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Impaired Health Care Practitioners: Help the Healer Heal Himself

Substance abuse risks multiply when ED care delivered by impaired clinicians

By Daniel M. Kincheloe, Esq. and Timothy A. Litzenburg, Esq., Hancock, Daniel, Johnson & Nagle, P.C., Richmond, VA.

The abuse of drugs and alcohol is a significant and troubling problem within the medical community. Without identification and proper treatment, impairment due to substance abuse inevitably results in a downward spiral that ultimately impacts the workplace. The danger, of course, is multiplied when the impaired person is responsible for treating critically ill or injured patients in an emergency department (ED) setting. It is imperative that medical professionals remain aware of this danger and protect against it — both for the sake of ED patients and the health care providers themselves.

Drug and Alcohol Abuse Among Health Care Providers

Substance abuse is formally defined by the DSM-IV as one or more of the following symptoms that develop within a 12-month period: recurrent substance use resulting in repeated failure to fulfill work, school, or home obligations; substance use in physically dangerous situations; substance use that results in legal problems, such as drug-related arrests; and continued use of substances despite adverse consequences.[1] Reports of substance abuse and concern about impairment in the medical community have been prevalent for the last century.[2] Although the term "impairment" was once used only in cases of gross dereliction of duty and chronic absenteeism, the definition has been expanded over time.[3] Impairment is now defined as an enduring condition that, if left untreated, is not amenable to remission or cure.[3]

The incidence of substance abuse among health care providers has been estimated at 6% to 8%, which mirrors that of the general population.[3,4] Interestingly, the rates of use (rather than abuse) of drugs by health care providers may be as much as five times higher than the background rate.[3] Some specialties are more prone than others to develop substance abuse problems. Generally, the more stressful the work environment, the higher

prevalence of drug or alcohol abuse within the specialty. Accordingly, ED physicians experience substance abuse at a higher rate than other physicians. One study concluded that ED physicians abuse drugs or alcohol at three times the rate of doctors practicing in other specialties.[5]

Alcohol or drug abuse among nurses and doctors can be related to a variety of factors, both intrinsic and extrinsic.[4] Certainly, some of the personality traits that lead people to become physicians can also lead to substance abuse. These characteristics include obsessiveness, a pattern of high achievement, and overwork.[4] Extrinsic factors include long work hours, time pressures, and the demands of the profession.[3,4] Easy and constant access to powerful prescription drugs also plays a clear role in substance issues seen in health care providers. Not surprisingly, physicians in general tend to use benzodiazepines and opiates more than illegal street drugs.[3] Interestingly, however, ED physicians have been reported to have a higher rate of use of marijuana and cocaine than health care providers in other specialities.[3] Due to long hours and stress associated with the increasingly prevalent manpower shortages in health care, the rate of substance abuse and health care provider impairment is expected to grow.[6]

Detection and Prevention of Harm

Despite the dire consequences associated with impairment of health care providers in the ED, drug abuse problems often go unreported and untreated for a number of reasons. Substance abusers often deny their own problems. Drug-abusing physicians also tend to self-diagnose and self-treat, rather than seeking help from other professionals. Patients are often uncomfortable with the reversal of roles presented by counseling or taking action against their nurse or doctor.[3] Moreover, noticeable lapses in clinical judgment and job performance are late signs of impairment. Thus, both the impaired practitioner and his patients are unlikely to take action until a drug or alcohol problem has spun out of control.

