

**Emergency Department
Treatment of the
Psychiatric Patient:
Policy Issues and Legal
Requirements**

Susan stefan

OXFORD UNIVERSITY PRESS

**Emergency Department Treatment
of the Psychiatric Patient**

American Psychology-Law Society Series

Series Editor

Ronald Roesch

Editorial Board

Gail S. Goodman

Thomas Grisso

Craig Haney

Kirk Heilbrun

John Monahan

Marlene Moretti

Edward P. Mulvey

J. Don Read

N. Dickon Reppucci

Gary L. Wells

Lawrence S. Wrightsman

Patricia A. Zapf

Books in the Series

Death by Design: Capital Punishment as a Social Psychological System

Craig Haney

Trial Consulting

Amy J. Posey and Lawrence S. Wrightsman

Psychological Injuries: Forensic Assessment, Treatment, and Law

William J. Koch, Kevin S. Douglas, Tonia L. Nicholls, and

Melanie L. O'Neill

*Emergency Department Treatment of the Psychiatric Patient: Policy Issues
and Legal Requirements*

Susan Stefan

Emergency Department Treatment of the Psychiatric Patient

Policy Issues and Legal Requirements

Susan Stefan

OXFORD
UNIVERSITY PRESS

2006

OXFORD

UNIVERSITY PRESS

Oxford University Press, Inc., publishes works that further
Oxford University's objective of excellence
in research, scholarship, and education.

Oxford New York

Auckland Cape Town Dar es Salaam Hong Kong Karachi
Kuala Lumpur Madrid Melbourne Mexico City Nairobi
New Delhi Shanghai Taipei Toronto

With offices in

Argentina Austria Brazil Chile Czech Republic France Greece
Guatemala Hungary Italy Japan Poland Portugal Singapore
South Korea Switzerland Thailand Turkey Ukraine Vietnam

Copyright © 2006 by Oxford University Press, Inc.

Published by Oxford University Press, Inc.
198 Madison Avenue, New York, New York 10016

www.oup.com

Oxford is a registered trademark of Oxford University Press

All rights reserved. No part of this publication may be reproduced,
stored in a retrieval system, or transmitted, in any form or by any means,
electronic, mechanical, photocopying, recording, or otherwise,
without the prior permission of Oxford University Press.

Library of Congress Cataloging-in-Publication Data
Stefan, Susan.

Emergency department treatment of the psychiatric patient : policy issues
and legal requirements / Susan Stefan.

p. cm.—(American Psychology-Law Society series)

ISBN-13: 978-0-19-518929-2

ISBN-10: 0-19-518929-9

1. Psychiatric emergencies. 2. Hospitals—Emergency service. 3. Crisis intervention
(Mental health services). 4. Mental health laws—United States. I. Title II. Series.
[DNLM: 1. Emergency Services, Psychiatric—legislation & jurisprudence—United States.
2. Emergency Service, Hospital—standards—United States. 3. Mentally Disabled Persons—United States.
4. Patient Rights—United States. 5. Attitude of Health Personnel—United States. 6. Quality of Health
Care—standards—United States. WM 33 AA1 S816e 2006]

RC480.5.S667 2006

362.2'2—dc22 2005020674

9 8 7 6 5 4 3 2 1

Printed in the United States of America
on acid-free paper

To my crisis intervention team, my respite services, my experts in de-escalation, and my providers of shelter, refuge, and support in the community—otherwise known as

*my mother, Gabrielle Stefan
my husband, Wes Daniels
and my best friend, Jamie Elmer*

This page intentionally left blank

Series Foreword

Ronald Roesch, Series Editor

This book series is sponsored by the American Psychology-Law Society (APLS). APLS is an interdisciplinary organization devoted to scholarship, practice, and public service in psychology and law. Its goals include advancing the contributions of psychology to the understanding of law and legal institutions through basic and applied research; promoting the education of psychologists in matters of law and the education of legal personnel in matters of psychology; and informing the psychological and legal communities and the general public of current research, educational, and service activities in the field of psychology and law. APLS membership includes psychologists from the academic research and clinical practice communities as well as members of the legal community. Research and practice is represented in both the civil and criminal legal arenas. APLS has chosen Oxford University Press as a strategic partner because of its commitment to scholarship, quality, and the international dissemination of ideas. These strengths will help APLS reach our goal of educating the psychology and legal professions and the general public about important developments in psychology and law. The focus of the book series reflects the diversity of the field of psychology and law as we will publish books on a broad range of topics.

