HOT TOPICS IN RISK MANAGEMENT

LPMA/MPA Spring Meeting
February 15, 2019

Charles D. Cash, JD, LLM
Assistant Vice President, Risk Management

Justin Pope, JD
Associate Risk Manager
Professional Risk Management Services, Inc. (PRMS)
More on Medical Marijuana

Published on February 20, 2018

In this article, we explore the risks and benefits of medical marijuana for healthcare providers. Some people believe that enforcement guidance memos issued by the Department of Justice (DOJ) allow for medical marijuana use if such use is allowed under state law. The most often cited DOJ memo on this issue is the “Cole Memo” from 2011, specifying that federal resources should not be used to enforce prohibition of marijuana for medical purposes in states where it is legal. While this memo provides some legal protection, there are significant barriers to implementing medical marijuana programs, including issues related to reimbursement, legal liability, and patient safety. The issue of prescribing medical marijuana, for example, is complex, with many states having regulations that differ from federal laws. This article discusses the legal and practical challenges faced by healthcare providers when considering the use of medical marijuana in their practice.
MR. CASH AND MR. POPE HAVE NO RELEVANT FINANCIAL RELATIONSHIPS WITH COMMERCIAL INTERESTS.
DISCLAIMERS

➢ Nothing we say today is legal advice.
OBJECTIVES

• Explain recent developments in the government’s investigatory approach towards physicians and their role in the opioid epidemic.
• Incorporate into clinical practice at least two risk management strategies to increase patient safety and reduce professional liability risk when prescribing opioids.
• Discuss current state law related to medical marijuana.
• Understand the federal government’s marijuana position, and its impact on psychiatrists.
• Understand why child and adolescent psychiatrists may be sued more often than psychiatrists treating adult patients.
• Address the tension between minor patients’ confidentiality rights and the parents’ right to know treatment information.
• Explain two duties that courts are requiring of IME physicians.
• Understand the need to manage the expectations of state licensure boards and professional societies in terms of forensic activities.
RESOURCES

Hot Topics in Psychiatry Risk Management
Louisiana Psychiatric Medical Association
February 15, 2019

Speakers:
David Cash, JD, LLM
Assistant Vice President, Risk Management

Justin Pope, JD
Associate Risk Manager

Professional Risk Management Services, Inc. (PRMS)

Resources:

www.prms.com/rmtalks
AGENDA

- Professional liability overview
- Psychopharmacology
  - Typical pitfalls
  - Opiates
  - Non-adherent patients, driving, and telepsychiatry
  - Medical marijuana
- Forensic practice exposures
- Child and adolescent practice exposures
Lawsuits by Specialty

A new study shows how often physicians by specialty are sued annually and how many end up making payments to plaintiffs who have sued them.


Accessed February 1, 2012
PSYCHIATRY CLAIMS

PRMS Experience

• 77% of claims close without indemnity payment or by dismissal or summary judgment
• 20% of claims settle
• 3% go to trial
  › Greater than 99% defense verdicts
GREATEST EXPOSURE

Greatest Professional Liability Exposure - Frequency

For psychiatrists:

- Patient suicide / attempted suicide
- Psychopharmacology
# The Psychiatrists’ Program®

## Cause of Loss – Claims and Lawsuits

### 2009 – 2018

<table>
<thead>
<tr>
<th>Primary Allegation</th>
<th>All Ages</th>
<th>Adults</th>
<th>Minors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect Treatment</td>
<td>34%</td>
<td>35%</td>
<td>25%</td>
</tr>
<tr>
<td>Medication Issues</td>
<td>19%</td>
<td>19%</td>
<td>16%</td>
</tr>
<tr>
<td>Suicide/Attempted Suicide</td>
<td>13%</td>
<td>13%</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Incorrect Diagnosis</td>
<td>6%</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Unnecessary Commitment</td>
<td>5%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Breach of Confidentiality</td>
<td>5%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Improper Supervision</td>
<td>2%</td>
<td>2%</td>
<td>9%</td>
</tr>
<tr>
<td>Vicarious Liability</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Improper Discharge</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Forensic (expert testimony, IMEs, etc.)</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Duty to Warn / Protect</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Abandonment</td>
<td>1%</td>
<td>1%</td>
<td>-</td>
</tr>
<tr>
<td>Boundary Violation</td>
<td>1%</td>
<td>1%</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes:

- “Primary allegation” is the main allegation by plaintiffs’ attorneys of what the psychiatrist did wrong.
- “Incorrect treatment” will represent a high percentage of cases because plaintiffs’ attorneys often use a broad, general allegation initially; this category includes all types of cases, including suicide and psychopharmacology.
- The category labeled “Improper Supervision” refers to supervision of patients as well as other providers.
GREATER EXPOSURE

