



Rx FOR RISK  
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# Rx FOR RISK

Addressing risk management issues and concerns in the field of psychiatry

## *Geriatric Psychiatry*





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# PRACTICAL RISK MANAGEMENT POINTERS FOR THE TREATMENT OF GEROPSYCHIATRIC PATIENTS

Recently, professional liability carriers and risk managers have reported 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 is emerging to name individual physicians in the litigation. While the number of cases against psychiatrists in this area currently is relatively 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. Given the aging baby-boomer population, and the shortage of geriatric psychiatrists, 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.

**DO 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 NOT forget to consult your state’s prescription monitoring program (PMP) – even if you are not technically required to check it.**

Elderly patients may not accurately report all of their medications

**DO provide patients with written instructions on how and when to take medications.**

Make certain that you use clear, concise language and explain the purpose of each medication and its intended effect.

**DO, to the extent possible, simplify dosing regimens.**

**DO encourage the use of devices to aid the patient in taking medication at the correct times.**

**DO ask patients to bring in all medications they are currently taking to each visit.**

This should include over-the-counter medications and supplements.



**DO encourage patients to fill prescriptions at only one location.**

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

For example, the *APA's Practice Guidelines on the Use of Antipsychotics in Patients with Dementia*

**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 NOT ignore calls from family members or friends who may have concerns about the patient.**

Although you may not have permission to speak to others, remember you can always listen.

**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.

**DO 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 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.



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**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.**

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## COMMUNICATING WITH FAMILY MEMBERS AND OTHER CAREGIVERS

Psychiatric diseases often necessitate the involvement of family members and other caregivers to assist the patient in managing his or her disease. As such, effective communication between physician and caregiver is paramount to achieving optimal care. And, because family members are often the impetus to litigation following a less than desired outcome, effective communication is also an important step in minimizing liability risk.

Family members caring for patients with significant psychiatric disease face a number of stressors. On top of worries about their loved one's health, is the burden of providing care while also trying to manage their other personal obligations. This often leads to exhaustion, a sense of guilt for feeling burdened, and unfortunately health problems for the caregiver. Any one of these can negatively impact a caregiver's ability to communicate effectively with healthcare providers.

There is often a disparity between the information the family member/caregiver receives and the information the physician believes he or she is delivering. Caregivers often do not feel that physicians are delivering all of the information they want while physicians believe that they are providing the necessary information. The problem may lie in the fact that while the physician is, in fact, giving caregivers information, this information is being presented in such a way that it is not being heard or understood.

Other times it is not too little information that is the problem, but rather information overload. Disease and treatment-related information is often complex and difficult to comprehend. Feeling so overwhelmed that they don't even know what questions to ask, some patients and families will keep questions to themselves and never get the needed answers.

### Tips for Communicating with Family Members

- Provide patients and family members with written information about the patient's condition that can be reviewed in a more relaxed setting and be used later as a reference. The American Psychiatric Association has patient education brochures on various psychiatric disorders and their treatments that may be accessed at [www.psychiatry.org/mental-health/lets-talk-facts-brochures](http://www.psychiatry.org/mental-health/lets-talk-facts-brochures).
- At the beginning of treatment, ascertain from the patient his or her desires as to family involvement. Particularly if the patient has a large family, suggest that one person be the one with whom you will primarily communicate. Ideally this will be the person most directly responsible for the patient's day-to-day care.



- Be accessible, open, and forthright.
- Think of the patient and the family as a single unit of care. Consider the practicality of the treatment you are recommending and try to take into account its effect on the entire family and not just medical efficacy. When treatment decisions are made taking into account the interdependencies of patient and family, more successful treatment outcomes result.
- Make certain that caregivers understand the patient's medication regimen and what potential side-effects to look for. In addition to putting instructions in writing, consider providing copies of medication information sheets such as those available via the FDA website, [www.fda.gov](http://www.fda.gov).
- Have at hand a list of resources for caregivers that may be available through a local hospital or elsewhere in the community. Either directly provide or refer caregivers for training in such areas as behavior management to increase their confidence in providing care.
- Even if the patient's disease has progressed to the point where he or she can no longer effectively communicate treatment wishes, always make an effort to direct comments to both the patient and the caregiver. It can be extremely upsetting for family members when the patient is not included in the conversation and is talked about as if he or she were not present.
- Help to minimize the stress of decision making by letting patients and caregivers know that every decision does not have to be made immediately. If the situation is not life-threatening, allow them time to consider their options.
- Recognize the hard work of the caregiver. Let them know you recognize the stress placed on them and other family members by asking from time to time how they are doing.