For this reason, the duty to identify impaired ED practitioners early often falls to their colleagues. Unfortunately, while substance abuse is widely considered a disease, health care providers often are hesitant to report their concerns or confront the impaired health care provider for fear of overreacting or damaging the reputation of the individual or the hospital.[7] In a recent study, while 17% of physicians had direct personal knowledge of a physician who was incompetent to practice in their hospital or group, only 67% of them reported the colleague to the proper authority.[8] In many cases, however, intervention by other health care professionals may be the only approach that can spur the impaired nurse or doctor to seek the help he needs.[8]

Pertinent Laws and Regulations

All 50 states have taken steps to facilitate identification and treatment of impaired health care providers.[9] State medical licensure boards typically require that a health care provider suffering from addiction self-report the problem to the state board, and that others who are aware of a problem report their peers. To address the fear of reprisal or negatively impacting another's life and livelihood, most states have a "bypass mecha-

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nism" that allows a health care provider to report his peer directly to the state's appropriate health program.[9] Typically, the impaired practitioner can engage in treatment and rehabilitation and avoid public reprimand or disciplinary action by the board. Some states exclude certain physicians from this "bypass," however, including: physicians already under discipline, those who have been terminated from a rehabilitation program, those diverting drugs from the workplace to give or sell to others, and those whose continued practice is a serious risk of harm to the public.[10] The Joint Commission supports the bypass model of treatment rather than punishment. Its 2001 standards state: "The purpose of the process [of identifying and treating impaired physicians] is assistance and rehabilitation rather than discipline."[10]

There is also federal legislation that inures to the benefit of the impaired practitioner. The Americans with Disabilities Act provides certain protections for addicted health care providers in treatment and recovery programs. It requires that employers provide "reasonable accommodation" for an alcohol or drug addict who is participating in a rehabilitation program or has successfully completed one. It does not, however, consider a person to be under a disability because they are "currently engaging in the illegal use of drugs."[11] Additionally, the Family Medical Leave Act requires employers to allow time off for qualified "treatment" of substance abuse.[12]

In interpreting relevant laws and regulations, courts have typically afforded a large measure of protection to health care providers' and medical boards' efforts to address substance abuse issues. By way of example, a Florida court granted qualified immunity to the director of an impaired practitioner program who suggested that a hospital suspend a physician's privileges until he underwent a substance abuse evaluation.[13] During a medical malpractice case in another Florida court, a physician refused to turn over records from his own substance abuse treatment several years earlier. The court ruled that those records were privileged and confidential, and protected them from being produced in the malpractice case.[14] A federal court in Hawaii dismissed a hospital from a malpractice suit in which negligent credentialing was alleged due to the surgeon's prior alcohol and drug abuse. The court found that the surgeon had undergone treatment and had complied with a monitoring program for years, and the hospital acted reasonably in granting him surgical privileges.[15]

Med Mal Issues and Case Studies

State laws require that health care providers comply with the standard of care, which is generally defined as what a reasonably prudent health care provider would do in the same or similar circumstances. Many medical malpractice lawsuits come down to a "battle of the experts" over whether the standard of care was breached, which is often a close question. As often as courts protect health care providers who obtain treatment, juries punish those who do not. Treatment of patients while under the influence of drugs or alcohol will invariably tip the scales heavily in favor of plaintiffs, and tends to act as a multiplier of verdict and settlement amounts.

In a 2005 Massachusetts case, a patient underwent surgical repair of his shoulder by an orthopedic surgeon. Following that surgery, the patient complained of weakness and loss of motion in the shoulder. X-ray revealed that the acromion bone had been completely resected during surgery. The surgeon had been arrested repeatedly for drunk driving in the past, and had, in fact, been sanctioned by the board of medicine for failing to disclose his driving offenses. While there was no allegation that he was under the influence of alcohol during the procedure at issue, the patient's attorneys made known their intention to bring

Update

Just days after the print version of the August 2010 *ED Legal Letter* went to press, the Wisconsin Supreme Court issued its decision in *Wisconsin Medical Society, Inc. v. Morgan*. In a "win" for the Medical Society and physicians, the court ruled that the state legislature violated the state constitution when it voted to take money from the malpractice patient compensation fund ("the Fund") to balance the state budget. The court determined that the legislative enactment of the Fund created an irrevocable trust protected by the Constitution's Takings Clause – prohibiting an unconstitutional taking of property without just compensation. Therefore, the court ordered the state to pay the money back to the fund, including interest and lost earnings.