Greatest Professional Liability Exposure - Severity

Cases involving significant permanent neurological or physical injuries that result in need for life-long care

- Financial costs associated with providing life-long care
- Loss of potential income
- Pain and suffering awards
ADMINISTRATIVE ACTIONS

• Take them seriously!
• No damages required
• Increased attention to professional discipline
• Call your insurer
The Psychiatrists’ Program®
Cause of Loss – Administrative Actions, Claims, and Lawsuits
1986 - 2018

<table>
<thead>
<tr>
<th>Primary Allegation</th>
<th>All States</th>
<th>MS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide / Attempted Suicide</td>
<td>27%</td>
<td>18%</td>
</tr>
<tr>
<td>Incorrect Treatment</td>
<td>23%</td>
<td>41%</td>
</tr>
<tr>
<td>Breach of Confidentiality</td>
<td>15%</td>
<td>9%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
<td>4%</td>
</tr>
<tr>
<td>Medication Issues</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>Incorrect Diagnosis</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Unnecessary Commitment</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Improper Supervision</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Boundary Violation</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Abandonment</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Duty to Warn / Protect</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Forensic</td>
<td>&lt; 1%</td>
<td></td>
</tr>
<tr>
<td>Lack of Informed Consent</td>
<td>&lt; 1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Notes:

- “Primary allegation” is the main allegation by plaintiffs’ attorneys of what the psychiatrist did wrong
- “Incorrect treatment” will represent a high percentage of cases because plaintiffs’ attorneys often use a broad, general allegation initially; this category includes all types of cases, including suicide and psychopharmacology
- The category labeled “Improper Supervision” refers to supervision of patients as well as of other providers

Copyright © 2019 Professional Risk Management Services, Inc. (PRMS)
<table>
<thead>
<tr>
<th>Primary Allegation</th>
<th>All States</th>
<th>LA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide / Attempted Suicide</td>
<td>27%</td>
<td>18%</td>
</tr>
<tr>
<td>Incorrect Treatment</td>
<td>23%</td>
<td>32%</td>
</tr>
<tr>
<td>Breach of Confidentiality</td>
<td>15%</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
<td>1%</td>
</tr>
<tr>
<td>Medication Issues</td>
<td>8%</td>
<td>16%</td>
</tr>
<tr>
<td>Incorrect Diagnosis</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Unnecessary Commitment</td>
<td>3%</td>
<td>14%</td>
</tr>
<tr>
<td>Improper Supervision</td>
<td>3%</td>
<td>7%</td>
</tr>
<tr>
<td>Boundary Violation</td>
<td>3%</td>
<td>-</td>
</tr>
<tr>
<td>Abandonment</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Duty to Warn / Protect</td>
<td>1%</td>
<td>-</td>
</tr>
<tr>
<td>Forensic</td>
<td>&lt; 1%</td>
<td>-</td>
</tr>
<tr>
<td>Lack of Informed Consent</td>
<td>&lt; 1%</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes:
- “Primary allegation” is the main allegation by plaintiffs’ attorneys of what the psychiatrist did wrong.
- “Incorrect treatment” will represent a high percentage of cases because plaintiffs’ attorneys often use a broad, general allegation initially; this category includes all types of cases, including suicide and psychopharmacology.
- The category labeled “Improper Supervision” refers to supervision of patients as well as of other providers.

Copyright © 2019 Professional Risk Management Services, Inc. (PRMS)
Elements Of A Lawsuit

Duty of Care
The physician owed a duty of care to the patient (to meet the standard of care)

Breach of Duty
The physician was negligent (the care provided fell below the standard of care)

Damages
The patient suffered an adverse outcome (injury)

Causation
The patient’s damages were a direct result of the physician's negligence
DETERMINING THE APPLICABLE STANDARD OF CARE

The degree of skill, care, and diligence exercised by members of the same profession/specialty practicing in light of the present state of medical science
Many items may be admissible, along with expert testimony, to determine the issue of standard of care. The following items could be relied upon as evidence of the appropriate standard of care:

- Statutes – federal and state
- Regulations – federal and state
- Case law – federal and state
- Other materials from federal and state regulatory agencies – state medical boards, DEA, FDA, etc.
  - Rules / Guidelines / Policy Statements
- Authoritative clinical guidelines
DETERMINING THE APPLICABLE STANDARD OF CARE

- Policies and guidelines from professional organizations
- Learned treatises
- Journal articles
- Research reports
- Facility’s own policies and procedures
- PDR recommendations
- Drug manufacturer recommendations
AGENDA

➢ Professional liability overview
➢ Psychopharmacology
   ➢ Typical pitfalls
   ➢ Opiates
   ➢ Non-adherent patients, driving, and telepsychiatry
   ➢ Medical marijuana
➢ Forensic practice exposures
➢ Child and adolescent practice exposures
"I think the dosage needs adjusting. I'm not nearly as happy as the people in the ads."
COMMON ALLEGATIONS

