Rx FOR RISK
IS A PRMS
PUBLICATION

2016 | Volume 24 | Issue 1

Rx FOR RISK

Addressing risk management issues and concerns in the field of psychiatry

Psychopharmacology: Part I

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The Psychiatrists' Program® data reflect that claims involving medication are the second leading cause of loss following suicide. The underlying causes of adverse drug events and, in some cases, subsequent medical malpractice claims, are complex.

IN THIS ISSUE OF Rx FOR RISK, we look at malpractice liability risk related to the prescription of psychotropic medications and suggest ways to minimize these risks.

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RISK MANAGEMENT AND PSYCHOPHARMACOLOGY

Advances in psychopharmacology have provided therapeutic options that were unavailable just a short time ago, leading to an increase in the use of psychotropic medication in all age groups. Unfortunately, as has historically been the case, these advances have been followed by an increase in medical malpractice lawsuits. Innovations typically add to the complexity of treatment and, at the same time, often increase patients' expectations for positive treatment outcomes. In the last few years, FDA public health advisories and safety alerts about psychotropic medications, along with related reports in the media about these issues, have added to the escalating national debate about post-approval safety of prescription medicines.

Against this background, psychiatrists' prescribing decisions are scrutinized more than ever. However, good risk management can be one very significant part of initiatives to reduce adverse medication events and related malpractice actions.

ALLEGATIONS OF NEGLIGENCE RELATED TO PSYCHOPHARMACOLOGY

Lawsuits and claims involving psychopharmacology typically allege one or more of the following:

Negligence in prescribing: Allegations of negligent prescribing concern the adequacy of the psychiatrist's assessment or evaluation of the patient, diagnostic formulations, and the decisions about which medication(s) to prescribe, including the dosage, frequency, and management of refills.

Negligence in administration: Lawsuits and claims alleging negligent administration of medications are not often seen against psychiatrists. Such problems are more likely to occur in crisis or emergency practice settings and often involve possible negligence of staff in the administration of the drug ordered by the psychiatrist. When a psychiatrist is named in these instances, allegations usually involve ordering and/or administering a medication by the wrong route, e.g., giving the drug intravenously instead of intramuscularly.

Negligence in monitoring: Liability claims based on alleged failure to properly monitor a prescribed medication may be particularly difficult to defend because of well-established standards and guidelines for the monitoring of most medications. Further, ongoing monitoring of drug treatment is a basic tenet of medical treatment and any failure to monitor will be characterized by a plaintiff's attorney as a virtual abandonment of the patient's care.

Negligence in obtaining adequate informed consent: Cases alleging negligence related to prescribing or monitoring psychotropic medications also typically include allegations of that the psychiatrist failed to appropriately inform the patient of the possible risks of treatment.

RISK MANAGEMENT – THE THREE C'S

Fortunately, there are steps that psychiatrists can take to reduce their malpractice risk. Effective risk management strategies for decreasing risk related to psychopharmacology that mirror best practices in clinical care are represented by the "three C's:"

THE THREE C'S:

COLLECTING INFORMATION
- about the medication
- about the patient

COMMUNICATING
- with the patient
- with others

CAREFULLY DOCUMENTING
- the patient's informed consent
- medication monitoring
- the decision-making process

These risk management strategies are "patient and physician-centered" rather than liability-centered. They support the patient-physician relationship by encouraging evidence-based best practices instead of fostering a defensive attitude. They also reduce physician anxiety about medical malpractice risk. These three strategies are not meant to over-simplify the complexities related to preventing and decreasing adverse drug events. Rather, they are intended as a way to effectively avoid errors and omissions most frequently giving rise to claims in this area.

RISK MANAGEMENT STRATEGY #1 – COLLECTING INFORMATION

Collecting Information about Medications

Staying current about medications being prescribed is fundamental to prescribing, but it's no small task. In a medical malpractice lawsuit the defendant physician's actions and decisions will be judged by looking at the information that was available to the physician about the medication at the time of the clinical decision-making.

It is more challenging than ever to stay current about prescription drugs due to the amount of information being produced, the speed a which it develops, and, in some cases, due to conflicting and/or incomplete information. Steps psychiatrists should consider include, but are not limited to:

- Reading the FDA label;
- Subscribing to *MedWatch E-list*;
- Taking notice of "Dear Healthcare Professional Letters;"
- Signing on to PDR.net
- Attending continuing medical education; and
- Staying current with professional literature and research.