up at trial his failure to report the drunk driving arrests. This pressure contributed to pre-trial settlement of the case in the amount of $350,000.[16]

In a 2000 Texas case, a patient underwent back surgery, during which he experienced acute blood loss and cardiac arrest. The patient sued the orthopedic surgeon and anesthesiologist. In addition, the patient sued the hospital for improper credentialing because the surgeon had committed malpractice in the past and was currently addicted to sedatives. While the physicians settled for comparatively modest sums, a jury assessed $12 million in punitive damages against the hospital for the credentialing claim.[17]

In a 1990 Maryland case, a teenage patient presented to the hospital for delivery of her baby. Fetal distress was detected and an emergency C-section was performed under general anesthesia. During the procedure, a kink developed in the oxygen hose, and the patient did not receive oxygen for five minutes. The patient sued the nurse anesthetist who was in charge of monitoring her breathing during the operation. He admitted to being under the influence of fentanyl at the time of the surgery. A jury returned a $4 million verdict in the case.[18]

Addressing the Problem

Considering the dangers a substance abuse issue poses to both patients and the practitioner himself, most states have established programs to prevent and treat these problems. There are two basic types of programs: "impaired practitioner programs" operated by licensure boards to deal with health care providers who have demonstrated impairment in their practice and may have inflicted harm on patients; and "practitioner health programs," often run by nursing or medical societies, which are preventative in nature and seek to help those with substance use issues before they become impaired.[5]

Health care providers should be familiar with the reporting requirements in their own states and institutions. In addition to state-operated programs, physician health committees often exist at hospitals, medical schools, and local and state medical societies, which serve as other options to aid the impaired practitioner in a non-disciplinary manner. If ED nurses or doctors suspect a colleague has a substance abuse problem, they should refer the impaired practitioner to the proper authority or program. In a minority of states, such reporting is required by law.[3] In states where reporting is required, the reporting nurse or physician is generally granted immunity for doing so.[3] But setting aside legislated reporting obligations, all health care professionals have the same ethical and moral obligations to "first do no harm" and protect against impaired ED care. Nurses and doctors should not wait until after a colleague's impairment has progressed to the point that it affects his or her job performance. Health care professionals have an obligation to report their peers when they first suspect impairment. This should not be thought of as "whistle-blowing," but rather an act of mutual help.

Treatment for and recovery from substance abuse is a multi-step process. First, some type of intervention must take place. This can take many forms. A health care provider might seek help from a physician health program, a colleague might report him to an appropriate authority, or the state licensure board might contact the practitioner as a result of some incident or report. The practitioner must then be evaluated to determine the extent of his impairment. This can take a matter of hours, or, in the case of advanced impairment, could require admission to an inpatient facility. Thereafter, the affected physician will need to undergo some type of treatment, which might include counseling, 12-step meetings, or residential treatment programs.

Fortunately, the skill set needed for successful rehabilitation has substantial overlap with the very qualities that may have led a physician to a substance abuse problem. Intelligence, strong will, and a history of high achievement will all aid the practitioner in putting these troubles behind him. As a result, overall recovery rates for physicians are routinely reported as being higher than those of the general population.[19] A majority of physicians who undergo treatment are able to retain or recover their license and return to unrestricted practice.[19]

Conclusion

Drug and alcohol abuse disproportionately plague ED nurses and doctors. The prevalence of ED health care provider impairment and the high-stakes consequences associated with unchecked substance abuse problems underscore the importance of awareness of this issue. A shift in attitude toward substance abuse in recent decades has created a more cooperative and less punitive environment for practitioners with sub-

stance issues. Additionally, although ED health care providers collectively may be somewhat pre-disposed to substance abuse, they are also, as a group, well-equipped for successful rehabilitation. Health care providers at risk for impairment and colleagues that notice signs of substance abuse should report it to the relevant board, society, or committee to help the ED practitioner avoid negative consequences and continue to enjoy a successful career.