Failure to:

• Perform adequate history and physical
• Properly prescribe
• Properly diagnose
• Obtain consultation or make referral
• Adequately inform of side effects
• Obtain informed consent
COMMON ALLEGATIONS

Failure to:

• Appropriately order and monitor lab testing
• Recognize and appropriately respond to adverse drug reactions
• Communicate with other providers
• Adequately screen for contraindications
• Access and review PMP data
COMMON PITFALLS

- Lithium levels
- RFT’s
- Depakote levels
- LFT’s
- Screening for metabolic disorders
- AIMS testing
- Checking the PMP database
AGENDA

- Professional liability overview
- Psychopharmacology
  - Typical pitfalls
  - Opiates
  - Non-adherent patients, driving, and telepsychiatry
  - Medical marijuana
- Forensic practice exposures
- Child and adolescent practice exposures
Opioid overdoses kill nearly 5 people every hour, CDC says

Doctor faces charges over opioid prescriptions and 5 patient deaths

Washington County heroin epidemic making national headlines

Governor Wolf Declares Heroin and Opioid Epidemic a Statewide Disaster Emergency

Jump In Overdoses Shows Opioid Epidemic Has Worsened

Drug-related deaths are up more than 600 percent over 35 years, study shows

Opioid abuse in the U.S. is so bad it’s lowering life expectancy. Why hasn’t the epidemic hit other countries?
More Than Half Of Opioid Prescriptions Go To People With Mental Illness

People with mood disorders receive 60 million prescriptions for painkillers a year.

By Lindsay Holmes
Demand sex for Rx
Withheld Methadone when patient refused
License Revoked

Rx for jailed patient (billed in-person visit)
Licenses (>1 state) Revoked

Pre-dated Rxs; early refills; ignored red flags; illegible charts
Surrendered License

Rx without regularly checking PMP
Reprimand; CME; $13,000 fine

Intentional Criminal Conduct

Good Clinical Care

Pill mill
Reportedly 36 patient deaths
Suspended License
Criminal Case Filed

Overprescribed, split Rx with patients
Suspended License; Reprimand; CME

Standardized Rx
Issued Lorclt, Soma, & Valium to all pts
License Revoked

Scant charts; no diversion safeguards; no treatment plans
Reprimand; CME
Operators of Bogus Medical Clinics Charged in Conspiracy to Divert Massive Amounts of Prescription Narcotics to the Black Market

Glendale Defense Attorney and Others Involved in Scheme Allegedly Obstructed Justice by Creating Fake Medical Records to Justify Fraudulent Prescriptions

LOS ANGELES – The operators of seven sham medical clinics were among 12 defendants taken into custody this morning on federal drug trafficking charges that allege they diverted at least 2 million prescription pills – including oxycodone and other addictive and dangerous narcotics – to the black market.

Two indictment charges in the 20-count indictment alleged the defendants, as part of a criminal conspiracy, trafficked the prescription drugs – including oxycodone, hydrocodone, and methadone – through a series of sales, some of which occurred in local markets and on the street.

“Los Angeles law enforcement and health care officials are determined to shut down this massive illegal trade in prescription drugs, which is tearing apart families and communities across our nation,” Acting United States Attorney Sandra R. Brown said.

In a recorded conversation described in court documents, Matsosyan discussed how one doctor was paid “for sitting at home,” while thousands of narcotic pills were prescribed in that doctor’s name and Medicare was billed more than $500,000 for purported patient care.

The conspirators also allegedly stole the identities of doctors who refused to participate in the scheme. In an intercepted telephone conversation described in court documents, Matsosyan offered a doctor a deal to “sit home making $20,000 a month doing nothing.” When the doctor refused the offer, the conspirators nevertheless created prescription pads in the doctor’s name and allegedly began selling fraudulent prescriptions for oxycodone without the doctor’s knowledge or consent.
DEA REGULATIONS

Ex: 21 CFR 1306.04(A):

“A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose...by an individual practitioner...acting in the usual course of his professional practice”
Practitioner’s Manual

An Informational Outline of the Controlled Substances Act

CDC Guideline for Prescribing Opioids for Chronic Pain

Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

CDC developed and published the CDC Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

What do you need to know?

