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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PHYSICIAN SUICIDE:
DECREASING STRESS SURROUNDING LAWSUITS

According to *A Tragedy of the Profession: Medscape Physicians Suicide Report 2022*, 9% of the 13,000 physicians surveyed reported having had thoughts of suicide, and an additional 1% reported having attempted suicide. The prevalence of suicidal thoughts among specialties varied from 2% in nephrology to 13% in pathology, with psychiatry coming in at 10%. This article presents commentary on just one of the many drivers of physician suicide - stress related to being sued. While the number of litigation stress-related physician suicides is not high, one is too many. Accurate information about the litigation process and psychiatrists' true professional liability risk can help to mitigate litigation-related stress.

Psychiatry is the least often sued medical specialty. Even if sued, psychiatrists, as well as physicians in other specialties, prevail in the vast majority of lawsuits. Data from our insurance program for psychiatrists show that over the past six years, 75% of our Program's claims and lawsuits are closed with no indemnity paid to the plaintiff. For those cases with indemnity paid to the plaintiff (usually from a settlement agreement), the average payment was $248,873.

But what if you are sued? Are you going to remember that the average payout is well within your insurance policy limits? No – it is understandable that a physician who receives notice of a lawsuit automatically becomes terrified of a jury verdict in excess of their insurance policy limits, which then leads to thoughts of losing their home, their savings, and all their other assets. Fortunately, the reality is we do not see these types of verdicts in psychiatry.

We know that the more we dread something, the more anxious we get, and the more anxious we get, the less precisely we calculate the odds of that something actually happening. We often worry about mere possibilities without considering probabilities. However, the stress induced by reading a complaint in a lawsuit filed against you, in which you are accused of terrible acts of negligence, can be gut-wrenching. And there are some unfortunate truths. For example, non-negligent physicians get sued, and plaintiffs may be able to find an expert witness to offer an opinion that there was negligence where there was none. However, that expert witness will be challenged by the defense and defense experts, if the case even gets that far.

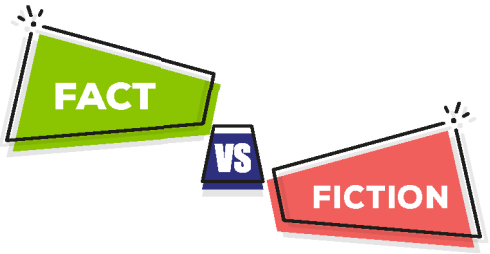
To keep your true risk in perspective, there are many fortunate truths that need to be kept in mind. The reality is that the vast majority of malpractice claims are dropped by the plaintiff, dismissed by the court, or settled within policy limits prior to trial. For those cases that do go to trial, only a very small percent result in a plaintiff's verdict. For those rare cases where there is a plaintiff's verdict against a psychiatrist, the amount awarded by the jury is often higher than that which the court orders the defendant psychiatrist to pay, and final judgments are usually within insurance policy limits.

Another fortunate truth is that you are not alone. You have a team working for you – a claims examiner at your insurance company and your appointed defense attorney who, though paid by the insurer, works for you. You also will have an expert witness who will testify on your behalf and support the care you provided.

Upon receipt of notice of a lawsuit, there are many do's and don'ts:

- DO notify your liability insurer ASAP
- DO limit your discussions about the lawsuit / incident
  - Discussions about the case may be discoverable and used against you
- DO collaborate and cooperate with your attorney
- DO understand potential stressors and how to best manage them – both professional and personal
- DO put your energy to good use – be involved:
  - Educate your attorney on the medicine
  - Be available for your attorney's questions
  - Find and forward medical literature
- DO NOT respond yourself – no matter how meritless the allegations are
- DO NOT ignore it – you risk a default judgment for the plaintiff
- DO NOT contact the patient
- DO NOT contact the attorney / agency / etc. that filed the case
- DO NOT talk to anyone about the specifics of case (other than your insurer and attorney) without the approval of your attorney
- DO NOT hesitate to establish a confidential treatment relationship to deal with your own emotions
  - DO NOT share confidential patient information

While we cannot totally eliminate litigation-related stress, remembering the information presented here can reduce it. The odds in any lawsuit greatly favor the psychiatrist. If litigation-related stress is troubling you, take care of yourself. Talk to the attorney assigned to your case and seek or reach out to your own treatment provider for support.



WHAT DO YOU THINK - FACT OR FICTION?

FACT OR FICTION?

When a patient comes to you already on a medication, and you continue prescribing the exact same medication at the exact same dose, it is not necessary to get informed consent again.

What do you think - fact or fiction?

Fiction!

Whenever you prescribe a medication for the first time, even if just continuing another treater's prescription, you need to have – and document – an informed consent discussion. You cannot presume that the prior treater discussed risks with the patient and you need to assure yourself that the patient knows and understands these risks. "I assumed he knew" will not cut it with a jury. The extent of the informed consent discussion will vary with the riskiness of the medication.

Remember that the FDA's patient medication information guides may be useful in your discussions. And remember to make sure you have made the patient aware of any applicable driving warnings associated with the medication.

MYTHS & 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.

WHERE'S PRMS HEADED THIS FALL?

Society of Liaison's of Psychiatry
Cocktail Party | August 22

Illinois Psychiatric Society
Career Fair | September 7

New York County Psychiatric Society
Meet & Greet | September 12

Southern Psychiatric Society and Tennessee Psychiatric Association
Annual Meeting | September 13-14

New Jersey Psychiatric Association
Resident Event | September 15

North Carolina Psychiatric Association
Annual Meeting | September 26-29

Florida Psychiatric Society
Fall Meeting | September 27-29

Indo-American Psychiatric Association
Fall Meeting | September 28

Indiana Psychiatric Society Regional Integrated Mental Health Conference | October 4-6

Psychiatric Society of Virginia
Fall Meeting | October 4

Illinois Psychiatric Society
Annual Meeting | October 5

Northern California Psychiatric Society Fall Members Meeting | October 9

Alabama Psychiatric Physicians Association
Fall Conference | October 11-12

... and more!

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