HOOT WHAT WHERE

WELCOME TO ANOTHER EDITION OF "HOOT WHAT WHERE," a newsletter developed by Professional Risk Management Services® for the behavioral healthcare network of psychiatrists and mental health professionals. From risk management and claims advice to risk alerts, PRMS announcements, and events, this quarterly newsletter will share relevant news, useful tips, and important updates in the field of psychiatry to help keep you, your patients, and your practice safe.

WHAT YOU'LL FIND INSIDE:

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MYTHS & MISCONCEPTIONS:
THE TREATING VS. THE FORENSIC ROLE

Myth: I can effectively provide treatment and forensic services to the same person.

Truth: Acting as both a treater and expert witness, or performing an evaluation for legal purposes, could adversely affect the therapeutic relationship and your objectivity as an expert.

These are two common scenarios in which psychiatrists find themselves:

A psychiatrist has been treating a woman, diagnosed with bipolar disorder, for three years. The patient and her husband are separated and have joint custody of their young son. The patient tells the psychiatrist that her estranged husband provides very little monetary support for the child and goes out of his way to make her life miserable. The psychiatrist thinks the patient is trying very hard to provide a good home for her child, but that sometimes she is barely holding things together. Now, the father wants sole custody, saying the mother is "unstable." The father has retained a very well-known attorney from a large and influential law firm to represent him. The patient's attorney has contacted the psychiatrist and asked her to write a report and provide oral testimony at a custody hearing in support of the patient/mother retaining custody of the child. The patient tells the psychiatrist that she cannot afford to pay for an independent medical expert and, "besides, you know better than anyone that it is best for my child to live with me."

A patient is receiving disability insurance through his employer as a result of an injury at work. The patient started psychiatric treatment about a year after the injury. The psychiatrist and the patient have been working on many issues, including issues related to the injury. Now, the patient is involved in a dispute with the insurance company because the disability payments are being discontinued. He has consulted an attorney about filing a lawsuit against the insurance company. If the patient loses the disability payments, it is unlikely that he will continue in treatment with the psychiatrist because of the cost. Previously, the psychiatrist provided limited information (with the consent of the patient) to the disability insurance company about the patient's current and previous diagnoses and about the recommended treatment plan. Now, the patient and his attorney have requested that the psychiatrist write a letter to the disability insurance company stating that the patient's current psychiatric problems were caused by the injury that he sustained at work.

In these scenarios, the psychiatrists are clearly acting in the role of "treating psychiatrist"; however, once they start giving opinions for the purposes of employment or litigation, they have moved beyond the scope of "treating psychiatrist" and into the role of "forensic psychiatrist," or even "expert witness." Multiple roles bring with them the very real possibility, even the inevitability, of conflicting obligations (i.e., the patient's clinical needs versus the patient's other needs). Conflicting obligations increase the risk of clinical, ethical and even legal problems. The American Academy of Psychiatry & the Law states in *Ethical Guidelines for the Practice of Forensic Psychiatry* "[t]reating psychiatrists should generally avoid agreeing

to be an expert witness or to perform evaluations of their patients for legal purposes because a forensic evaluation usually requires that other people be evaluated and testimony may adversely affect the therapeutic relationship."

The psychiatrist in each of these situations should be justifiably concerned about being drawn into litigation as an expert witness. With proper authorization from the patient, it may be appropriate for the psychiatrist, as the treater, to provide factual information in a report or testimony about the patient's clinical status. However, if the psychiatrist's asessments, recommendations, and opinions do not exactly match the litigation needs of the patient/party as the lawsuit develops, then the psychiatrist's usefulness as a witness is finished. At that point, she could even be detrimental to the patient's case, which could have serious implications for the therapeutic relationship.

If, on the other hand, the psychiatrist tailors her assessments, recommendations, and opinions to the needs of the lawsuit, then her effectiveness as a treating psychiatrist is seriously compromised, if not destroyed, and she may even be falling below the standard of care. In either situation, if the patient thinks he has been harmed by the doctor's involvement, the patient may then have a cause of action against the psychiatrist based in negligence (i.e., negligent treatment or negligent forensic evaluation).

Risk Management Advice:

Psychiatrists should be wary when asked for opinions or predictions by third-parties, such as patients' employers, disability insurance companies, and attorneys. The safest response is for the psychiatrist to discuss the issue with the patient, explaining the limits of her role as a treating psychiatrist and outlining the potential conflicts. She can advise the requesting parties that if they want an opinion or a prediction, then they should obtain an independent medical exam for that specific purpose.

