Curbside Consultations: When is it a Doctor-Patient Relationship?

By Michael Brand, Esq.
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You are sitting at your desk writing a session note when the phone rings. On the line is a colleague who wants to discuss a patient with you. You are not involved in the patient’s care and treatment but the colleague wants your input on a particular course of treatment. No problem . . . Right? Psychiatrists may often encounter this situation but does this informal conversation open them up to liability?

The short answer is not necessarily; however, answers about liability are not always straightforward. Uncertainties of medical liability arise in the gray areas between the formal physician-patient relationship and informal conversations sometimes referred to as “curbside” consultations. Curbside consultations occur in all practice areas, including psychiatry. While the cases and law in this article deal with general concepts of medical malpractice, its conclusions and lessons are applicable to all physicians, including psychiatrists. This article will discuss the physician-patient relationship, liability issues, and “gray areas.” It will also outline recommendations for psychiatrists.
Formal Consultation versus “Curbside” Consultation

A formal consultation occurs when a treating physician directly requests the written and/or verbal opinion of a consulting physician. Formal consultations result in the creation of a physician-patient relationship, and consequently, a legal duty to the patient. The consultant physician typically documents in the patient’s medical record. For example, a patient sees his primary care physician for newly diagnosed Type II Diabetes. During the appointment, the patient complains of lack of motivation, increased sadness and frequent tearfulness. The PCP refers to you, the psychiatrist, for evaluation and recommendations. This would be considered a formal consultation.

A “curbside” or informal consultation may take several forms, but generally occurs when a treating physician seeks the informal advice of a colleague regarding a course of treatment for a patient. The consultant rarely knows the patient’s identity, reviews the patient’s medical record or has direct contact with the patient. The consultant physician should obtain permission from the informal consultant prior to documenting his name in the medical record. In a true curbside consultation, generally where no formal advice is sought, and the consulting physician takes no responsibility for patient care, no liability exists. Unfortunately, not every situation is quite so clear.

The Creation of the Physician-Patient Relationship

In order for there to be a legal duty, there must be an existence of a physician-patient relationship. Accordingly, before a psychiatrist may be found liable for an act of medical malpractice, it is essential that a physician-patient relationship exist. A physician-patient relationship is contractual in nature. Such a relationship may result from a number of situations, but it is not necessarily dependent upon the existence of a formal or express agreement. However, the physician must take some affirmative step, such as consenting to treat a patient, for the physician-patient relationship to be established.

Liability and Curbside Consultations

Not surprisingly, whether a physician-patient relationship exists is often difficult for both physicians and the courts to determine. Courts have created factors to determine whether a physician-patient relationship exists. The District Court of Maryland used the following three factors to determine the existence of a physician-patient relationship:

1. The existence of a relationship between the consulting doctor and the facility providing care that would require the consulting doctor to provide advice;
2. The degree to which the consultation given affected the course of treatment; and
3. The relative ability and independence of the immediate care provider to implement his or her own decision.

The test above is but one example of factors that courts may consider in determining the existence of a physician-patient relationship. The policies behind it seem to be shared in other states and by other courts.

The Texas Court of Appeals in Lopez v. Aziz also examined curbside consultation. In this case, Dr. Martinez was treating a patient who came in to deliver a baby. Dr. Martinez called Dr. Aziz to discuss the treatment of the patient. Dr. Aziz answered Dr. Martinez’s inquiry. Subsequently, the patient died of complications and Dr. Aziz had not seen the patient prior to her death.

The Aziz court found that a physician-patient relationship did not exist between Dr. Aziz and the deceased patient. The court indicated that there was no consensual relationship between Dr. Aziz and the patient which would form the basis of a physician-patient relationship and that Dr. Aziz did nothing more than answer an inquiry from a colleague. Thus, the court did not impose liability for one physician simply conferring with another.
Gray Areas
The problem lies with those cases that fall within the “gray areas.” In *Schendel v. Hennepin Cty. Med. Ctr*, a Minnesota court found liability for an on-call physician who had never seen an injured patient because his agreement with the hospital obligated him to provide not only direct patient care, but also guidance and direction to the hospital’s residents and interns. In yet another case, *Mead v. Legacy Health System*, an Oregon court found the existence of a physician-patient relationship where an on-call physician told an emergency room physician that a patient was not a candidate for surgery and should simply be held for observation.