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Lawsuit for a Misread of ED Ultrasound? Not Likely

No lawsuits to date for missed findings

Given the fact that most emergency medicine residencies now include ultrasound in their training, and the use of ultrasound in EDs is clearly increasing, one obvious liability risk involves misreads of ultrasound examinations performed in the ED.

"People are really afraid of this, but should not be, for several reasons." says **Michael Blaivas, MD, RDMS**, vice president of Bear, DE-based Emergency Ultrasound Consultants and director of emergency ultrasound at Northside Hospital in Atlanta, GA.

Blaivas notes that everyone misreads imaging studies occasionally. "Radiologists are sued for misreading X-rays, MRIs, CTs and ultrasounds all the time," says Blaivas. "I have been an expert in about ten cases now where radiology misread very simple ultrasound examinations with very obvious findings. It will happen to clinicians also, one day."

However, according to the latest published study on the topic, there were no lawsuits filed against ED physicians for missing something on ultrasound as of 2007 in state or federal courts.[1]

"There were however, three known lawsuits filed alleging emergency physicians should have performed a point-of-care ultrasound to catch something," says Blaivas. These involved two abdominal aortic aneurysms (AAAs), with one case lost by the ED physician and one that wasn't resolved, and an ectopic pregnancy case that settled out of court.

Focused use of ultrasound "leads to very safe practice," says Blaivas. "[ED physicians] find with some experience, they are better than radiologists at the narrow applications they are performing. This is because most radiologists now get very little training in residency in ultrasound, and often have no interest in it."

Examples include point-of-care AAA evaluation, a pelvic ultrasound to determine if an intrauterine pregnancy is present, and a simple focused assessment with sonography in trauma (FAST) examination to see if there is fluid present in the abdomen of an unstable patient.

"Other procedures, such as thoracentesis and paracentesis, should be done with ultrasound assistance," says Blaivas. "When ultrasound is used, the chances of complications go down."

Blaivas notes that the series of questions on some plaintiff's attorney websites include whether the prospective plaintiff or a loved one have been injured during the placement of a central line, and if the answer is yes, whether ultrasound was used. "This will be more of a problem, as word gets out among plaintiff's groups," says Blaivas.

Different Legal Standard

Leonard Bunting, MD, FACEP, is assistant professor of emergency ultrasound at Wayne State University and emergency ultrasound director at St. John Hospital & Medical Center, both located in Detroit, MI. He says that he is unaware of any successfully litigated suits involving ED ultrasound, but that current risk comes from misinterpreting an exam.

"The gray area we are anxious about is what standard we will be accountable to. We are not radiologists," says Bunting. "Our bedside ultrasound training is focused on answering specific clinical questions that impact the patient's emergent condition."

The question is, what exposure will ED physicians face if they perform a limited exam of a trauma patient's spleen and fail to diagnose an adjacent renal mass? "We shield ourselves by limiting our training, but is this a defensible position? Time will tell," says Bunting.

Robert B. Takla, MD, FACEP, chief of the Emergency Center at St. John Hospital and Medical Center in Detroit, MI, says, "We will be

With ED Ultrasound, Credentialing Is at Issue

Dangerous practice could result

One of the major issues currently facing emergency ultrasound is credentialing, according to **Leonard Bunting, MD, FACEP**, assistant professor of emergency ultrasound at Wayne State University and emergency ultrasound director at St. John Hospital & Medical Center, both located in Detroit, MI.

Although bedside ultrasound has been required content for years in emergency medicine residencies, many of the graduating residents end up practicing in hospitals without privileges in place for emergency ultrasound.

"So they have the education, the skill, and the machine, but are unable to incorporate ultrasound into their practice," says Bunting.

This could lead to the dangerous practice of physicians performing studies, allowing it to affect their decision making, but failing to properly document their findings. "From a legal standpoint, this is a nightmare," says Bunting. "More programs need to pursue privileging in emergency ultrasound to lend validity and rigor to the practice."

