

Assessment of the Acute Psychiatric Patient in the Emergency Department: Legal Cases and Caveats

Benjamin Good, MD
Ryan M. Walsh, MD
Geoffrey Alexander, MD
Gregory Moore, MD, JD

Madigan Army Medical Center, Department of Emergency Medicine, Tacoma, Washington

Supervising Section Editor: Leslie Zun, MD, MBA

Submission history: Submitted May 28, 2013; Revision received August 12, 2013; Accepted August 15, 2013

Electronically published April 15, 2014

Full text available through open access at http://escholarship.org/uc/uciem_westjem

DOI: 10.5811/westjem.2013.8.18378

[West J Emerg Med. 2014;15(3):312–317.]

INTRODUCTION

Assessment of the acute psychiatric emergency is challenging and fraught with error. This paper, using legal cases, will discuss the assessment of new onset psychiatric illness, exacerbation of chronic psychiatric disease, and the suicidal patient. We will share diagnostic caveats, medical clearance, and suicide assessment tools.

METHODS

The authors, who have significant medical legal experience, selectively chose illustrative legal cases to discuss caveats of assessment of acute psychiatric emergencies. We selected representative cases after reviewing legal journals and publications. Cases involving restraint and sedation were excluded as they were covered in a prior manuscript.

Assessing New Onset Psychiatric Disorders

Psychosis is a relatively common syndrome affecting 3% to 5% of the population at some point in life.^{1,2} Encountering undiagnosed psychiatric conditions, such as psychosis or bipolar disorder, is commonplace for the emergency physician (EP). The following case illustrates the challenge and importance of the assessment of new onset psychiatric disorders.

In *Brown v Carolina Emergency Physician* (2001), Mr. Brown noted a gradual change in his wife's behavior as she became more lethargic and depressed. He presented to Greenville Memorial Hospital's emergency department (ED) on a Friday to obtain a physician's note that would excuse him from his 2-week National Guard annual training session. Dr. Benjamin Crumpler examined Mrs. Brown and diagnosed her with acute delusional psychosis. Based on his observations, he recommended that she be admitted to the hospital, but neither Mr. nor Mrs. Brown wanted her to be admitted. Mr. Brown

assured Dr. Crumpler that he would care for his wife at home during the weekend and return to the ED if needed. Dr. Crumpler then obtained collateral information from a family friend regarding the couple. Satisfied by this conversation and Mr. Brown's assurances, he arranged for the required National Guard physician's note, provided referral to a mental health center the following Monday, and prescribed hydroxyzine for Mrs. Brown.

Initially, Mrs. Brown seemed better. However, by Sunday she was strangely energetic, racing around the family's home singing religious hymns. Mr. Brown physically restrained her and then carried her to their bedroom after she suddenly fell asleep in the midst of a struggle. She woke 30 minutes later very agitated. A verbal and physical confrontation with Mr. Brown ensued. She repeatedly hit him with a rod. Following another physical struggle, she again suddenly went limp and appeared to be asleep. Mr. Brown went to the kitchen to call 911. While he was on the phone, Mrs. Brown beat the couple's 16-month-old son to death.

At Mrs. Brown's criminal trial, psychiatric experts testified that she suffered from paranoid schizophrenia and was not guilty by reason of insanity. The family then filed a civil action against the hospital and Dr. Crumpler seeking damages. The Browns claimed that Dr. Crumpler's negligent failure to properly diagnose, treat, and hospitalize Mrs. Brown proximately caused the death of their son. The trial court granted summary judgment for the defendant hospital and physicians.