The liability imposed by each of these courts, however, can be explained. First, the *Schendel* court found a physician-patient relationship because the terms of the on-call physician’s contract created a duty to emergency room patients. Similarly, the *Mead* court believed the case to be different than an informal consultation because: (1) the emergency room physician did not call the on-call physician as a colleague but as an on-call specialist; and (2), the on-call physician made what the Court perceived to be an affirmative diagnosis. Accordingly, neither of these cases assigned liability for a true “curbside” consultation. Instead, the physician-patient relationship arose because of some distinguishing factor that created a duty to the patients involved.

Recommendations
So how can a psychiatrist be on notice that a consultation could potentially give rise to liability? The unifying factor is the creation of the physician-patient relationship. This type of relationship can arise through contract or circumstances. A relationship can be created in person or through a number of indirect means such as email, telephone call or through another professional. Obtaining advice from another colleague may be a valuable risk management strategy; however, psychiatrists should be cautious when it appears that what was once an informal inquiry turns into actual patient diagnosis/treatment. It may be better to not give advice but rather have a formal consultation with the patient. Also, be aware of your employment contractual obligations and whether it can give rise to a physician-patient relationship.

Keep in mind that even if you provide a curbside consultation to another colleague and seemingly there is an absence of a physician-patient relationship, you may not be immune from liability. For example, Dr. Smith consulted you in a “curbside consultation” in the care and treatment of his patient. The patient/family files suit against Dr. Smith. During the course of discovery, Dr. Smith will likely testify under oath at deposition. At some stage in his deposition, the patient/family’s attorney will likely ask Dr. Smith who he has spoken with about the patient’s care and treatment. Dr. Smith must answer this question honestly and you, as the
consulting physician, may be identified. The attorney for the patient/family may add you as a defendant in the lawsuit even if you simply provided a curbside consultation to Dr. Smith. Though you may be dismissed from the case before the matter proceeds to trial, being involved in a lawsuit can cause you stress and time away from your practice.

Although there may be some disagreement on whether you should document a curbside consultation (as it gives the appearance that there was a true physician-patient relationship), a psychiatrist may wish to keep records of all informal consultations. For example, when a colleague seeks some advice, you may consider making notes of the conversation, including its informal nature, and place it in a “curbside” consult file. By doing so, in the event of a lawsuit, there will at least be some evidence of the informal nature of the consultation. A lawsuit may not be filed until a number of years after the care/treatment at issue, after memories fade. Having some documentation may help you remember the circumstances of the case and may assist in your defense.

Conclusion
While all physicians need to be cautious, informal collaboration is an important part of practice. It increases knowledge between physicians and may be highly beneficial in the overall care and treatment of patients.

Bear in mind that laws from state to state vary. Be aware of your jurisdiction’s laws on curbside consultation as well as the principles of medical ethics. Another resource which may be of assistance is the APA Resource Document: Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Nonmedical Therapists. Finally, consulting with an attorney or risk management professional should you have questions is an important consideration.

COULD YOU BE POTENTIALLY LIABLE FOR YOUR ADVICE ABOUT ANOTHER PROFESSIONAL’S PATIENT?

YES, IF YOU…*

- are asked about a patient because you are the on-call physician.
- are asked about a colleague’s patient for whom you are covering.
- have a supervisory role over the medical/non-medical staff seeking the advice.
- give specific advice after a detailed conversation about the patient.
- give advice and later bill for the consult.
- personally examine the patient.
- review the patient’s medical record.
- communicate directly with the patient.

* This list is not exhaustive. Courts/juries will examine the facts of each case in order to determine whether a doctor-patient relationship existed.

About the Author
Michael Brand is a partner with the Florida law firm of Cole, Scott & Kissane. Mr. Brand received his Juris Doctor from Temple University and his B.A. in Economics at the University of Pennsylvania. He is admitted to practice law in Florida and Massachusetts. He practices across all fields of litigation, including medical malpractice, physician malpractice, nursing home litigation, and others. He has tried over 100 jury trials to verdict in his career.