Michael Blaivas, MD, RDMS, vice president of Bear, DE-based Emergency Ultrasound Consultants and director of emergency ultrasound at Northside Hospital in Atlanta, GA, points to a notable case from the Midwest. An emergency physician with no ultrasound credentialing from the hospital and incomplete training decided to rule out an ectopic pregnancy.

The ED physician mistook the ectopic pregnancy sitting just behind the uterus on the scan as being in the uterus. The patient was sent home and her ectopic ruptured at home.

"She sued, but interestingly enough, the emergency physician was not named due to an oversight by the plaintiff attorney," says Blaivas. "The emergency physician should have easily realized this was an ectopic if [he] had performed a standard point of care evaluation of the uterus."

To avoid situations like these, a strong quality assurance and improvement process is necessary. "Our use of ultrasound requires both the technical skill to obtain the images and the knowledge base to appropriately interpret them," says Bunting. "Monitoring your department's performance ensures no one is falling behind."

Verify Training, Skill

Blaivas says "there has been a tendency to simply let people fly by the seat of their pants with ultrasound in the ED."

One example is ultrasound-guided central

(continued on next page)

held to the standard of care for ER physicians and not radiologists or any other specialty. Once we acknowledge and recognize our limit, then our obligation is to peruse further diagnostic testing as clinically appropriate."

In other words, if the ED physician cannot tell from a FAST exam with a reasonable degree of medical certainty that the patient has no intraabdominal injuries, then he or she has an obligation to utilize other modalities, such as a CT scan or observation with serial examinations.

According to Takla, "it is pretty close to standard of care, especially at tertiary care institutions and teaching institutions, that ER physicians have this skill set. Smaller community hospitals have yet to make that same progress."

However, Takla says that it is even more important for ED physicians in those smaller community hospitals to be skilled at ultrasound, since resources and diagnostic testing at those facilities are more limited.

Standard of Care?

"If the growth of the field continues on its current trajectory, we will likely see a time when ER physicians will be at risk for not using this tool," says Bunting. "Although many of us hardcore ultrasonographers would like to believe ED ultrasound is the standard of care, I don't think we are there yet."

Blaivas says that point-of-care ultrasound "is definitely rapidly on its way to becoming standard of care," and that ultrasound guidance for central lines, trauma evaluation, and AAA evaluation already is standard of care.

"Anyone not using ultrasound in this fashion is

(continued)

line placement. "Many programs have made the assumption that if an emergency physician can put in a line blindly, they can definitely do it with ultrasound and need almost no training and credentialing," says Blaivas. "Unfortunately, this is not true."

In fact, there are some complications that can occur specifically with ultrasound guidance if someone does not adhere to, or never learned, proper technique, says Blaivas.

"If you have a complication and bad outcome using ultrasound, which is supposed to make the procedure nearly foolproof, how do you explain it other than malpractice?" says Blaivas. "At least this is what will be said to the jury by the plaintiff. Fortunately, it is not hard to avoid."

Blaivas says that until EDs can be confident that all graduating residents are well-trained in ultrasound use, it is important for a department to have a credentialing process and verify training and skill.

"This is especially the case for practicing physicians that did not get ultrasound training in residency. This is not a block to ultrasound use, but a safety measure," says Blaivas.

To ensure safety, he recommends the following:

- Implementing a structured credentialing process and good quality assurance process.
- Requiring re-credentialing every several years.
- Requiring CME training in ultrasound on a regular basis.
- Working with others in the hospital. Discuss how ultrasound will decrease your institution's liability, increase safety and improve patient care and satisfaction. The idea is to be sure the ED ultrasound program is not operating in a vacuum. "While your radiologists may not be happy you are using ultrasound, other colleagues may love it and even send you patients," says Blaivas.
- Making sure that ED physicians are performing well thought-out applications, with finite end points and focused questions. "We cannot and should not duplicate the services provided by a full-time radiology ultrasound suite," says Blaivas. "We simply have no use for most of their examinations."
- Having a policy when incidental findings arise.

You are looking at a gallbladder and think you see something in the kidney. You realize it might be a mass and scan it, but still aren't sure. What do you do?