Collecting Information about the Patient

The second part of this risk management strategy focuses on the importance of collecting information about the patient throughout the course of treatment. Information should be gathered from:

- The patient as part of the ongoing assessment and evaluation of the patient in order to develop a diagnosis, and to develop and implement an ongoing treatment plan, which may include prescribing medications;
- Family members and significant others, as appropriate; and
- Other healthcare providers, including obtaining past treatment records.

Assessment tools: Psychiatrists should consider consistently using some sort of tools – such as a worksheet - when assessing patients, as this will help to create an assessment process that is reliable and replicable. We have learned from malpractice lawsuits and patient safety research that such replicable processes establish systems that make it less likely that important information will be overlooked.

Inquire about all treatments: In addition to inquiring about the use of other prescription medications and over-the-counter medications, psychiatrists should inquire about complementary and alternative treatments, such as herbal remedies, dietary supplements, and any other treatments the patient uses. See below for a further discussion of CAM.

Monitoring system: An ongoing monitoring system to keep track of and evaluate the use of medications provides information that is essential for the continued evaluation and treatment of the patient. Such a system lowers the likelihood that certain testing or follow-up activities (such obtaining or reading lab results) will be inadvertently missed – by the psychiatrist, the patient or other treatment team members. A psychiatrist establishing a monitoring system may want to consider including the following:

- List of medications that routinely require blood levels monitored, a schedule for frequency of testing, list of testing to be done
- List of medications and patient conditions that require baseline and ongoing laboratory tests
- Procedure for the timely review and response to results of lab testing
- Documentation of instructions to patients to obtain lab testing and documentation that testing was done. (If patients refuse or are unable to obtain lab testing, documentation of response and plan to manage this situation.)
- Information and instructions to patients (and families when appropriate) about why monitoring is needed.
- Periodic review, and documentation, of the efficacy of medications and adjustments made as a result of information obtained (change in dosage, change in route, change in time of administration of medication, etc.).
- Side-effects and adjustments made as a result of information obtained and documentation of same.

RISK MANAGEMENT STRATEGY #2 - COMMUNICATING

Communicating with the Patient

Informed consent discussions are one of the most important types of physician-patient communication and provide an excellent opportunity to decrease malpractice risk.

What to disclose in informed consent discussions: There are often questions about how much information psychiatrists need to disclose. They should disclose the common, as well as the material risks, but not every conceivable risk. A material risk is defined as a risk that would be significant to a reasonable person in the patient's situation. Materiality can also be thought of in terms of frequency and severity of the risk. A risk that is severe, even if it occurs infrequently, would be a material risk. Similarly, a risk that occurs frequently, even if not severe, is a material risk that should be disclosed.

CASE SCENARIO:

In one lawsuit, the physician omitted information about the risk of Stevens-Johnson syndrome (SJS) with a drug being prescribed because he thought the information would prevent the patient from taking the recommended medication. As a result, the patient did not know to seek timely treatment when a rash started and she developed SJS.

One practical approach for deciding what information to disclose calls for the prescriber to ask the question, "What information would I want a physician to disclose to my loved one if I were not present and my loved one needed to give consent to a treatment recommendation?"

Psychiatrists should remember that one of the benefits of the informed consent process is that it can help manage patient expectations. Unrealistic expectations for treatment outcomes often result in patient dissatisfaction and in some cases can prompt a lawsuit.

Psychiatrists may want to consider using FDA or similar medication guides to augment patient education when prescribing a medication. Obviously, any educational or informational materials are just one part of the informed consent process. For more information on using medication information sheets in informed consent discussions, see the article "Use of Medication Guides" below.

Remember to clarify necessary dietary and/or activity restrictions (such as driving) while taking the medication. Potential allergic reactions, ways to identify them, and what to do if the patient experiences a reaction should be discussed.

Communicating with Other Healthcare Professionals

CASE SCENARIO:

A psychiatrist arranged to have the patient's primary care physician (PCP) conduct blood draws and perform laboratory tests for the patient's lithium level and renal function. Laboratory test results were sent to both the psychiatrist and the PCP. Assuming the PCP was monitoring them, the psychiatrist had staff file the test results without his review. The PCP was not monitoring the test results either, believing that the psychiatrist, as prescriber, was responsible. The patient eventually developed lithium toxicity and required dialysis and a renal transplant.