Mr. Brand is an elected member of the American Board of Trial Advocates (ABOTA) and is routinely selected in various “Best of” publications for his litigation expertise. He serves as a pro bono attorney for children through the Attorney Ad Litem Program and Lawyers for Children of America. Mr. Brand also has been selected as “Top Attorneys in Florida” by The Wall Street Journal (July 2011) and named as Florida Super Lawyer by Super Lawyer Magazine (2009 - 2012).
Psychiatrists often encounter patients and family members from diverse cultures and backgrounds. Although there are many differences and variations within a culture, we feature different cultural groups which may be of interest to you in your daily practice as well as some relevant issues which you may encounter. It is important not to stereotype a person from a specific culture by assuming that he has the same beliefs as someone else from that same culture. Learning whether a patient considers himself typical or different from others in his cultural group is important as there are many factors which influence how an individual views his own culture/beliefs. You may never encounter some of the featured cultures in your practice; however, we hope you find the information on the featured cultures interesting nevertheless. In this newsletter, we feature the Mexican American culture.

Please note, throughout this article, the terms Mexican and Mexican Nationals are used. Mexican Nationals are individuals who were born in Mexico and may not have obtained U.S. residency.

Mexican American

Background: Mexicans have a long history of migrating to the United States, crossing borders in both directions. By 1900, approximately 500,000 people of Mexican ancestry lived in the U.S. The first documented wave of immigrants came to the U.S. from 1900-1930 during “The Great Migration” which was as a result of political upheaval in Mexico as well as economic opportunities in the Southwest.\(^\text{17, 18}\) In the early 20th century, the borders between Mexico and the U.S. were virtually unrestricted until the creation of the Border Patrol in 1924. At that time, it was common for men to enter the U.S. to work and then return to Mexico periodically. Beginning in the 1960s-1970s, federal legislation limited the number of immigrants from most countries; however, there were still considerable numbers of immigrants entering the U.S. from Mexico (in some cases, illegally). Between 1970 and 2010, the Hispanic/Latino\(^\text{19}\) population in the U.S. increased by 38 million. Mexican-Americans make up 63 percent of this population, with the largest number immigrating to California, Texas, Illinois and Arizona.\(^\text{20, 21}\)
The increase in the number of undocumented workers entering the U.S. is due to the availability of employment coupled with high rates of unemployment and slow downs in the Mexican economy. As a result, most U.S. border states face strained budgets as they attempt to provide services to undocumented workers living within their borders. Recently, there have been many efforts by both the state and federal government to address this issue.

As a result of these efforts, courts have struggled to address the tension between developing an effective immigration policy, and upholding certain rights endowed under the U.S. Constitution, particularly in the areas of education and health care. For instance, the United States Supreme Court, in a 1982 landmark decision, *Plyler v. Doe*, ruled that illegal immigrants and their children, though not citizens of the United States are people, “in any ordinary sense of the term” and, therefore, are entitled to state funded primary and secondary education. Recently, in mid-June 2012, President Obama used existing legal authority to promulgate a policy change that stops deporting young, illegal immigrants who entered the United States as children, if they meet certain requirements. Later that same month, the United States Supreme Court struck down as unconstitutional three parts of an Arizona law (1) making it unlawful for illegal immigrants to apply for work; (2) allowing suspected illegal immigrants to be detained; and (3) making it illegal for an immigrant to fail to complete or carry an “alien registration document.”

**Major Language/Dialects:** Mexican Nationals/Mexican Americans may only speak English but many may also be bilingual. This may be generational, as children have assimilated into U.S. school systems and have become increasingly integrated into the American culture. Mexico has 62 languages. Residents from remote areas of northern Mexico speak Spanish which is similar to the language spoken in Spain; however, others speak “Mexican Spanish.” The Mexican Spanish language spoken in the U.S. may vary across regions and may also be contingent upon other factors such as length of time in the U.S., economic status, education and whether the person lives in a rural or remote location. In the event that an interpreter is needed, psychiatrists should avoid using a relative as an interpreter as issues may be disclosed that a patient may not feel comfortable sharing.

**Nonverbal Communication:** Mexican Nationals/Mexican Americans may interpret staring as a challenge/intimidation. They may avoid sustained eye contact with authority figures/opposite gender. When greeting, a handshake may be appropriate, particularly between strangers whereas hugs (*abrazos*) are reserved for close relatives/friends. This population may find it uncomfortable to touch or be touched by strangers. Mexican Nationals/Mexican Americans may not share family issues/conflicts with persons outside the family.

