RESIDENT OWLERY

WELCOME TO THE NEXT EDITION OF "RESIDENT OWLERY," a newsletter developed by Professional Risk Management Services® to provide psychiatry residents in training with *owl* you need to help manage your risks as you prepare to start your psychiatric careers. Featuring risk management resources, educational articles, and the latest announcements and events from PRMS, 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, from residency to retirement.

WHAT YOU'LL FIND INSIDE:

PRMS IS SOCIAL!

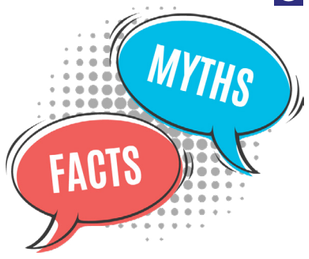
Click the social media icons below to follow PRMS and get an inside look at the company, follow along on our travels, and access timely risk management alerts and helpful resources from our team of experts.

2024 | VOLUME 2 | ISSUE 1

10 THINGS ABOUT: INFORMED CONSENT

1. 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. Although we now take the legal requirement of informed consent for granted, it is in fact a fairly recent development.
2. While the need to obtain informed consent for invasive procedures has long been recognized, physicians have not always appreciated the need to obtain informed consent for care involving non-surgical treatment and certain medications; particularly those used for off-label and investigational purposes. This has all changed in recent years as lawsuits involving allegations of failure to obtain informed consent to treatment have become more frequent.
3. When alleging lack of informed consent in a lawsuit, a patient need not prove a deviation from the standard of care - nor even assert negligence on the part of the physician - to prevail. The patient need only prove that the physician breached his duty to the patient by failing to inform him of the material risk of treatment, that the patient suffered damages and that the physician's failure to inform the patient was the proximate cause of the damages.
4. Informed consent is an ongoing communication process; it is not a piece of paper. While a signed form does support the assertion that the consent process took place and establishes at least some of what was disclosed, without documentation of the informed consent discussion, a form alone will likely be insufficient to establish that the consent given was truly informed consent.
5. Informed consent comprises a discussion of the nature and purpose of the proposed treatment, potential risks and benefits of that treatment, reasonable alternatives to the proposed treatment, risks and benefits of the proposed treatment and the likely risks of doing nothing. The patient should be made aware of material risks - side-effects that occur frequently or those that would be significant were they to occur although the likelihood may be minimal.
6. While listing the risks is important, it often confuses the act of providing information with having the patient comprehend that information. As important as the information given, is how it is received and utilized by the patient. Risks should be presented in such a way that patients appreciate the likelihood that the complication discussed will occur and its possible level of severity.
7. Although individual state statutes may allow for informed consent discussions to occur between the patient and a mid-level provider, it is preferable that the physician who is ultimately responsible for the patient conduct the discussion. This is particularly true if there is the possibility of significant risk to the patient. While a physician may legally be able to delegate the activity, he may not delegate the ultimate responsibility for ensuring that informed consent was obtained.
8. Many physicians spend a great deal of time educating their patients on potential risks and benefits of treatment but fail to give themselves credit for these efforts by providing a detailed note. In addition to documenting a discussion of risks and benefits, you should also document any risks particular to the patient due to underlying illnesses or conditions, particular questions the patient may have asked, and who was present during the discussion.
9. Because informed consent is an ongoing process, a patient's satisfaction with treatment should be periodically re-assessed and other options discussed when appropriate. These discussions should also be reflected in the patient's chart.
10. Inherent in a patient's right to consent to treatment is also the right to refuse treatment. Just as with consent, a physician has an obligation to make certain that a patient's refusal of treatment is truly informed. Once satisfied that the patient understands the ramifications of his decision, the discussion between patient and physician should be thoroughly documented.

MYTHS AND MISCONCEPTIONS:
PRESCRIPTIONS FOR NON-PATIENTS



Myth: 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?

Truth: 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, with all the attendant obligations and liability.

Two other "sticks" which may establish a psychiatrist-patient relationship, or at least create a question as to whether or not 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.

Rest assured, however, that it is unlikely that answering general questions in a social setting would be sufficient to create a psychiatrist-patient relationship. Anything more, such as a general conversation that culminates in a psychiatrist providing specific advice or recommendations, could conceivably expose the psychiatrist to liability. In social situations, the psychiatrist being questioned should state explicitly that he or she is not acting as the individual's psychiatrist and cannot make specific diagnoses or treatment recommendations. It is always appropriate to advise the individual to see a psychiatrist for an assessment. In addition, when approached in a social setting, a psychiatrist also 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.

EXAMINERS PERSPECTIVE:
WHAT ARE THE MOST DAMAGING CLAIMS

Q: What are the most damaging claims that you see? Suicides?

A: Suicides are a high-risk event that frequently results in lawsuits; however, the cases with the highest judgments or settlement values are not death cases but cases that involved significant permanent neurological or physical injuries that result in the need for life-long care. The financial costs associated with providing life-long care combined with the loss of potential income and, in some jurisdictions, the cost of "pain and suffering" are the reasons for the awarding of hundreds of thousands, sometimes even millions, of dollars.

Three examples of such a claim might include:

1. A patient that has developed permanent renal failure from an instance of lithium toxicity and must endure kidney dialysis and/or replacement;
2. A patient that suffers from significant Tardive Dyskinesia due to a failure to detect warning signs and symptoms; and
3. A patient that suffers brain damage as a result of a failed suicide attempt.

One of the primary causes of these types of injuries is the alleged mismanagement of a patients medication regimen. Reason, risk management advice dictates that psychiatrists prescribe carefully and monitor medication levels in appropriate physiologic functions regularly. Also, patient compliance with monitoring should be tracked.

Catch up on our other editions of the Resident Owlery on our website!

CONTACT US
(800) 245-3333
TheProgram@prms.com
PRMS.com

PRMS® the psychiatrists' program®

MORE THAN AN **INSURANCE POLICY**