The "communication" risk management strategy includes putting into place and maintaining effective and appropriate communications with other professionals involved in the care of the patient. Regular communication with other involved healthcare professionals about medication responses, side-effects, and laboratory results helps ensure coordinated care.

Consultation: Consultation with colleagues is a valuable clinical and risk management approach. Obtaining consultation tends to support thoughtful decision-making, demonstrate objectivity in the choice of treatment modalities, and may provide some assurance for the psychiatrist that the quality of care delivered meets the standard of care.

Written communication: Written communication is also essential. Prescriptions and drug orders must be legible. A prescription that is impossible to decipher or difficult to read poses a danger to the patient. Similarly, data entry must be accurate. In an example of innovation as precursor to increased malpractice risk, data entry errors may eclipse handwriting errors as a source of adverse drug events.

RISK MANAGEMENT STRATEGY #3 – CAREFULLY DOCUMENTING

Treatment records are created to provide for the clinical care of patients. As such, treatment records should be written so that a subsequent treatment provider can review the record and know what happened in treatment and why. Often, information regarding clinical actions not taken is as important as information about actions that were taken. Such careful documentation provides subsequent readers with information about the basis for the physician's clinical decisions and is critical to the ongoing care of patients.

When prescribing medications, information is obtained in an ongoing fashion and must be documented diligently. Too often, patient records are reviewed after a lawsuit is filed only to find that initial assessments are well-documented but follow-up evaluations and monitoring are documented less completely. This creates the impression that ongoing assessments and medication monitoring were lacking.

The basics of documentation when prescribing medications include documenting:

- Patient assessments (initial and ongoing)
- Monitoring efforts and response to treatment
  - » All ongoing laboratory testing and other patient monitoring actions taken
- Medication log
  - » Name of medication
  - » Start and stop dates
  - » Changes in dosage
- Informed consent discussions
- Basis for clinical decisions related to prescribing (diagnosis, medication chosen, why this medication was chosen for *this* patient, why a dosage was changed, for example)
- That informational materials were reviewed with the patient and that the patient was provided a copy
- Place a copy of any informational materials given to the patient about the medication in the patient's record

CASE SCENARIO:

A patient requested that his psychiatrist not keep a written treatment record because he was going to disclose extremely sensitive information that could ruin his life if it ever were revealed. The psychiatrist agreed, partly because the patient was a psychiatrist himself. When the patient later sued the treating psychiatrist, there was no record on which to defend the treatment provided. Further, the psychiatrist's licensing board disciplined him for failing to keep a treatment record.

Documentation is extremely important, not only for clinical care reasons, but also for the defense of medical malpractice lawsuits. For defense purposes, the treatment record accomplishes several things. It:

- Substantiates clinical judgment
- Demonstrates knowledge and skill exercise during treatment
- Provides a contemporaneous assessment of the patient's needs and behaviors
- Documents significant events, changes to the treatment plan and explanations of decisions

Moreover, in medical malpractice lawsuits, courts give deference to treating psychiatrists when there is a documented, reasonable basis for treatment decisions in question. Remember that documenting the basis for clinical decision-making is vital.

Physicians can rest assured that there is no such thing as perfect treatment record documentation. A treatment record, first and foremost, should be adequate for clinical purposes. If it is adequate for clinical purposes, it likely will be adequate for defense purposes.

SPECIAL MEDICATION ISSUES

Off-Label Prescribing

Collecting information about medications plays an important role in off-label prescribing. Off-label prescribing is a widespread and well-accepted part of medical practice and is not, in and of itself, a professional liability risk. However, critical to the evaluation of professional liability risk is whether the decision to prescribe off-label is evidence-based and whether there is supporting documentation of the psychiatrist's clinical judgment and decision-making for prescribing *this* drug in *this* instance for *this* patient. Without these elements there is a lack of evidence to defend a malpractice case should a lawsuit arise with allegations that the off-label use injured a patient.

Additionally, communication about off-label use should be part of the informed consent process. When prescribing off-label, discuss the off-label nature of the use with the patient and the basis for the recommendation. For more information see the article, "Practical Pointers for Off-Label Use of an Approved Drug" below.

Complementary and Alternative Medicine (CAM)

Patients are increasingly embracing complementary and alternative approaches to health. Patients often do not report the use of alternative approaches to their "traditional physician." While some of these approaches are medically inert, many are not. Physicians should:

- elicit information from patients about whether they use alternative medicine to consider when formulating treatment plans and prescribing;
- advise patients about known interactions with other prescribed treatment and medications;
- caution them that there is much to be learned about the entire field and that they should inform you about the use of any complementary or alternative approaches; and
- consider a professional consultation or a referral to a physician with specialized training and expertise, when appropriate.