On appeal, the South Carolina Court of Appeals reversed and held that Dr. Crumpler's inadequate treatment of Mrs. Brown's psychosis in the ED was the proximate cause of her fatal assault on the couple's youngest son a few days later. The court was convinced by the plaintiff's expert witnesses who opined that Mrs. Brown's condition "warranted either a

Report Documentation Page				Form Approved OMB No. 0704-0188	
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE APR 2014		2. REPORT TYPE		3. DATES COVERED 00-00-2014 to 00-00-2014	
4. TITLE AND SUBTITLE Assessment of the Acute Psychiatric Patient in the Emergency Department: Legal Cases and Caveats				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Madigan Army Medical Center, Department of Emergency Medicine,,Tacoma,,WA,98431				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited					
13. SUPPLEMENTARY NOTES Western Journal of Emergency Medicine,Volume XV, NO. 3 : May 2014					
14. ABSTRACT					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT Same as Report (SAR)	18. NUMBER OF PAGES 7	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

psychological evaluation to be performed by a licensed psychologist or a psychiatric consultation to be performed by a licensed psychiatrist.” The experts agreed that given Mrs. Brown’s psychotic state as identified by Dr. Crumpler, hospitalization was the proper course of action. Failing to do this, Dr. Crumpler negligently failed to prescribe appropriate antipsychotic medication.³

In the above case the EP correctly diagnosed a psychiatric problem and developed the appropriate plan for admission. However, subsequently he discharged the patient home (in contrast to his initial plan) and prescribed medications to treat an acute psychiatric condition. At trial, the court verified that this is really outside of the scope of practice of an EP. Assessment and diagnosis of acute psychiatric conditions is complicated and involves a multitude of specific criteria. Psychiatrists require multiple years of training to develop these special skills. EPs should always consult a psychologist or psychiatrist when managing patients with a new significant psychiatric condition. This may involve transferring the patient to a regional referral center. Implementation of a legal hold status may be required depending on local custom and state law. Some states allow a physician to unilaterally make this decision while others require an independent acute crisis team to make the assessment. Physically detaining the patient until his safe decision-making capacity is established has been clearly supported by the U.S. Supreme Court.⁴

Assessing for Medical Clearance in the Acute Psychiatric Presentation

Jackson v East Bay Hospital, et al. (2001) Robert Jackson visited the Lake County Mental Health Department to see a psychiatrist. He had a history of a psychotic disorder, borderline intellectual functioning, and pedophilia. Lake County instructed Mr. Jackson to obtain medical clearance from the Redbud Hospital ED prior to returning for psychiatric treatment.

At Redbud’s ED, Mr. Jackson presented with concerns of hallucinations, dizziness, and general unsteadiness. Dr. Schug evaluated Mr. Jackson and ordered several laboratory studies. Following this review and based largely on his examination, he diagnosed Mr. Jackson as suffering from acute psychosis.

No psychiatric care was provided at Redbud ED. Dr. Schug arranged for Lake County to follow up with Mr. Jackson as was intended originally. A Lake County employee evaluated him following his discharge.

Mr. Jackson returned to the Redbud ED 2 days later where he was evaluated by Dr. Miguel Ollada for concerns of a sore throat, pleuritic chest pain, and dry heaves. During the interview, it was recorded that Mr. Jackson was talking to himself. Dr. Ollada performed a complete physical exam and ordered a battery of tests (including an electrocardiogram, urine drug screen, and an arterial blood gas). The urine drug screen indicated that Mr. Jackson was taking his prescribed tricyclic antidepressant, Clomipramine. Following this evaluation, Mr.

Jackson was diagnosed with chest contusions, hypertension, and psychosis. Dr. Ollada requested a psychiatric evaluation by Lake County Mental Health, which refused because he had been evaluated recently and found to not be suicidal. Dr. Ollada released Mr. Jackson and instructed him to follow up with Lake County Mental Health in the morning.

Mr. Jackson returned to the Redbud ED within several hours after his wife found him wandering in the middle of the road. Dr. Ollada, who still was on duty, performed another assessment. Although he found Mr. Jackson to be very agitated, he denied any other physical symptoms and had a regular heartbeat. Mr. Jackson was given haloperidol and diphenhydramine. Dr. Ollada then contacted Lake County and advised them of Mr. Jackson’s condition.

Later that morning, a Lake County Mental Health crisis worker came to the ED and evaluated Mr. Jackson. The worker determined that he met criteria for inpatient involuntary psychiatric admission. Following Lake County’s recommendation, Dr. Ollada then medically cleared Mr. Jackson for transfer to East Bay Hospital, which functioned almost exclusively as a psychiatric hospital.

