

REDUCING MALPRACTICE RISK

When practicing in any medical specialty, there is always the risk of a malpractice suit by a patient. This chapter deals with the steps you can take to reduce your chances of being sued.

COMMUNICATE EFFECTIVELY

Communication is essential, not only between you and your patients, but also among clinicians and with other staff. Patients know whether or not their physician is really paying attention to them. They also can tell whether or not she honestly cares about them. Happier patients are more likely to comply with treatment, which should facilitate better outcomes, and they are also more likely to be understanding if there is an adverse outcome to treatment. Good communication involves not only speaking in terms the patient can understand, but being a good listener as well.

It is also important that you and other staff members function as a cohesive team and communicate effectively. Clear policies should be in place that address how to handle confidentiality, record-keeping, release of information, billing, telephone contacts, adverse events, patient complaints, referrals, after-hours coverage, and emergency situations.

OBTAIN INFORMED CONSENT

Informed consent (see Chapter 22 for a more complete discussion of informed consent) is permission given by a patient, who is fully aware of all the material aspects of a situation, for his physician to initiate a certain action or procedure. In the psychiatric profession, it is necessary to obtain informed consent in a variety of situations. Not only do patients need to be informed about their course of treatment, including medication options, possible side effects, and any possible adverse reactions to nontreatment; they also need to be informed about, and give express permission for, information on their case to be released to any third party. With the advent of managed care, more and more people request to see patient records. No one may receive such information without the patient's knowledge and permission. Patients' confidentiality release forms, and all other consent forms should be kept on file.

MAINTAIN RECORDS APPROPRIATELY

Many lawsuits can be prevented by maintaining accurate and detailed records. (See Chapter 24, Medical Records.) Records should include the following:

- Documentation of having received informed consent from the patient;
- A list of significant problems as determined from the initial evaluation;
- Ongoing and one-time issues as determined by each encounter, including related life problems;
- Notations of resolutions of problems as they occur--if the problem recurs, it can be added back to the list;
- A medication list, including names of medications, dosages, when medication is prescribed, and any adverse reactions;
- Blood levels and results of other tests;
- Documentation of contacts with a managed care organization or other reviewer when care is denied;
- Specific instructions given to the patient, and whether or not there were any questions; and
- An annual summary of treatment if the patient is in therapy for a year or longer.

This information can help reduce the risk of a malpractice suit and increase your chances of winning a suit if one is brought against you.

In addition, it is important to follow certain guidelines when keeping the medical record:

- Always write clearly and legibly. Do not try to cram words on a line where there is not enough space and draw a line through any spaces that are not used when making an entry.
- Always write the patient's name and the date and time of each entry on each page.
- Never erase an entry. If something is incorrect that you later want to fix, put a line through the incorrect information with the date of the correction. In addition, you should never add anything to a previous entry, unless it is in a separate note that includes the new date. It is possible to calculate the date ink is put on paper, and therefore a test can determine if something was added to the original record.

SUSTAIN APPROPRIATE OFFICE PROCEDURES

It is imperative that all office staff work to ensure the appropriate handling of records, billing, and other responsibilities to minimize errors in the system and

therefore reduce the chances of a malpractice suit. Office staff should follow these guidelines:

- **Inform the psychiatrist of any incoming reports:** Filing reports, whether they be lab results or letters/reports from other physicians or therapists, without the knowledge of the psychiatrist can lead to errors in treatment and possible malpractice claims.
- **Inform the psychiatrist of a patient's noncompliance:** The doctor needs to know about missed appointments and tests that were ordered and not taken so that the patient can be contacted if necessary.
- **Maintain accurate and up-to-date billing:** Incorrect repeated billing of a patient can cause unnecessary annoyance and dissatisfaction. If a patient contests a certain bill, cease billing until the matter is resolved.
- **Do not discuss patient cases among office staff:** Patient medical records and cases should only be discussed among office staff with consent from the patient.
- **Maintain a supportive atmosphere:** Patients respond to a friendly environment and individual attention. All members of the office staff contribute to the patient's overall impression of the psychiatrist and treatment.

FOLLOW APPROPRIATE PROCEDURES WHEN AWAY FROM YOUR PRACTICE

It is important that patients have access to the same high-quality care from another psychiatrist when you are away or otherwise unavailable. If patients receive substandard care when you are away, both you and the covering psychiatrist can be held liable. If you plan to be away from your practice for an extended period of time, be sure to take the following precautions:

- Carefully choose who will cover your practice, and make sure it is someone whom you trust and know to be responsible.
- Inform the covering psychiatrist of your most difficult cases so that if a problem arises, she will be better prepared to deal with it. Be sure to leave a number so you can be consulted in case of an emergency.
- Prepare your patients for scheduled absences. Be specific about the length of time you'll be away and provide them with written materials with all the necessary information about their care during your absence.

