PRMS®

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:

- TREATING VIP PATIENTS
- PRACTICAL POINTERS
- JOIN US FOR PSYCH-CESS!
- FACT VS FICTION

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 I VOLUME 2 I ISSUE 3

CLAIMS EXAMINER'S PERSPECTIVE: TREATING "VIP" PATIENTS

Q: Does the risk of malpractice lawsuits increase if a physician treats colleagues, colleagues' family members, or other "VIP" patients?

A: treating "VIP" patients brings to mind images of celebrities being whisked in and out of rehab facilities via limousines surrounded by paparazzi. But a much more common situation for physicians and other healthcare professionals, is being asked to treat colleagues or colleagues family members.

The "VIP syndrome" has been recognized as occurring when a person with a particular status (a Very Important Person) presents for treatment, and the person's status impacts the decisions that healthcare professionals make about the VIP's care. This phenomenon can occur in instances where the patient is not a celebrity or political figure or other high-profile individual. The VIP syndrome may operate when the status of the patient, or the pre-existing relationship with the patient, causes the healthcare professional(s) to treat the patient differently than he/she would normally treat a patient. The potential alteration in treatment is where an increased risk of professional liability can occur. Considering the following case scenario:

A young adult male (Mr. D) was brought to the hospital emergency department (ED) via ambulance after he attempted suicide by cutting both wrists. The patient was an EMT well known to the staff of the hospital as they frequently worked with him when he was part of an emergency transport team bringing critical patients to the ED. The emergency physician assessed Mr. D and contacted the psychiatric crisis team at the neighboring psychiatric hospital for further evaluation, per ED policy. A member of the crisis team, a psychiatric nurse, met with the patient in the ED. Mr. D told the nurse that he had not meant to kill himself. He stated that he now realized it was a "stupid thing to do," and that he had cut his wrists in an attempt to get "my wife's attention." He wanted her to focus on problems in their marriage which she was avoiding. Furthermore, Mr. D stated that as an EMT "if I really meant to kill myself, I know how to do it."

The psychiatric nurse contacted the on-call psychiatrist and related this information to her. Both had both worked with Mr. D on numerous occasions. The psychiatrist then briefly conferred with the emergency physician. The patient's wife was not contacted and the treatment team did not inquire about any past psychiatric treatment. The emergency physician, the nurse, and the psychiatrist decided on a treatment plan that included stitches to the cuts and instructions for Mr. D to set up an appointment to see a therapist or psychiatrist within the next week. Mr. D promised to do this and stated he would find his own therapist or psychiatrist. He was then discharged from the ED. Three days later, Mr. D killed himself with a gunshot to the head.

A medical malpractice lawsuit was filed by wife against the emergency physician, the psychiatric nurse, the psychiatrist, the general hospital, and the psychiatric facility. During the discovery phase of the lawsuit it

was found that Mr. D had previously been in treatment for depression and, also, that his wife was not aware of the recommendation that he seek treatment within a week. At trial, a verdict was returned for the plaintiffs and all defendants were found by the jury to have been negligent in the assessment and treatment of Mr.D.

The health care professionals involved in this case made assumptions about the patients that they probably would not have made if they had not had a prior work relationship with this patient. Additionally, they failed to gather all the information they would typically gather to thoroughly assess the patient and implement an effective treatment plan. These shortfalls were, at least in part, responsible for the tragic outcome for this patient. Here, the patient was also signaling to the clinicians "don't treat me like a regular patient because I'm not" in a number of ways - including his comments about knowing how to kill himself if he really wanted to, and by providing no information about prior treatment. The VIP patient may experience his or her own feelings, such as shame and discomfort about sharing sensitive information with colleagues, which may prevent him/her from taking a productive patient role.