Mr. Jackson was transferred to East Bay Hospital where he was evaluated by a psychiatrist, Dr. Steele, who performed a psychiatric assessment but not a physical exam. Dr. Steele prescribed more haloperidol for Mr. Jackson. Later that day Mr. Jackson went into cardiac arrest and staff began to perform CPR. He was transported to Brookside Hospital where despite resuscitation efforts, he was pronounced dead. An autopsy determined that Mr. Jackson had died from a lethal cardiac arrhythmia caused by a toxic level of Clomipramine.

Mr. Jackson’s widow and daughter brought suit against the treating hospitals and physicians claiming EMTALA violations. The district court granted summary judgment for the defendant healthcare providers, and the family appealed. They also filed a state-based malpractice claim, the result of which is unknown.

In upholding the trial court’s grant of summary judgment the appellate court noted that a screening exam does not have to be medically adequate to satisfy the statutory requirement. Mr. Jackson was seen by a triage nurse during each of his visits and was assessed by a physician who performed a physical exam and ordered tests. Accordingly, the court held his screening was similar to other patients presenting to the defendant hospitals, which satisfies the statutory requirement. Additionally, because the hospitals never detected the drug toxicity, under EMTALA they cannot be held liable for failure to stabilize this condition prior to transfer. The statutory requirement only applies to medical conditions actually discovered prior to transfer.⁵

This case is an excellent example of the danger of missing the diagnosis of delirium. Multiple physicians overlooked the possibility of delirium and the probability of clomipramine toxicity. In a confused known psychiatric patient one must always consider medication-related medical issues (neuroleptic malignant syndrome, serotonin syndrome, anticholinergic

poisoning, tricyclic antidepressant poisoning, lithium poisoning, etc.).

The EP often provides “medical clearance” for the psychiatric or combative patient. It must be recognized that “medical clearance” is a misnomer and that on completion of the ED evaluation the patient is not “cleared” of all possible medical conditions.^{6,7} In one study by Tintinalli, 80% of patients documented as “medically clear” should have had a medical disease identified.⁸ In addition, there is no standard process of providing what may be more accurately termed a “focused medical assessment.”⁹ As no standard exists, we would recommend documenting that no acute organic cause of the patient’s current psychiatric illness has been identified at this time.

The incidence of organic disease in patients presenting with psychiatric complaints ranges from 24% to 63%.^{6,8,10,11} The more relevant issue for the EP is to detect medical problems that are causing or contributing to the patient’s agitated behavior. Misattribution of aberrant organic behavior in a patient with known psychiatric pathology is a common cause of litigation.¹²

Several historical features distinguish functional (psychiatric) from organic (medical) illness. Patients older than 40 years who have a new onset of psychiatric symptoms are more likely to have an organic cause.^{10,13} Also, elders are at higher risk for organic delirium due to medical illness or adverse reactions to medications. Patients with a history of drug or ethanol abuse may exhibit violent behavior as a manifestation of an intoxication or withdrawal syndrome. The acute onset of agitated behavior, as well as behavior that waxes and wanes over short periods of time, hours to days, suggests an organic origin. Most psychiatric patients are alert and oriented and have an established psychiatric diagnosis.

Patients with persistently abnormal vital signs, a clouding of consciousness, or focal neurologic findings are more likely to suffer from organic disease and require further diagnostic evaluation. Agitated behavior often occurs in association with head trauma, hypoxia, hypoglycemia, electrolyte imbalance, infections (particularly herpes encephalitis), drug intoxication or withdrawal or adverse reaction, and metabolic and endocrine derangements.^{14,15} In the ED setting, drug and ethanol intoxication or withdrawal are the most common diagnoses in combative patients.^{16,17}

Diagnostic studies should be guided by the information obtained from the history and physical examination. Although some authors advocate a standardized panel of laboratory and radiographic studies for patients with psychiatric symptoms, most recommend tailoring diagnostic studies based on clinical findings.^{6,9,10,18,19,20,21}

A rapid blood glucose determination and pulse oximetry should be obtained on all acute psychiatric patients. Patients younger than 40 years of age with a prior psychiatric history, a normal physical exam including vital signs, a calm demeanor,

normal orientation, and no physical complaints likely require no further diagnostic testing.¹⁹ Additional studies that may be useful in selected patients include serum electrolytes, blood and urine toxicology screening, serum ethanol, thyroid screening test if emergently available, and cranial imaging.^{10,15,22,23} Specific medication levels may be determined when toxic levels would affect therapy. An ECG may be useful in elders and in the setting of a suggested intentional ingestion such as tricyclic antidepressant overdose. Patients who may have intentionally ingested a toxic substance should also have an acetaminophen level measurement, as this potentially fatal ingestion may be difficult to diagnose clinically and has an effective treatment.

