

FORESIGHT

RISK MANAGEMENT FOR EMERGENCY PHYSICIANS

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Working With Consultants

OBJECTIVES

*After reading this issue,
you should be able to:*

- Describe the obligations of a consultant to respond to calls from the emergency department.
- Describe the emergency physician's obligations to the patient after a consultation has been requested.
- List ways to mediate a dispute with a consultant.
- Discuss ways to detect and report an impaired consultant.

**David A. Hexter, MD, MPH,
FACEP, Assistant Professor of
Surgery, Division of Emergency
Medicine, University of Maryland
School of Medicine, Baltimore**

**Gregory L. Henry, MD, FACEP,
served as editor of this issue.**

INTRODUCTION

Emergency physicians rely on consulting physicians to bring their expertise to a significant number of patients who require care that is beyond the scope of emergency medicine training and practice. The good news is that the vast majority of interactions between emergency physicians and consultants are conducted in a friendly, collegial manner with the best outcomes for patients in mind.

Unfortunately, all emergency physicians, at some time in their practices, probably have experienced an unsatisfactory interaction with a consultant. The causes of these unsatisfactory interactions are many, including everything from personality differences to someone "just having a bad day" to true disagreements about the appropriateness of care. More worrisome causes include incompetent or impaired consultants. One major source of unhappiness among consultants is the increasing burden of the uninsured and underinsured among emergency department patients.

When problems occur with emergency department consultants, it is essential for emergency physicians to be familiar with the legal, moral, and ethical responsibilities for both themselves and the consultants concerning emergency department patients. Legally, the responsibilities of on-call physicians are governed by the Emergency Medical Treatment and Active Labor Act (EMTALA) and hospital policy. National medical societies have ethical standards by which their members are to abide. Other standards may be imposed by state licensing boards, abandonment laws, and insurance contracts. Case law regarding previous malpractice decisions may also have an impact on on-call physicians' responsibilities.

The following fictitious cases illustrate the risk management issues related to emergency physicians' interactions with consultants and the potential pitfalls of not being familiar with the responsibilities of consultants.

ON SIGHT - 1

On a warm spring afternoon, 12-year-old Stacey Campbell stops her bicycle abruptly and flips over the handlebars onto the street. Her friends get her parents, and the parents bring her to the emergency department at St. Raphael Hospital. On arrival, the triage nurse places Stacey on a gurney with a backboard and hard cervical collar. Stacey complains of left shoulder and left chest pain. The nurse notes abrasions on the left side of her face, left arm, and left knee. Vital signs are blood pressure 155/80, pulse rate 100, respiratory rate 20, and temperature 36.5°C (97.7°F). Approximately 35 minutes later, she is evaluated by Bill Reniger, MD, who is 6 hours into a very busy shift.

Dr. Reniger notes the abrasions and tenderness elicited in the left shoulder, left lateral inferior chest wall, and left upper quadrant of the abdomen. Breath sounds are clear and equal, and the neurovascular status of the left arm is intact. Radiographs of the cervical spine and chest and a CT scan of the abdomen are obtained while Dr. Reniger tends to other patients.

Approximately 3 hours later, Dr. Reniger reviews and interprets the radiographs as normal. He receives a report from the radiologist that there is a significant splenic laceration. Dr. Reniger pages the general surgeon on call, Andres Soliman, MD, who calls back 15 minutes later. Dr. Soliman listens to the description of the case, and then asks what insurance the patient has. Dr. Reniger finds and relates this information, and Dr. Soliman is pleased to say that he accepts this insurance. He tells Dr. Reniger that he is out shopping with his family but will stop by as soon as he can. Dr. Reniger documents the time of the conversation and resumes seeing other patients, assuming that Dr. Soliman, after being informed that the patient has a ruptured spleen, will respond within 30 minutes or so.

Two and a half hours later, Dr. Soliman arrives. He is greeted by Stacey's angry parents, who are very upset that they have been waiting so long and "nothing has happened." Stacey is pale and diaphoretic and so weak that she can barely answer simple questions. Dr. Soliman immediately asks the nurse to obtain vital signs and start intravenous

fluids through two large-bore catheters. Vital signs include a blood pressure of 60/palp and a pulse rate of 165. Uncrossmatched blood is ordered, and Stacey is taken to the operating room for emergency exploratory laparotomy and splenectomy. She survives the operation but has a stormy postoperative course and succumbs to ARDS and sepsis 4 days later.

