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# M E M O R A N D U M

TO: WACEP Board

FROM: Guy DuBeau

DATE: August 27, 2018

RE: Inter-Facility Transport of Psychiatric Patients

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## BACKGROUND

You have requested our legal opinion regarding potential liability for psychiatric patient transfers. We understand that it is common for a patient to voluntarily present to emergency departments expressing thoughts of self-harm and, after screening, your physicians will determine that the patient is appropriate for transfer to an in-patient behavioral health facility. Physicians will, when they deem it acceptable, allow the patient to be transported to such facility by a trusted family member or friend rather than through an EMS service. Some hospitals have raised concerns and sought to prohibit this practice by requiring all patients to be transported to an in-patient behavioral health facility by registered EMS providers. There is a concern that requiring EMS transport burdens patients with unnecessary expense, delays transfer placing additional burdens on emergency department staff and, in some cases, could be psychologically harmful to patients by being separated from their known support network as the process unfolds.

You have asked for our analysis of the law governing the transport of patients in this situation. For purposes of this analysis, we are not considering the special case of the transfer of patients subject to chapter 51 detention beyond the initial screening decision.

## SHORT ANSWER

Emergency physicians and hospitals have a legal duty to screen patients presenting with thoughts of self-harm to determine if involuntary commitment is required. Assuming it is not, the physicians providing the care have both the authority and responsibility to determine appropriate ongoing treatment pursuant to generally accepted standards of care. This includes making decisions on safe transport to an in-patient behavioral health treatment facility to which a patient voluntarily consents to go. Hospitals have duties of care to such patients while the patients are in their custody and control. Assuming the hospital meets those duties, upon discharge from the hospital pursuant to physician direction, we perceive no basis for a hospital's ongoing legal liability to protect against the patient harming him or herself. For these reasons, we do not believe it is appropriate for hospitals to impose a requirement that patients discharged for voluntary admission into an in-patient behavioral health facility be transported only by professional EMS services.

## ANALAYSIS

There is no statute or administrative code in Wisconsin governing the transport of patients between an emergency department and an in-patient behavioral health facility. Accordingly, this analysis focuses on the potential for civil liability on physicians and hospitals in the event a patient being transported harms themselves *en route*.

We begin with the proposition that a patient presenting at an emergency department expressing suicidal ideation must be screened for involuntary admission. The general rule is that a hospital must exercise such ordinary care and attention for the safety of its patients as the patient's mental and physical condition, which is known or should have been known, may require.

*Cramer v. Theda Clark Memorial Hosp.*, 45 Wis. 2d 147, 149, 172 N.W.2d 427, 428 (1969). While the precise standards have changed since the issuance of this decision, its core principle stated here has not. When a patient first presents, it is tautological that their mental and physical conditions is not known, and accordingly what care and attention they require for their own safety is also not known. Thus, when a patient presents voluntarily expressing thoughts of self-harm or evidencing any psychosis, there is an affirmative duty on the providers to monitor, and as necessary detain, the individual until this determination is made. Case law suggests that completion of an examination to determine if a chapter 51 proceeding is required. *Boles v. Milwaukee County*, 150 Wis. 2d 801, 819 (Ct. App. 1989).

*Boles* involved a patient who, upon showing aberrant behaviors after coming to the emergency department, was placed in restraints and the physician ordered a psychiatric consult. Before the psychiatrist arrived for the consult, the patient left, apparently unnoticed by professional staff. The court reasoned that until that screening had occurred, the hospital and physician could not know what was required to fulfill their duty of care and attention. Because the patient was allowed to leave without the hospital knowing what was required to treat her, it was found negligent. While there is no requirement that every patient receive a formal psychiatric consult, to the extent that the physician determined this was a necessary step in the treatment, the hospital had a duty to make sure it happened.

Of interest, though, is a comment in the *Boles* case regarding what could happen after the screening. While the discussion occurred outside the direct liability part of the opinion, the court noted that the failure to perform an involuntary commitment screening "prevented a final diagnosis which would have resulted either in a Chapter 51, Stats., proceeding **or in discharge of [the patient] to [her sister]**." *Id.* Though this language is non-binding *dicta*, it does signal that the court did not perceive a particular issue with the notion that a psychologically troubled patient

could be discharged into the care of a family member if they did not meet the criteria for involuntary commitment. This is consistent with a much broader and well-recognized policy that, except in very limited circumstances, medical providers cannot prevent patients from leaving against their will or dictate their activities outside the institutions unless there is a legal basis to do so. While this language is interesting, it does not address the key question of transfer to an in-patient facility and whether that creates a special circumstance. Accordingly, we look to additional principles.