An additional consideration in the diagnostic workup must be the concerns of the psychiatrist who will ultimately evaluate the patient. Although serum ethanol and toxicology screening may not significantly influence a patient’s ED treatment, the psychiatrist may use them to assess the degree to which ethanol or drug use contributes to the patient’s behavioral issues.^{10,24,25,26} Ideally, an agreement on a diagnostic strategy should be reached between the psychiatrist and EP prior to referral. Unnecessary diagnostic testing may prolong ED length of stay thereby delaying definitive psychiatric care. Once the medical screening evaluation is completed the findings should be communicated to the consulting psychiatrist. The medical record should reflect that the evaluation showed no evidence that an acute medical condition caused or contributed to the patient’s behavior. If the cause of the patient’s violent behavior is drug or ethanol intoxication, the patient should be observed until he has reached the point where a therapeutic interview can be conducted by the psychiatrist. Alternatively, the patient may be transported to a facility where observation can occur until the effects of the intoxicants have abated. Rather than declaring the patient “medically clear,” the EP should clearly document his or her findings and recommendations to the consulting psychiatrist.

Assessment of Suicide Risk

In *Estate of Elizabeth Kitchen v. Michael Dargay, D.O., et al* (2005), a 45-year-old woman was transported by ambulance after attempting to overdose on alprazolam and hydrocodone/acetaminophen. She claimed that the acute trigger for this event was a breakup with a boyfriend. In the ED the patient allegedly endorsed wanting to end her life to a nurse but then denied the same to both Dr. Dargay and the social worker that Dr. Dargay consulted. The patient was discharged. The next morning the patient threatened suicide to her adult daughter, who took no action. Later in the day, the patient was found by her minor son after she had hung herself. The plaintiff brought suit and claimed that the patient should have been admitted involuntarily. The defendant argued that the patient had denied any suicidal thoughts both to him and the social worker, and therefore discharge was reasonable. The defendant also argued that suicide may have been prevented if emergency services had

been called by the family on the day of the patient's death after she had threatened suicide. The jury rendered a verdict for the defense.²⁷

In *Garcia v. Lifemark Hospitals of Florida*, (1999) Ramon Garcia was evaluated twice in the same ED by 2 different EPs. His first visit was for an overdose of over-the-counter pain medications. As Mr. Garcia had recently had orthopedic surgery, he was diagnosed with a non-life-threatening accidental overdose and discharged home. Two days later Mr. Garcia crashed his car into a concrete dividing wall and was transported to the ED. During his work-up, Mr. Garcia requested to be released against medical advice. After he signed the appropriate AMA paperwork, he left the ED and returned home. He killed himself shortly thereafter. Mr. Garcia's family members argued to the court that the ED physicians should have recognized and treated Mr. Garcia's psychiatric ailments in addition to his overdose and traumatic injuries. The court found that the EP's duty is to treat the emergent condition that brought the patient to the hospital and that expecting ED physicians to discover every one of a patient's conditions was like trying to "contend that there is a duty for an [ophthalmologist] to diagnose and treat the patient for hemorrhoids." The court stated that the "outward manifestations of infectious diseases lend themselves to accurate and reliable diagnoses . . . [however] the internal working of the human mind remain largely mysterious." As such, the verdict was for the defense.²⁸