**Tone of Voice:** Mexican Nationals/Mexican Americans may consider loudness as rude or inappropriate, and shouting may cause patients to “disengage” and not follow through with treatment recommendations. Thus, requests or treatment recommendations should be presented in a non-confrontational manner. On the other hand, their expressions of emotion may be intense,

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**RISK MANAGEMENT TIP:** WHAT TO DO WHEN YOU ARE THRUST INTO THE SPOTLIGHT

Sometimes, despite exercising sound clinical judgment, your patient’s actions will thrust you -- as their psychiatrist -- into the spotlight. Your response in the time immediately following a high profile incident can have a direct impact on future proceedings. By staying calm and enlisting assistance from an attorney and your malpractice carrier, you can minimize your risk, as well as some of the accompanying stress. The following risk management tips may help you navigate through a high profile situation.

**Steps to Take:**
- Notify your insurance carrier when you learn of an incident, even if it has not yet turned into a formal lawsuit
- If you have an attorney, notify him/her of the situation
- Refer all requests for information through your attorney

**Steps to Avoid:**
- Don’t release client information without consulting your attorney and verifying that all necessary releases have been signed
- Don’t overreact
- Don’t alter the patient’s medical records
- In some situations, don’t contact/communicate with the patient or his/her family
and it is important to interpret these expressions within the context of cultural norms, and not necessarily as reflecting pathology.  

Religion: Most Mexican Nationals/Mexican Americans are Roman Catholic; however, Protestant and Pentecostal religions are also observed.  

Consents: The issue of consent may be of significant importance particularly if a patient is an undocumented immigrant. The undocumented patient may be suspicious of any type of consent (including written) as he/she may fear deportation. A bilingual healthcare provider may be of assistance in obtaining consent. As stated above, however, it is important to remember that there are significant differences in dialects within the various Latin cultures. Bear in mind that some Mexican Nationals may not read or write in Spanish or English. Thus, it is important to ask for consent directly.  

The Family Unit: Family is very important in the Mexican culture. Historically, this population was a patriarchal society but, today, there are many women who are head of households. Traditionally, family honor and unity were of significant importance. Family units as a whole typically make decisions, but this may vary depending upon the composition of the individual family.  

Concept of Health: The underutilized medical system may be the most significant health issue within the Mexican National/Mexican American population. Typically, Mexican immigrants rely upon traditional western medicine. However, some may seek assistance from a folk curer (curandero) and may be reluctant to disclose any herbal or non-traditional remedies that they have been taking with healthcare providers. In addition, as a result of the strong family connection found in the Mexican culture, they often consult with family members and ask them to accompany them to medical appointments.  

Mental Illness: There are divergent views on how Mexican Nationals/Mexican Americans view mental illness. It is a large population and views may be dependent upon a number of factors, including some who may adhere to religious beliefs pertaining to mental illness. On the other hand, it is noted that Mexican Nationals and Mexican Americans may be more tolerant of psychiatric disorders and may be willing to undergo therapy. It is also noted, however, that they may not seek treatment.  

- Substance abuse: Alcoholism afflicts Hispanics 2-3 times the national average, with Mexican Americans and Puerto Ricans suffering the highest rates. Mexican Americans have an 8-12% higher incidence of alcohol abuse across all age groups compared to non-Hispanics in the same category. The highest incidence is in families of lower economic status. The frequency level of cirrhosis of the liver is 40% higher among Mexican Americans than Anglo Americans.  

- Depression: Generally, mental health treatment may only be sought as a last resort. Assistance may be first sought from their parish priest or family members.  

- Suicide: The U.S. Department of Health and Human Services Office of Minority Health reports that in 2008, the death rate from suicide of Hispanic men is 5 times greater than compared to Hispanic women. However, the suicide rate for Hispanics is half that of the non-Hispanic, Anglo American population. However, in 2009, suicide attempts for Hispanic girls, grades 9-12, were 70% higher compared to Anglo American girls in the same age group.  

About Our Co-Author

Laura (Garza) Martínez was born in Brownsville, Texas to Texas born parents. Her ancestors “migrated” to the United States when the land they lived on in Northern Mexico (north of the Rio Grande River) became U.S. land. Her grandparents became U.S. citizens. Raised in an area rich in the Hispanic culture, Laura has faced the challenges of providing healthcare to Mexican Nationals and Hispanics as a Registered Nurse and Certified Rehabilitation Counselor. Laura has been in healthcare for over thirty years.  