Susan Stefan's book focuses on an increasingly important problem that has in part resulted from the changes that have taken place in the mental health system in the past several decades. Although the reorientation of mental health treatment from the institution to the community is a welcome change, it has thrust upon emergency departments a variety of roles for which they are ill-suited. Emergency department staff members now often

serve as the gate-keepers for inpatient beds, the crisis management providers that most communities still lack, and the basic health care safety net when Medicaid budgets are trimmed or doctors' schedules are too busy. For many people with serious psychiatric disabilities—and, even more importantly, for care providers, police, and family members—emergency departments are the solution when the health care system is inadequate, too complex to navigate, or has refused requests for assistance. Thus, hospital emergency departments become the answer to a wide range of problems they were never intended to solve.

How have emergency departments dealt with these changes? Stefan provides a critical analysis of the problems faced in emergency rooms, from the perspective of both emergency department patients and the professionals who treat them. She also examines statutory and case law, which provides the context for both the current situation as well as the changes that need to be made if we are to improve the quality of care of persons in the community who experience mental health problems. Overall, she finds that those labeled as “psychiatric patients” are all too often treated by emergency room personnel with impatience and even hostility. Stefan concludes the book with a clear set of recommendations for changing the manner in which emergency departments deal with patients who have mental health problems. Importantly, she also discusses community-based alternatives to emergency rooms for those with mental health problems, such as family foster homes, crisis hostels, mobile treatment units, and home companion programs.

Preface

This book began with the tears of devastated women as they told me about their experiences in emergency departments (EDs). These women lived in different states, in large cities, small towns, and rural areas. They had gone to EDs for help with depression, anxiety, or other serious psychiatric problems and were told they had to take off all their clothes. Many of these women had harrowing histories of childhood sexual abuse and were terrified. Others didn't understand why seeking help for a psychiatric crisis meant they had to take their clothes off. Some who initially refused to remove their clothing were held down and stripped by security guards and restrained by their wrists and ankles to the gurney if they struggled. By the time they had been at the ED for a few hours, they were in much worse emotional condition than when they arrived. Some of these women just wanted to tell their stories. Others wanted to fight back, but they had no idea what remedies were available to them. Indeed, there was no book, Web site, or other resource to which I could refer them.

I spoke to ED nurses, clinicians, and administrators about these complaints and others relating to the treatment of people with psychiatric disabilities. While some ED staff were defensive and hostile, most were genuinely troubled by what they perceived to be irresolvable conflicts between safety concerns, liability issues, time constraints, crowded spaces, and the needs of people in psychiatric crisis for time, comfort, listening, and caring. They, too, had questions about how to achieve better practices within inevitable constraints inherent in ED practice.

I did extensive research and found few uniform practices or standards

on how to treat people with psychiatric disabilities in ED settings. The American Psychiatric Association Task Force on Psychiatric Emergency Services (2002) and the Consensus Guidelines on Treatment of Behavioral Emergencies (2001) contain recommendations that are helpful in the subject areas that are covered. However, neither addressed in depth the kinds of issues I was hearing from clients and ED staff. Nor were there any works summarizing the vast array of federal and state legal and regulatory standards that patients could invoke to seek relief or explaining the ways patients could advocate for themselves. Finally, there was little analysis of why these problems, which are so pervasive, are so generally ignored by policymakers. The analysis presented in this book suggests an explanation for the depth of the problems, their seeming intractability, and the vast silence from politicians and policymakers addressing health care and mental health issues.

Although I am a lawyer, the more I studied the issues, the less that I believed that litigation would provide the necessary solutions, except in the most egregious cases. Rather, working out new approaches for ED treatment of people with psychiatric disabilities requires an arduous process of dialogue and discussion between *all* the parties—the people who receive the services and ED professionals, of course, but also representatives of the public mental health system, managed care, accreditation bodies, the research community, Medicaid administrators, and those who have developed community crisis treatment alternatives.

I persuaded the Center for Public Representation, where I work, to focus on ED treatment of psychiatric patients as a major systemic initiative and to seek funding to work on developing these new approaches. The first step was to compile and analyze the research and case law on the standards governing the treatment of people with psychiatric disabilities in ED settings. Where there were no standards or significant disagreement, we assembled a group of experts representing the communities described above, and they assisted us in developing solutions and standards that were sensitive to the concerns and interests of all involved parties.

