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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10 THINGS ABOUT CONSULTS

1. Medicine is a collegial profession, both in theory and in practice, and physicians consult with one another regularly. There is in fact an expectation of consultation, particularly when faced with a situation beyond one's usual area of expertise or level of experience.
2. Consults may be formal (where the patient is seen by another psychiatrist who examines the patient and renders treatment advice) or informal (also known as a "curbside" consult where the other psychiatrist is presented only with a scenario or specific questions.
3. With an informal consult, because the colleague whose advice is being sought has no patient contact and the doctor seeking the consult remains free to accept or reject the advice given, there is little if any liability exposure for the doctor providing advice.
4. On the other hand, when faced with a challenging patient or situation, the fact that you had thought to seek the assistance of a trusted colleague will be useful in your defense in the event of a bad outcome and subsequent litigation
5. There is no consensus on how to document an informal consult. While this lack of clear guidance can be anxiety provoking, the upside is that it gives physicians significant leeway about whether and how to document such encounters. In other words, you have significant discretion to exercise your professional judgment.
6. If as a consultant the advice you give is academic and solely for the education of the provider seeking the consult, then typically it should not be necessary to document the encounter. If the advice that you give is more patient-specific, consider creating a note of the encounter that details the advice that you gave. In the highly unlikely event that you are named in a lawsuit, such contemporaneous documentation would serve to bolster your defense.
7. Diagnostic formulation probably should not be entrusted to a curbside consult. Because of the potential stakes, the same likely holds true for most admission or discharge decisions. Diagnosis and admission or discharge decisions in most cases should be the subject of formal consultations rather than curbside consults.
8. A formal consult should also be considered when the situation is highly complex or the consultant feels it necessary to actually examine the patient in order to give appropriate advice. Care should be taken by both doctors to explain the limited role of the consultant if he or she is not expected to remain involved in patient care.
9. Remember that the treating physician controls patient care. If you as a consultant step in and begin to direct care (for example, order laboratory tests, write prescriptions, adjust medications, etc.) you will almost certainly be establishing a professional relationship with all the attendant obligations and liability risks.
10. Various websites and listservs now allow physicians to seek consults online which may prove to be risky as the transcript of any such communication could potentially be taken out of context or used against either participant. A better method would be to select a particular psychiatrist and communicate with that doctor directly.

TO COLLECT OR NOT TO COLLECT?
OVERDUE BILLS AND RESULTING MALPRACTICE CLAIMS

A question that is frequently posed to PRMS risk management and claims staff is whether a psychiatrist should pursue an outstanding balance on a patient's account. The fear, of course, being that the patient may retaliate with a lawsuit or other type of action. Given the current practice environment, the options available to a healthcare provider - to collect or not to collect - can be equally uninviting.

It should be clear from the outset that anyone who provides a service for fees has the legal right to pursue payment according to the agreement made between the provider and the client. That being said, it is an oversimplification to suggest that one must exercise every available legal right that one possesses. This article will briefly explore potential negative outcomes that can occur when seeking collection on a patient's overdue bill.

One of the most common concerns of psychiatrists is that the patient will file a malpractice lawsuit in retaliation. Indeed, many an angry patient or patient's family member has made this very threat. Although the more likely scenario is a counter-claim made by the patient asserting that the services were not provided at all or that the services were so dissatisfactory that no payment should be required, patients do often make allegations of negligence in order to put more pressure on the physician to resolve the matter before a lawsuit is filed.

Patients are even more likely to file a complaint with the medical board or a healthcare organization because doing so is much easier and less costly than filing a malpractice lawsuit. Furthermore, these organizations have a greater goal of serving patients and the public at large. As a result, they are likely to have complaint forms readily available for patients to fill out and procedures in place for reviewing a member's standing with the entity.

The state board of medicine sets certain ethical and professional conduct standards. Professional organizations, workers compensation commissions, hospitals, HMOs and MCOs may also have standards for admission and continued membership as well as a mechanism in place to enforce those standards. In addition, such organizations/agencies may have specific rules and procedures with regard to collection proceedings.

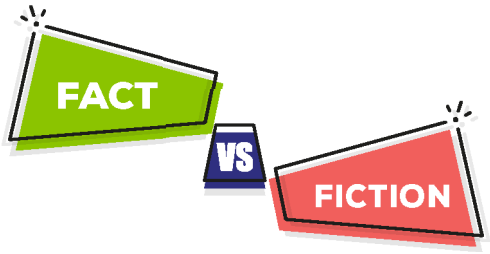
Complaints made to such organizations can be difficult for the psychiatrist to defend because, unlike a lawsuit, the patient does not have to prove negligence and damages. Rather, a few select individuals affiliated with the entity will determine whether or not the psychiatrist has violated the entity's standards. This process takes place with few - if any - mechanisms to ensure fairness and objectivity; the extensive checks and balances present in the litigation process do not exist in these systems.