- **Patients**
  - Information and resources for patients

- **Health Care Providers**
  - Overview of the guideline for providers

- **Resources**
  - Fact sheets, clinical tools, and other materials related to the guideline

Clinical practices addressed in the guideline

- Determining when to initiate or continue opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use
FSMB: MODEL POLICY FOR THE USE OF OPIOID ANALGESICS IN THE TREATMENT OF CHRONIC PAIN

UNIVERAL PRECAUTIONS – SUMMARIZED:

1) Make a diagnosis with an appropriate differential.
2) Conduct a patient assessment, including risk for substance use disorders.
3) Discuss the proposed treatment plan with the patient and obtain informed consent.
4) Have a written treatment agreement that sets forth the expectations and obligations of both the patient and the treating physician.
5) Initiate an appropriate trial of opioid therapy, with or without adjunctive medications.
6) Perform regular assessments of patient and function.
7) Reassess the patient’s pain score and level of function.
8) Regularly evaluate the patient in terms of the “5 A’s”: Analgesia, Activity, Adverse effects, Aberrant behaviors, and Affect.
9) Periodically review the pain diagnosis and any comorbid conditions, including substance use disorders, and adjust the treatment regimen accordingly.
10) Keep careful and complete records of the initial evaluation and each follow-up visit.
Welcome to the website of the Louisiana State Board of Medical Examiners

Established in 1894, the Louisiana State Board of Medical Examiners (LSBME) protects the health, welfare and safety of Louisiana citizens against the unprofessional, improper, and unauthorized practice of medicine by ensuring that those who practice medicine and other allied health professions under our jurisdiction are qualified and competent to do so. In addition, the Board serves in an advisory capacity to the public and the state with respect to the practice of medicine.

www.lsbme.la.gov
www.msbml.ms.gov
THE ISSUE:
MISUSE OF CONTROLLED SUBSTANCES

- Abuse
- Addiction
- Overdose
- Diversion

Abstract

**Background:** Prescription opioid-related overdose deaths increased sharply during 1999–2010 in the United States in parallel with increased opioid prescribing. CDC assessed changes in national-level and county-level opioid prescribing during 2006–2015.

**Methods:** CDC analyzed retail prescription data from QuintilesIMS to assess opioid prescribing in the United States from 2006 to 2015, including rates, amounts, dosages, and durations prescribed. CDC examined county-level prescribing patterns in 2010 and 2015.

**Results:** The amount of opioids prescribed in the United States peaked at 782 morphine milligram equivalents (MME) per capita in 2010 and then decreased to 640 MME per capita in 2015. Despite significant decreases, the amount of opioids prescribed in 2015 remained approximately three
THE RESPONSE: REGULATION

• Federal
• State
FEDERAL VERSUS STATE

- DEA works closely with state licensing boards and state local law enforcement
- Majority of investigations of controlled substance laws are done by state authorities
- DEA will also conduct investigations of federal law
DEA PROBLEM AREAS:

1) Failure to recognize doctor shoppers
   • Red Flags
     › Symptom incompatible with reported injury
     › Visit physician some distance from home
     › History of problems with no medical records
     › Multiple accidents
     › Insist on drug of choice
     › Loss of prescription or medication
     › Fails to provide or go for testing
     › Takes more meds than directed
     › Requests meds early
     › Meds from multiple physicians
     › Prescriptions filled at multiple pharmacies

www.acponline.org/about_acp/chapters/az/rivera-armando.pdf
FEDERAL

DEA PROBLEM AREAS:

2) Diversion

• Methods
  › Practitioners / Pharmacists
  › Employee pilferage
  › Pharmacy theft
  › Patients / Drug Seekers
  › Medicine Cabinet / obituaries
  › Internet
  › Pain Clinics

[www.mbc.ca.gov/board/meetings/materials_2013_02_21_prescribing-2.pdf]
FEDERAL

(CONTINUED)

• Possible indicators
  › Inordinately large quantity of controlled substances was prescribed
  › Large numbers of prescriptions were issued
  › No physical exam
  › Physician warned patient to fill prescriptions at different pharmacies
  › Physician issued prescriptions to patient known to be delivering drugs to others
  › Physician prescribed controlled substances at intervals inconsistent with legitimate medical treatment
  › Physician used street slang rather than medical terminology for drugs prescribed
  › No logical relationship between drugs prescribed and treatment of alleged condition

www.acponline.org/about_acp/chapters/az/rivera-armando.pdf
DEA PROBLEM AREAS:

3) Excessive / Unauthorized Prescribing
4) Internet Prescribing

www.acponline.org/about_acp/chapters/az/rivera-armando.pdf
How to minimize professional liability risk

Utilize three risk management strategies to provide good clinical care

Strategy #1: COLLECTING INFORMATION

Strategy #2: COMMUNICATING

Strategy #3: CAREFULLY DOCUMENTING
COLLECT INFORMATION

- Patient
- Medications
- Treatment / standard of care
- Abuse / diversion
COLLECT INFORMATION – ABOUT THE PATIENT

- History
- Prior records
- Previous psychiatrist
- Other clinicians
- Family
- PMP
COLLECT INFORMATION – ASSESSMENT AND MONITORING

• Conduct thorough patient examination, interview, and assessment

• Consider standardized assessment and documentation tool
  › Especially for pain
COLLECT INFORMATION – ABOUT THE MEDICATIONS