Dr. Reniger does not hear about the case again until he reads about it in the local newspaper 3 months later—and learns that the parents are filing a \$7 million action against him. They claim that his failure to attend to their daughter in a timely manner and his failure to recognize the signs of shock led to her death. The Campbells are quoted as saying they have no problem with the care provided by the surgeon, Dr. Soliman, who "acted so quickly and courageously after finding Stacey so ill in the emergency department."

INSIGHT - 1

Physicians who are on call to the emergency department must respond within a reasonable period of time. But who defines what is reasonable? The Center for Medicare and Medicaid Services (formerly HCFA) has interpreted a "reasonable" period of time to be 30 minutes for true emergencies in large cities. New Jersey and Missouri have state laws requiring 30-minute response times for a physical presence of the consulting physician in the emergency department.¹ Other reasonable response times are defined by medical staff bylaws.² To maintain reasonable emergency department throughput times, some authors have recommended the physical presence of the consultant within 45 minutes of having been contacted.³

In reality, emergency physicians determine what is reasonable. A patient with a ruptured spleen requires a different response time than a patient with a clogged gastrostomy tube. Thus, the timeliness of the on-call response depends on the current needs of the patient, which can be judged by the emergency physician in consultation with the on-call physician. When discussing a case with an on-call physician, the emergency physician should express his or her opinion on

whether the on-call physician needs to come in, and if so, by when. The on-call physician should tell the emergency physician when he or she will come in ("OK, I'll be there in an hour," or "I'll be there in 45 minutes."), and this time interval should be in keeping with hospital policy and acceptable to the emergency physician based on the patient's need for specialty care. The conversation should, and generally will, end in mutual understanding.

But what if there is no mutual understanding? The emergency physician, as the patient's advocate, must solidify the specific time interval in which the on-call physician should come in to see the patient. It is ethically and morally wrong to hold an emergency physician responsible for an imprudent on-call specialist who inappropriately delays care of a patient then retrospectively blames the emergency physician for not telling the whole story.⁴ If pressing the on-call physician to commit to an appropriate time interval still does not achieve the necessary result, the emergency physician must take other action, according to procedures established in hospital policy or medical staff bylaws, to obtain the specialty care the patient requires. This may involve contacting another specialist, or the emergency department medical director, or the on-call physician's clinical department head, or the hospital chief of staff. And if the patient must be transferred to another facility for specialty care because the on-call physician "failed to appear within a reasonable time to provide necessary stabilizing treatment" for an emergency medical condition, the transferring hospital is required by law to send to the receiving hospital that on-call physician's name and address.⁵

Hospitals and on-call physicians are permitted under EMTALA to ask what kind of insurance a patient has as long as this inquiry does not delay the medical screening examination or stabilizing treatment for an emergency medical condition or discourage the patient from staying for further evaluation.⁶ Some states have stricter regulations that specifically prohibit even asking about the method of payment prior to stabilization. (Physicians should be aware of the rules in the states where they practice.) Yet, knowing the patient's

health plan can help emergency department providers coordinate the care of stabilized patients.⁷ However, hospitals and on-call physicians must provide stabilizing treatment for emergency medical conditions and cannot require authorization from health plans before completing medical screening examinations—regardless of a patient's insurance status. If another physician who is not on call is willing to assume care of the patient, as is sometimes requested by the patient or the primary care provider, this is permissible as long as care is not delayed.

HINDSIGHT - 1

Unfortunately, delays by on-call physicians are an everyday part of emergency department practice. There are many reasons cited—"I'm in the OR," "I'm at another hospital," "The on-call list is wrong," "My pager was turned off," and so on. In most cases, delays, while inconvenient and a contributor to emergency department overcrowding, do not affect patients' conditions or outcomes. This may or may not be the case.