At this point in the article, one may have the impression that the best thing to do is simply write off the bill and forget about it. However, one obvious downside to doing that is lost revenue from the non-paying patient and from the paying patient who could have been seen. Another downside is that treating a non-paying patient can ultimately impact care which could give rise to a malpractice claim.

When faced with a non-paying patient, taking the following actions may minimize the possibility of an undesirable outcome. Provide patients with a financial policy at the outset of treatment and address

non-payment of fees promptly. If a situation arises where use of a collection agency is being considered, the psychiatrist, as opposed to a staff member, should always make that determination. The psychiatrist has the training, experience, and personal knowledge of the patient necessary to determine whether or not collection is appropriate for a specific situation. Psychiatrists should be familiar with and adhere to state and federal laws, as well as the standards and requirements of the state medical board, professional organizations, and all relevant third-party payors concerning collections. Disclose only the minimum information necessary to the collection agency to avoid breaching the patient's confidentiality. Under HIPAA's Privacy Rule, covered providers must have a business associate agreement in place with the collection agency; non-covered providers should consider such agreements, as well.

In conclusion, as unfair as it may seem, a malpractice lawsuit or complaint to a licensing board or healthcare organization can arise simply because a provider chooses to collect on a patient's overdue bill. To minimize these risks, make your financial policy known to patients, address unpaid bills promptly, and approach the decision to pursue collection thoughtfully and professionally.



WHAT DO YOU THINK - FACT OR FICTION?

FACT OR FICTION?

A patient invited you to invest in an innovative project that you fully support. Your only contribution would be financial - you would not be providing any type of service. Before agreeing, you pondered whether this arrangement could be seen as some type of boundary violation, but you decided no, as your involvement would be purely financial, and certainly nothing of a personal or sexual nature.

Boundary violations have to involve some kind of personal relationship (which is usually sexual) between the psychiatrist and the patient.

What do you think - fact or fiction?

Fiction!

Boundary violations are not limited to sex and other personal relationships. Over the years, boundary violations has always made it to our list of top causes of actions brought against our insured psychiatrists - and not at the bottom of the list! Fortunately, not all of these cases involve sexual allegations.

Boundary violations can result from numerous types of "multiple" or "dual" relationships. Such relationships can occur anytime a psychiatrist relates to patients in more than one relationship, whether professional, social, or business, in addition to being in the treatment relationship. Multiple or dual relationships can lead to allegations of taking unfair advantage of the treatment relationship to exploit or otherwise further the psychiatrist's personal, religious, political, or business interests. As a general rule - once you are the patient's psychiatrist, that is all you should be.

Even if the psychiatrist has only the best of intentions, if something goes wrong, there will be allegations that there were non-therapeutic motivations involved.

WHERE'S PRMS HEADED THIS SPRING?

South Carolina Psychiatric Association Annual Meeting | January 24-25

Maryland Psychiatric Society Trivia Night | January 28

Northern California Psychiatric Society Career Fair | February 1

San Diego Psychiatric Society Winter Social | February 1

Northern California Regional Organization of Child & Adolescent Psychiatry Annual Meeting | February 1

AACAP Pediatric Psychopharmacology Update | February 2-3

Georgia Psychiatric Physicians Association Winter Meeting | February 7-8

Nevada Psychiatric Association Annual National Psychopharmacology Update | February 12-15

Louisiana Psychiatric Medical Association / Mississippi Psychiatric Association Spring Meeting | February 14-16

Ohio Psychiatric Physicians Association Annual Psychiatric Update | March 1-2

American Association of Directors of Psychiatric Residency Training Annual Meeting | March 4-8

Kentucky Psychiatric Medical Association (KPMA) Spring Meeting | March 7

Wisconsin Psychiatric Association Annual Conference | March 13-15

Northern California Psychiatric Society Annual Meeting | March 14-16

American Association for Geriatric Psychiatry Annual Meeting | March 14-17

American Academy of Clinical Psychiatrists Spring Update | March 20-22

Midwest American Academy of Psychiatry & Law Annual Meeting | March 21-22

Pennsylvania Psychiatric Society Pittsburgh Chapter Spring Symposium | March 22

Florida Psychiatric Society's Spring CME Meeting & Expo | March 28-30

Central California Psychiatric Society Annual Meeting | March 28-30

... and more!

CONTACT US

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

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