanced Trauma Life Support (ATLS), and participate in emergency medicine continuing medical education, says Searcy. "Establishing competency requirements for procedures in the ED that are clearly elective in nature would be appropriate," she adds.

However, requiring board-certified ED physicians to maintain certification in ACLS and ATLS is "going overboard," according to Janiak. "Why would we have to take a special course in part of that core concept? Are the surgeons taking an annual appendectomy course?" he asks. "We do this for a living. If a physician wants to take the course on their own, fine, but to require it — to say it's an insult would be a gross understatement."

Many of these credentialing requirements come from individuals who don't understand emergency medicine, says Janiak. "Lately I have seen logic winning out, with physicians no longer required to take all these courses," he says. "Otherwise your entire work year will be spent taking courses and you will never see any patients. By definition, that's saying your residency is useless."

Avoid setting up unrealistic expectations such as requiring ED physicians to perform periocardiocentesis only in conjunction with cardiologists, warns Janiak. "If the cardiologist is not available and the ED physician does it and it doesn't work, then they've violated their credentialing," he says.

As a general rule, requirements for rarely done procedures need to be written more broadly, says Janiak. "Emergency physicians need to be able to attempt life saving procedures without fear of something bad happening to them," he says. ■

Sources

Nancy J. Auer, MD, FACEP, Chief Medical Officer, Swedish Health Services, 747 Broadway, Seattle, WA 98122. Telephone: (206) 386-6071. E-mail: Nancy.Auer@swedish.org.
Christina W. Giles, CPMSM, MS, President, Medical Staff Solutions, 32 Wood Street
Nashua, NH 03064. Telephone: (603) 886-0444. Fax: (810) 277-0578. E-Mail: chriswg@medicalstaffsolutions.net. Web: www.medicalstaffsolutions.net
* Bruce David Janiak, MD, FACEP, FAAP, Vice Chair, Department of Emergency Medicine, Medical College of Georgia, 1120 15th Street, Augusta, GA 30912-4007. Telephone: (706) 721-7144. E-mail: bjaniak@mcg.edu.
Vicki L. Searcy, CPMSM, Practice Director, Credentialing & Privileging, The Greeley Company, 200 Hoods Lane, Marblehead, MA 01945. Telephone: (951) 506-9845. Fax: (951) 848-0720. E-mail: vsearcy@greeley.com