The Ittleson Foundation and the van Ameringen Foundation generously funded the project. This book and the recommendations appearing in its appendix represent these first two steps. But this book also reflects my conclusion that to focus solely on ED treatment of people with psychiatric disabilities is to miss an important larger picture. This picture includes more appropriate and less expensive crisis treatment alternatives, which are described in this book. It also includes a socio-legal analysis of the source of the problems and the larger solution to them. While some people with psychiatric disabilities blame EDs for the pain and damage they suffer, and some ED staff have little patience for the people they see repeatedly and can't seem to help, the policymakers whose problems are solved by this arrangement are not held accountable.

Emergency departments and their staff share some of the attributes of people with psychiatric disabilities they see—they go from crisis to crisis,

with insufficient structural support and very little public understanding of the pressures they face. They inhabit a culture that few outsiders can comprehend. For many, the fact that they continue to function at all is heroic under the circumstances they face. Most of all, they are expected to shoulder the burdens of the unraveling public mental health care system, ever-diminishing Medicaid coverage and reimbursement, and inadequate or non-existent community crisis care services.

This book is about a major focal point of the health care crisis in this country. It offers solutions, from the concrete and mundane to more aspirational and systemic. If nothing else, it may serve as the springboard for a social policy conversation that should have started years ago.

This page intentionally left blank

Acknowledgments

This book was researched and written with the generous assistance of grants from the Ittelson Foundation and the van Ameringen Foundation. Anthony Wood of the Ittelson Foundation in particular was willing to fund the start-up costs of the Center for Public Representation's Emergency Department Project. Without him, this book would not exist.

The Center for Public Representation was also fortunate enough to attract an outstanding advisory council from across the nation for the Emergency Department Project. The members of the advisory council are Dr. Robert Factor, director of the Emergency Services Unit of the Mental Health Center of Dane County, who also provides emergency psychiatric services for the Veteran's Administration; Dr. Robert Glover, executive director of the National Association of State Mental Health Program Directors; Dr. Edward Knight, vice president for recovery, rehabilitation and mutual support of Value Options and Adjunct Professor, Rehabilitation Sciences, Boston University; J. Rock Johnson, J.D., of the National Association of Protection and Advocacy Systems; Dr. Charles Lidz, director of the Center for Mental Health Services Research, University of Massachusetts Medical School; Steven Miccio, executive director of PEOPLE, Inc., in Poughkeepsie, New York; and Dr. Robert Okin, chief of psychiatry at San Francisco General Hospital. The council was very much involved in developing the proposed standards and recommendations at the end of this book. They also read much of this book in draft and gave helpful comments. Opinions and conclusions expressed in the text of the book are my own.

I was also fortunate to receive outstanding research support from Kerry Kotar of Suffolk University Law School for two years, from Amy Cyphert

of Harvard Law School for two years, and from Satyanand Satyanarayana of Harvard Law School for a semester. My colleagues at the Center for Public Representation, including Joy Bergman, Marcia Boundy, Bob Fleischer, Pam Long, and Steven Schwartz, devoted a great deal of time and energy to ensure the success of the Emergency Department Project, and I thank them for their continuing support. Amy Gunderson has been an extremely helpful and efficient secretary; this manuscript would never have made it out of the office without her assistance.

Scores of people have patiently given me the benefit of their first-hand experiences from working in and around emergency departments. There is insufficient space to thank them all here, but I would remiss not to particularly thank Nan Stromberg, Kathy Coughlin, and Michael Weeks of the Massachusetts Department of Mental Health Licensing Division; Dr. Anna Fitzgerald of Boston Medical Center; Dr. Robert Factor of the Mental Health Center of Dane County, Wisconsin; Amy Gremillion, R.N., of Austin, Texas; Deborah Provost and Ann Maynard, R.N., the director and nurse manager, respectively, of the Emergency Department at Baystate Medical Center in Springfield, Massachusetts; Beckie Child, of Choices for Change in Portland, Oregon; Maryann Spicer, Director of Corporate Compliance at Massachusetts General Hospital; Dr. Joel Dvoskin, Tucson, Arizona; and Russell Colling, Colling and Kramer Security Consultants, in Salida, Colorado.