Psychiatrists who practice in small towns or rural areas sometimes find that it is difficult to avoid dual roles; however, they should still make every effort to do so.

PRESCRIBING CONTROLLED SUBSTANCES: MANAGING THE RISKS

While scrutiny of controlled substance prescribing has increased, there are three proven strategies to manage the risks associated with prescribing controlled substances:

1. Collecting information
2. Communicating
3. Carefully documenting

COLLECTING INFORMATION

About the Patient:

- Perform, and document, a complete initial patient evaluation, including medication history
- Review your state's Prescription Monitoring Program (PMP) prior to prescribing
  - If the report shows prescriptions not reported by the patient, address the issue clinically with the patient.
    - Do not abandon by terminating without notice
    - Do not report the entries to law enforcement

About the Medications:

- Stay up-to-date with the medications you prescribe
- Read the labels for the medications you prescribe
- Subscribe to FDA's MedWatch (1) for notification of medication safety alerts
- Be familiar with FDA's REMS for the medications you prescribe (2)

About Treatment / Standard of Care:

- Stay current with and follow:
  - Applicable federal and state laws related to prescribing controlled substances
  - Applicable federal and state regulations
  - Guidance from regulatory agencies such as
    - DEA
    - State licensing board
  - Guidance from others such as
    - Federation of State Medical Boards
    - Professional organizations –APA, AACAP, etc.
- Complete appropriate CME courses related to prescribing controlled substances
- Follow universal precautions when prescribing opioids (3)
  - Make a diagnosis with an appropriate differential
  - Conduct a patient assessment, including risk for substance abuse disorders
  - Discuss the proposed treatment plan with the patient and obtain informed consent
  - Have a written treatment agreement that sets forth the expectations and obligations of both the patient and the treating physician
  - Initiate an appropriate trial of opioid therapy, with or without adjunctive medications
  - Perform regular assessment of patient and function
  - Reassess thepatient's pain score and level of function
  - Regularly evaluate the patient in terms of the "5 A's": Analgesia, Activity, Adverse effects, Aberrant behaviors, and Affect
  - Periodically review the pain diagnosis and any comorbid conditions, including substance use disorders, and adjust the treatment regimen accordingly
  - Keep careful and complete records of the initial evaluation and each follow-up visit

About Abuse and Diversion:

- Recognize the drug abuser –from the DEA (4)
  - Common characteristics
    - Unusual behavior in waiting room
    - Assertive personality, often demanding immediate attention
    - Unusual appearance
    - Unusual knowledge of controlled substances and/or textbook symptoms
    - Evasive or vague answers to questions regarding medical history
    - Reluctant or unwilling to answer questions regarding medical history
    - No regular doctor; no health insurance
    - Will request a specific mediation and is reluctant to try a different one
    - No interest in the diagnosis; fails to keep appointments for further diagnostic tests or refuses to see a consultant
    - Exaggerates medical problems and/or simulates symptoms
    - Cutaneous signs of drug abuse
  - Common modus operandi:
    - Must be seen right away
    - Wants an appointment toward end of office hours
    - Calls or comes in after regular business hours
    - Travelingthrough town, visiting friends or relatives
    - Feigning physical problems
    - Feigning psychological problems
    - States that certain medications to no work or is allegoric to them
    - Lost or stolen prescription
    - Requests refills more than originally prescribed
    - Pressures by eliciting sympathy or guilt
    - Utilizes a child or elderly person when seeking stimulants or narcotics
- Recognize doctor shoppers –red flags –from the Tucson DEA (5)
  - Symptom incompatible with reported injury
  - Visits physician some distance from home
  - History of problems with no medical records
  - Multiple accidents
  - Insists on drug of choice
  - Loss of prescription or medication
  - Fails to have testing done
  - Takes more meds than directed
  - Requests meds early
  - Obtains meds from multiple prescribers
  - Prescriptions are filled at multiple pharmacies
- When confronted by a suspected drug abuser –from the DEA (4)
  - DO:
    - Perform a thorough examination appropriate to the condition
    - Document examination results and questions asked of the patient
    - Request picture ID
    - Confirm telephone number
    - Confirm current address at each visit
    - Write prescriptions for limited quantities
  - DON'T:
    - Take the patient's word for it if suspicious
    - Dispense meds just to get rid of drug-seeking patients