## References

Communicating with Your Doctor, Part II, Family Caregiver Alliance. <http://www.caregiver.org>.

Family Care America, Inc., Give it to Me Straight. <http://www.caregiverslibrary.org/caregivers-resources/grp-medical-care/hsgrp-doctors-and-hospitals/closing-the-doctor-patient-gap-article.aspx>.

National Family Caregivers Association, Improving Doctor/Caregiver Communication. [www.nfcacares.org](http://www.nfcacares.org)

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# RECOGNIZING ELDER ABUSE

While most healthcare providers are keenly aware of their obligation to report child abuse, many do not appreciate their concurrent obligation to report suspected abuse of adults, particularly the elderly or incapacitated. Although the laws vary, in most states physicians are required to make a reporting when they suspect elder abuse which is defined by the CDC as “an intentional act, or failure to act, by a caregiver or another person involving an expectation of trust that causes or creates a risk of harm to an older adult. (An older adult is defined as someone age 60 or older).”<sup>1</sup>

Researchers recognize five major types of elder abuse:<sup>2</sup>

**Physical abuse** – acts carried out with the intent to cause physical pain or injury. This may also include inappropriate use of drugs, restraints, or punishment.<sup>3</sup>



**Psychological or verbal abuse** – acts carried out with intent to cause emotional pain or injury. This may include insults, threats, humiliation, and harassment and may stem from both verbal and non-verbal acts.<sup>4</sup>

**Sexual abuse** – nonconsensual contact of any kind to include exposure and nudity.

**Financial exploitation** – the misappropriation of money or property.

**Neglect** – failure of a designated caregiver to meet the needs of a dependent older person.

## Who are the Abusers?

According to the 1998 National Elder Abuse Incidence Study conducted by the National Center on Elder Abuse at the American Public Human Services Association and Westat, in almost 90% of the cases with a known perpetrator, that individual is a member of the victim's family. Two-thirds of these are either the victim's spouse or an adult child. Sadly, the stress of caring for an older dependent adult of limited physical or mental capacity, combined with other stressors such as financial concerns, may be too much for family members who are not adequately trained or prepared to take on the role of caregiver. This sometimes leads to physical abuse or neglect. In other situations, an older person may continue to receive the same abuse from a spouse that he or she experienced throughout their marriage. Individuals who abused their own children may now find that they are on the receiving end of the abuse.

## POTENTIAL SIGNS OF ELDER CARE ABUSE

Patients may be reluctant to report abuse, fearing that they will not be believed or that they will be sent away from their families and be placed in a potentially worse situation. In other instances, "actions that constitute abuse may not be recognized as such by the abused party."<sup>4</sup> For example, a victim may ignore or not be aware of the abuser's ulterior motives when shown attention and romantic affection by the abuser. In other instances, the victim may not report losses due to humiliation.

Accordingly, physicians and other health care providers need to be aware of the following signs of abuse and neglect.

**Physical abuse:** fractures, cuts, suspicious burns, bruises on arms consistent with having been grabbed or shaken, other bruises not readily explained, bite marks, depression, delirium.

**Sexual abuse:** reports of new instances of venereal disease or UTIs

**Psychological or verbal:** confusion, dramatic changes in sleep patterns, unusual or excessive fear, loss of interest in self and surroundings, unexplained weight changes, deprivation of personal property, seclusion.

**Financial exploitation:** significant disparity between assets/income and lifestyle, sudden failure to pay bills, failure to renew prescriptions or keep appointments, malnutrition or weight loss, lack of knowledge of personal finances, anxiety regarding finances, sudden appearance of caretaker upon whom the patient seems abnormally dependent.

