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.

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PRMS IS SOCIAL!

Click the icons to follow PRMS for an inside look at the company, our travels, timely risk management alerts and helpful resources from our team of experts.

10 THINGS ABOUT SOCIAL MEDIA

1. The way patients seek out healthcare information and physicians has changed. Many psychiatrists are recognizing that in order to be found by prospective patients, they need an online presence and are exploring options for achieving this.
2. At this juncture, we do not know all of the liability issues that may arise from use of the Internet and how this will play out in the courts. At a minimum, we can assume that risks will be the same as they are for activities conducted off-line. Technology does not change the obligation to meet clinical, legal, and ethical standards.
3. The Internet does not change your duty to maintain boundaries with your patients and you should never interact with them on personal social media sites. If a patient attempts to contact you via a social media site, you should make it clear to them that you do not communicate with patients by these means and will not respond to further attempts at contact.
4. State licensing boards can and have disciplined physicians for inappropriate online behavior. This includes depictions of such things as excessive drinking and suggestive content as well as misrepresentation of credentials.
5. Privacy controls are not an absolute guarantee that your information can't/won't be viewed by those other than you had intended. Once you have posted something, it may be copied and forwarded to others. Never post anything that you would not want a patient, colleague, employer, or licensing board to see.
6. It's a good idea to do a search of yourself using all potential variations of your name to determine what information may be seen by others. Clean up your social media pages and ask friends to remove anything that might cause professional embarrassment.
7. When using a website or social media platform to market your practice, remember that the greater the amount of interactivity allowed between the practice and individuals accessing the site, the greater the risk. Responses to inquiries from non-patients might create a treatment relationship should that person construe your response as medical advice.
8. Physicians should be aware of potential liability risk to their practices through the misuse of social media by employees – both inside and outside the workplace. A comprehensive social media policy (with special emphasis on the need to maintain confidentiality) can help insulate the practice from exposure.
9. Even if you choose not to use social media to advertise your practice, consider establishing a LinkedIn profile which works much like an online CV. An important benefit is that LinkedIn scores very high on Google searches meaning that if someone were to search for you, that result would appear before physician review sites, thus allowing you to control the information a patient first sees about you.
10. The Federation of State Medical Board's (FSMB) Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice is an excellent tool for ensuring that you and your staff utilize social media in such a way as ensure professionalism and limit liability exposure.

PRACTICAL RISK MANAGEMENT POINTERS FOR THE TREATMENT OF GEROPSYCHIATRIC PATIENTS

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

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

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

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

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

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

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

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

DO seek information from the patient, as part of the patient's assessment, about the patient's use of prescription medications, over-the-counter medications, herbal remedies, dietary supplements, other treatments, and dietary practices.

This is important information when developing a treatment plan, especially when prescribing medications.

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

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

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

DO document the clinical basis for medication recommendations to patients.

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

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

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

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

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

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

FAILING TO PLAN...IS PLANNING TO FAIL

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

Scenario 1: The last time anyone saw Dr. R, a solo practitioner who lived alone, she was getting into her car as she left the office for the day. When she failed to arrive at the office by 8 a.m. the next day, her secretary called everyone she could think of there were several unhappy and alarmed patients in the waiting room. The secretary told the patients she had no idea where company reviewer phoned to discuss a treatment plan. The hospital called to see why the doctor had not come to see her patients that morning.

No one knew that the doctor, driving home the night before, had hit a deer and skidded off the road into a ravine. If there had had died in the accident. During those days, the secretary had authorized prescription refills, provided information to managed care organizations, and This had never happened before. I just did what I thought Dr. R would want me to do."

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

One morning, Dr. B suffered a massive stroke. Mrs. B stayed at his side in the hospital for three days until he died. Dr. Z could not get into the office, could not get Mrs. B to talk to him, and could not reach the patients he was treating. Building management said they could

PRACTICING TELEPSYCHIATRY?
WE CAN COVER YOU

As the practice of psychiatry intersects more with technology through the use of telemedicine, you can count on PRMS® to protect your practice. Our psychiatric professional liability policy includes coverage for telepsychiatry at no additional cost, as well as many other preeminent program benefits.

JUSTIN POPE, JD
SENIOR RISK MANAGER

More than an insurance policy

not allow Dr. Z into the suite as his name was not on the lease. Dr. Z ended up putting a handwritten sign on the office door, advising patients to call him directly. When Mrs. B finally spoke to Dr. Z after the funeral, she said that the practice was Dr. B's only asset, and she needed to talk to a lawyer to find out how she could sell it. She would not give Dr. Z a key to the suite, nor would she provide him access to patient records.

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

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

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

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

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

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

WHERE'S PRMS HEADED THIS SPRING?

American Association of Directors of Psychiatric Residency Training Annual Meeting | February 27-March 2

Louisiana Psychiatric Medical Association / Mississippi Psychiatric Association Spring Meeting | March 1-3

American Neuro-Psychiatry Association Annual Meeting | March 6-9

Central California Psychiatric Society Annual Meeting | March 8-10

Wisconsin Psychiatric Association Annual Conference | March 14-16

Northern California Psychiatric Society Annual Meeting | March 15-17

American Association for Geriatric Psychiatry Annual Meeting | March 15-17

Black Psychiatrists of America Spring Conference | March 21-24

Midwest American Academy of Psychiatry & Law Annual Meeting | March 22-23

North Carolina Psychiatric Association Resident & Career Expo | March 22-23

American Society of Addiction Medicine 55th Annual Conference | April 4-7

Florida Psychiatric Society's Spring CME Meeting & Expo | April 5-7

Ohio Psychiatric Physicians Association Annual Psychiatric Update | April 12-14

Washington Psychiatric Society 75th Anniversary Celebration | April 13

New York County Psychiatric Society Annual Presidential Reception | April 16

Maryland Psychiatric Society Annual Meeting | April 18

Colorado Psychiatric Society Spring Meeting | April 18

Texas Society for Psychiatric Physicians Spring Conference | April 19-21

Michigan Psychiatric Society Annual Meeting | April 19

Iowa Psychiatric Physicians Association Spring Symposium | April 26

Massachusetts Psychiatric Society Annual Meeting | April 30

Arizona Psychiatric Society Annual Meeting | May 18

... and more!

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MORE THAN AN **INSURANCE POLICY**

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