As a vice president in the global risk management department for AWAC Services, a Member Company of Allied World, Laura provides education and consultation to medical professional policyholders, helping them assess and manage their organizational risk.
Should you ever be named in a lawsuit, you may encounter unfamiliar terms throughout the litigation process. Some of these terms include: mediation, arbitration and possibly alternative dispute resolution ("ADR"). Familiarizing yourself with these terms and, more importantly, the events described by the terms, will allow you to focus on the important decisions during the process rather than on deciphering their meaning.

Mediation is defined as “(a) method of nonbinding dispute resolution involving a neutral third party who tries to help the disputing parties reach a mutually agreeable solution.”

A mediation may last a half to a full day, or even two.

Through the course of litigation, your defense counsel may determine that liability issues may be questionable or difficult to defend in the jurisdiction in which the suit has been filed, or may determine that early resolution of the matter could be beneficial to you. At that point, and with your consent, defense counsel may suggest mediation. Alternatively, the court may order the parties to mediate. The opposing counsel must also agree to the specific process and to the neutral third party mediator, who is likely to be a retired judge or an attorney. The mediator will inform you of the process and advise that all discussions through the course of the mediation are confidential and not admissible should the case proceed to trial. The mediator does not have any power to decide an issue, but rather works to guide the parties to a mutually agreeable position.

A successful mediation is one in which both parties are satisfied that the claim resolved, but mutually displeased with the ultimate number.

Depending on the mediator and counsel involved, there may be a joint session at the beginning of mediation. This may be the only time that all parties and their attorneys are in the same room. The joint session allows plaintiff’s counsel to present the strengths of his case to the defendant(s) and the defense attorney to present the defenses of his case. Counsel may present opinions of supportive expert testimony or evidence such as autopsy reports. Some joint sessions include Power Point Presentations or video clips depicting plaintiff’s damages. During the joint session, the mediator will confirm that the process is confidential and that during the course of the mediation no information
will be shared with the opposing side unless express permission is granted. This allows the parties – when meeting separately with the mediator – to speak freely with the mediator regarding their perceived strengths and defenses without compromising further litigation efforts should the claim not resolve through the mediation process.

Following the joint session, the parties are directed to separate conference rooms. The mediator has the option to initially meet with either party, but typically speaks to the plaintiff first to determine plaintiff’s position and any monetary demand.

Throughout the mediation, in an effort to bring both sides to a mutually agreeable point, the mediator will make many trips between the two conference rooms. You may hear a mediator say that a successful mediation is one in which both parties are satisfied that the claim resolved, but mutually displeased with the ultimate number. One of the most important points to remember regarding mediation is that the process is voluntary and non-binding. Unless both parties agree, there is no settlement. In the event that mediation is unsuccessful, the parties may attempt a subsequent mediation at a later date.

 Arbitrations, on the other hand, are typically binding and involve one or three decision makers, depending on the forum. An arbitrator or arbitration panel hears the case as presented by the parties – including their experts – and makes a decision which is binding for all. Arbitration is akin to a mini-trial but there is no right of appeal. The arbitrator’s ruling is final.

The last term mentioned at the beginning of this article was alternative dispute resolution, or ADR. This term encompasses both mediations and arbitrations. ADR is an attempt to settle claims without the need to proceed to a lengthy and often costly trial. ADR usually gives the parties more control of the process versus a trial where evidence is presented in a courtroom with a jury/judge rendering a verdict.

Should you be named in a lawsuit, your claims representative and defense counsel will guide you through the litigation process and provide the information you need to make an informed decision as to whether mediation, arbitration, or trial is the best approach to resolving the claim.

About Our Author
Joanne Wayman is a Vice President and Health Care Professional Liability Claims Manager overseeing Allied World’s Medical Malpractice, APA/Psychiatry, and Health Care Management Liability Claims.

Prior to joining Allied World, Joanne managed a Medical Malpractice Claims Department at the Chubb Group of Insurance Companies and had responsibility for Eastern U.S. claims at One Beacon Professional Insurance. She has worked in law offices in Hollywood, Florida and Austin, Texas.

Joanne has clinical experience working as an emergency department nurse for a teaching hospital in the Chicago area, a community hospital in New Hampshire and a trauma center in Massachusetts. She is a registered nurse with a Master’s Degree from the University of Texas at Austin where her specialty was adult health. She did a clinical rotation in the heart transplantation area. In addition to an MSN, Joanne holds the RPLU designation.