Hundreds of people with psychiatric disabilities who received services in emergency departments were generous enough to fill out surveys, correspond with me, and speak to me regarding their experiences in emergency departments. Many of these people told me about experiences that have haunted and damaged them; their courage, humor, and resilience humbles me. For the most part, they have asked to remain anonymous, but some, like Cyndi McKnight and Louisa Smith, gave me permission to use their names, while others, like Linda Stalker, asked that their names be used, and I have gladly done so.

I also thank the dedicated attorneys and advocates with protection and advocacy agencies who shared with me insights from the work they have done to protect the rights of people with psychiatric disabilities in emergency department and crisis settings: Bill Brooks and Cliff Zucker in New York, Mark Joyce in Maine, Beth Mitchell in Texas, Kathy Wilde in Oregon, Patrick Washburn in Ohio, Laura Cain in Maryland, Emmett Dwyer in New Jersey, and Nancy Alisberg in Connecticut. I thank them for their assistance and for the work that they continue to do.

I have had a tremendously good experience with Oxford University Press. Heartfelt thanks to Dr. Ron Roesch for helpful edits and the benefit of his expertise, and to Joe Zito, Norman Hirschy, Cristina Wojdylo, and Keith Faivre for prompt, responsive, and professional assistance with my many questions.

Thanks to Laura Ziegler, Kermit Brown, Tom Behrendt, Ira Burnim, Adrienne Stefan, and Susan Mann for their love, support, wisdom, and their never-ending willingness to help me in moments of need.

Contents

Series Foreword xii

1 Introduction 3

2 Overview of Emergency Services for People with Psychiatric Disabilities 11

3 Patients' Problems in Emergency Department Care 33

4 Professional Issues in Emergency Department Care 59

5 Legal Rights and Standards in Emergency Department Treatment of People with Psychiatric Disabilities 79

6 Solutions to Problems in Emergency Department Treatment of People with Psychiatric Disabilities 113

7 Conclusion 141

Appendix A Emergency Department Treatment of People with Psychiatric Disabilities: Findings and Proposed Standards 149

Notes 171

Index 207

This page intentionally left blank

**Emergency Department Treatment
of the Psychiatric Patient**

This page intentionally left blank

1

Introduction

I am feeling very traumatized because of a situation that happened at Baystate Emergency Room last Wednesday night. I was forced by police to go to the ER after I had gotten very flustered with PCS [crisis services] and hung up on them and they chose to call the police to do a check on me. The police came to my apartment and gave me the choice of going “voluntarily” or getting section 12ed [involuntarily detained]. Since I am terrified to end up in any hospital in this area I cooperated and went along peacefully. I was totally angry as I had already had a very bad day and at that point I just wanted to take my meds and go to bed.

When I arrived at the ER no one was paying attention so I spent about 15–20 minutes outside smoking figuring they would sooner or later catch up to me. I was eventually asked to come inside so I did and curled up on a stretcher as I was feeling totally overwhelmed and couldn’t respond to anyone. That is when the trouble began. I was told to take my clothes off and get into a johnnie. When I didn’t respond I was then wheeled into a small room and surrounded by several people both male and female and was forcibly undressed down to my underwear. I was pinned down and the orderly who had my arm held down was twisting so tight that I felt like he was going to break it. I begged him to release it but every time I moved he twisted it tighter. They put me into restraints and left me. To add insult to injury I was call-

ing out a friend of mine's name to help calm me down and heard the hospital staff out in the hallway mocking me . . .

As a former trauma survivor this has had serious psychological effects on me. My sense of safety has been shattered . . . I am relating this to you because this is not an isolated case. So many consumers have horror stories of how they have been treated at emergency rooms yet the abuse is still continuing . . . Meanwhile I have no trust in ever getting help if I am in a crisis. The thought of ever ending up at the ER even for medical reasons absolutely terrifies me and no longer can I trust [crisis services] . . .