• Label
  ➢ Know the label
  ➢ Can change
    • FDA’s MedWatch:
      www.fda.gov/Safety/MedWatch/default.htm
COLLECT INFORMATION – ABOUT TREATMENT / STANDARD OF CARE

• Medication-specific
  › Ex: opioids

• Patient-specific
  › Ex: C&A

• Expectations of regulators
  › State
  › Federal
COLLECT INFORMATION – ABOUT ABUSE

MODUS OPERANDI / SCAMS USED

• From the MO Task Force:
  › Obese person scam
  › Grandparent scam
  › Pain while traveling scam
  › Hyperactive child scam
  › Forged or stolen records scam
COLLECT INFORMATION – ABOUT ABUSE

MODUS OPERANDI / SCAMS USED

• From the MO Task Force (Continued):
  › Help me, I’m an addict scam
  › Police report scam
  › Friend in doctor’s office scam
  › Asleep at wheel scam
  › Aggravated stump scam

http://health.mo.gov/safety/bn dd/doc/PreventingPrescriptionFraud.doc
COMMUNICATION WITH PATIENTS

Educate the patient on issues such as:

• Restrictions (driving, diet, activity, etc.) associated with the medication
• Monitoring, such as blood work, that is needed
• Purpose, dose, and frequency of the medication
• How to identify side effects, and what to do if patient experiences
• Ensuring patient’s other physicians are aware of new prescriptions
COMMUNICATE – INFORMED CONSENT

Standard Elements:

• Nature of proposed medication
• Risks and benefits of proposed medication
  › Including potential for tolerance, dependence, addiction, overdose
• Alternatives to proposed medication
• Risks and benefits of alternative treatments
• Risks and benefits of doing nothing

Plus:

• Prescribing policies
• Reasons for which medication may be changed or stopped
COMMUNICATE – INFORMED CONSENT

“MATERIAL RISK”

• Disclose risk if SEVERE, even if infrequent
• Disclose risk if FREQUENT, even if not severe
• FDA medication guides
• Disclose possible driving impairment
• Golden Rule
COMMUNICATE – INFORMED CONSENT

Medication Guides

• FDA
  › www.fda.gov/drugs/drugsafety/ucm085729.htm

• AACAP / ParentsMedGuide - ADHD

FDA’s Patient Counseling Document for Opioids

COMMUNICATION WITH PATIENTS

Communicate to obtain informed consent:

• Reminders if you choose to use medication information sheets:
  › You are responsible for tailoring them to meet your patient’s needs and for ensuring the information is up-to-date
  › Be sure to document in the record that the medication information sheet was reviewed with the patient and the patient was provided a copy
Communicate to obtain informed consent *(continued)*:

- Remember that informed consent is an ongoing communication process
- Know who has decision-making authority - obtain and retain proof of that authority
- Understand that communication is crucial to your patients’ understanding of the treatment plan
- Document the informed consent process
Communicate to obtain informed consent (continued):

• If you are prescribing off-label, discuss off-label nature of the use with the patient
  » FDA position
  » All off-label prescribing is NOT the same in terms of medical malpractice risk
COMMUNICATE – TREATMENT AGREEMENT

• Can Cover:
  ▶ Intended benefits of using controlled substances
  ▶ Risks of the treatment – tolerance, dependence, abuse addiction
  ▶ Prescription management – security of meds
COMMUNICATE – TREATMENT AGREEMENT

• Can Cover *(Continued)*:
  › Office policies
    • Only one prescriber
    • Only one pharmacy
    • Not replacing lost or stolen prescriptions
    • Prohibiting dose or frequency increased by patient
    • Use of PMP
    • Random pill counts
    • Random urine screening
  › Termination for
    • Failure to adhere to treatment plan
    • Aberrant Behavior
Sample Patient Agreement Forms

Introduction

This resource includes two sample patient agreement forms that can be used with patients who are beginning long-term treatment with opioid analgesics or other controlled substances. These documents contain statements to help ensure patients understand their role and responsibilities regarding their treatment (e.g., how to obtain refills, conditions of medication use), the conditions under which their treatment may be terminated, and the responsibilities of the health care provider. These documents can help facilitate communication between patients and healthcare providers and resolve any questions or concerns before initiation of long-term treatment with a controlled substance.

http://www.drugabuse.gov/nidamed-medical-health-professionals

Patient Agreement Form

Patient Name: _____________________________
Medical Record Number: ___________________
Addressograph Stamp: ______________________

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of __________________________(print names of medication(s)) may cause addiction and is only one part of the treatment for __________________________(print name of condition—e.g., pain, anxiety, etc.).