- Prescribe, dispense, or administer controlled substances outside the scope of your professional practice or in the absence of a formal practitioner-patient relationship

COMMUNICATING

With the Patient:

- Ensure adequate on-going monitoring of the patient and progress toward treatment goals
- Consider standardized assessment tool
  - Especially pain management (6)
  - Especially for buprenorphine treatment (7)
- Ensure adequate on-going monitoring of the medications –efficacy, side effects, etc.
- Informed consent
  - Nature of proposed medication
  - Risks and benefits of proposed medication, including
    - Severe risks, even if infrequent
    - Frequent risks, even if not severe
    - Potential for tolerance, dependence, addiction, overdose
    - Potential for driving impairment
  - Alternatives to proposed medication
  - Risks and benefits of alternative treatments
  - Risks and benefits of doing nothing
  - Prescribing policies
  - Reasons for which medication may be changed or stopped
- Use resources to assist with patient understanding
  - Medication guides
    - FDA (8)
    - Professional organizations, such as AACAP (9)
  - FDA's "Patient Counseling Document for Opioids" (10)
- Your office policies related to prescribing controlled substances, such as:
  - Only one prescriber
  - Only one pharmacy
  - No replacement of lost or stolen prescriptions
  - Prohibition on dose or frequency increases by patient
  - Use of PMP
  - Random pill counts
  - Random drug screening
  - Etc.
- Consider the use of a treatment agreement, especially for pain management, which could include:
  - Intended benefits / goals of using controlled substances
  - Risks of the treatment, including tolerance, dependence, abuse, addiction
  - Prescription management –how patient can keep medications secure, etc.
  - Office policies
  - Termination for
    - Non-adherence
    - Aberrant behavior
  - Etc.
- Ensure the security of your prescriptions –from the DEA (11):
  - Use tamper-resistant prescription pads
  - Keep all prescription blanks in a safe place where they cannot be stolen; minimize the number of prescription pads in use
  - Write out the actual amount prescribed in addition to giving a number to discourage alterations
  - Use prescription blanks only for writing a prescription and not for notes

- Discuss proper disposal of unused medication

With Others:

- Ensure communication between all involved in the patient's care (such as covering physician, other treaters, etc.)
- Communicate with family members as authorized by the patient
  - In emergency situations, remember that safety of the patient or others is an exception to confidentiality, so no authorization is required
  - You can listen to what third parties want to tell you without breaching patient confidentiality, as long as you are not disclosing information

CAREFULLY DOCUMENTING

- Document your treatment decision-making process
  - Documentation allows your work to be understood
- Record should contain:
  - Medication log
  - Evaluation
  - Medical indication for prescribing
  - Treatment plan –initial and updated
  - Informed consent –including patient education materials
  - Ongoing assessment
    - Adherence to treatment plan
    - Medication monitoring
    - Aberrant behavior
  - Referral / consultation, if necessary
  - Treatment agreement, if used
  - Assessment forms, if used

Sources:

1. www.fda.gov/medwatch

2. www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm111350.htm

3. www.fsmb.org/pdf/pain_policy_july2013.pdf

4. www.deadiversion.usdoj.gov/pubs/brochures/pdfs/recognizing_drug_abuser_trifold.pdf

5. www.acponline.org/about_acp/chapters/az/rivera - armando.pdf

6. www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/maperc/online/Documents/Pain%20Assessment%20Documentation%20Tool%20(PADT).pdf

7. www.suboxone.com/hcp/pdfs/app_use_checklist.pdf

8. www.fda.gov/drugs/drugsafety/ucm085729.htm

9. www.aacap.org/App_Themes/AACAP/Docs/resource_centers/adhd/adhd_parents_mediation_guide_201305.pdf

10. www.fda.gov/downloads/forindustry/userfees/prescriptiondruguserfee/ucm361110.pdf

11. www.deadiversion.usdoj.gov/pubs/manuals/pract/postmarketdrugsafetyinformationforpatientsandproviders/ucm111350.htm

POP QUIZ!

Failure to meet the standard of care is:

A. Negligence
B. Medical malpractice
C. A criminal act
D. Not covered by professional liability insurance

see answer on page 9!