Key risk management strategies for minimizing potential for professional liability risk include:

1. VIP patients must be provided the same standard of treatment as other patients. For example:
    - When applicable, informed consent should be provided as thoroughly as it is for all patients. For the VIP who is a medical professional, do not assume that he/she know already knows and understands the treatment you are recommending
    - If you find your objectivity as a clinician is wavering (such as taking shortcuts and treatment, ordering more than or less than the usual tests, avoiding a thorough history and exam, etc.) obtain clinical supervision and/or refer the treatment to another clinician
    - Special privileges for VIP patients may compromise their care and ultimately their health
    - Do not avoid extra-sensitive topics such as the possibility of alcohol or substance use/abuse, suicidal behavior, issues around sexuality, infectious disease, etc.
2. The same level of confidentiality and professionalism must be afforded to the VIP patient as is provided to all patients
    - Members of the treatment team must resist the temptation (and sometimes the urging of other health care providers) to share patient information with those who have no need to know.
    - Colleagues' family members have the same rights of confidentiality as all other patients. Their information should not be shared with their family members without proper authorization, although colleagues may have unreasonable expectations to the contrary.
3. Be aware of legal issues related to reducing or waiving fees ("professional courtesy") when treating colleagues or their family.

PRACTICAL POINTERS FOR MANAGING RISK WHEN TREATING PATIENTS WITH SUICIDAL BEHAVIORS

1. Include specific exploration of suicidal potential in examinations at the outset of treatment and at other points of decision during treatment. Suicidal potential should be re-assessed at least: 1) whenever there is an incidence of suicidal or self-destructive ideation or behavior; 2) when significant clinical changes occur; 3) when any modification in supervision or observation level is ordered; and 4) at the time of discharge or transfer from one level of care to another. Based on these reassessments, make adjustments to the treatment plan as needed.
2. Explore past treatment. Obtain treatment records where possible for new or returning patients. Record attempts to obtain records if they cannot be obtained.
3. Review patient records prior to lifting precautions or otherwise reducing the nature or intensity of treatment. Review the entries of other professionals as well as your own.
4. Conduct follow-up discussions with staff members whose record entries may be inconsistent with treatment options under consideration. Include the basis for resolution of the inconsistency in a record entry of the decision.
5. Instruct staff to notify you immediately if they are concerned about a patient's potential for suicide.
6. Communicate with other treaters, especially when the patient is being treated in a split or collaborative treatment arrangement.
7. At the outset of treatment, or after breaks in treatment, consult family members or others close to the patient, as appropriate, for information about the patient's history, presenting condition, and life circumstances.
8. Address the need for a safe environment for patients with suicidal behaviors. The accessibility of firearms or other weapons should be assessed and an appropriate plan for safety should be instituted, including getting information from and instructing family/significant others about this issue.
9. Record all potentially relevant information provided by family and close friends.
10. Know the criteria and procedures for involuntary hospitalization in your state.
11. Do not rely solely on "no-harm" contracts as a guarantee of patient safety. These "contracts" have no legal force and cannot take the place of an adequate suicide risk assessment. It may be appropriate for a "no-harm" contract to be one part of a comprehensive treatment plan but it is the clinician's responsibility to evaluate the patient's overall suicide risk and ability to participate in the overall treatment plan.
12. Be alert for- and respond to- developments in a patient's life that may increase the risk of suicide.
13. Address financial constraints directly. If recommended treatment is not financially possible, then attempt to find equivalent alternatives. Document the adequacy of the alternative that is ultimately chosen.

14. Document all rlevant information about a patient's condition, treatment options considered, risk/ benefit analysis performed, and the rationales for choosing or rejecting each option.
15. Never alter or destroy a patient record after an adverse incident.
16. Develop a follow-up treatment plan for discharge or for transfer from one level of care to another that is consistent with a patient's situation and abilities. You may need to take steps to monitor patient compliance if another psychiatrist or professional has not yet assumed care.
17. Familiarize yourself with the policies of all hospitals or other institutions/organizations where you provide treatment. Practice accordingly.
18. The decision about type and amount of medication given to a suicidal patient - and the resulting record entry - should reflect the extent of your experience with the patient, your knowledge of the patient, the severity of the patient's suicidality, and the extent to which physician prescribed medications may be of significance to the patient.
19. Refill prescriptions for other psychiatrists' patients with care. Review such refills with the psychiatrist if possible. Where such review is not possible, consider prescribing only enough medication to cover the patient until the psychiatrist returns or can be consulted.
20. Terminate treatment with potentially suicidal patients with extreme care. Avoid terminating during periods of crisis. Consider termination during inpatient treatment, if termination is necessary.
21. Prepare patients for scheduled absences and make provisions for coverage.
22. Consider alerting family members to the risk of outpatient suicide when:
    - the risk is significant,
    - the family members do not seem to be aware of the risk, and
    - the family might contribut to the patient's safety.
23. Consistently use an authoritative guideline to assess the level of suicide risk and facilitate the development of a reasonable intervention and treatment plan based on the assessed risk level.