**Neglect:** poor general hygiene, poor oral hygiene, unexplained weight loss, dehydration, malnutrition, decubitus ulcers, unkempt appearance, inadequate clothing, absence of eyeglasses, dentures, or hearing aids, signs of overdrugging or indications that patient is not being given prescribed medications.



The actions or inactions of caretakers may also provide evidence of mistreatment. The following is a list of behaviors of which you should take note:

- A show of anger or frustration toward the patient;
- A lack of knowledge or indifference regarding the patient's condition;
- A history of doctor-hopping at the caregiver's direction;
- Implausible explanations of the patient's injuries/condition;
- Attempts to monopolize conversation or preclude patient from speaking directly to you;
- Failure to visit the patient in the hospital;
- Inappropriate display of affection between the caregiver and the patient;
- Apparent financial dependence of caregiver upon the patient;
- Excessive concern over the cost of treatment; or
- Evidence of substance abuse or mental health problems on the part of the caregiver.<sup>4</sup>

Office staff should be alerted to signs of potential elder abuse. They may be in a position to pick up on situations that seem out of the ordinary when interacting with or observing patients and caregivers.<sup>3</sup>

## What to Do?

If you believe that you may be seeing signs of abuse, interview the patient and the caregiver separately to give the patient the opportunity to confide in you and uncover any inconsistencies in their stories.<sup>2</sup> But just as a patient may be reluctant to report abuse he or she may also be reluctant to admit that it has occurred when questioned. You may also wish to confer with other healthcare providers actively involved in your patient's care. Carefully document your findings and your efforts at investigation. If you determine that abuse has occurred, you must report this in accordance with the laws of your state.

## Endnotes

- 1 [www.CDC.gov/violenceprevention/elderabuse/definitions.html](http://www.CDC.gov/violenceprevention/elderabuse/definitions.html)
- 2 Lachs MS, Pillemer KA, Elder Abuse. *N Engl J Med* 2015;373:1947-56
- 3 <http://www.psychiatrictimes.com/geriatric-psychiatry/elder-abuse>
- 4 <http://www.psychiatrictimes.com/geriatric-psychiatry/four-categories-elder-abuse-evaluation-approaches>



# IMPAIRED DRIVERS: MAXIMIZING SAFETY, MINIMIZING LIABILITY RISKS

As a general rule, psychiatrists are not held liable for the actions of their patients except in cases of serious, imminent harm to an identifiable victim(s), in which case most states require the psychiatrist to take some form of action to warn or otherwise protect the victim(s). When dealing with patients who are or may be impaired drivers, however, the obligation to take action is less clear-cut.

Psychiatrists diagnose and treat many conditions that can potentially impair a patient's ability to drive safely. In addition to psychiatric disorders, other medical conditions, treatments/medications or changes incident to aging can affect one's ability to drive. Because patients may present with numerous impairments to driving that put their safety – as well as that of others – at risk, psychiatrists must be prepared to address this issue with their patients. They must also be aware of their potential obligation to report impaired drivers to their state's licensing agency.

These risks and obligations to the patient, and to the public at large, in turn pose attendant risks to the psychiatrist providing care in the form of potential breaches in confidentiality and third-party liability stemming from their patients' acts.

In this article, we will address these areas of concern and provide suggestions for maximizing patient safety while minimizing liability risks, and provide additional resources for managing impaired drivers.

## Identifying the Impaired Driver

The first step in dealing with an impaired driver is identifying the impairment. This begins with a comprehensive psychiatric evaluation which can reveal conditions and/or medications that could affect driving ability, as well as safety concerns or changes in driving habits that the patient or family member has observed. A physical examination with the patient's internist may also be considered to uncover such things as muscle weakness, limits to range of motion, or the slowing of reflexes that could all affect the patient's ability to drive safely.

With some patients, driving impairment will be readily apparent. With others, it will be far less obvious. One reason for this is that driving involves behaviors such as judgment and risk-taking that are often difficult to assess during an office visit.<sup>1</sup> Additionally, patients who fear the loss of independence may underreport problematic symptoms, as may family members who rely upon the patient for transportation.

Whenever a patient's potential for driving impairment has been assessed, regardless of whether actual impairment is noted, it is important to document the steps taken to make the determination. And remember, from a risk management perspective, negative findings are often just as important to record as positive findings.