Linda Stalker

Northampton, Massachusetts (2001)¹

This letter eloquently summarizes many common complaints that people with psychiatric disabilities have about their treatment when they are in crisis. They are unnecessarily and coercively taken to emergency departments (EDs) or hospitalized, often as a result of reaching out for help to crisis services or hotlines. Once at the ED, they may be ignored in the waiting area or left unattended on a gurney for hours. This may be because the ED is overcrowded and rushed. However, research discussed later in this book also confirms that emergency staff sometimes ignore psychiatric patients to “punish” them for coming in too often. People who present with psychiatric emergencies report being locked in small, bare rooms with no toilet and no knowledge of when the door might be unlocked—and these are people who were in emotional crisis in the first place. As was the case with Linda Stalker, sometimes people in psychiatric crisis are ordered to remove their clothing. If they resist, they may be forcibly stripped of their clothing by security guards. Many who bang on the locked doors or resist efforts to disrobe them are restrained with four-point leather restraints by security guards. People with psychiatric disabilities may be treated impatiently or roughly, without regard for how this treatment might affect an already fragile, vulnerable person. This is the experience of thousands and thousands of people with psychiatric disabilities, who view EDs with bitterness and distrust.

These experiences, of course, take place in a context. It is the context of EDs which are themselves in crisis, under pressure, and facing impossible demands with no end in sight. Many EDs are overcrowded, underfunded, and facing increasing staff shortages and a dwindling availability of hospital beds. Increasing ambulance diversions, as well as the ever-present threat of manmade or natural disasters, threaten to overwhelm an already teetering system. The shortage of nurses impacts EDs both in terms of staffing and in creating barriers to admitting patients to hospitals, which often have available beds but cannot accept patients because they do not have sufficient nurses available to provide safe care.

In this potent mix, the serious problems faced by people with psychiatric disabilities who seek treatment in EDs are often lost or obscured. Some of

the problems that people with psychiatric disabilities encounter in EDs reflect common complaints: long delays, lack of inpatient beds or community follow up, and refusals by insurance or managed care to approve treatment. There is reason to suspect that people with psychiatric disabilities experience the worst of these common complaints: longer delays, fewer inpatient beds, sparser community resources and more denials of care by insurance companies.²

The good news is that some EDs rise to these challenges, genuinely seeking to improve the care they provide people with psychiatric disabilities. In fact, the ED staff at Baystate Medical Center, the hospital where Linda Stalker experienced the conditions described above, chose to embark on an ambitious program to improve ED care for people with psychiatric disabilities—a program whose successes have been published in *The Journal of Emergency Nursing* and presented around the country. They did this without additional funding or litigation. The story of the crafting of solutions by Baystate and other hospitals like it is as much a part of this book as the story of the people in great psychiatric distress who continue to be hurt unnecessarily by ED staff who are themselves stressed to the limits of their own endurance, and who do not understand (often because they have not been told) the harm that they are doing.

This book will analyze the treatment of people with psychiatric disabilities in ED settings through a number of lenses:

- federal and state legal and regulatory standards,
- case law,
- research literature (abundant in some areas and strikingly sparse in others),
- standards for treatment and practice proposed by a variety of professional groups, and
- people with psychiatric disabilities and the ED staff who serve them.

These voices have been gathered from survey responses by people with psychiatric disabilities and ED staff, as well as from a number of personal interviews. These interviews took place with authors of articles in the ED literature, following up information presented in the articles, or as follow ups to survey responses, when the respondents indicated that they did not mind further contact. The interview with Linda Stalker generated the interviews with the Baystate staff involved in responding to her situation.

The second chapter of this book presents the context of ED treatment of people with psychiatric disabilities, discussing the place of the ED in the hospital structure and in the mental health system. In addition, information about patterns of usage of EDs is presented, along with a description of the ways in which visits to the ED by people with known psychiatric disabilities are fundamentally different from visits by people who either do not have psychiatric disabilities or whose diagnoses are unknown to the ED staff. Myths about unnecessary use of EDs by uninsured people are debunked, as

are assumptions about the frequency and subject matter of litigation against EDs on behalf of people with psychiatric disabilities.

Chapter 3 summarizes the principal complaints that people with psychiatric disabilities voice about their treatment in EDs. The majority of problems experienced in EDs by people with psychiatric disabilities are unique and are not shared by other ED patients. First, a level of force and coercion is directed at psychiatric patients in EDs that is not generally experienced by medical patients. The force and coercion arise in large part from the ED's duty to examine and detain patients who are believed to be dangerous to themselves or others as a result of mental illness. Emergency departments often involuntarily detain people who come voluntarily for help in a psychiatric crisis and who pose no danger until they can be assessed by a mental health professional, a practice whose questionable legality increases as the hours go by. In addition, to prevent psychiatric patients from leaving either prior to or after assessment EDs have adopted a host of policies, such as forced disrobing (even when the patient has a rape or trauma history), restraint to a gurney or bed for hours, and solitary hours and even days unattended in a locked room, all of which cause untold emotional and physical damage to the patient. Hospital EDs also have been known to use pepper spray and Taser guns on psychiatric patients.