The goals of this medicine are:

☐ to improve my ability to work and function at home.
☐ to help my __________________________(print name of condition—e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:

- I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else’s medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)
- I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- I agree to give a blood or urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. No exceptions will be made. I will not come to Primary Care for a refill until I am called by the nurse.

I must keep track of my medications. No early or emergency refills may be made.

Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

The name of my pharmacy is ____________________________
COMMUNICATE – WITH OTHERS

• Other providers:
  › Covering
  › PCP, specialists
  › Consultants

• Family
  › Remember: safety = exception to confidentiality
Generally:

- Medication log
- Evaluation
- Medical indication for prescription
- Treatment plan
  - Initial
  - Updated
- Treatment agreement, if any
  - Subsequent discussions about agreement
Generally *(Continued)*:

- Informed consent
  - Patient Education Materials
- Ongoing assessment
  - Adherence to treatment plan
  - Medication monitoring
  - Aberrant behavior
- Referral / consultation, if necessary
- Basis for clinical decision-making
Consider:

- Treatment agreement
- Standardized assessment form
CAREFUL DOCUMENTATION

Remember:

• There’s no such thing as a perfect record
• Defense attorneys can work with adequate records
• Defense attorneys cannot work with no records or altered records
Professional Judgment – Bottom Line:

- By articulating the basis for medical decisions in the record, the psychiatrist’s professional medical judgment will be clear and available to defend the psychiatrist against allegations of malpractice.
AGENDA

- Professional liability overview
- Psychopharmacology
  - Typical pitfalls
  - Opiates
  - Non-adherent patients, driving, and telepsychiatry
  - Medical marijuana
- Forensic practice exposures
- Child and adolescent practice exposures
NON-ADHERENT PATIENTS: WHO ARE THEY?

The signs

• Missed appointments
• Labs
• Prescriptions
• Worsening symptoms/no improvement
• Risky behavior
WHO ARE THEY?

Digging deeper

• How are they taking meds?
• When?
• Doses missed?
• Side-effects
• Refills
• Appointments
BARRIERS TO ADHERENCE

- Health literacy
- Language
- Culture
- Hearing ability
- Poverty
Poverty and Child Health in the United States

Almost half of young children in the United States live in poverty. The American Academy of Pediatrics is committed to combating and ultimately eliminating child poverty in the United States. Poverty and related social determinants of health can lead to adverse health outcomes in childhood and across the life course, negatively affecting physical health, socioemotional development, and educational achievement. The American Academy of Pediatrics advocates for programs and policies that have been shown to improve the quality of life and health outcomes for children and families living in poverty. With an awareness and understanding of the effects of poverty on children, pediatrics and other pediatric health practitioners in a family-centered medical home can assess the financial stability of families, link families to resources, and coordinate care with community partners. Further research, advocacy, and continuing education will improve the ability of pediatricians to address the social determinants of health when caring for children who live in poverty. Accompanying this policy statement is a technical report that describes current knowledge on child poverty and the mechanisms by which poverty influences the health and well-being of children.
NON-ADHERENCE & MEDICATION

• Anosognosia
• Multiple prescriptions
• Dosing confusion
• Difficulty taking
• Side-effects
• Addiction concerns
• Personality
NON-ADHERENCE & MEDICATION

- Stigma
- Slow results
- Cost
- Benefits not recognized
- Improvement = cure
FACILITATING ADHERENCE

• Bring all medications
• One pharmacy
• Report new meds
• Therapeutic alliance
  ▪ Why used
  ▪ Expectations
  ▪ Patient’s role
  ▪ Factors affecting adherence
  ▪ Role of meds in achieving goals
FACILITATING ADHERENCE

- Written instructions
- Medication flow sheet
- Simplify dosing
- Devices
- Generics
- Patient assistance programs
- Adjust interventions
Physician Strategies to Reduce Patients’ Out-of-pocket Prescription Costs

G. Caleb Alexander, MD, MS; Lawrence P. Casalino, MD, PhD; David O. Meltzer, MD, PhD

Background: Physicians often do not communicate with patients about out-of-pocket costs, although research indicates that physicians and patients value such discussion.

Methods: Cross-sectional national random sample mail survey of 1400 cardiologists and general internists to quantify barriers to communication about out-of-pocket costs and strategies used to assist patients in order of likelihood (from 5 [extremely likely] to 1 [not at all likely]).

Results: Overall, 519 (39.1%) of 1328 eligible physicians responded to the survey. The most common barriers were lack of habit, insufficient time, and concern over patient discomfort. The most common strategies used to assist patients were switching to a generic drug (mean, 4.34; SD, 0.86), using office samples (mean, 4.16; SD, 1.22), and discontinuing nonessential medicines (mean, 4.03; SD, 0.99). There were no statistically significant differences between cardiologists and general internists in barriers or strategies examined (P<.05).