The above cases illustrate both the difficulty of recognizing suicidal tendencies and in establishing an accurate assessment of suicidal risk.²⁹ EPs have been shown to be more likely to assess a patient's risk for repeat self-injurious behavior as high.³⁰ However, there have been no well-established risk assessment tools validated for use by medical professionals.³¹ Kaplan and Sadock's *Comprehensive Textbook of Psychiatry* agrees that "there are no psychological scales or tests that ensure prediction" of suicide.³² Commonly used scoring systems, including the modified SAD PERSONS score, are inadequate to replace clinical judgement.³³ Additionally, recent research shows that EPs are adept at identifying patients who are at low risk for suicide but identification of those at high risk remains elusive.³⁴

The modified SAD PERSONS score is easy to remember but can be cumbersome to use as different points are assigned to the elements of the scoring system (Table). With a sensitivity of 94% and a specificity of 71%, patients with a score of 5 or less and probably safe for discharge home with follow up and those individuals with a score of 6 or higher are likely in need of hospitalization.³⁵

These few cases represent the majority of court rulings. The court recognizes that the assessing physician must rely on the history that the patient relays and that predicting future actions and unvoiced thoughts by a patient are near-impossible expectations. To assist with determining risk of suicide, the

physician should also review nursing notes and collateral information from the patient's family. When a physician has made a thorough and good faith evaluation of a potentially suicidal patient, the fact that ensuing suicide is completed, does not often expose them to a plaintiff verdict.

When Assessment and/or Disposition Are Not Completed

In *Jenkins v Evangelical Hospitals Corp.*, (2002) an adult male, George Jenkins, was evaluated at Christ Hospital after being discovered lying face down in a muddy puddle with his clothes partially removed and blood staining his underwear. While being evaluated in the ED, Mr. Jinkin's family reported that he had been intentionally walking in front of cars and talking about death, in addition to describing several examples of paranoid behavior. Notable in his evaluation were a blood alcohol level (BAL) of 0.203% and a positive urine screen for marijuana. The EP and social worker completed initial paperwork for involuntary psychiatric hospitalization. The patient was boarded in the ED while his BAL decreased and the patient was subsequently transferred to an outside psychiatric facility. A board-certified psychiatrist and a licensed professional counselor each interviewed the patient and his family. Mr. Jenkins and his family recanted their suicidal histories, and Mr. Jenkins was discharged with outpatient follow up for an alcohol-related disorder. Once he got home that evening, Mr. Jenkins shot himself in the head and died. Mr. Jenkins's widow sued the EP and the Christ Hospital ED claiming that their care was negligent in so far that the transfer to the psychiatric hospital was the proximate cause of Mr. Jenkins's death. The court found that the interview and the ensuing release of Mr. Jenkins was an intervening event and subsequently absolved the defendants of liability.³⁶

Another illustrative case is *Harvey v William Naber, M.D.*, et al. (2008). In this case, a 30-year-old female presented with her parents to the ED for evaluation of a psychiatric emergency. A nurse evaluated the patient and then called Dr. Naber into the bedside after the nurse was unable to determine whether the patient was suicidal. During Dr. Naber's evaluation he was called out of the room for a phone call. Court records indicate that Ms. Harvey believed she was discharged and left the room. She ran into the hospital garage with hospital personnel in chase. She either jumped or fell off an upper story of the parking garage and subsequently died. Plaintiff claims included negligence in so far that hospital staff failed to definitively determine that the patient was suicidal, that the parking garage was a dangerous design, and that hospital personnel giving chase were not trained security guards. Claims against Dr. Nader were for negligence because he allegedly failed to complete his evaluation and rule out suicidal tendencies before leaving the room. Dr. Nader argued that the patient did not appear immediately suicidal and that he had a duty to take the interrupting phone call. The verdict in this case was for the defense.³⁷

These 2 cases are reassuring to the EP and represent the

Table. The modified SAD PERSONS score.

Letter	Meaning	Number of points assigned
S	Sex: male	1
A	Age: < 19 or > 45 years	1
D	Depression or hopelessness	2
P	Previous attempts or psychiatric care	1
E	Excessive alcohol or drug use	1
R	Rational thinking loss	2
S	Separated/divorced/widowed	1
O	Organized or serious attempt	2
N	No social supports	1
S	Stated future intent	2

general trend. When suicidal patients escape, are unable to be assessed before departure, or have a disposition changed by others, the EP is not usually held liable.