While waiting for a consultant, emergency department personnel must continue to monitor patients appropriately. Physicians can affect patient care and protect themselves by documenting interval evaluations and progress notes. Dr. Reniger certainly wishes that he or the nurses had been the ones to find that Stacey's condition had deteriorated rather than the late-arriving surgeon.

The case was settled against St. Raphael and Dr. Reniger for \$3.7 million. It was reported to the state licensing board, which conducted a thorough investigation into the claim raised by Stacey's parents. A reprimand was issued, but Dr. Reniger was allowed to keep his license. One year later he found himself in the local news again when the Campbells expressed their outrage at the "system" for failing to police itself and allowing Dr. Reniger to keep his license.

- Consultants who are on call to the emergency department must respond within a reasonable period of time.

- Emergency physicians have an ongoing responsibility to provide stabilizing care to the patients in their departments.
- Unresolved conflicts with consultants should be resolved in accordance with hospital policy.

ON SIGHT - 2

H. James Kintrell is a 32-year-old CPA who has a history of a ventriculoperitoneal shunt placement as a child for congenital hydrocephalus. His wife has brought him to the emergency department at University Hospital at 11:30 PM because he has had fatigue and a mild headache for 1 day. Vital signs are blood pressure 129/88, pulse rate 85, respiratory rate 20, and temperature 36.6°C (97.9°F). Mr. Kintrell tells the triage nurse that his shunt has been revised three times. He is triaged as urgent and is called back from the waiting room at 1:30 AM.

Sarah Nolan, MD, a first-year emergency medicine resident, steps out from one of the three trauma cases in the emergency department and picks up Mr. Kintrell's chart at 2:15 AM. She elicits the history of fatigue and headache and finds no apparent neurologic deficit. At 2:50 AM, she discusses the case with her attending, Steve Merrick, MD, and they agree to obtain "shunt series" radiographs and ask for a neurosurgery consultation to rule out a problem with the shunt.

At 4:00 AM, Ashok Patel, MD, a second-year neurosurgery resident, examines Mr. Kintrell and reviews the shunt series radiographs, which have been read by the radiology resident as "unremarkable." Dr. Patel also is concerned about a possible problem with the shunt, so he discusses the case with his chief resident. They decide to perform a "shunt tap," checking pressures and sending the cerebrospinal fluid for analysis. Mrs. Kintrell signs the consent form then leaves the emergency department to get their children ready for school; the procedure is performed without complications. At 6:30 AM, Dr. Patel reviews the results with his chief resident and completes his written consultation. Dr. Patel tells Dr. Nolan that Mr. Kintrell is ready to be discharged. Mr. Kintrell signs the discharge papers and leaves the

treatment area at 7:00 AM, just as a shift change gets underway.

Just as Ken Solce, MD, gets ready to see the first patient of his shift, the triage nurse asks him what to do with a certain patient, Mr. Kintrell, who was discharged during the overnight shift but does not know where to go or how to get there. Dr. Solce asks the triage nurse to retrieve Mr. Kintrell's chart and bring him back to the treatment area.

Dr. Solce examines Mr. Kintrell at 7:30 AM. Mr. Kintrell offers no complaint except that he is tired from being up all night. Vital signs are normal, and he is alert and oriented, but he does not know his address or how he got to the emergency department. After reviewing the social history and noting that Mr. Kintrell is a CPA, Dr. Solce realizes that this patient should know this information. He orders a head CT scan and requests a reevaluation by neurosurgery. At 9:00 AM, the CT scan is read and compared to previous studies and reveals hydrocephalus consistent with an obstructed shunt. The neurosurgery attending examines Mr. Kintrell and admits him to the hospital for a shunt revision procedure.

INSIGHT - 2

Working with consultants, particularly in the teaching hospital environment, presents some unique challenges to emergency physicians. Although most consultants in training provide much-appreciated expertise and skill to the care of emergency department patients, there are occasions when the care they provide falls short of what is needed. Attending emergency physicians have a duty to be strong advocates for all patients and to ensure that they obtain medically necessary, high-quality care.⁸ Failure to serve as an advocate, even after a consultant has been called and care has been transferred, can result in significant liability.⁹

First of all, emergency physicians must be cognizant of the ability of a tired consultant to provide the best information and skill in patient care when he or she is exhausted. Surgical residents typically have very busy operating and rounding schedules that start early in the morning and last late

into the evening. Calling a resident physician between 1:00 and 5:00 AM may well be eliminating the 3 or 4 hours of sleep he or she was going to get that night. As a result, the resident's judgment may be impaired.