Conclusions: Our findings suggest that patient-physician communication about out-of-pocket costs is a problem affecting specialists and generalists nationwide. Despite barriers, physicians use multiple strategies that may vary in efficacy to assist patients burdened by these costs.

Arch Intern Med. 2005;165:633-636

GOING FORWARD

• Ramifications of non-adherence
  ▪ Patient’s condition
  ▪ Your ability to treat
  ▪ Family?
• Termination
• Document
TERMINATION

1. Give reasonable notice/time to find alternative treatment
   ▪ Modal time: 30 days (and required by the BME)

2. Educate on treatment recommendations
   ▪ Might include: caution against abrupt discontinuation of medication, reminder of driving restrictions, urge patient to find a new psychiatrists ASAP, others

3. Assist with finding alternative treatment
   ▪ Specific name of willing provider generally not required

4. Offer to provide records, as requested by the patient

5. Send follow-up letter
   ▪ Both certified and regular mail or
   ▪ Delivery confirmation
TERMINATION

Compare:

- Your licensing board
- Facility/group policies & procedures
- Provider contracts
Patient in crisis?

Termination by:

Psychiatrist

No

Yes

Patient
Patient in crisis?

Termination by:

Psychiatrist

Patient

No

Standard Process

Yes
Patient in crisis?

Termination by:

Psychiatrist

Standard Process

No

Modified Process

Yes

Patient

No

Yes
Patient in crisis?

Termination by:

- Psychiatrist
- Patient

No

- Standard Process
- Modified Process

Yes

- Very Risky
Patient in crisis?

Termination by:
- Psychiatrist
- Patient

No
- Standard Process
- Modified Process

Yes
- Very Risky
- Assess
DRIVING: LIABILITY TO THIRD PARTIES

Two lines of cases imposing liability:

1) Controlled substance (usually methadone) was ADMINISTERED despite risks that were known or should have been known

2) Controlled substance was PRESCRIBED without warning patient of known side effects that could impair driving
TO PRESCRIBE CONTROLLED SUBSTANCES VIA TELEMEDICINE

• Ensure compliance with all state and federal laws, including:
  › State law – some states prohibit
  › Federal Controlled Substance Act
    • Including the Ryan Haight Act amendment
  › Federal DEA registration requirements
  › State equivalent of federal DEA registration, if applicable
• Federal law (CSA as amended by the RHA)
• Some boards say in-person exam is not required
• Some boards say it depends
  › On where the patient is located
  › On prescribing
AGENDA

➢ Professional liability overview
➢ Psychopharmacology
  ➢ Typical pitfalls
  ➢ Opiates
  ➢ Non-adherent patients, driving, and telepsychiatry
  ➢ Medical marijuana
➢ Forensic practice exposures
➢ Child and adolescent practice exposures
State Approaches to Marijuana
(Non-exclusive)

Decriminalization

Medical

Recreational
TERMINOLOGY

- Cannabis: plant family that has many species, including
  - Hemp
    - Low THC levels
    - High CBD levels
    - Effect: relaxing, calming
  - Marijuana
    - High THC levels – gets users high
    - Low CBD levels
    - Effect: psychoactive
FEDERAL LAW

Marijuana is a Schedule I controlled substance

- Defined as drugs with no currently accepted medical use and a high potential for abuse
- It is illegal to prescribe Schedule I drugs
- It is illegal to help people illegally possess Schedule I drugs
- Examples of Schedule I drugs are:
  - heroin
  - lysergic acid diethylamide (LSD)
  - marijuana (cannabis)
  - 3,4-methylenedioxymethamphetamine (ecstasy)
  - methaqualone
  - peyote
FEDERAL LAW

Exceptions

- Three FDA-approved medications from marijuana
  - Epidiolex – Schedule V
    - Patients 2 and over
    - Seizures associated with Lennox-Gestaut Syndrome or Dravet Syndrome
  - Marinol – Schedule III
    - Adults
    - Anorexia associated with AIDS
    - Nausea and vomiting associated with chemo
  - Cesamet – Schedule II
    - Adults
    - Nausea and vomiting associated with chemo
Consequences of marijuana being Schedule I/illegal

- Federal law prohibits firearm sales to marijuana users
  - Federal law prohibits any person who is an unlawful user of or addicted to any controlled substance from possessing firearms
    - Marijuana use is illegal
    - No exception for use allowed under state law
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. City and State</td>
<td>Ft.</td>
<td>Lbs.</td>
<td>Male</td>
<td>Month</td>
</tr>
<tr>
<td>-OR-</td>
<td>In.</td>
<td>Female</td>
<td>Day</td>
<td>Year</td>
</tr>
<tr>
<td>Foreign Country</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Social Security Number</th>
<th>9. Unique Personal Identification Number (UPIN) if applicable (See Instructions for Question 9.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Optional, but will help prevent misidentification)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10.a. Ethnicity</th>
<th>10.b. Race (In addition to ethnicity, select one or more race in 10.b. Both 10.a. and 10.b. must be answered.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic or Latino</td>
<td>American Indian or Alaska Native</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>Black or African American</td>
</tr>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td></td>
<td>Native Hawaiian or Other Pacific Islander</td>
</tr>
</tbody>
</table>