DISCUSSION

We have reported several legal cases that illustrate pitfalls and general trends in assessing the acute psychiatric patient in the ED. It is clear in the literature that assessment of this population is difficult and fraught with error. EPs should have a low threshold for obtaining psychiatric specialty consultation, especially in new-onset disease.

The ED is universally used to provide medical clearance for psychiatric patients. The physician should have a systematic approach and a broad differential diagnosis when a behavioral emergency presents. Agitated behavior often occurs in association with head trauma, hypoxia, hypoglycemia, electrolyte imbalance, infections (particularly herpes encephalitis), drug intoxication or withdrawal or adverse reaction, and metabolic and endocrine derangements. The absence of these should be insured before psychiatric disposition occurs.

In assessing the risk of suicide, the courts have been lenient and sympathetic in recognizing the difficulty of predicting future suicide. It is imperative to gather as much history from the patient, family, authorities, and records, as well as optimally interview the patient. EPs should have comfort in realizing that after a good evaluation, they will not likely be held liable for a successful suicidal outcome.

Likewise, EPs often fear that a patient escape, or discharge from a subsequent facility, will expose them to liability. In the majority of cases, the hospital via the nursing staff is responsible for monitoring and prevention of escape, as well as successful transport to another facility if transfer occurs.

CONCLUSION

We have provided several court cases that illustrate general trends, pitfalls, and caveats when assessing the acute

psychiatric patient. Being aware of these will decrease exposure to liability when assessing this patient population that frequently presents to the ED.

Address for Correspondence: Benjamin Good, MD. Madigan Army Medical Center, Department of Emergency Medicine, 9040 Fitzsimmons Drive, Tacoma, WA 98431. Email: begood@gwmail.gwu.edu.

Conflicts of Interest: By the WestJEM article submission agreement, all authors are required to disclose all affiliations, funding sources and financial or management relationships that could be perceived as potential sources of bias. The views expressed herein are solely those of the authors and do not represent the official views of the Department of Defense or Army Medical Department. The authors disclosed none.

REFERENCES

1. van Os J, Hanssen M, Bijl RV, et al. Prevalence of psychotic disorder and community level of psychosis symptoms: an urban-rural comparison. *Arch Gen Psychiatry*. 2001;58(7):663–668.
2. Perälä J, Suvisaari J, Saarni SI, et al. Lifetime prevalence of psychotic and bipolar I disorders in a general population. *Arch Gen Psychiatry*. 2007;64(1):19–28.
3. *Brown v. Carolina Emergency Physicians*, P.A., 560 S.E.2d 624 (2001).
4. *Youngberg v. Romero*, Supreme Court, Case No. 80–1429 (1982).
5. *Jackson v. East Bay Hospital et al.*, 246 F.3d 1248 (9th Cir. 2001).
6. Henneman PL, Mendoza R, Lewis RJ. Prospective evaluation of emergency department medical clearance. *Ann Emerg Med*. 1994; 24(4):672–677.
7. Dubin WR, Weiss KJ, Zeccardi JA. Organic brain syndrome: The psychiatric imposter. *JAMA*. 1993;269(1):60–62.
8. Tintinalli JE, Peacock FW, Wright MA. Emergency medical evaluation of psychiatric inpatients. *Ann Emerg Med*. 1994;23(4):859–862.
9. Lukens TW, Wolf SJ, Edlow JA, et al. Clinical policy: Critical issues in the

