FAILING TO PLAN…IS PLANNING TO FAIL

The solo practice of psychiatry is more challenging than ever. Most practitioners, however, overcome the challenges, successfully treating patients, managing staff, and making a living. Unfortunately, many also overlook the need to have a plan in place for the day when they are unable to treat their patients. The following vignettes are compilations of calls made over the past few years to our Risk Management Consultation Service helpline.

Scenario 1: The last time anyone saw Dr. R, a solo practitioner who lived alone, she was getting into her car as she left the office for the day. When she failed to arrive at the office by 8 a.m. the next day, her secretary called everyone she could think of to try to locate her. At the secretary's request, the police checked Dr. R's home and found nothing amiss. By mid-morning, there were several unhappy and alarmed patients in the waiting room. The secretary told the patients she had no idea where the doctor was and began sending them home. A longtime, elderly patient, distraught over the secretary's apparent panic and the doctor's unexplained absence, hyperventilated. Pharmacies called for authorization of prescription refills. A managed care company reviewer phoned to discuss a treatment plan. The hospital called to see why the doctor had not come to see her patients that morning.

No one knew that the doctor, driving home the night before, had hit a deer and skidded off the road into a ravine. If there had been any witnesses, they didn't alert the police. Rather, her car was found several days later by a road maintenance crew. Dr. R had died in the accident.

During those days, the secretary had authorized prescription refills, provided information to managed care organizations, and gave several patients their original records and told them to "find a new psychiatrist." She said, "I didn't know what else to do. This had never happened before. I just did what I thought Dr. R would want me to do."

Scenario 2: Dr. B had successfully practiced psychiatry on his own for 35 years. In anticipation of retirement, he had brought Dr. Z, who had a full-time salaried position elsewhere, into the practice six months earlier on a part-time basis. Dr. Z, who wanted to become a full-time private practitioner, took over the care of several of Dr. B's more challenging patients, and the relationship was going well. Only Dr. B, however, had keys to the office, only his name was on the door, and only his name was on the office lease. Dr. B's wife had acted as the office manager for many years.

One morning, Dr. B suffered a massive stroke. Mrs. B stayed at his side in the hospital for three days until he died. Dr. Z could not get into the office, could not get Mrs. B to talk to him, and could not reach the patients he was treating. Building management said they could not allow Dr. Z into the suite as his name was not on the lease. Dr. Z ended up putting a handwritten sign on the office door, advising patients to call him directly.

When Mrs. B finally spoke to Dr. Z after the funeral, she said that the practice was Dr. B's only asset, and she needed to talk to a lawyer to find out how she could sell it. She would not give Dr. Z a key to the suite, nor would she provide him access to patient records

Clearly, both of these scenarios are rife with potential for disastrous patient care and liability exposures. It is equally clear that both situations should have been anticipated and prepared for. Doctors are not immortal, and those practicing on their own must prepare staff for the day when, for whatever reason, they cannot practice and cannot give staff instructions. The reasons could be as simple as a sudden, severe case of the flu or as catastrophic as sudden death.

Before opening a solo practice, the psychiatrist should draw up a set of instructions for staff, family members, and willing colleagues regarding what they should do in the event of the psychiatrist's sudden incapacity. This kind of professional "advance directive" will save the psychiatrist's staff and family much anxiety and ensure continuing care for patients.

Once drafted, the plan should be regularly updated to reflect changes in the practice and the practices of the colleagues who have agreed to assist with contingency plans. The plan need not be complex, but it must be documented and readily available to anyone who may need to implement it. The following is a list of suggested items to be covered in a contingency plan:

- All contact information: the physician's pager number, cell phone number, home phone number, e-mail address, and home address.
- All contact information for the physician's spouse, life partner, adult children, or anyone else who would likely know of the physician's whereabouts or sudden health problems.
- A statement that staff is authorized to contact these people in the event of the physician's unexplained absence from the practice.
- Instructions regarding how long staff should wait before implementing the emergency contact plan in the event of any unexplained absence. One hour is probably the longest period of unexplained absence the plan should allow.
- Instructions regarding who is authorized to have access to patient records in the physician's unexplained absence. These instructions also should specify what information can be released from the records.
- Instructions regarding prescription refills and release of information to third parties.
- Instructions regarding how to deal with patients who become upset, either physically or emotionally, in the event of a crisis.
- Names, addresses, and phone numbers of psychiatrists who have agreed to act as emergency backups. There should be more than one. Staff should be trained on proper referral procedures and proper termination-of-care procedures.
- Instructions on how those psychiatrists can access the physical office and the electronic patient records in the event this becomes necessary, including passwords, etc.

Solo practitioners would be well advised to inform their patients (at the inception of the doctor-patient relationship) that there may be times when they will be unavailable due to illness, family emergencies, and so forth. Patients should be assured that staff knows what to do in the event of an emergency in the psychiatrist's life.

Psychiatrists who associate themselves with a solo practitioner, such as Dr. Z did in the second vignette, need to be certain that they will have access to necessary records and other practice resources in the event the principal in the practice is suddenly incapacitated. Obviously, these matters must be discussed at the beginning of the association before the assumption of responsibility for patient care in a practice controlled by a single practitioner.

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