Once it has been determined that the patient suffers from a driving impairment, the following risk management strategies may be useful in both protecting patient safety and limiting liability exposure for the treating psychiatrist:

- C** — Clinically address the underlying cause(s) of the impairment
- A** — Advise/educate/warn the patient
- R** — Report in accordance with your state law

## Clinically Address the Impairment

Once impairment has been observed, the next steps are to ascertain the cause of that impairment (e.g., is it disease or medication-related) and to determine whether it can be minimized or removed altogether. Impairment may be variable, as a patient's mental status may fluctuate as a function of the natural course of his or her illness, response to treatment, psychodynamic factors, metabolic status, intercurrent illnesses or the effect of medication.<sup>2</sup> Relatively simple changes such as alterations to medication, or perhaps even the timing of taking certain medications, may be effective in reducing impairment. Particularly in patients with comorbidities, interventions may include consultation with the patient's other physicians or referral to other specialists to appropriately treat or manage the conditions contributing to the patient's increased driving risk. Other factors might include vision or hearing loss or limited mobility that is the result of untreated pain all of which would merit referral to an appropriate specialist. Ideally, all physicians involved in a patient's care will make consistent recommendations to the patient regarding driving restrictions.

*The Physician's Guide to Assessing and Counseling Older Drivers* is an excellent resource to help you assess whether a medical condition is the cause of a driving impairment. This guide may be found on the National Highway Traffic Safety Administration (NHTSA) website. As always, timely and careful documentation of your clinical assessments, reasoning, and actions serves as the best tangible indicator that you have met the standard of care should your decisions ever be challenged.

## Advise, Educate and Warn the Patient (And where appropriate, family members)

Advising/educating/warning the patient (and to the extent permitted, family members) about impairments to safe driving is essential. Advising about possible impairments to safe driving goes hand-in-hand with your clinical assessment of the same and to the extent this possible impairment relates to medications prescribed, it is an extension of the informed consent to the treatment process. Per the APA Position Statement on the Role of Psychiatrists in Assessing Driving Ability (2016):

[P]sychiatrists do have a role in advising patients about the potential impact of their illnesses and treatments on driving ability. When appropriate, psychiatrists should discuss with patients, caregivers, and family members symptoms of their patients' mental disorders that may substantially impair driving ability. Like all physicians, psychiatrists should warn their patients about the possible effects of medications, including psychotropic medications, on alertness and coordination.

Discussing driving restrictions and other interventions, as well as the possible duty to report, is also advised. Ideally, education should begin with a candid, but sensitive, discussion between the psychiatrist and patient, allowing time to address the patient's questions and concerns.



Another important element of patient education is planning for potential impairment that may result from medication and/or other treatment. As stated previously, driving impairment should be communicated as a potential risk during the informed consent process. Any recommendations made to the patient with regard to driving should be clearly noted in the patient's medical record. It may also be prudent to have the patient sign a form acknowledging receipt of these recommendations. Medication Fact Sheets such as those available through the FDA's website are useful take-home reminders for patients and family.

Educating patients with regard to potential impairment – be it due to side effects of medication or disease progression – is not only important from a patient safety perspective but also from a liability perspective. In addition to malpractice cases brought by patients against physicians, some courts have allowed third-party actions against physicians when another person was harmed by a patient due to the physician's failure to provide sufficient information about potential risks to the patient.

One example of this is a New York case, *Davis v. South Nassau Communities Hospital* (2015 Slip Opinion 09229), where the appellate court held that where a medical provider has administered a medication that impairs or could impair the patient's ability to safely operate an automobile, the medical provider has a duty to third parties to warn the patient of that danger. In this case, the patient drove herself to the defendant hospital's Emergency Department; at 11:00 am she was intravenously administered Dilaudid and Ativan. Although there are numerous side effects of these drugs that would affect the patient's ability to operate a motor vehicle, the physician did not warn her of these side effects before she left the hospital. She was discharged at 12:30 pm the same day. The patient drove away and roughly twenty minutes later she crossed the double yellow line and hit a bus driven by the plaintiff. The court, in finding the physician had a duty to discuss driving prohibitions, noted that its decision imposed no additional obligation on a physician who administers medication. It is already the function of a physician to advise the patient of the risks and possible side effects of prescribed medication. And the court noted that in this case, the defendants are the only ones who could have provided a proper warning of the effects of medication [since there was no pharmacy involved].