RISK MANAGEMENT SERVICES
For members of the APA who are Allied World policyholders, we provide:
• 24-hour risk management hotline access
• Risk management seminars
• Individual CME Education through our relationship with Medical Risk Management, Inc.
• Access to our library of risk management resources
Today’s Emergency Departments (“EDs”) provide more than acute emergency care services. They also serve as safety nets for indigent patients, perform public health surveillance, occupational care, procedural care, employee health, and often, primary care services, just to name a few. As a result, many EDs experience overcrowding that may jeopardize patient safety and hinder patient care. This issue may impact you whether you are working as a psychiatrist in the ED, an attending in a hospital setting or are in private practice. Regardless of the type of practice, at some point in your career, you will likely have a patient who receives care in an Emergency Department. The goal of this article is to provide risk management tips for psychiatrists, as patients seeking psychiatric care may be particularly vulnerable to the effects of this crisis.

The primary cause of overcrowding is known as “boarding,” the practice of holding patients in the ED after they have been admitted to the hospital, because no inpatient beds are available. This not only happens with patients who are being admitted for medical treatment but also for patients who are seen in the ED for psychiatric issues. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) mandates that boarded patients be provided the same level of care that they would receive in inpatient units, yet the vast majority of EDs lack adequate staff, space, and expertise to care for patients held in the ED.

According to the Institute of Medicine, ED crowding and inadequate inpatient capacity is a public health crisis.

Some Background/Contributing Factors
In 2010, the Agency for Healthcare Research and Quality reported on a study showing that in 2007 alone, approximately 12 million visits to U.S. EDs involved mental health or substance abuse diagnoses, accounting for 12.5% of all ED visits that year (up from 5.4% of all
visits in 2000). Moreover, a 2011 study confirmed that patients experiencing psychiatric emergencies wait an average 11.5 hours in the ED.

Many factors contribute to lengthy ED wait times, including:

1. Use and results of toxicology screening
2. Restraint/observation use
3. Use and results of diagnostic imaging
4. Insurance status
5. Medical clearance criteria for transfer to a psychiatric facility

A significant factor contributing to ED boarding is the inability to transfer patients to inpatient beds. Specifically, patients admitted to a psychiatric unit within the hospital waited in the ED longer than those being discharged home, and those patients admitted to a psychiatric facility outside the hospital, or the overall health care system, stayed in the ED even longer.

Long ED waits and boarding can create health and safety concerns for psychiatric patients. Since 1995, among suicides reported to the Joint Commission, 827 were inpatient suicides and of those, 8.02% occurred in the ED. Most of these suicides occurred in ED bathrooms, bedrooms, closets, showers, after discharge or after leaving the hospital against medical advice. The methods of suicide included hanging, asphyxiation other than by hanging, gunshot, jumping from a height, drug overdose, laceration, drowning, other methods (e.g., jumping in front of a moving vehicle, ingestion of poison, stabbing or burning). In addition, two studies showed that suicide attempts within the general hospital environment were more violent (hanging, jumping or gunshot) than those on psychiatric units.

Lawsuits and insurance claims typically arise from ED boarding as a result of:

- Inadequate risk assessments
- Lack of a safe treatment environment
- Lack of appropriate monitoring procedures
- Untrained staff
- Ill-timed transfers to appropriate settings

**Tips for Reducing Risk in the Emergency Department**

While issues creating the long wait times or boarding in EDs for psychiatric patients may take time to resolve, there are a number of ways you may reduce your liability risk while increasing patient safety in the ED.

1. **Establish best practices in the ED.** This includes but is not limited to: policies/guidelines on suicidal assessments, rapid triage and identification of patients at risk, establishing the frequency of monitoring and re-assessments, identifying what encompasses a safe environment for this patient population, outlining the expectations for 1:1 observation, guidelines for the involuntary commitment process, determination of competency/capacity, as well as violence reporting and zero tolerance workplace violence policies.

2. **Ensure that thorough, timely, and well-documented assessments are completed by staff and that reassessments are performed when indicated.** Along with documenting a particular course of treatment, document reasons for not pursuing a particular course of action. In evaluating patients, care providers should attempt to access the patient’s prior medical records.