CONCLUSION

Using these risk management strategies - collecting information, communicating, and carefully documenting - when prescribing medications supports quality patient care and can decrease malpractice risk.

USE OF MEDICATION GUIDES FOR PATIENTS

Patient medication guides are an extremely useful tool for educating patients and their families about the risks and benefits of particular medications. Readily available to physicians and patients, these guides are written in language readily understood by most patients and can serve as an adjunct to the informed consent discussion between physician and patient. It must be remember, however, that they are only a tool and cannot be used as a substitute for the informed consent discussion.

Reminders for physicians choosing to use medication guides:

- **Physicians will be responsible for tailoring information to meet their patients' needs and will be required to ensure that the information is up-to-date.** A valuable resource available to keep up to date on the latest developments with medications is the FDA's MedWatch program. Physicians can view the safety information online here and sign-up to receive email alerts of FDA announcements, such as product safety alerts, withdrawals, and important labeling changes.
- **Be sure to document in the patient record that the medication information sheet was reviewed with the patient and the patient was provided a copy.** It may be advisable to place a copy of the medication information sheet that was given to the patient in the patient record.

Some of the resources for existing patient medication guides include:

- The FDA has issued many medication information sheets for patients:
  - » Patient Information Sheets for more than 200 medications can currently be accessed online here.
- There are additional resources for children and adolescent patients:
  - » The APA and AACAP have jointly prepared guides for patients and families about mediations for depression, ADHD, and bipolar disorder which can be accessed online at parentsmedguide.org

PRACTICAL POINTERS FOR OFF-LABEL USE OF AN APPROVED DRUG

Off-label use of medications is a widespread and well-accepted part of medical practice and is not, in and of itself, a professional liability risk. Off-label uses range from those that are clearly controversial to those that are considered the established standard of care. Some typical off-label uses include prescribing a medication for a condition not indicated on its FDA-approved label, prescribing at a different dosage than indicated, or prescribing for a different patient population.

One example of a potentially high-risk off-label use is the prescribing of psychotropic medications for very young children. The prevalence of this prescribing practice is escalating despite the limited knowledge base that underlies it. There have been no large-scale systematic studies, and there is little or no proven efficacy

for such treatment. Recent articles and letters in the professional literature have discussed the frequency of and controversy about prescribing psychotropics for this relatively unexamined population. The attention given to this subject has caused an increased awareness among consumers, and psychiatrists should anticipate more questions about off-label prescribing of medications from patients and patients' families.

Malpractice allegations related to the off-label use of medications would most likely claim a deviation from the standard of care in prescribing, administering, and/or monitoring of the medication, and/or a lack of informed consent. Therefore, it is imperative that physicians prescribing medications for off-label uses ensure that their practices in this area meet the applicable standard of care and that their documentation supports the medical treatment that was given.

Set forth below are risk management tips regarding prescribing medication for off-label use:

DO remember that prescribing a drug for *any* use other than that *specifically* approved by the FDA constitutes an *off-labe*l use. The off-label use of an approved medication is different than the use of non-FDA approved medications.

DO realize that the off-label use of a medication can increase liability risks, if relevant information about using the medication for the proposed off-label use is scarce or non-existent. Educate yourself about off-label uses and stay informed as new information about the medication and its uses becomes available.

DO stay current with professional literature and research regarding the prescribing of medications for off-label use. For example, Practice Guidelines developed by the APA address the off-label use of medications.

DO maintain a file containing any scientific literature, professional information, and contacts with the FDA and others which supports the off-label use of medications. Keep this file separate from patients' files.

DO obtain the patient's informed consent and as always, document the consent. The documentation should reflect that the patient was informed about and understood (1) the nature of the proposed treatment, (2) the risks, benefits, and potential side-effects of the proposed treatment, (3) any alternatives to the proposed treatment, (4) the risks and benefits of the alternatives, and (5) the risks and benefits of doing nothing.

DO clarify to the patient that the proposed treatment is an off-label use of the medication. Do not describe the use as "experimental" or "investigational" as these terms do not accurately reflect the status of medications that have been approved by the FDA and are being prescribed for off-label use. Keep copies in the patient's record of all written instructions or informational materials provided to the patient.