Loss of driving privileges has no small impact on a patient, and for many it is a life-changing event. "If the patient does stop driving, his or her life may become profoundly altered, often leading to depression, dependency and isolation. This is particularly true because transportation options for frail or medically impaired patients are inadequate."<sup>3</sup> And for many individuals, "The car is more than just a way of transportation. It's a symbol of independence and economic status."<sup>4</sup> As such, it is important to begin preparing the patient (and the patient's family) for the day he or she will have to cease driving as soon as that eventuality arises.

The idea of not driving may be more palatable if it is something that the patient eases into. Early in the progression of a patient's disease, he or she may be able to drive safely with some modification. If appropriate, the psychiatrist may consider advising the patient to restrict driving in terms of the time of day, distance, frequency, or weather and road conditions. A switch to a vehicle with an automatic transmission may also improve safety.

If a patient has time to plan for life as a non-driver, he or she may be able to arrange for alternate means of transportation or perhaps even relocation to a place where a personal vehicle may not be needed. Enlisting the support of family members and/or friends may also be beneficial. Often, family members are willing to enforce driving restrictions or take away car keys when doing so is recommended by a physician.<sup>5</sup> Family members can also be asked to help the patient find alternative transportation to minimize the isolation, loss of independence and depression that often accompany driving cessation.



You may also wish to consider referring the patient to a driver rehabilitation specialist (DRS), often a specially trained occupational therapist. Again per the APA's Position Statement, "Accurate assessment of the impact of symptoms on functional abilities usually is not possible in an office or hospital setting because such an assessment typically requires specialized equipment or observation of actual driving, which goes well beyond the scope of ordinary psychiatric care."

A DRS will evaluate the patient's functional abilities pertinent to driving and will conduct a driving test.<sup>6</sup> The DRS will then recommend enhancements to driver safety, driving restrictions or driving cessation. Such a referral may be especially useful when the patient will be seen infrequently, when the condition's effect on driving ability is uncertain, or when necessary to preserve the doctor-patient relationship. The Association for Driver Rehabilitation Specialists provides a link to locate a DRS, as well as fact sheets for driving with specific impairments, which may be a helpful resource for patients.

### Report in Accordance with Your State law

Ideally, when the time comes for a patient to give up the car keys, either he or she will recognize that fact and voluntarily agree to stop driving or will have family members who make sure this occurs. Unfortunately, this is not always the case, and there are times when a psychiatrist must consider whether to report the patient as being an unsafe driver. In some instances, the decision is already made for the physician as reporting is mandatory (as in the case of a patient with epilepsy or seizure disorder). When reporting is optional, the psychiatrist must consider not only whether reporting is appropriate, but also whether he or she has any potential exposure for making the report, as well as its possible impact on the treatment relationship.

Ethically, both the APA and the AMA acknowledge that, under certain circumstances, physicians may disclose confidential information. The AMA discusses this situation specifically in their *Code of Medical Ethics Opinion 8.2 Impaired Drivers & Their Physician*:

Physicians have unique opportunities to assess the impact of physical and mental conditions on patients' ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patient's medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.

The opinion further states that prior to reporting, a physician should explain to the patient (and family) a physician an obligation to report a medically at-risk driver "when continuing to drive poses a clear risk to public safety or the patient's own well-being and the patient ignores the physician's advice to discontinue driving..."

Under HIPAA, a covered entity may disclose protected health information without authorization as required by law. However, HIPAA does not specifically allow for unauthorized disclosure to state motor vehicle departments and thus, one must look to individual state law. In the few states with mandatory reporting requirements, immunity is usually offered to physicians who comply with the law. In the majority of states, physician reporting is voluntary and protections afforded vary. Thus, physicians may face a conflict between the duty to maintain confidentiality and the obligation to protect the patient/public from harm. In this situation, it is recommended that you seek additional guidance from your malpractice liability carrier risk manager or personal counsel when deciding whether reporting is the best option for a given set of circumstances.



