PRACTICAL RISK MANAGEMENT POINTERS FOR THE TREATMENT OF GEROPSYCHIATRIC PATIENTS

Professional liability carriers and risk managers have been reporting an increase in claims in some states related to the treatment of geriatric patients. Hospitals and nursing homes historically have been defendants in these cases, but a trend has emerged to name individual physicians in the litigation.

While the number of cases against psychiatrists in this area currently is small, several factors have risk managers concerned that this situation may change. Some jurisdictions have seen expansive judicial interpretation of elder abuse and neglect statutes, which offer plaintiff attorneys additional theories for recovery and the possibility of higher damage awards. While historically nursing homes and hospitals have been the defendants in cases alleging negligence in the care of elderly patients, plaintiff attorneys are increasingly including as defendants medical directors and consulting psychiatrists, in addition to treating physicians. Given the aging baby-boomer population, the specialty of geropsychiatry likely will grow in the future and more psychiatrists will be exposed to the professional liability risks related to treating elderly patients.

Psychiatrists need to be aware of these trends. Therapeutic interventions require special attention to ensure the safety of elderly patients. The clinical expertise and judgment of the treating psychiatrist is crucial in managing the risks involved. Set forth below are tips for decreasing the potential professional liability risks associated with the treatment of elderly patients.

DO know that an elderly patient's capacity to give informed consent to treatment may be impaired.
Psychiatrists should assess the patient's ability to give informed consent. This may include a cognitive workup. Consent from a patient without capacity is no consent. In some situations, a patient may need a surrogate decision-maker to consent to treatment. If the patient already has a surrogate decision-maker, the psychiatrist should know who can give consent for treatment and maintain appropriate documentation of such in the patient's treatment record.

BE AWARE of the increased risk of over- and under-medicating elderly patients.
Monitoring patients for the continued effectiveness and safety of prescribed medications is crucial. Most lawsuits against psychiatrists include allegations involving medications.

DO know your state's statutes and/or regulations regarding the reporting of elder abuse or neglect.

DO understand and be knowledgeable about current intervention techniques and professional standards/guidelines regarding the treatment of elderly patients.

Contact the organizations listed below for more information. Several of these organizations have guidelines for the treatment of elderly patients.

DO seek information from the patient, as part of the patient's assessment, about the patient's use of prescription medications, over-the-counter medications, herbal remedies, dietary supplements, other treatments, and dietary practices.
This is important information when developing a treatment plan, especially when prescribing medications.

DO communicate with other treatment providers about the important aspects of the patient's treatment – especially medications.
Elderly patients are more likely to have co-occurring somatic conditions. Medications used for the treatment of those conditions can interact and place the patient at risk of serious injury.

DO exercise considered judgment in prescribing medications.
In one study, drugs particularly dangerous to elderly patients were prescribed in about eight percent of their office visits. In a U.S. Pharmacopeia study, 55 percent of reported fatal medication errors involved patients over 65 years of age, highlighting the vulnerability of this patient population to medication errors.

BE AWARE of the increased risk of injury from falls, for which elderly patients may be especially vulnerable, when benzodiazepines and other sedating or performance-inhibiting medications are prescribed.
Performance-inhibiting medications call for careful monitoring.

DO document the clinical basis for medication recommendations to patients.

DO know that older adults have higher suicide rates than other age groups.
Assess elderly patients carefully for suicide risk and protective factors, particularly patients with depressive symptoms. The assessment, treatment plan, and steps taken to enhance protective factors and address risk factors should be documented.

DO respond decisively when faced with a patient at risk for suicide.
Suicide risk and protective factors should be addressed with patients, patients' family members, and significant others (this includes staff at a nursing home where a patient is being cared for) and a plan formulated and implemented to improve patient safety. In some cases, hospitalization may be the best option. The highest-risk course is to do nothing.

DO know your state's statutes or regulations regarding the reporting of impaired drivers.
Deciding whether or not to report an elderly patient as an impaired driver can be difficult and complicated. Some states have addressed the issue specifically in state law and provide clear guidance about reporting obligations, but many others have not.

DO consider other options *before* resorting to making a report about a patient's driving.

A patient's clinical improvement or willingness to voluntarily refrain from driving may eliminate the need to make a report under some statutes or regulations. A patient's significant others may need to be enlisted to help in this area.

DO consider a professional consultation or referral to a geropsychiatrist, when appropriate.

Compliments of:

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