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- If you work in an inpatient facility, it is helpful to introduce your co-worker to your patients before you leave, so that both the doctor and patient will know better what to expect.
 - Inform your answering service of who your replacement is and how he can be contacted.
 - Carefully check your managed care contracts to see if there are any limitations imposed on your choice of coverage providers.
 - Instruct staff not to release confidential information to anyone without your advance approval.
 - Leave instructions for staff on how to deal with suicidal patients. After patient is directed to the proper care, you should be notified immediately.
 - Be aware of potential breaches of confidentiality if you communicate by cellular phone, fax, or voice mail.
 - Be wary of treating patients by phone if a follow-up office visit can't be scheduled in the near future.
 - Maintain documentation of all calls to and from a patient and to and from a third party about a patient. (This may require you keep a small notebook or pack of forms with you when you're away from the office, so that the record can be filled in upon your return)
 - Save documentation such as your plane tickets, hotel bills, and your coverage instructions. They may prove vital if you are accused of malpractice during a time when you were, in fact, out of town.

If others turn their practices over to you when they are away, remember that you must treat these new patients as if they were your own. Depending on the situation, you alone may be held liable if something goes wrong. Be sure to: find out about any patients who will to likely to require your assistance during your colleague's absence; find out how to gain access to any medical information you may need about patients; know to which institutions your colleague refers if in-patient care is required and be sure you have privileges there; and be clear about any other situations that might arise while you will be covering the practice.

MANAGED CARE ISSUES

More and more of today's psychiatrists are affected by managed care. It is important to remember that patients' rights and appropriate treatment are still of greatest priority. There are a number of "staples" of managed care that can potentially get psychiatrists into trouble.

Utilization Review

A basic tenet of managed care is that requests for treatment are reviewed by the third party, so that excessive (and overly expensive) care is not given. This can pose some problems for psychiatrists. There is often a lag time before the care is approved, and if something happens to the patient during that time, the psychiatrist may be held accountable. Problems can also arise when the managed care company denies the requested care. If you feel that the care is absolutely necessary for your patient, you are obligated to appeal the denial, and it is best to continue providing care during the appeal. If you do not appeal, and there is a negative outcome, such as suicide, you may be held liable. In at least one case on record, the psychiatrist was held accountable with the managed care organization, because it was felt that the psychiatrist did not do everything possible to help the patient.

Capitation

Under a capitated system of care, physicians would seem to earn more money by doing less work. If you are given a fixed fee per month no matter how many patients you see, you are being paid at a higher rate for your services if you see ten patients rather than fifty. With that understood by everyone, it is essential that psychiatrists working under capitation take extra care to ensure that they are providing the best care possible. The incentive may be to provide less care to save money, and this can be detrimental to a patient in need of treatment. If a patient feels that care has been denied simply to cut costs, this can lead to a lawsuit.

Gag Clauses

Patients have the right to know all the treatment options available for their illness. They also should be aware of the physician's payment arrangements, such as capitation. If the psychiatrist is not permitted to inform the patient fully because of restrictions imposed by the managed care organization, and there is an adverse outcome, the psychiatrist may be held liable. Psychiatrists should be wary about signing any contracts with gag clauses in them (see Chapter 28 on managed care contracts).

Formulary Exclusions

In addition to restrictions of speech, as required by gag clauses, restrictions in formularies can also pose problems for psychiatrists. If a patient 1.) is denied access to a particular medication because it is not in the formulary, or 2.) was on a medication with positive results and had to switch because the medication is no longer covered, and in either case has an adverse reaction, the patient can

sue the psychiatrist. It is important to appeal any denials for medications that you prescribe.

Patient Records

Managed care organizations often want to see patient records to authorize continued care or for quality assurance purposes. Always obtain informed and written consent from the patient, and never give a managed care organization a chart for a patient covered by a different organization. Following these procedures will reduce your chances of malpractice suits.

ENCOURAGE ETHICAL BEHAVIOR

Generally promoting and adhering to ethical standards is your safest bet for avoiding malpractice suits. Following the procedures laid out in this chapter and practicing good medicine should decrease your overall chance of risk for a lawsuit and put you in better stead should a lawsuit occur.