Second, residents are physicians in training, and according to the doctrine of *respondeat superior*, the ultimate responsibility for the clinical services provided rests with the supervising attending physician. The attending emergency physician is the attending physician of record until another physician has been contacted and has assumed responsibility for the patient's care. Any disagreements regarding the care of a patient should be resolved attending to attending, not with a resident. Failure to achieve agreement should result in the attending consultant seeing the patient or perhaps a discussion between chiefs of service, according to established policy.

Finally, emergency physicians have a duty to inform patients of any significant, unresolved disagreements that may exist with consultants, even to the point of offering other consultants. The emergency physician's responsibility for a patient does not end when he or she calls a consultant, nor does it end when the consultant merely arrives. It is generally understood that the emergency physician remains responsible for such a patient until there has been a proper transfer of care and an agreement on the treatment plan. If the emergency physician believes that he or she is a witness to a major breach of a reasonable standard of medical care, that emergency physician has a duty to take steps to resolve it or at least inform the patient of his or her opinion.

Every emergency department should have a conflict resolution policy that emergency physicians and consulting physicians can rely on when faced with potential disagreements. The policy must reflect the emergency physician's independent duty to the patient.⁸ It should dictate a specific set of actions to take if, after discussions between the emergency physician and attending physician, the conflict cannot be resolved. First, the on-call physician must come into the emergency department and personally evaluate the patient to obtain the same knowledge base the emergency physician has about

the patient's condition. Then, if the two physicians still cannot agree on a course of action, the patient must be informed of both opinions to be able to make a sound, informed decision about treatment. As an alternative, a neutral third party could be called in to arbitrate the dispute. This person could be the chief of the consultant's department, the emergency department chief, or the chief of the medical staff. This option should be agreed on in advance of the conflict.¹⁰ Conflicts of opinion are common between physicians, but conflict resolution must never put patients in jeopardy.

HINDSIGHT - 2

James Kintrell was very fortunate that his shunt obstruction was discovered and treated before he left the emergency department. He was taken to the operating room later that day, and a successful shunt revision was performed. His condition improved on the first post-op day, and he was able to return to work 2 weeks later.

The astute observation of a triage nurse and the willingness of an oncoming emergency physician to reevaluate Mr. Kintrell prevented a poor outcome. Emergency physicians must avoid the temptation of saying, "That patient's already been discharged. It's not my problem."

This case was reviewed in a morbidity and mortality conference, and a standard protocol for shunt evaluation was established for the emergency physicians to follow. Both Dr. Nolan and Dr. Patel and their attendings were present for this conference.

- Know the expected outcome of a request for consultation.
- Know the institution's procedure for handling disagreements with consultants.
- Emergency physicians have an independent duty to emergency department patients.
- Attending physicians should be involved with important decisions regarding their patients.

ON SIGHT - 3

Richard Worrell, a 43-year-old man with longstanding alcoholism, cirrhosis, and esophageal varices, presents to the emergency department at Mercy Hospital at 7:30 PM on New Year's Eve with a complaint of vomiting blood. Vital signs are blood pressure 126/70, pulse rate 125, respiratory rate 20, and temperature 36.6°C (97.9°F). He is triaged as emergent and brought to the treatment area. Paige Minell, MD, who works only occasionally at Mercy, is the emergency physician on duty. She examines Mr. Worrell and suspects upper gastrointestinal hemorrhage. She instructs the nurse to start two large-bore IVs and send labs for CBC, chemistries, and a type and cross-match for 4 units.

At 8:45 PM, a hemoglobin of 7 is reported by the lab; a nasogastric tube is placed and returns bright red blood that clears with 500 mL of saline. Dr. Minell calls the physician who is covering for Mr. Worrell's primary care provider, and he accepts the admission of Mr. Worrell to the ICU. He tells Dr. Minell to request an urgent consultation with gastroenterology.