DO remember that informed consent is a continuous process. Document your discussions with the patient about the medication, his/her response to the drug, any subsequent actions taken, and the reasoning behind your clinical decision-making process.

DO realize that the usual issues that are part of the on-going communication between the patient and psychiatrist when medications are prescribed may take on heightened importance with off-label use. Be sure to inquire about the use of other prescription medications, over-the-counter medications, herbal remedies, and any other treatments the patient uses. Clarify dietary and/or activity restrictions. Discuss potential allergic reactions, ways to identify them, and what to do if the patient experiences a reaction. Make sure that the patient knows whom to call if he/she has any questions or concerns.

DO use caution when "stacking" medications/using polypharmacy. Obviously, the greater the number of medications prescribed, the greater the potential for adverse interactions. The potential for problems can

increase with off-label uses due to the possibility of unknown interactions. Educate yourself about off-label uses and stay informed as new information becomes available.

DO communicate with other health care providers about the medications that are being prescribed by all physicians involved in the patient's treatment and about signs, symptoms, and responses to the medications. Communication is an important tool for providing quality care.

DO consider a professional consultation or a referral to another physician with appropriate training and expertise, when appropriate.

DO remain aware of the potential for misuse or abuse of medications by the patient or those who may have access to the medication.

MYTHS & MISCONCEPTIONS:
Prescriptions for Non-Patients

Q: I occasionally help out someone I know (e.g., a colleague or a family member) with a prescription or sample of medication. I do not keep records of these types of encounters as I do not have a physician-patient relationship with those involved, nor do I bill for my services. I do not consider such a limited encounter to be "treatment." Since I don't see these individuals as patients in my office for a visit, I have no liability, correct?

A: Nothing could be further from the truth. The psychiatrist-patient relationship, like a bundle of sticks, is not a clear-cut phenomenon. Just as sticks may be added to or removed from a bundle without altering the existence of the bundle itself, certain aspects of the psychiatrist-patient relationship may be added to or removed from a given situation without affecting the existence of the relationship.

The largest "stick" in the psychiatrist-patient relationship "bundle" is the act of prescribing/administering medication. That act alone is almost certainly sufficient to establish a psychiatrist-patient relationship, regardless of any other actions taken or not taken. In other words, should you prescribe or administer medication to any individual, you must assume that you are that individual's physician.

As you are then technically treating the person you must consider the nature of any existing relationship with the individual and the possibility of a conflict. It is unwise, and may be ethically prohibited, to treat a friend, colleague, or family member.

Further, there are ethical considerations when prescribing for family members. AMA Ethics Opinion 8.19 – Self-Treatment or Treatment of Immediate Family Members provides, "Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members."

Two other "sticks" which *may* establish a psychiatrist-patient relationship, or at least create a question as to whether such a relationship exists, are billing for services rendered and informal counseling. The presence of a bill for services rendered is not determinative of a psychiatrist-patient relationship, as a psychiatrist may provide services pro bono or decide to write off a bill for professional reasons.

Likewise, the trappings of a formal office visit constitute a relatively small "stick" in the psychiatrist-patient relationship "bundle"; therefore, the absence of a formal office meeting likely would have little impact on the existence of a psychiatrist-patient relationship.

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PRESCRIPTION DRUG MONITORING PROGRAMS: WHAT YOU NEED TO KNOW

A Prescription Drug Monitoring Program (PMP) is a state-run electronic database that stores and analyzes information on the prescribing and dispensing of specific controlled substances. The general purpose of a PMP is two-fold: 1) to reduce misuse and diversion of controlled substances and 2) to improve patient safety. These programs, found in a majority of states, specify the following:

- the scheduled substances to be monitored, typically Schedule II, III, and IV drugs (drugs of concern or nonscheduled drugs may also be included), and
- those individuals authorized to access and use PMP data. Authorized users typically include prescribers and dispensers; law enforcement agencies; representatives of professional or occupational boards, directors of state commissions or agencies; and individuals whose prescription history has been captured by the database.

Legal and Clinical Implications

What are the legal and clinical ramifications of PMPs for physicians prescribing controlled substances? Legally, physicians must know what state law requires of them, in particular, whether they are required to access the data. New York became the first state to create a duty for practitioners to review PMP data prior to prescribing Schedule II, III, and IV controlled substances. Some states, such as Kentucky, set forth certain circumstances under which a prescriber must check the database, while most states currently allow the practitioner to determine when the data is needed. Even if review of PMP data is not required by law, the fact that the capability to do so exists may impact the standard of care.