## Risk management strategies

When faced with a patient whose driving ability is or may be impaired, consider the following suggestions for maximizing patient safety while minimizing liability risks:

- Perform an evaluation of the patient's general competency;
- Familiarize yourself with consensus recommendations for counseling patients with impaired driving ability;
- Discuss the problem and your recommended interventions with patients and family members, if the patient has given authorization to do so;
- Communicate with the patient's other healthcare providers;
- Consider referral to another physician or a DRS where appropriate;
- Discuss potential for driving impairment as part of the informed consent process including impairment due to side effects of medication;
- Document discussions with the patient and family about recommended interventions;
- Familiarize yourself with the reporting requirements in your state;
- Check for changes in reporting requirements each time the issue arises;
- Discuss your obligation to report, honestly and compassionately, with your patient. Explain the process to the patient so that s/he understands that the state agency, not you, will determine restrictions to or revocations of the driving privilege. Reassure the patient that you will provide the minimal amount of information necessary;
- Seek guidance from a risk manager for your malpractice liability insurance program, or personal counsel before reporting;
- Document evaluation of and discussion with the patient, the patient's compliance with driving restrictions and the basis for reporting;
- Follow the state's process for reporting, including use of forms if required;
- Disclose the minimal amount of information necessary;
- Place a copy of the report in the patient's medical record.

## Endnotes

- 1 Campbell GH, Lutsep HL. Driving and neurological disease, available at <http://emedicine.Medscape.com/article/1147487-print>.
- 2 Applebaum, PS, Roth LH. Clinical issues in the assessment of competency. *Am J Psychiatry* 138(11):1462-1467
- 3 Odenheimer, GL. Driver safety in older adults: The physician's role in assessing driving skills of older patients. *Geriatrics* 2006; 61(Oct):14-21.
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# OBTAINING INFORMED CONSENT WHEN PATIENT LACKS DECISION-MAKING CAPACITY

Informed consent is rooted in the ethical imperative that competent adults have the right to accept or reject medical treatment based upon their own personal goals and beliefs. In Western culture, a patient's right to autonomy is paramount. Accordingly, when faced with a patient whose mental capacity is in question, a physician may find himself in the difficult position of having to choose between preserving patient autonomy and preventing harm to that patient.

## What is Capacity?

Incompetence and incapacity are two words that are often used interchangeably when referring to a patient's ability to consent to treatment. In fact, they are distinct concepts. Competency is a legal determination. An individual who has been adjudicated as incompetent will typically have a guardian appointed to handle such matters as medical decision-making.

Capacity, on the other hand, is a clinical determination. A patient who is incapacitated is one who, due to physical or mental impairment, is incapable of making informed decisions regarding his healthcare. Generally speaking, a person may be said to possess capacity if he can communicate a choice, understand the relevant information, appreciate the medical consequences of the situation, and reason about treatment choices.<sup>1</sup>

Capacity is often a fluid concept. Unless unconscious, a patient's capacity may vary from day to day or even hour to hour. It may fluctuate as a function of the natural course of his or her illness, response to treatment, psychodynamic factors, metabolic status, intercurrent illnesses, or the effect of medications.<sup>2</sup>

A patient may lack the capacity to make certain decisions but not others. For example, a patient may lack the capacity to manage his financial affairs but be perfectly capable of understanding and consenting to medical treatment. Or he may be able to execute some medical decisions, such as agreeing to take medication, but not others. The question then becomes whether the patient possesses the capacity to make a specific treatment decision.

## Assessing Capacity

Clearly it is not necessary to perform a formal capacity assessment on each and every patient. In fact, capacity is typically presumed. Although capacity must never be judged solely upon the content of a patient's decision, it is often not until a patient chooses a course of treatment that is in direct conflict to that which the physician believes to be in the patient's best interest that capacity is even questioned. There are, however, other instances when physicians should consider whether patients have the capacity to consent to treatment; for example, abrupt changes in a patient's mental status, or the presence of a chronic neurologic or psychiatric condition.<sup>3</sup> Although a patient's capacity is typically not questioned when he acquiesces to treatment, a patient's quick decision to undergo treatment with serious risk potential may merit a closer look. An assessment should also be made anytime the risks of treatment are relatively high in comparison to the expected benefit.