Most of the case law that has developed in this arena involves patients who are already in secure facilities. Nonetheless, they contain valuable insights. "As a general rule, Wisconsin, like most jurisdictions, does not impose a duty on a person to stop a third person from committing harm to another or to himself or herself." *Jankee v. Clark County*, 235 Wis. 2d 700, 755 (citing *Schuster v. Altenberg*, 144 Wis. 2d 223, 238 n.3, 424 N.W.2d 159 (1988)). Nonetheless, certain caregivers, such as hospitals and prisons, assume enhanced responsibilities in protective or custodial situations. Restatement (Second) of Torts § 315. This increased duty obligates the caregiver to shield the protected person from the foreseeable consequences of injurious conduct." *Id* (citing *McMahon v. St. Croix Falls Sch. Dist.*, 228 Wis. 2d 215, 226, 596 N.W.2d 875 (Ct. App. 1999)). "When such a special relationship exists, the caregiver assumes the duty to provide reasonable care of the protected person to prevent harm. Restatement (Second) of Torts § 319. 31. "Under this approach, therefore, a plaintiff must show that: (1) a special relationship existed, giving rise to a heightened duty of care; and (2) the defendant caregiver could have foreseen the particular injury that is the source of the claim." *Id*, at 756. Importantly, a hospital "is not an insurer of its patients against injury inflicted by themselves," *Dahlberg v. Jones*, 232 Wis. 6, 11, 285 N.W. 841 (1939), but is only required to use such means to restrain and guard its patients as would seem reasonably sufficient to prevent foreseeable harms. *Id*. Thus, the duty of a hospital is to exercise such ordinary

care as the hospital knows, or should know, the patient's mental or physical condition requires." *Id*, at 757. Importantly, even though care providers have this duty, it is still the case that the patient has a duty not to inflict self-harm unless they are "totally unable to appreciate" their own risk of harm to themselves. *Hofflander v. St. Catherine's Hosp., Inc.,* 2003 WI 77, ¶36.

Several things are germane from this analysis. First, as long as a patient is at a hospital, the hospital and physician have duty to the patient to protect them from harm. That duty is contingent on what is known about a patient's physical or mental condition and specifically what is perceived regarding foreseeable harm. What is known depends, then, on the observations of trained providers to assess the patient's physical or mental condition. That responsibility will fall primarily on the emergency physician to make the assessment and develop a treatment plan based on their own observations as well as observations relayed to them by hospital staff. Part of that professional decision would necessarily involve determining what risks attend transporting a patient to another facility. As the physician ultimately authorizes the discharge, this falls squarely on the physician.

Before turning to how physicians should analyze and document this decision, we note that, once a patient leaves a facility, we do not see any legal basis for liability on the hospital assuming that it met all its obligations while the patient was there. As noted above, the duty to protect another from self-harm is a limited duty that requires a special relationship focused on custody and control of the patient. Once a patient leaves the hospital with a physician's direction, the hospital cannot exercise custody and control over the patient; it is doubtful any healthcare provider can absent a legal order under Chapter 51. Even in the event that a patient being transported by a trusted individual does injure themselves in the course of transport to an in-patient facility, it would appear that as a matter of law the hospital would have no legal duty to them, assuming the hospital rendered appropriate care while the patient was within their control.

Accordingly, we conclude that there is no legal justification for a hospital to demand that all patients destined for in-patient treatment facilities be transported only by professional EMS carriers. In a very real sense, this interferes directly with the physician's judgment. The caveat to WACEP members, of course, is that it does place the onus for determining what transfer is safe squarely on the physicians. The key that physicians must always rely on is whether it is foreseeable that the patient will inflict self-harm during the transport. There is obviously no foolproof manner to make such predictions. Physicians are not required to be perfect, but only to use their care, skill and judgment in making the determination. Though we would always defer to members' trained clinical judgment, we believe assessing and documenting the following factors will address the foreseeable risk of self-harm associated with private transfer from a legal perspective:

- Did the patient present to the emergency department voluntarily?
- Does the patient have a history of suicide attempts?
- Does the patient have a history of threats of self-harm without attempt?
- Has the patient articulated a plan, particularly one that could be executed while in transport?
- Is the patient reasonably calm and expressing a consistent desire to receive help?
- What is the anticipated length of transfer?
- What is the provider's impression of the person who would perform the transport?
- Is there more than one friend or family who will be involved in the transport such that one person could assist the patient while the other is driving?
- Will choosing one transport method over the other unnecessarily delay the patient's admission to an in-patient facility?
- Is the patient likely to become agitated if being entrusted to strangers for the duration of the transfer?

This list is not exhaustive nor are we suggesting that every factor here is required in order to authorize a friend or family member to transport a patient. Rather, some exploration and documentation that the physician considered factors such as these when deciding on how a patient might safely transported will make claims defensible and it is factors such as these that keep claims from being brought. Knowing that your members engage in an analysis of factors like this should also provide some measure of reassurance to hospital risk managers who may be hesitant regarding the policy.

## CONCLUSION

For the reasons set forth above, we do not believe there is a legal basis for hospitals to require that all patients being transferred for voluntary admission to an in-patient behavioral health facility be transported solely by professional EMS services. Under the right circumstance, both the hospital and physician can fulfill their legal duties to such patient while allowing a trusted friend or family member to perform the transfer. Good practice in this regard requires the physician to make a specific assessment of the situation and the factors which would bear on the safety of the transport and to document that assessment.

GJD:dmr