Physicians should also know that their prescription histories will be tracked, as over-prescribers are targets of increased scrutiny. Two other legal issues to be aware of are that some states permit physicians to delegate authority to access PMP data to another person under their direct supervision and, at the present time, PMP laws do not require physicians to notify law enforcement of suspicious behavior on the part of the patient.

From a clinical perspective, a patient's prescription history may be valuable information to have when prescribing allowing you to see whether they are obtaining medications from multiple prescribers and whether they are taking other medications that may otherwise impact your prescribing decisions. States are beginning to share PMP data which should prove clinically useful to psychiatrists who have patients that cross state lines to obtain prescriptions. States are also striving to move to real-time reporting so that practitioners can get the most current information on their patients.

Risk Management Advice

Legal and professional obligations: Familiarize yourself with the PMP in your state and its requirements, if any, for prescribers. Licensing boards and professional organizations are good resources for this information. The National Alliance for Model State Drug Laws Programs www.namsdl.org is also a good resource for general information.

Inform your patients: Some states, such as Virginia, require that prescribers provide notice to their patients that they will access PMP data. You may want to do this even if not required to by the state as part of educating and informing your patients and also discourage those who may be drug seekers. Remember, however, that you do not need patient authorization to access the PMP. Moreover, you should not seek patient authorization to access the PMP as doing so may lead patients to believe they can prevent you from reviewing it when they cannot.

Proper prescribing and monitoring of medications: Consider whether applying for access to and using the data might assist you in making decisions on prescribing controlled substances. Incorporating review of the data into your practice may be particularly useful when seeing new patients who request prescriptions for controlled substances. Having the data may also make it easier to initiate a conversation with your patients on proper use of controlled substances, the risks of abuse and diversion, and the availability of substance abuse programs. We know that allegations of improper prescribing and monitoring of medications form the basis for a significant majority of lawsuits filed against our insured psychiatrists. Use of PMP data may minimize the risks of those allegations being made against you with regard to controlled substances and may indicate when a treatment relationship needs to be terminated.

Documentation: Reviewing your practice state's PMP laws and regulations, as well as those relevant to prescribing controlled substances, for any documentation requirements. For example, in New York, the law only requires noting that a review of the PMP registry was done or that it was not done along with the applicable exception. Similarly, our general advice is for your documentation to reflect that the PMP data was reviewed. Due to the highly protected nature of PMP data and the stiff penalties for improper disclosure, unless required by state law, we advise against including a copy of the PMP report in the medical record. If PMP reports are printed for review, you should have a policy and procedure in place for the secure shredding of the documents after review.

MYTHS & MISCONCEPTIONS:
Patients Who Obtain Multiple Prescriptions

Q: I have been notified by a local pharmacy that a patient of mine has been filling prescriptions for the same medication from multiple physicians, not just from me. I feel betrayed and angry. I also think this activity should be reported to the authorities but to whom do I report it?

A: It is understandable to feel betrayed and angry in this situation when it appears that the patient has taken advantage of your good will and undermined the therapeutic relationship. Despite this, your professional obligation to your patient remains. It is important to promptly address this issue clinically with your patient – either in-person or by phone.

You will need to gather additional information, reassess the patient, and possibly modify treatment recommendations. You may even need to end the treatment relationship, taking care not to abandon that patient. All of this can be accomplished best within the clinical framework of the patient-clinician relationship where you - as the clinician - do not take the patient's actions personally but recognize them as symptomatic of an underlying illness.

The questions of whether and how to report to authorities are much trickier. There is no national requirement to report this type of activity. State laws vary, but very few states either require or allow reporting by the physician – giving considerable deference to confidentiality. In most states, the burden for reporting is placed on the pharmacy and/or pharmacist. Your state medical board and local medical or psychiatric society should be good resources for determining the standards in your state. If you are told that there is a requirement to report in your state, be sure to obtain a copy of the statute, rule, or regulation for yourself.

Should the police investigate your patient, you are limited by confidentiality as to what information can be disclosed. Any request for information should be in writing and cite the requestor's authority to access the information. Questions about authority can be discussed with your personal attorney. Participants in The Psychiatrists' Program should feel free to contact the Risk Management Consultation Service (RMCS) helpline for assistance with evaluating such a request.

Have any comments or questions about an article?

We would love to hear from you!

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