At 9:30 PM, Dr. Minell speaks with Stuart Panch, MD, the physician on call for gastroenterology. Dr. Minell notices that Dr. Panch is slow in his speech and that he asks her several times to repeat what she has just said. He tells Dr. Minell that he will come in to see Mr. Worrell.

At 10:20 PM, Dr. Panch arrives, reviews the chart, and goes in to see Mr. Worrell. One of the nurses remarks to Dr. Minell that Dr. Panch has the odor of alcohol on his breath. Dr. Panch asks the nurse for a Sengstaken-Blakemore tube, which has to be obtained from central supply because it has not been used in a long time. With the nurse's help, Dr. Panch places the tube; the bleeding is controlled, and Mr. Worrell is admitted to the ICU. Dr. Minell is busy tending to other patients but catches a glimpse of Dr. Panch staggering out of the emergency department. For a moment she wonders if she should say anything about what she saw, but then moves on to her next patient.

INSIGHT - 3

Statistically, alcoholism has an estimated prevalence of 3% among physicians. Drug abuse also is a significant issue, with a prevalence of 2%.¹¹ Emergency physicians are the specialists most likely to notice substance abuse problems among their colleagues because they interact with most hospital services at all hours of the day and night. Consulting physicians, particularly those who are infrequently called to respond, may be tempted to consume alcohol while on call. Beyond the misguided social drinkers, there are substance abusing physicians who may be called to respond at any time and found to be impaired.

Once again, emergency physicians must be advocates for patients and protect them from impaired physicians.⁸ Unfortunately, this is easier said than done. First there is difficulty in detecting impaired physicians. However, emergency physicians deal with impaired individuals on a regular basis, so they should be adept at identifying intoxication and cognizant of the warning signs of chemical dependence (Figure 1). Once impairment is suspected, what should the emergency physician do? Few problems in emergency medicine are as vexing as dealing with an impaired professional. On one hand is the duty to protect the patient, and on the other hand is the consequence of making false accusations. A conspiracy of silence is often the easier and more attractive course in a busy emergency department, but this is not an acceptable option when lives are at stake.¹²

In the end, the way to approach an impaired colleague depends on the degree of impairment and the urgency of the situation. At one extreme, when a physician who is clearly unfit for duty arrives to care for a patient, an administrator of the hospital or the clinical department head should be notified immediately. Depending on the individual hospital, this also could be the medical director of the emergency department, the medical director of the consultant's department, the president of the medical staff, or a hospital administrator. Hospital bylaws should be reviewed and revised as necessary to be sure that they include procedures for

handling incidents regarding quality of medical care and the process for identifying and managing impaired physicians.¹³

At the other end of the spectrum is the physician who is not clearly impaired but has had a glass of wine with dinner. Physicians have a legal duty not to provide professional services while under the influence of alcohol.¹⁴ Those who try to walk the fine line between sober and "under the influence" risk action against their licenses and hospital privileges. All such incidents should be documented carefully on a confidential incident report and referred to the appropriate hospital administrator for action.

Most state licensing boards have systems available for confidential reporting and treatment that can be very useful in this situation.¹⁵ There are no easy answers, but documentation of incidents by all witnesses is very important to establish a credible case to confront the substance-abusing physician.

Denial is the cardinal symptom of untreated chemical dependence. Once impairment is suspected, intervention must be implemented promptly yet carefully.¹⁶ The process of reporting an impaired physician should be predefined; it typically involves contact with the department director, chief of staff, and state licensing agencies. A properly performed intervention can be lifesaving, both for patients and the impaired physician.

The procedure for an effective intervention should be as follows:

- Conduct preintervention planning with a professional facilitator—or someone who has experience with interdiction techniques—with the desired outcome of inpatient treatment.
- Include a wide net of friends, family members, and colleagues to demonstrate unity in the encounter.
- Ensure that the intervention session is a nonjudgmental but candid discussion of the indisputable facts and the inevitable negative consequences of the physician's behavior.
- Allow intervenors to speak first without interruption.
- Permit the physician who is suspected to be impaired to speak last.
- Institute treatment (or negative consequences) immediately.