3. **Work to establish safe treatment environments for the psychiatric patient as well as the ED staff.** Examples include:

   - Education and training for staff regarding sensitivities and stigmas associated with care of psychiatric patients. This may improve the overall safety and care of ED psychiatric patients.
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• Triage screenings, performed by nurses, are designed to alert staff of signs that the patient may resort to violence to self and/or others. In addition, triage screening procedures should detail (according to applicable state laws/regulations) when to contact law enforcement officials, when to facilitate an involuntary commitment, as well as how to comply with the “duty to warn” obligation imposed under the Tarasoff doctrine. The Tarasoff doctrine, as you know, imposes a mandatory duty to warn on psychiatrists when they learn of a serious danger of violence to others. This rule may or may not be followed in your state and is important to know your specific state regulation regarding duty to warn third parties.

• Relocate patients who are being treated for a psychiatric condition out of the waiting area. Maintain a separate room/area within the ED. Ensure that this area is visible to staff.

• Remove potentially hazardous items (which patients could use to injure themselves or others) from accessible areas. Pay particular attention to items such as patient clothing, medical equipment cords, “sharps,” light fixtures, door knobs, sprinkler heads, meal trays, bathrooms, clocks, bell cords, bandages, sheets, restraint belts, plastic bags, elastic tubing and oxygen tubing.

• Establish a safe treatment area. This includes locking rooms such as staff lounges, utility closets and other non-patient areas to prevent unauthorized access.

• Perform frequent observation/assessments at clinically appropriate intervals by ED staff trained in non-violent crisis management and de-escalation techniques. All monitoring and observations should be documented.

• Establish ED elopement protocols. Overcrowded hospital EDs may encounter patients who refuse care and leave against medical advice (AMA). In 2005, 2% of ED patients left without being seen by a healthcare provider. Patients who leave AMA expose themselves to health risks and expose providers and facilities to liability. As nursing staff are often the first to become aware of a patient’s desire to leave AMA, it is crucial to ensure that staff members receive ongoing education regarding the facility’s protocol for handling such situations. To lessen the frequency of patients leaving AMA or eloping from the facility, staff should be trained to approach the patient as an advocate, inquiring about the reason for leaving and asking whether he or she is aware of the possible adverse outcomes. This can help decrease these occurrences.

• Additional safety measures may include the use of electronic metal detectors in high crime areas, closed circuit television monitoring, alarm systems, shatter-proof glass, bright lighting, break away locks and implementing electronic badges to restrict access to the ED and other areas within the facility.

4. Help facilities establish 24 hour security personnel and staff trained in safety measures and de-escalation methods. Use security personnel and observers/sitters trained in communication techniques. Security personnel may intimidate some psychiatric patients, so in order to minimize intimidation, security should wear uniforms, but not full “police” uniforms. In addition, they should not carry guns, pepper spray or tasers and should be well-trained in de-escalation techniques, redirection, overcoming personal stereotypes related to mental illness, and with training, achieve a better general understanding of behavioral health.

5. Ensure appropriate and lawful use of restraints/seclusion. Restraints impinge on patients’ autonomy and free choice, thus their use is heavily regulated. Use restraints to prevent injury to the patient or others, or to prevent patient interference with his/her treatment. Bear in mind that seclusion is a form of restraint used only with patients meeting predetermined seclusion criteria, and not to prevent a voluntary patient from leaving the hospital prior to assessment. The use of seclusion to determine if a patient has a life threatening condition, or is able to make informed decisions, is permitted as long as it complies with the applicable regulatory requirements.

Risk management strategies when using restraints in the ED may include:

• Ensure that your facility has policies and procedures in place that comply with all applicable regulatory requirements. The standards can be...
found within your state’s department of health or mental health.

- Educate staff on proper restraint application and maintenance techniques.
- Whenever possible, avoid holding a patient’s face down. Patients can asphyxiate during the chaos that often accompanies the restraint process.
- Thoroughly document all measures taken, assessments conducted and observations made while patients are in restraints. A thorough medical record with completed restraint flow sheets can be of great assistance during a lawsuit or regulatory investigation.
- Through your quality assurance or quality improvement program, track your facility’s safety record for the use of restraints and seclusions, and develop a process for decreasing their use.
- Maintain an effective system for addressing patient or family member complaints.

Conclusion
The patient safety implications for psychiatric patients due to long ED waits or boarding are significant, costly, and complex. Nonetheless, psychiatrists can manage their risk through collaboration with hospital/ED administrators, and may help facilitate and promote safe treatment environments for psychiatric patients in the ED.