In addition, patients with psychiatric histories who arrive at an ED seeking medical care often encounter a degree of skepticism that their medical concerns are imaginary or exaggerated not faced by people who do not have psychiatric histories. The use of force and the minimization of the medical complaints of people with psychiatric disabilities have led to injury and even death.

Other injuries are less visible but equally real. People who arrive seeking treatment for psychiatric emergencies are often treated by ED personnel with impatience, hostility, and contempt. Unlike most medical patients, psychiatric patients, especially so-called repeaters, can be perceived as manipulative, or not truly ill. Some ED personnel are so repelled by people they call "clutter"³ that they engage in punitive responses. As one text notes: "The negative attitudes of emergency physicians, emergency nurses, and emergency medical technicians toward the person who requires treatment for attempted suicide are well documented. An attitude often expressed is that painful, punitive treatment will 'teach the patient a lesson' not to repeat the self-destructive behavior."⁴

Not surprisingly, ED staff have their own difficulties treating psychiatric patients. Some of these are mirror images of complaints expressed by people with psychiatric disabilities, and others are quite different. Chapter 4 canvasses the difficulties that administrators, physicians, nurses, psychiatrists, and other ED staff experience in the treatment of people with psychiatric disabilities. Because EDs have been historically ambivalent about whether psychiatric crises really belong in their domain, the development of standards of care for treating psychiatric emergencies has been slow, stalled, or

non-existent. For example, as of today there is no agreement on what constitutes a psychiatric emergency that renders ED care “necessary.”⁵ There is no agreement on how a psychiatric assessment in an ED should be conducted.⁶ An effort by the New York Office of Mental Health to develop a standard assessment tool failed. There is no agreement on the level of medical assessment required to constitute proper medical clearance, a serious problem since many illnesses present as psychiatric problems.⁷ There is no agreement on whether medical clearance of psychiatric patients should, as a general rule, include toxicology tests for alcohol and drugs. There is no agreement on appropriate cognitive assessment in the psychiatric emergency service.⁸ There are no standards, and little agreement, on when a psychiatric patient should be admitted rather than discharged to the community. There are no standards to guide the use of law enforcement/security personnel in EDs. Even a recent attempt to come up with guidelines for treatment of behavioral emergencies did not address these issues.⁹

Even where there are standards in emergency medicine’s treatment of psychiatric patients, those standards often conflict with existing standards in the field of psychiatry. Nowhere is this more clear than in the area of seclusion and restraint. Other less publicized disagreements include the level of medical and laboratory tests that EDs should routinely administer to people presenting with psychiatric disabilities.

These issues, too, are inextricably intertwined with legal and regulatory issues relating to the right to evaluation and stabilization, civil commitment, rights to informed consent and to have advance directives honored, the right to be free from seclusion and restraint, the Americans with Disabilities Act, and other statutory and regulatory enactments. Although a plethora of complicated federal and state laws and regulations govern EDs, neither ED staff nor patients are familiar with their requirements. If the standards missing from ED treatment of people with psychiatric disabilities are to be developed, as a practical matter they must be developed or harmonized in the context of existing federal and state legal and licensing requirements. Chapter 5 delineates federal and state legal and regulatory requirements governing the treatment of people with psychiatric disabilities, covering questions such as to whom the laws apply, what standards they impose, and what questions arise uniquely in the context of ED treatment of people with psychiatric disabilities.

Most of the unique problems associated with the treatment of people with psychiatric emergencies are intertwined with the law and its requirements. Psychiatric patients, unlike other people at EDs, may be brought involuntarily and may not want treatment at all. Many of these patients are brought to EDs by police officers. Unlike other patients, individuals with psychiatric disabilities encounter ED doctors with the knowledge that those doctors have the legal authority to detain them against their will. Both the law and regulatory requirements are constantly changing. In the last few years, the Joint Commission on Accreditation of Health Care Organizations