"Be upfront with the patient that your examination was focused and it is not part of your practice to find renal tumors, but you simply cannot ignore the finding," says Blaivas. "Then, decide if this needs immediate follow-up testing or outpatient follow-up."

Sources

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definitely at risk," Blaivas says. "Other applications are also becoming the standard, but are not quite there. The worst thing for an ED is if others in the region, or worst of all a competition in town, has ultrasound available and you don't. It is very easy for a plaintiff's attorney to point a finger and say, 'They have it.' The worst part is, juries will agree."

Bunting says that once it is fully implemented, bedside ultrasound "has the potential to greatly reduce exposure." Studies have demonstrated that use of emergency medicine ultrasound can decrease the time to diagnose and treat several life-threatening conditions.[2-6]

Blaivas says to consider some of the more subtle ways in which ultrasound can reduce risk. This is because of the information it can rapidly deliver at the bedside, and its screening potential.

For instance, at the same time an ultrasound can rapidly rule out an AAA, it can also help the ED physician to determine whether someone has a pneumothorax, so that the patient doesn't end up waiting too long for a chest X-ray in a busy ED.

Similarly, using ultrasound with nerve blocks allows the ED physician to avoid conscious sedation in some cases. "This will avoid the occasional sedation complication, and take less nurse time away from other patients," says Blaivas.

Blaivas adds that other applications, such as gallbladder and focused cardiac evaluation and ruling out deep venous thrombosis, can avoid delays and improve care.

For example, patients sitting for hours in the ED waiting to get a lower extremity ultrasound can be diagnosed or ruled out quickly, and placed on anticoagulants if needed. Likewise, a patient with shortness of breath may be discovered to have a pericardial effusion and be admitted instead of sent home, or perhaps even drained to avoid a sudden decompensation and arrest later.

"Simply catching it early and notifying a cardiologist of a moderate size effusion may avoid a disaster, if it remains unknown until much too late," says Blaivas.

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When You Did It and You Documented, but Others' Charting Differs

Acknowledge discrepancies before lawyer does

[Editor's Note: This is the second of a two-part series on documentation and ED liability. This month, we cover liability risks when the ED physician or nurse's documentation is inconsistent with documentation by other caregivers. Last month, we reported on the legal risks of inadequate documentation and information that should not be omitted.]

What if a crucial aspect of patient care is documented by more than one ED caregiver, and the two accounts conflict?

"If there is one theme to teach staff in an emergency department regarding charting, it would be consistency," according to **Linda M. Stimmel, JD,** a partner with the Dallas, TX-based law firm of Stewart Stimmel. "It is much easier to defend a lawsuit when the staff charts in the same or similar manner."

Stimmel defended one case where a patient's wound or bed sore was described completely differently by two nurses who saw the patient with the same hour. One nurse used the size of a coin to describe the size of the wound, and another used inches.

"The inconsistency in the chart was used by the plaintiff's attorney to show how no one was really paying attention to the wound on the patient," says Stimmel. "In actuality, everyone was looking at the same wound, but they did not have a consistent way that had been agreed upon to describe bed sores."

Other discrepancies involve the use of different types of graphic records, with some nurses using a slash in a box, others circling a box, and some placing an X in the box. "Many times, they do not remember what that meant two years later when they are looking at the chart," says Stimmel.

For this reason, Stimmel says that her advice as a defense attorney is for ED staff to agree on a consistent way of charting.

"It does not matter which way you choose to chart. Just make sure everyone uses the same, consistent types of terms and descriptions for charting," she says. "This is very important in charting vital signs."

Review Nursing Notes

Discrepancies often occur between ED physician charting and nursing notes, says **Gabor D. Kelen, MD**, director of the Department of Emergency Medicine at The Johns Hopkins University in Baltimore.

"For some reason these days, nursing now documents more than anything I learned in medical school," says Kelen. "They do their own history and physicals and they do all sorts of assessments. Sometimes those assessments are different than what the physician assessment is, but if you don't read the nursing notes you have no idea."