Out and About...
Since our last issue of In Session, AWAC Services Company’s Risk Management Team has had the opportunity to visit numerous locations to meet with APA members to discuss risk-related topics germane to your practice. Thank you to those who hosted us, and the members who attended and shared their personal insights and feedback.

Some recent presentations:
- **June 14, 2012 / Central NY District Branch:** Moira Wertheimer spoke on the topic: “Legal, Risk and Ethical Considerations in the Age of Technology.”
- **June 26, 2012 / Massachusetts Bar Association:** Kristen Lambert addressed the Annual Health Law Conference on the topic: “Medical Records in the Cloud: Social Media in Healthcare.”
- **August 8, 2012 / Columbia University/Weill Cornell Medical Center/Harlem Hospital CAP Fellow’s Meeting:** Kristen Lambert spoke on the topic: “Risk Considerations in the Age of Technology” and “Life after Residency: Risk Issues When Setting Up a Private Practice.”

WELCOME ...
Michelle Hoppes
Senior Vice President, Global Risk Management and Loss Control Services Lead

Michelle has joined AWAC Services Company as the Senior Vice President, Global Risk Management and Loss Control Services Lead where she is responsible for the development and implementation of risk management and loss control services in support of Allied World insurance offerings globally. Michelle has performed many functions throughout her 30-year career in the fields of nursing, risk financing, claims management, business development, leadership and consulting. She has served on several national organizations such as the USP, EMPSF and as past president of MSHRM and the 2011 president of ASHRM.

Michelle is a frequent national speaker at organizations such as RIMS, PLUS, EMPSF, NPSF and ASHRM. She has had numerous risk management articles published, as well as book chapters. She has completed the AHA/ASHRM/NPSF leadership program as a patient safety fellow and obtained a Master’s degree in Healthcare Management with an emphasis in Risk Management from the Finch University; the Chicago Medical School. She is certified in risk management and quality review and is a Distinguished Fellow of the American Society for Healthcare Risk Management.

We welcome Michelle as our Risk Management Team Lead and as the new co-editor of In Session.
Upcoming Speaking Events

We will be speaking at the following events:

SEPTEMBER 11
Louisiana State University
SHREVEPORT, LA

SEPTEMBER 14
University of Mississippi
JACKSON, MS

SEPTEMBER 15
Louisiana Psychiatric Medical Association 2012 Annual Fall Meeting
SHREVEPORT, LA
Topic: “Legal & Risk Considerations in the Age of Technology”

OCTOBER 6
APA 64th Institute on Psychiatric Services
NEW YORK, NY
Topic: President’s Town Hall Meeting

OCTOBER 20
Alabama Psychiatric Physicians Association
MOBILE, AL
Topic: “Risk Management Considerations When Using Social Media and Technology in Psychiatry”

OCTOBER 22
Orange County Psychiatric Society
IRVINE, CA

NOVEMBER 2
Maine Association of Psychiatric Physicians
MAINE - TBD
Social Media Panel Discussion

NOVEMBER 9
Pennsylvania Psychiatric Society
KING OF PRUSSIA, PA
Topic: “Internet Boundaries and the Dilemma of Social Media”

End Notes

Curbside Consultations
2 Ibid
3 Ibid
6 Ibid
7 Ibid
8 Ibid
9 Ibid

Culture Corner

19 The U.S. Census Bureau defines “Hispanic or Latino” as a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.
20 Lipson

Recent Publications:

Kristen Lambert recently served as the Chair of the American Society for Healthcare Risk Management Behavioral Health Pearls Task Force. The publication, “Risk Management Pearls for Behavioral Health across the Continuum,” is available through the ASHRM bookstore at: ashrm.org.
25 Lipson; Englekirk & Marin
26 Englekirk & Marin
27 Lipson
28 Lipson
30 Lipson
31 Lipson
32 Lipson
33 Lipson
35 Lipson
37 Lipson
38 Englekirk & Marin
39 Lipson
40 Englekirk & Marin
41 Englekirk & Marin
42 Note: this resource identifies statistics for Hispanics, not Mexican/Mexican Americans specifically, and which will include other Hispanic populations.

Claims Insights

Emergency Department Crowding

52 Ibid
53 Ibid
55 Ibid
61 2008 ECRI Institute Emergency Department Liability, Executive Summary Vol. 4

Editors
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Vice President Risk Management
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