Finally, adverse interactions with consulting physicians have a tendency to occur at night or on weekends. And these are the times at which part-time providers are most likely to be filling in to complete coverage schedules. Physicians who work only occasionally at certain hospitals are less likely to be familiar with established policies, and consultants called after hours may want to bend the rules to avoid coming to the hospital. Patients themselves are more likely to be under the influence of drugs and alcohol and thus more difficult to care for. Thus, it is essential that all emergency physicians be familiar with local hospital policies and state and federal laws that apply to interactions with consultants. Part-time physicians, residents, and physician extenders must be familiar with the rules as well.

Figure 1. Warning signs of chemical dependence

- Chronic tardiness
- Missing shifts or frequent last minute rearrangements
- Sloppy charting
- Incomplete or altered medical records
- Variable handwriting quality
- Inappropriate orders
- Increasing complaints from patients and colleagues
- Won't answer the telephone when off duty
- Chronically broken pager
- Excessive irritability when contacted at home
- Frequent use of cologne or breath mints
- Prescribing controlled drugs for self or family
- Spends excessive time in bathroom
- Orders partial Tubex doses
- Carries saline vial and syringes on person at work
- Frequent visits to car during shift
- Erratic behavior with sudden wide mood swings
- Involvement in politics to the detriment of medical practice
- Exaggerated exhilaration or negativism

Reprinted from Whitehead DC. The impaired professional. In: Salluzzo RF, Mayer TA, Strauss RW, et al, eds. *Emergency Department Management: Principles and Applications*. St. Louis, Mo: Mosby; 1997:725-728.

HINDSIGHT - 3

Dr. Minell had several reasons to suspect that the consultant, Dr. Panch, was impaired. Some of the evidence was quite convincing, such as a staggering gait and slurred speech. Some of the evidence was more subtle, as indicated by Dr. Panch's use of outdated medical therapy: endoscopy for esophageal varices has essentially supplanted the use of balloon tamponade with a Sengstaken-Blakemore tube as treatment for acute variceal hemorrhage.¹⁷ But because Dr. Minell worked part time at Mercy, she was not familiar with the hospital's procedures for reporting impaired physicians. She did not want to "make waves" and chose to ignore the incident, telling herself that she was too busy to worry about it. And the code of silence prevailed.

About 9 months later, Dr. Panch came to the hospital one night to consult on an inpatient. Obviously impaired, he was confronted by the nursing staff. An incident report was

filed. Because Dr. Panch was an esteemed, long-term member of the medical staff, his colleagues did not refer him to the hospital's impaired physician program and took no action against his privileges. The code of silence prevailed once again.

The nursing staff, frustrated by the hospital's response to this and previous incidents, reported Dr. Panch directly to the state licensing board, which referred the issue to its impaired physician program. After verifying the facts, the director of the program confronted Dr. Panch and suggested that he voluntarily report to the state's confidential program for impaired physicians. Dr. Panch angrily denied all accusations and refused to cooperate. The state then went through the proper procedure to suspend Dr. Panch's license and required that he complete a rehabilitation program for reinstatement of his license. Initially defiant, Dr. Panch subsequently came to believe in what was the best course of action. He completed the state rehabilitation program and submitted to

monitoring by its aftercare program, which included followup counseling and random drug testing.

Emergency physicians have excellent observational skills; they must remain alert for impaired consultants and protect their patients. They are in the unique position of being able to observe and respond to events across most hospital departments. A consultant's problem is also an emergency physician's problem; emergency physicians cannot allow these issues to adversely affect patients. An emergency physician who is unsure of the best way to handle such a situation should get in touch with the emergency department medical director or hospital compliance officer, or the hospital administrator on call if the situation is urgent.

- Know the signs and symptoms that suggest a physician is impaired.
- Be familiar with the hospital's impaired physician policies.
- Emergency physicians have a duty to protect patients from their impaired colleagues.

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FORESIGHT

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Prepared under the guidance of the *Foresight* Editorial Panel

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Gregory L. Henry, MD, FACEP
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