For instance, the nursing notes may state that the patient had a pain level of 10, with substernal piercing chest pain for the last two hours, with dizziness. "The doctor may say that the patient's toe was stubbed. If that patient goes out and has a myocardial infarction, it looks like the nurses picked it up and you didn't."

In this case, you need to document some type of explanation as to why the nurses got one type of history and you got another. "Otherwise, the discrepancy will kill you every time," says Kelen.

Kelen has seen many cases where the nurse's notes were helpful to a plaintiff. In these cases, the physician's charting appeared as though the ED physician either didn't see, or didn't understand, what the nurse had charted.

"If nurses say the belly was tender and the physician writes that it was nontender, and it turns out to be some abdominal catastrophe, they'll take the nurse's side on that every time," says Kelen. "The attorney will ask, 'Doctor, how carefully did you examine the patient?' And that is a tough explanation in court."

Instead, document something that shows you looked at the nursing notes and acknowledged the discrepancy, such as "I noted the nurse's notes. I believe she was wrong," or "By the time I examined the patient, the exam was pain-free."

Also, if the nurse's triage note says there was a complaint of chest pain, but when you interview the patient you get a different chief complaint, you still need to explain the original complaint that was documented. "I've seen a large number of suits based on unaddressed findings or complaints noted by another member of the health care," says Kelen. "The attending of record must document something—even if it's just 'patient now denies original complaint.'"

Stop Psych-related EMTALA Violations

Don't improperly assess as "stable"

Robert D. Kreisman, JD, a medical malpractice attorney with Kreisman Law Offices in Chicago, says that while the Emergency Medical Treatment and Active Labor Act (EMTALA) does not deal specifically with medical malpractice complaints, following its guidelines regarding psychiatric patients will help EDs avoid both EMTALA violations and potential medical malpractice.

Kreisman explained that, like any patient presenting to the ED, psychiatry patients are covered under EMTALA. As such, they are subject to the same requirements of an appropriate medical screening, stabilizing treatment, and appropriate transfer.

However, for psychiatric emergency patients, the medical screening must focus not only on the psychiatric emergency, but also document any contributing medical factors, such as chronic illness, trauma, or intoxication.

"In fact, other than the obvious liability that comes from discharging a mentally unstable patient, there is also the potential to miss a medical emergency, such as a stroke or drug overdose, that can be masked by the psychiatric symptoms," says Kreisman.

While EMTALA does not require the ED to rule out every possible diagnosis, it does require that the ED determine if the patient's presenting complaints/condition constitute an "emergency medical condition," as that term is defined by EMTALA; if necessary to determine if an emergency medical condition exists, this may include testing for potential medical, toxic, or traumatic causes for the patient's behavior.

"Similarly, under medical malpractice law, physicians are required to meet the medical standard of care," says Kreisman.

The medical standard of care for stabilizing psychiatric patients would be similar to the EMTALA requirements, adds Kreisman. "Any breach of that standard of care could be considered medical malpractice and expose the ED to legal risks," he says.

In terms of performing an adequate mental health exam, EMTALA requires that the ED assesses the patient's suicide or homicide risks, disorientation, or threatening behavior that makes them a danger to themselves or others.

"Under EMTALA, psychiatric patients are classified as 'stable' when they have been protected from hurting themselves or others, at which point they may be transferred to another facility," says Kreisman. "However, if the psychiatric patient is to be discharged rather than transferred, they must no longer be a threat to themselves or others in order to be ruled stable."

Improper Assessment

"Most of the liability risks for an ED involve the improper assessment of a psychiatric patient as stable," says Kreisman.

In order to back up the decision to transfer or discharge a psychiatric patient, Kreisman says that emergency physicians should document that the patient was deemed stable based on either a medical evaluation, chemical restraints, or physical restraints.

"However, when using restraints in order to stabilize a patient for transfer, make sure to document that no other less restrictive measures were available, such as admitting the patient to the initial hospital," says Kreisman. "Otherwise, the ED might be at risk for violating patient rights requirements."

