Consent to Treatment

TOP 50 PROFESSIONAL LIABILITY POINTS FOR CHILD AND ADOLESCENT PSYCHIATRISTS

Professional Liability in General

1. The greatest professional liability exposures related to minor patients are the same as for adult patients – psychopharmacology and treating patients with suicidal behaviors.
2. More licensing board complaints are filed involving minor patients than adult patients.
3. Licensing board complaints filed against child and adolescent psychiatrists often involve divorced / divorcing parents and / or psychopharmacology complaints. Licensing board complaints are also common following a psychiatrist's report of child abuse.
4. The vast majority of licensing board investigations involving minor patients are dismissed.
5. Most prescribing for minors is off-label, which can lead to heightened scrutiny of prescribing decisions.
6. State statutes of limitations (time period after which lawsuits may be barred) are much longer for minor patients. Some states allow patients treated as minors to bring suit once they reach 18, regardless of the age during treatment.
7. Minors are a particularly vulnerable patient population – most minors depend on their parents for adherence to the treatment plan, and it is difficult to hold a minor responsible when an unanticipated outcome occurs.
8. Minor patients (as well as their parents typically) will engender a great deal of sympathy from juries. Juries may have protective feelings and believe that kids should not have to deal with issues leading to the litigation, such as SJS or molestation in a facility.
9. A greater number of claims involving minor patients than claims involving adult patients may result in payment to the patient.
10. Payment amounts to patients for claims involving minors are lower than those for adult patients. Reasons for lower damages in cases involving minor patients include speculative economic losses (such as future lost wages), and minors typically do not have dependents.
11. As with lawsuits involving adult patients, plaintiff attorneys like to keep allegations broad initially, so "incorrect treatment" is the most frequent allegation made in both minor and adult patient claims.
12. Because of harm to minor patients in facilities from other patients and from staff, psychiatrists who serve as facility medical directors have increased liability exposure.

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13. It may take time to establish an accurate diagnosis of a child or adolescent. This should be addressed with the patient and the family because the certainty of the diagnosis will impact the treatment recommended and subsequent changes in the treatment, including medications.

14. Generally, a parent or legal guardian must consent to the treatment of a minor. Consent given by one who does not have the legal authority to give consent is no consent.

15. If a minor patient's parents are divorced, take reasonable steps to determine which parent(s) have the legal authority to consent to treatment. These legal rights should be spelled out in a custody order or similar document.

16. Document your requests to obtain custody orders.

17. In the event both parents share equal medical decision-making, or if it is not addressed, and the parents disagree, the attorneys or the court should resolve the issue of which parent has the final say in medical decisions.

18. In some states, minors of a certain age may have been granted the right to consent to mental health treatment. However, even in those states, the minor is usually not allowed to give consent for psychotropic medications.

19. Minors who have been deemed by the court to be "emancipated" can consent to mental health treatment.

20. In an emergency, treatment may be provided without consent. However, you should be careful if it is questionable that a true emergency exists, such as when the presenting party does not have the legal authority to consent but has other motives for obtaining medical intervention and the related medical records.

21. Ensure that a minor of appropriate age is provided with understandable information to obtain the minor's assent.

Psychopharmacology

22. Educating the family and the age-appropriate minor patient about the medications is crucial and is part of the informed consent process.

23. If prescribing off-label, explain what that means and why you are recommending it.

24. Ensure appropriate monitoring related to the medications you prescribe.

25. Stay current with safety issues related to the medications you prescribe, via MedWatch, clinical studies, authoritative clinical guidelines (such as those from AACAP), etc.

Documentation

26. The primary purpose of the clinical record is for continuity of care. Document so that another provider (subsequent treater or expert witness reviewing your care) can understand your treatment and the basis for it. Document not only what you did and why, but also what you considered but rejected and why.

27. When documenting in the minor's record, bear in mind that regardless of any agreement made by the parents to not access the written record, parents can almost always obtain a copy of a minor child's treatment record.

28. Return all phone calls. Patient and parents may need to provide important information related to patient safety or the safety of others.

29. Document all phone calls, even after hours, noting what the caller said and what your response was.

30. It is not a breach of confidentiality to listen (without confirming the person is a patient) to what third parties want to tell you. You may learn important information relevant to your treatment plan.

31. Document your ongoing assessment of violence.

32. Records of minor patients should be maintained well past the age of majority, as the time within which to sue in many states starts once the minor turns 18.

33. Maintain a separate record for each person attending a family session or for each person seen separately in relation to the minor's treatment. This will assist in preserving confidentiality and will facilitate processing requests for release of that information.

Release of Information

34. Patient safety and safety of others is an exception to confidentiality.

35. Understand the requirements for reporting child abuse in your state(s).

36. To the extent possible, adolescents should be accorded the same confidentiality rights as adults.

37. Confidentiality of the minor's treatment information should be discussed and agreed upon prior to initiation of

38. treatment, or when the patient has reached an appropriate age in on-going treatment.

39. Parents generally have the right to exercise a minor patient's right to access and authorize disclosure of medical records. However, the parents' right to access the minor patient's medical record does not mean that the parents must be told everything that the minor patient tells the psychiatrist.

40. Generally, both divorced parents have the right to access their child's treatment record, unless parental rights

41. have been terminated.

42. If a guardian ad litem has been appointed by the court for a minor patient and requests a copy of the record, you should request and review a copy of the court order granting the guardian that right.

Termination

43. To avoid allegations of abandonment, the termination process should be utilized – notice, education on treatment recommendations, referral resources, and follow-up letter.

44. Confirmation letter should be sent when patient has transferred care to another provider or no longer wishes to continue treatment with you.

45. Clarify the continuation versus termination of treatment for patients attending college out of the area.

Dual Roles

46. Avoid assuming the dual role of forensic psychiatrist in custody disputes involving your patient. Once such additional role has been assumed, there will almost certainly be conflicting demands that ultimately impact negatively upon the treatment relationship.

Technology

47. Understand that technology does not change your ethical and legal obligations.
48. When utilizing social media, remember that patient confidentiality must be protected, and that there is more to de-identification than simply not using the patient's name.
49. Assume that everything you post online will be found by patients, plaintiff attorneys, and your licensing board.
50. Ensure that you have an accurate understanding of exactly what your minor patients are doing online (including gaming, gambling, pornography, etc.) and to what extent.
51. When treating patients remotely, services are deemed to be rendered where the patient is physically located, so the licensing board in the state where the patient is should be contacted to determine if a license is required.
52. When treating patient remotely, licensing boards have made it clear that the standard of care is the same as if the patient is seen in-person.

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