RESIDENTS AND FELLOWS:

ARE YOU MOONLIGHTING?

One of the most important decisions you will make in your career is choosing a professional liability insurance company you can rely on, from residency to retirement. With more than 35 years of psychiatry-specific experience, PRMS® provides moonlighting residents and fellows with the insurance coverage and risk management resources necessary to practice with peace of mind – so you can focus on developing your skills and taking care of patients.

RICHARD STAGNATO, RPLU
SENIOR UNDERWRITER

Learn more at PRMS.com/Residents

PRMS Psych-cess: Hispanic Psychiatry

READY FOR SUCCESS IN YOUR PSYCHIATRIC CAREER?

JOIN US FOR PRMS PSYCH-CESS!

WEDNESDAY, SEPTEMBER 18 • 6:30 - 8:00 PM (ET)

PRMS® Psych-cess is a virtual webinar for residents, fellows, and early career psychiatrists, led by experts in the field to set you up for success. In honor of Hispanic Heritage Month, we're proud to present **Psych-cess: Hispanic Psychiatry**, which will feature a panel of three knowledgeable psychiatrists leading a discussion on their diverse experiences as Latinx physicians studying and practicing psychiatry, and treating diverse communities.

PANEL OF SPEAKERS:

Ruby C. Castilla-Puentes, MD, FAPA, DrPH, MBA

Co-founder, President WARMI Mental Health | Philadelphia, PA

Juan A. Gallego, MD, MS

Assistant Professor, Zucker School of Medicine | Glen Oaks, NY

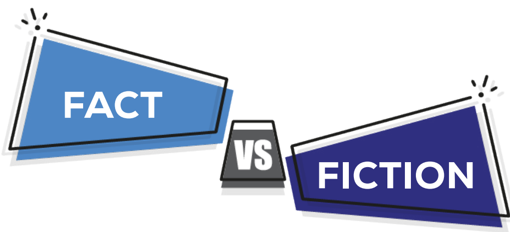
Almari Ginory, DO, DFAPA

Program Director, University of Central Florida | Gainesville, FL

PLATFORM
Zoom Webinar
Link sent after registration

PRIZE
One $50 gift card
All participants who join the webinar will be entered to win!

REGISTER FOR **FREE** TODAY! Visit www.PRMS.com/Psych-cess



WHAT DO YOU THINK - FACT OR FICTION?

FACT OR FICTION?

When parents continue to pay for services once a patient turns 18, they continue to have access to patient information the same as when the patient was a minor.

What do you think - fact or fiction?

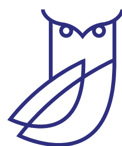
Fiction!

Once a patient turns 18, parents no longer automatically have the right to access the patient's record. Once a patient turns 18:

- To release information to parents, even if they are continuing to pay for your services, you need the patient to authorize such release.
- If parents had access to the patient's records on your patient portal, be sure to discontinue that access.
- Remember to get informed consent from the now adult patient for all medications, even those the patient is currently taking.

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**

Professional Risk Management Services ("PRMS") provides the information contained in this article for general use and information. Information provided is intended to improve clarity on issues regarding psychiatry services and insurance coverage, and related issues regarding those services. This information is intended, but not promised or guaranteed, to be current, complete, or up-to-date. PRMS is neither a law firm nor a provider of professional medical services, and the materials in this article do not constitute legal, medical, or regulatory advice. You should not act or rely on any legal or medical information in this article without first seeking the advice of an attorney, physician, or other appropriate professional. PRMS, The Psychiatrists' Program and the PRMS Owl are registered Trademarks of Transatlantic Holdings, Inc., a parent company of Fair American Insurance and Reinsurance Company (FAIRCO).

©2024 Professional Risk Management Services (PRMS). All rights reserved.