Because of the heightened potential for missing

Source

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a medical emergency when examining psychiatric patients, ED staff should take extra care when screening psychiatric patients for both psychiatric and medical issues, says Kreisman.

"In an attempted suicide case, the most damaging written documentation would be anything that supports a misdiagnosis of the patient's mental status," says Kreisman. "In this situation, the treatment plan would not correspond to the needs of the patient."

The danger is that the ED fails to recognize the patient's suicidal ideation, and the discharged patient successfully commits suicide within a relatively short time after discharge. "In this type of lawsuit, the ED records and the lack of follow-up would be significant," says Kreisman.

In a missed medical emergency lawsuit, Kreisman says the lack of an appropriate medical examination would be damaging evidence, as would a complete failure to correctly diagnose the medical information contained in the chart.

For example, if a psychiatric patient presents with a history of head trauma, the failure to obtain a CT scan of the head could be a violation of the standard of care. Similarly, if an ED physician discharges a psychiatric patient despite evidence of a subdural hematoma on that CT scan, this could also be a violation of the standard of care.

"So while the medical chart can provide evidence that an ED met all EMTALA requirements and acted within the appropriate standard of care, it can also be used to prove that EMTALA violations or medical malpractice did in fact occur," says Kreisman.

However, Kreisman notes that medical malpractice occurs when a medical provider fails to meet the appropriate standard of care. "Physicians are held to a reasonable level of care. It does not require physicians to be perfect in emergency medical situations," says Kreisman.

CNE/CME QUESTIONS

10. Which of the following is true regarding liability risks of performing ultrasounds in the ED?
    A. ED physicians have been sued for misreading ultrasounds more often than radiologists.
    B. Some lawsuits have alleged that emergency physicians should have performed a point-of-care ultrasound to catch an abdominal aortic aneurysm.
    C. ED physicians will always be held to the same standard of care as radiologists in the event a malpractice lawsuit is filed.
    D. EDs using ultrasounds for central line placement and trauma evaluation is not considered the standard of care, so a plaintiff's attorney wouldn't be able to tell a jury that the ED should have utilized this.

11. Which of the following is recommended to reduce risks involving use of ultrasound in the ED?
    A. ED physicians should avoid performing procedures such as thoracentesis and paracentesis with ultrasound assistance, because the risk of complications increases significantly.

CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

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

CNE/CME INSTRUCTIONS

Physicians and nurses participate in this CNE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■

B. If incidental findings are noted during focused use of ultrasound in the ED, the patient should generally not be informed of them.
C. Almost no training and credentialing is required for ultrasound-guided line placement.
D. ED physicians should have finite end points and focused questions with use of ultrasound.

12. Which documentation practice is recommended to reduce liability risks of inconsistent charting between members of the ED health care team?
    A. ED physicians should avoid acknowledging a discrepancy with nursing triage notes.
    B. ED physicians should document something to explain any notable discrepancies between their own charting and nursing notes.
    C. If the patient reports a different chief complaint to the ED physician than is documented by the triage nurse, it is not advisable for the ED physician to offer an explanation on the original complaint.
    D. If a finding is noted in the patient's chart by other members of the health care team, it is not advisable for the ED physician to comment on this in the patient's chart unless he or she also noted the finding.

13. Which is required by EMTALA for a medical screening examination of a psychiatric patient?
    A. The medical screening examination must focus on the psychiatric emergency specifically, not other contributing medical factors, such as chronic illness, trauma, or intoxication.
    B. If necessary to determine if an emergency medical condition exists, ruling out potential medical, toxic, or traumatic causes for the patient's behavior.
    C. EDs are not required to assess the patient's suicide or homicide risks, disorientation, or threatening behavior that makes them a danger to themselves or others.
    D. Psychiatric patients are classified as 'stable' for discharge when they have been protected from hurting themselves or others, and do not necessarily have to be determined to no longer be a threat to themselves or others.

Answers: 10. B, 11. D, 12. B, 13. B