- diagnosis and management of the adult psychiatric patient in the emergency department. *Ann Emerg Med.* 2006;47(1):79–99.
10. Williams ER, Shepherd SM. Medical clearance of psychiatric patients. *Emerg Med Clin North Am.* 2000;18(2):185–198.
 11. Hall RC, Gardner ER, Stickney SK, et al. Physical illness manifesting as psychiatric disease: Analysis of a state hospital inpatient population. *Arch Gen Psychiatry.* 1980;37(9):989–995.
 12. *Estate of Reverend Ronel Huggins v Eastern Health Care.* Medical Malpractice: Verdicts, Settlements, and Experts 2006; 22:24.
 13. Reeves RR, Pendarvis EJ, Kimble R. Unrecognized medical emergencies admitted to psychiatric units. *Am J Emerg Med.* 2000; 18(4):390–393.
 14. Tardiff K. The current state of psychiatry in the treatment of violent patients. *Arch Gen Psychiatry.* 1992;49(6):493–499.
 15. Rice MM, Moore GP. Management of the violent patient: Therapeutic and legal considerations. *Emerg Med Clin North Am.* 1991;9(1):13–30.
 16. Dubin WR, Weiss KJ. *Emergency psychiatry.* In: Michels R, Cavenar JD, Cooper AM, et al, ed: *Psychiatry.* Philadelphia: Lippincott-Raven; 1997:1–15.
 17. Lavoie FW. Consent, involuntary treatment, and the use of force in an urban emergency department. *Ann Emerg Med.* 1992;21(1):25–32.
 18. Herbert M. Assessment for medical clearance. *Ann Emerg Med.* 1995; 25(6):852.
 19. Korn CS, Currier GW, Henderson SO. “Medical clearance” of psychiatric patients without medical complaints in the emergency department. *J Emerg Med.* 2000;18(2):173–176.
 20. Olshaker JS, Browne B, Jerrard DA, et al. Medical clearance and screening of psychiatric patients in the emergency department. *Acad Emerg Med.* 1997;4(2):124–128.
 21. Janiak BD, Atteberry S. Medical clearance of the psychiatric patient in the emergency department. *J Emerg Med.* 2012;43(5):866–870.
 22. Tardiff K. *Diagnosis and management of violent patients.* In: Michels R, Cavenar JD, Cooper AM, et al, ed: *Psychiatry.* Philadelphia: Lippincott-Raven; 1997:1–17.
 23. Tardiff K. Unusual diagnoses among violent patients. *Psychiatric Clin North Am.* 1998;21(3):567–576.
 24. Rice MM, Moore GP. Management of the violent patient: Therapeutic and legal considerations. *Emerg Med Clin North Am.* 1991;9(1):13–30.
 25. Allen MH, Currier GW. Medical assessment in the psychiatric emergency service. *New Dir Ment Health Serv.* 1999;82:21–28.
 26. Tenenbein M. Do you really need that emergency drug screen? *Clin Toxicol (Phila).* 2009;47(4):286–291.
 27. *Estate of Elizabeth Kitchen v. Michael Dargay, DO, et al., Wayne County (MI) Circuit Court, Case No. 05-524387-NH.*
 28. *Garcia v Lifemark Hospitals of Florida, FL District Court of Appeal, Case No. 99-77., October 20, 1999.*
 29. Zun LS. Pitfalls in the care of the psychiatric patient in the emergency department. *J Emerg Med.* 2012;43(5):829–835.
 30. Kapur N, Cooper J, Rodway C, et al. Predicting the risk of repetition after self harm: cohort study. *BMJ.* 2005;330(7488):394–395.
 31. Bolton JM, Spiwak R, Sareen J. Predicting suicide attempts with the SAD PERSONS scale: a longitudinal analysis. *J Clin Psychiatry.* 2012; 73(6):e735–741.
 32. Sadock BJ, Sadock VA, Ruiz P, et al. Kaplan and Sadock’s Comprehensive Textbook of Psychiatry. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, c2009.; 2009.
 33. Bolton JM, Spiwak R, Sareen J. Predicting suicide attempts with the SAD PERSONS scale: a longitudinal analysis. *J Clin Psychiatry.* 2012; 73(6):e735–741.
 34. Ronquillo L, Minassian A, Vilke GM, et al. Literature-based recommendations for suicide assessment in the emergency department: a review. *J Emerg Med.* 2012;43(5):836–842.
 35. Hockberger RS, Rothstein RJ. Assessment of suicide potential by nonpsychiatrists using the SAD PERSONS score. *J Emerg Med.* 1988; 6(2):99–107.
 36. *Jenkins v. Evangelical Hospitals Corporation, 783 N.E.2d 123 (2002)*
 37. *Robert Harvey and Ruby Harvey, indiv. and as co-admins. Of the Estate of Brandi Harvey v. The Christ Hospital, William Naber, M.D., et al, Hamilton County, (OH) Court of Common Pleas, Case No. A0809228.*