There are two ways in which to assess capacity: by conducting a clinical interview or by using a formal assessment tool. When assessing capacity through the use of a clinical interview, it may also be necessary to conduct a physical examination, obtain lab work, and to consult with other healthcare providers who have previously treated the patient as well as family members. The clinical interview should contain components which:

- Determine the ability of the patient to understand the proposed treatment and possible treatment alternatives
- Determine the patient's ability to apply information given to his or her own medical situation
- Determine the ability of the patient to reason with the information in a manner supported by the facts and the patient's own values
- Determine the patient's ability to communicate and express a choice clearly<sup>3</sup>

In addition to or instead of a clinical interview, a formal assessment tool, such as the Aid to Capacity Evaluation (ACE) or the MacArthur Competence Assessment Tool (MacCat), may be used. In either case, thorough documentation of the method used to ascertain capacity, including the physician's thought process, is imperative.

What happens when the presence or absence of decision-making capacity is not clear-cut? What if it appears that the patient has capacity but does not appear to be making a logical decision, such as with a person who possesses lower health literacy skills? In that instance, it may be simply that the patient does not fully appreciate the facts that have been given to him. It then becomes the duty of the physician to help the patient to better understand the information presented in order to make an informed treatment decision.

What about a patient whose capacity is in question but who agrees to follow the treatment recommendations of his physician? A patient's selection of the seemingly "correct" choice of treatment options is not in and of itself an indication that the patient has the necessary capacity to make an informed treatment decision. Here the physician must also consider the consequences of the patient's choice. When the risks are few and the anticipated benefit is great, less scrutiny may be required than when the risks are high and the anticipated benefits few.

## Obtaining Consent to Treatment

If the determination has been made that the patient lacks capacity to make an informed treatment decision, the next question to be asked is whether that incapacity is temporary. If this is the case and further harm will not come to the patient by delaying treatment, then treatment decisions should be postponed until such time as the underlying illness affecting capacity is treated and capacity is restored. If the patient's incapacity is due to the effects of medication, then consent discussions should be timed to coincide with periods of lucidity.

When faced with a patient who lacks the capacity to consent to treatment, it then becomes the physician's responsibility to find a way to arrive at decisions that will best reflect the patient's particular healthcare goals. Two values guide decision-making for competent patients that should also guide decision-making for incompetent patients: promoting patient welfare and respecting patient self-determination.<sup>4</sup> Many patients who are deemed to lack decision-making capacity still have preferences regarding outcomes. To the extent possible, efforts should be made to provide them with information to solicit their opinions even if the ultimate decision is left to another.<sup>5</sup>



When a patient is deemed unable to provide consent to his or her treatment, the physician must then look to a surrogate decision-maker. In many instances this person will be someone who has been appointed as the legal guardian of the patient or is someone who holds a power of attorney for healthcare decisions. If either of these is the case, the person claiming the right to make medical decisions should have legal documents granting such authority. Physicians should request copies of these documents and, if necessary, enlist the assistance of their risk manager or attorney to determine the holder's right to consent to treatment. Oftentimes, those holding a power of attorney will have only been granted the right to make financial decision for the patient. If formal arrangements have not previously been made, then family members may be entitled to make decisions on behalf of the patient. As laws may vary from state to state, physicians should familiarize themselves with their state's laws concerning substituted consent.

Per *AMA Code of Medical Ethics Opinion 2.1.2 Decisions for Adults Who Lack Capacity*, once a surrogate is identified, a physician should provide "advice, guidance, and support to the surrogate" and "assist the surrogate to make decisions in keeping with the standard of substituted judgment" basing those decisions in part on the patient's preferences as expressed in an advance directive or as documented in the medical record.

