It's Nice To Be Nice, But…..
A Little Risk Management Can Go a Long Way in Reducing Your Liability Risk

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Psychiatrists can easily find themselves in a situation where agreeing to help someone, such as a colleague or a patient, results unexpectedly in an increase in their own professional liability risk. Certainly the most frequent specifically identifiable malpractice risks for psychiatrists remain patient suicide/suicide attempts and medication issues. However, the various examples below, while certainly not an exhaustive list, illustrate the importance of evaluating your own risk exposure when agreeing to others' seemingly reasonable requests.

Be careful when "helping" a patient

Bartering with a patient: Psychiatrists may be asked by patients who are unable to pay their bill to agree to a barter arrangement, whether exchanging professional services for a tangible item or for personal services, such as employment. For example, a psychiatrist may agree to allow a patient who is having financial difficulties work for him/her. How will the barter arrangement be structured? Are there tax implications? Is one hour of therapy equivalent to one hour of work? What if the work is not acceptable? What if the patient becomes too ill to work? In some cases, the psychiatrist had the best intentions, but then something went wrong in the relationship, and allegations of non-therapeutic motivations involved in taking on the dual role resulted. In such situations, psychiatrists are advised to consider working out a monthly payment plan to help the patient meet his financial obligation. If this is unacceptable, the psychiatrist may need to consider termination of the treatment relationship and referral to community mental health services or other services which can meet the patient's clinical needs. For more information, see *Myths & Misconceptions: Expansion of Boundary Violations*, Rx for Risk, Vol. 9, Issue 3 (Summer 2001).

Prescribing extended amounts of medication: Patients may ask psychiatrists to prescribe large amounts of medication, often for the purpose of receiving better prescription drug plan benefits. Such requests must be evaluated as to the clinical appropriateness, including the patient's risk of overdose, even if it may cost the patient more money.

Prescribing after termination of the psychiatrist – patient relationship: Psychiatrists need to understand that if they prescribe after the termination date, they are still treating the patient they purportedly terminated with. Sometimes former patients request a medication refill after a termination date. There may be a valid basis for the patient's request, such as a delay in being seen by the new psychiatrist. Certainly psychiatrists who weigh the risk and benefits of prescribing versus not prescribing may decide to prescribe. If this is done, the prescriber should understand his/her responsibility for meeting the patient's clinical needs, as always, and prescribe only the minimum amount necessary. Also, it should be clarified with the patient that

the termination date is being extended this one time and that there is a new termination date, after which medications will no longer be prescribed.

Treating patients at a distance: Numerous calls to the Risk Management Consultation Service (RMCS) have illustrated the problems associated with agreeing to treat a patient at a distance. Usually these calls for risk management consultation involve some type of crisis that the psychiatrist cannot manage appropriately due to the distance. The bottom line is that the treating psychiatrist is responsible for delivering treatment that meets the standard of care; the standard of care may require in-person evaluation. Even the most stable patients can end up in crisis. During patient emergencies, a remote psychiatrist will be of limited assistance at the time the psychiatrist's services are needed the most. Also, if the psychiatrist is not licensed in the state where the patient is located, the medical board in the patient's state could find the psychiatrist violated the state's Medical Practice Act and/or other statutes and regulations. Such violations could include practicing without a license, which could lead to professional discipline as well as possible insurance coverage issues. For more information, see *Line Dancing: Psychiatry and Crossing State Lines*, Rx for Risk, Vol. 10, Issue 4 (Fall 2006), and *Treating College Students: Understanding the Risks*, Rx for Risk, Vol. 13, Issue 4 (Fall 2005).

Treating patients via e-mail: E-mail has become an important part of our day to day lives and may be appropriate in psychiatric practice for administrative issues, such as confirming appointments. Given the ease and convenience of e-mail, patients may want to use e-mail to communicate with their physicians for all treatment issues, not just administrative issues. Psychiatrists should proceed with caution when actually treating patients via e-mail and realize that e-mail is not appropriate for every treatment situation or every patient. It is easy to become complacent with technology and let it dictate one's actions to some extent. As always, the responsibility for patient care remains the same, regardless of the treatment modality employed. Sometimes problems develop when the psychiatrist agrees to treat via e-mail under specific conditions (such as periodic office visits), the patient initially agrees to these conditions, but then refuses to comply because he/she finds it easier and more convenient to be treated via e-mail than to be seen in person. For more information, see *Risk Management in Cyberspace* and *Practical Pointers for the Practice of Cybermedicine*, Rx for Risk, Vol. 9, Issue 2 (Spring 2001), *Myths & Misconceptions: E-Mail*, Rx for Risk, Vol. 10, Issue 4 (Fall 2002), and the APA's *Cybermedicine FAQs* and *e-Therapy FAQs* available at http://www.psych.org/psych_pract/.

Failing to terminate the treatment relationship for continuing non-adherence: Patients, by their own non-adherence, may limit the psychiatrist's ability to effectively treat them, such as a patient who is prescribed lithium but who refuses to get the ordered blood work. If the situation gets to the point where the patient is not complying with the treatment plan, after reasonable efforts have been made to work with the patient and resolve this issue, the psychiatrist needs to understand the risk associated with staying in a treatment relationship with a patient who does not allow the psychiatrist to provide treatment within the standard of care. Once it is clear that there is no agreement on a treatment plan, including actions (such as testing) required of the patient, the psychiatrist needs to consider terminating the treatment relationship. Often psychiatrists in these situations believe that sub-standard care is better than no care, as would be the case if the treatment relationship was terminated. However, from the risk management perspective, substandard care is just that – care that does not meet the standard of care. Psychiatrists are encouraged to not allow patients to convince them to be negligent. For more information, see *Practical Pointers for Terminating the Psychiatrist-Patient Relationship* (includes model termination letter), Rx for Risk, Vol. 8, Issue 1 (Spring 2000) and *Monitoring Guidelines and the Adverse Affects of Medication*, Rx for Risk, Vol. 14, Issue 4 (Fall 2006).