10 THINGS ABOUT SUICIDE

1. An impression shared by many psychiatrists is that to avoid liability related to patients with suicidal behaviors, they must be able to predict whether a particular patient will attempt suicide and prevent all suicide attempts however unforeseeable. Fortunately, courts recognize that psychiatrists are only human and do not expect impossible powers of prediction.
2. If a patient reports a history of suicide attempts or ideation, make certain that you obtain past treatment records if possible. If you are unable to obtain records, document your efforts to do so. Plaintiff attorneys often cite a psychiatrist's failure to obtain past treatment records in post-suicide lawsuits.
3. A formal suicide risk assessment tool should be utilized for consistency and thoroughness. Two excellent tools are the Columbia Suicide Severity Rating Scale and SAFE-T (Suicide Assessment Five Step Evaluation and Triage.
4. Address the need for a safe environment for patients with suicidal behaviors. The accessibility of firearms or other weapons should be assessed and an appropriate plan for safety should be instituted, including getting information from and instructing family/significant others about this issue.
5. Make certain that your records reflect what treatment options/actions were considered, what options/actions were chosen and why, and what options/actions were rejected and why. In the event of litigation, it is important to your defense that your record reflects your clinical judgment and choices, the knowledge and skill you exercised during treatment, a contemporaneous assessment of the patient's needs and behaviors, revisions to the treatment plan, and explanations of your decisions.
6. Reassess suicide potential whenever there is an incidence of suicidal or self-destructive ideation or behavior, when significant clinical changes occur, when any modification in supervision or observation level is ordered, and at the time of discharge or transfer from one level of care to another.

7. Never agree to treat a suicidal patient in a split treatment relationship if you are uncomfortable working with the other treater. When managing a suicidal patient, it is imperative that psychiatrist and therapist are able to work as a team. In the best-case scenario, split-treatment can enhance care and patient safety as it allows for closer patient monitoring using the separate expertise of two skilled clinicians; however, when clinicians do not work well together, both patient and clinicians are put at risk.
8. Remember, patient safety always trumps confidentiality. Accordingly, even without patient consent, consider alerting family members and significant others to the risk of outpatient suicide when: the risk is significant, the family members do not seem to be aware of the risk, and the family might contribute to the patient's safety. Likewise, a psychiatrist should never ignore offers of information from family members or close friends that might be relevant to a patient's safety. It is not a HIPAA violation to listen. You do not want to be in a courtroom listening to a plaintiff attorney argue that a patient's suicide could have been prevented had you only bothered to return a call.
9. Do not rely solely on "no-harm" contracts as a guarantee of patient safety. These "contracts" have no legal force and cannot take the place of an adequate suicide risk assessment. It may be appropriate for a "no-harm" contract to be one part of a comprehensive treatment plan but it is the clinician's responsibility to evaluate the patient's overall suicide risk and ability to participate in the overall treatment plan.
10. As a psychiatrist, you are expected to know the standards and procedures for civil commitment in your state. When contemplating commitment, document that you have considered this option and the clinical basis for rejecting or proceeding with it. Even if you think it is unlikely that police will take your patient to the hospital, if you believe that he/she is at imminent risk of suicide, you should still make the effort of calling 911.

ANSWER

The answer is A. Failure to meet the standard of care is negligence. Negligence is just one of four elements of a medical malpractice action:

1. Duty of Care – the physician owed a duty of care to the patient (to meet the standard of care)
2. Breach of Duty – the physician was negligent (the care provided fell below the standard of care)
3. Damages – the patient suffered some type of harm (physical, financial, emotional)
4. Proximate Cause – the patient's harm was a direct result of the physician's negligence

Malpractice is more than simply negligence. It is defined as the act(s) or continuing conduct of a physician that does not meet the standard of professional care and results in injury/damage to the patient, but does not include the exercise of professional judgment, even when the results are detrimental to the patient.

HAPPY HOLIDAYS

This holiday season, PRMS is proud to support organizations working to support wellbeing and mental health in our local community and across the country. Join us in supporting: **Arlington Food Assistance Center,** which provides dignified access to free groceries and allows families to devote their limited financial resources to obligations such as housing, utilities, medication, and other basic needs in the Northern Virginia area; **Trevor Project**, whose mission is to end suicide in LGBTQ+ young people through research, advocacy and support programs; **World Central Kitchen**, a global organization developing a new model for disaster relief by providing meals to humanitarian, climate, and community crises; and **Child Mind Institute**, which is dedicated to transforming the lives of children struggling with mental health and learning disorders by providing evidence-based care and resources, training educators in underserved communities, and developing breakthrough treatments.

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