## Psychiatric Advance Directives

A Psychiatric Advance Directive (PAD) which is essentially an advance directive planned for mental health decisions, is something gaining in popularity which psychiatrists may expect to see in the future. PADs may be used to name a healthcare proxy or may give specific instructions regarding the type of care a patient wishes to receive (or not receive) in the event of a psychiatric crisis. Psychiatric advocacy groups such as NAMI and Mental Health America support the use of PADS as a way to promote patient autonomy. Currently 25 states have laws allowing for their use.<sup>6</sup>

## A Final Thought

When faced with a patient whose mental capacity is compromised, it becomes the physician's duty to affect a decision that will advance the patient's goals and interests. Unfortunately, this sometimes means that the physician's actions are later called into question – particularly when a less than optimal outcome is reached. By thoroughly documenting all efforts in assessing capacity, as well as all efforts in obtaining informed consent from the patient or an appropriate surrogate, a physician can ensure that his patient's right to self-determination is protected and his own liability risk minimized.

## Endnotes

- 1 Appelbaum, P. S. 2007. Assessment of Patients' Competence to Consent to Treatment. *N Engl J Med* 357(18):1834-1840
- 2 Appelbaum, P.S. and Roth, L.H. 1981. Clinical Issues in the Assessment of Competency. *Am J Psychiatry* 138(11):1462-1467
- 3 Tunzi, M. 2001. Can the Patient Decide? Evaluating Patient Capacity in Practice. *Am Fam Physician* 64:299-306
- 4 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Implementing Human Research Regulations* (Washington, DC: GPO, 1983)
- 5 AMA code of Medical Ethics: Opinion 2.1.2 Decisions for Adult Patients Who Lack Capacity
- 6 [www.NAMI.org](http://www.NAMI.org)



## A CLAIM EXAMINER'S PERSPECTIVE: NOTICE OF A PATIENT DEATH

**Q:** I have been treating an 82 year-old female patient for the past 2 years. I usually see her once a month for a short med check visit. She has always kept her appointments and been pleased with my care. I have never involved her family in anything beyond the initial information gathering when I started working with her. Today, my office manager showed me the obituary page in our local newspaper. My patient's obituary is included. She died unexpectedly of a heart attack at her home several days ago.

I don't know what to do. Should I call the family and ask if there is anything I can do?

**A.** Sadly, this is the type of situation that we receive calls about from time to time. It is not unusual for a psychiatrist to hear of a patient death through indirect means.

A guiding principle for these situations is that your relationship with the patient's family and significant others after the patient's death should more or less reflect the relationships that existed prior to the death.

In the situation described above, the psychiatrist had only limited contact with the patient's family at the outset of treatment; therefore, a reasonable course of action would probably be to do nothing or to send a brief condolence note that does not specifically identify the deceased as a patient. In this way, the psychiatrist would be able to acknowledge the death without intruding into the family situation.

If the psychiatrist had been in regular contact with the family, it might have been appropriate for her to call, let the family know that she is aware of the death, and express her condolences in addition to sending a brief condolence note.

In some situations, the mental health professional may wish to attend a memorial service, wake, or funeral. Factors to consider in making such a decision include the preexisting relationship with the family and the family's comfort level with the possibility that friends and other family members will become aware, through the mental health professional's attendance, that the deceased was receiving psychiatric treatment. Generally, it is appropriate to attend only if invited to do so by the family.

There may be instances in which there are questions about the manner of a patient's death (e.g., was it suicide or an accident?). While the mental health professional may be tempted to inquire about specifics from family or others, it is almost always inappropriate to do so unless a prior relationship exists in which such questions could be freely asked.

It is important also to remember that patient confidentiality continues after the death of the patient and that authorizations the patient signed in life are no longer valid. In order to disclose information about the patient to friends and family, you must have the necessary authorization of the person who legally controls that information. Who that individual is will vary depending on circumstances and state law.

However, an appreciation of confidentiality obligations need not prevent the psychiatrist from offering support and expressing caring and concern for the patient's family. If appropriate, the psychiatrist can inform them of appropriate resources and/or recommend and refer family members for counseling or treatment, all without disclosing confidential patient information. Fortunately, most psychiatrists find that families usually understand that the doctor must follow legal and ethical requirements for releasing patient information when it is tactfully explained and discussed with them.

Have any comments or questions about an article?

**We would love to hear from you!**

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