Not asking for proof of substitute decision-maker's authority: Whenever the patient is incompetent to make treatment decisions, particularly minors with divorced parents or adults who have had guardians appointed, the treating psychiatrist should obtain proof of the substitute decision-maker's authority. Such authority could include court documentation of appointment of the guardian for an incompetent adult or a copy of the custody order for minor children of divorced parents. Problems for psychiatrists have occurred where proof was not obtained and the psychiatrist treated the patient based on the representations of the party bringing the patient to the appointment, when in fact, that party had no authority to consent to treatment. When the party with authority to consent found out, the psychiatrist was accused of treating without consent. For more information, see *Myths & Misconceptions: Rights of Divorced Parents*, Rx for Risk, Vol. 14, Issue 4 (Fall 2006).

Taking on dual role of expert witness, in addition to treating psychiatrist: Psychiatrists are often asked by patients who are involved in litigation (where the treating psychiatrist is not a party to the litigation) to provide expert witness testimony. However, taking on the dual roles of treater and expert witness (or performing an evaluation for legal purposes) could adversely affect the therapeutic relationship and your objectivity as an expert. For child and adolescent psychiatrists, this situation can often arise in the context of a parent requesting testimony in a custody dispute. While it may be appropriate for the psychiatrist, as the treater, to provide factual information (with proper authorization), multiple roles bring with them the very real possibility, even the inevitability, of conflicting obligations (i.e., the patient's clinical needs versus the parents' legal needs). Conflicting obligations increase the risk of clinical, ethical, and even legal problems. If possible, avoid assuming multiple roles. The safest response to such a request is to explain the limits of your role as a treating psychiatrist, outlining the potential conflicts, and reiterating that the patient's treatment is the primary concern. If an expert opinion is needed, that should be obtained from an independent expert.

Psychiatrists are also encouraged to let the record speak for itself. For example, when a patient's attorney wants to talk to you about the patient's care, remember that you do not have to agree to speak informally (versus formally in a deposition) with the patient's attorney, even if the patient authorized such discussions. Rather, you can advise the attorney that with the proper authorization, you can release your record and that you have nothing to add to the record. Psychiatrists can find themselves in a tough situation after agreeing to talk to the patient's attorney about the treatment, and later (often very close to the trial date) learning that patient and the patient's attorney are expecting the treating psychiatrist to provide expert witness services. For more information, see *Myths & Misconceptions: The Treating v. The Forensic Role*, Rx for Risk, Vol. 9, Issue 2 (Spring 2001), *ECP FYI: When a Parent Wants Your Testimony in a Custody Dispute*, Rx for Risk, Vol. 13, Issue 4 (Fall 2005), and *Independent Evaluations in Child Custody Disputes*, Rx for Risk, Vol. 14, Issue 4 (Fall 2006).

Giving a deposition without notifying your malpractice insurance carrier: Psychiatrists may find themselves being asked to assist in a patient's litigation, aside from being an expert witness. The patient's attorney may want to depose the psychiatrist about treatment issues. Participants in the Psychiatrists' Program are encouraged to contact us regarding all subpoenas for deposition. In addition to confidentiality issues, there could be issues related to the psychiatrist's own liability. There have been cases where the psychiatrist, who was not a defendant in the patient's medical malpractice case against another healthcare professional, agreed to give a deposition, and did not notify his/her malpractice insurance carrier prior to the deposition. As a result of the deposition testimony, given without legal counsel representing the psychiatrist's interests, the psychiatrist was named a defendant in the underlying medical

malpractice case. For more information, see *Claims Examiner Perspective: Subpoena for Deposition*, Rx for Risk, Vol. 14, Issue 3 (Summer 2006).

Be careful when "helping" a colleague

Prescribing for a colleague: Psychiatrists should understand that prescribing is generally equated with treating. Accordingly, if prescribing for a colleague (or other non-patient, such as a family member), it is likely that the state medical licensing board would attach the same expectations as with a formal patient, such as examination before prescribing and documentation of the evaluation and treatment. For more information, see *Myths & Misconceptions: Prescriptions for Non-Patients*, Rx for Risk, Vol. 10, Issue 2 (Spring 2002)

Agreeing to not keep records: While the urge to accommodate a colleague may be very strong, psychiatrists need to keep in mind that the standard of care must always be met, and documenting the care provided is part of the standard of care. Consider the case where a physician sought treatment from a psychiatrist and asked the psychiatrist not to keep any records. The psychiatrist - as a courtesy to her colleague - agreed, but regretted this decision later when the patient (physician) sued the psychiatrist and filed a board complaint. Because there were no records, the psychiatrist's defense of her care in the lawsuit was compromised and she was disciplined by the board.

Renting office space for a percentage of fees collected: Psychiatrists may be approached by colleagues who practice independently and want to rent office space. Often the renting providers want to pay a percentage of fees collected for rent and administrative support. While such business arrangements are very common, there are ethical and legal issues that must be considered. Legal counsel for clarification of these issues may need to be sought. The preferred arrangement would be to negotiate a mutually agreed upon fair market value fee for the use of space and, if applicable, administrative support. For more information, including citations to relevant ethics information, see *Myths & Misconceptions: Renting Space*, Rx for Risk, Vol. 9, Issue 4 (Fall 2001).

Note: The articles referenced above are available to Program Participants online at www.psychprogram.com, in the Rx for Risk archives located in the Risk Management section.

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