20 SUREFIRE STEPS TO INCREASE THE RISK OF A MALPRACTICE LAWSUIT OR BOARD COMPLAINT

Nobody enters into medical practice planning to be the subject of a malpractice lawsuit or a board complaint. Most psychiatrists are simply trying their best to provide quality patient care, improve revenue streams, and reduce paperwork under difficult, even hostile, circumstances. Unhappily, the compromises made while juggling these goals can increase psychiatrists' professional liability exposure. Claims Examiners and Risk Managers who review complaints and lawsuits against clinicians often take note of certain behaviors that increase the clinicians' professional liability risk. To illustrate this point, we offer the following list, gleaned from actual cases, of surefire steps to ***increase*** your risk of a malpractice lawsuit or a board complaint.

- Documenting ***only*** the first suicidal risk assessment done on a patient; not documenting ongoing monitoring and evaluation of suicidality
- Allowing a patient with suicidal behaviors to be lost to follow-up
- Neglecting to document the clinical basis for ordering a change in the level of patient supervision and/or level of care for a patient with suicidal behaviors
- Not responding at all (even appropriately within professional standards) to family members who call with concerns about a patient with suicidal behaviors because you don't have an authorization from the patient to release treatment information to the family member(s)
- Failing to evaluate the safety of the environment for a patient with suicidal behaviors, e.g., accessibility of firearms and other weapons
- Failing to warn a third party, (or take alternative appropriate steps) when a dangerous patient has identified the party as a potential victim, as allowed or required by law
- Thinking that the other clinician in a collaborative treatment (shared or split treatment) relationship will know what patient information is important to discuss with you and when to call you without ever having had an agreement or discussion about these expectation with the other clinician
- Prescribing lithium ***without*** conducting regular tests on lithium and electrolyte levels
- Prescribing psychotropic medications without going through the informed consent process (and documenting it), especially when prescribing off-label for children.
- Failing to document what medications have been ordered, the basis for prescribing the medications, and changes to medications
- Sending a patient's overdue bill straight to collections without reviewing the chart and speaking to the patient about it

- Assuming that the patient will be grateful and, therefore, not sue you for providing care that falls below the standard of care, because you are helping by providing at least minimal care since the patient cannot sufficiently pay for your services
- Allowing patients to pay for services by mowing your lawn, washing your car, painting your house, babysitting your kids, etc.
- Failing to conduct a thorough neurological evaluation on a patient who presents with decreased level of consciousness, an altered mental state, or who falls during hospitalization
- Ignoring the steps in the clinician-patient termination process
- Summarily terminating treatment with a patient who is in crisis (e.g., a patient assessed to be a danger to self or others) believing this will decrease potential malpractice risk in the event of an adverse clinical outcome
- Assuming that your clinical rationale and professional judgment, which is the basis for the patient's treatment plan, does not need to be documented in the patient record
- Ignoring a subpoena for patient records or to testify, since you are not sure of the proper response. Or, conversely, anytime you receive a subpoena, releasing the patient's record right away.
- Deciding not to establish a patient record for a patient who has very sensitive issues to discuss in treatment
- Altering a patient record after an adverse event
- Becoming involved in a sexual relationship with a patient

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