11. Answer the following questions by checking or marking “yes” or “no” in the boxes to the right of the questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Are you the actual transferee/buyer of the firearm(s) listed on this form? Warning: You are not the actual transferee/buyer if you are acquiring the firearm(s) on behalf of another person. If you are not the actual transferee/buyer, the licensee cannot transfer the firearm(s) to you. Exception: If you are picking up a repaired firearm(s) for another person, you are not required to answer 11.a. and may proceed to question 11.b. (See Instructions for Question 11.a.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Are you under indictment or information in any court for a felony, or any other crime for which the judge could imprison you for more than one year? (See Instructions for Question 11.b.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Have you ever been convicted in any court of a felony, or any other crime for which the judge could have imprisoned you for more than one year, even if you received a shorter sentence including probation? (See Instructions for Question 11.c.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Are you a fugitive from justice? (See Instructions for Question 11.d.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Are you an unlawful user of, or addicted to, marijuana or any depressant, stimulant, narcotic drug, or any other controlled substance? Warning: The use or possession of marijuana remains unlawful under Federal law regardless of whether it has been legalized or decriminalized for medicinal or recreational purposes in the state where you reside.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FEDERAL LAW

Consequences of marijuana being Schedule I/illegal

• Federal law prohibits firearm sales to marijuana users
  ➢ Cannot sell to buyer if
    • Buyer marked “yes” to question 11
    • Buyer uses marijuana card for ID or proof of residency
      ➢ Even if “no” to question 11
September 21, 2011

www.atf.gov

OPEN LETTER TO ALL FEDERAL FIREARMS LICENSEEES

The Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) has received a number of inquiries regarding the use of marijuana for medicinal purposes and its applicability to Federal firearms laws. The purpose of this open letter is to provide guidance on the issue and to assist you, a Federal firearms licensee, in complying with Federal firearms laws and regulations.

A number of States have passed legislation allowing under State law the use or possession of marijuana for medicinal purposes, and some of these States issue a card authorizing the holder to use or possess marijuana under State law. During a firearms transaction, a potential transferee may advise you that he or she is a user of medical
Consequences of marijuana being Schedule I/illegal

- It is illegal to “prescribe” marijuana
  - States use different terms
    - Federal government could still see it as illegal
- Healthcare systems may prohibit their physicians from talking to patients about cannabis treatment options
- Localities may ban in states that allow
FEDERAL ENFORCEMENT IN STATES ALLOWING MARIJUANA

DOJ enforcement memos

- 2009 – “Ogden Memo” – medical marijuana
- 2013 – “Cole Memo” – medical and recreational marijuana
- Guidance only – not binding
- Both listed conditions which, if met by state, would deprioritize federal prosecution
  - Prosecution would still be considered if
    - Sales to minors, unlawful use of firearms, etc.
MEMORANDUM FOR ALL UNITED STATES ATTORNEYS

FROM: Jefferson B. Sessions, III
   Attorney General

SUBJECT: Marijuana Enforcement

In the Controlled Substances Act, Congress has generally prohibited the cultivation, distribution, and possession of marijuana. 21 U.S.C. § 801 et seq. It has established significant penalties for these crimes. 21 U.S.C. § 841 et seq. These activities also may serve as the basis for the prosecution of other crimes, such as those prohibited by the money laundering statutes, the unlicensed money transmitter statute, and the Bank Secrecy Act. 18 U.S.C. §§ 1956-57, 1960; 31 U.S.C. § 5318. These statutes reflect Congress’s determination that marijuana is a dangerous drug and that marijuana activity is a serious crime.

In deciding which marijuana activities to prosecute under these laws with the Department’s finite resources, prosecutors should follow the well-established principles that govern all federal prosecutions. Attorney General Benjamin Civiletti originally set forth these principles in 1980, and they have been refined over time, as reflected in chapter 9-27.000 of the

FEDERAL ENFORCEMENT IN STATES ALLOWING MARIJUANA

2014 Congressional Budget Amendment

- Prohibiting DOJ from using funds to prevent states from implementing their medical marijuana laws
- Rohrabacher Amendment
FEDERAL ENFORCEMENT - THE KETTLE FALLS FIVE CASE

• 2013: indictment
• 2014: Congressional amendment prohibiting DOJ from using funds to prevent states from implementing their medical marijuana laws
• 2015: prosecution continues
• 2017: feds finally agreed – no $ to prosecute
  ➢ But doesn’t drop charges
• January 2018: case dropped, but “without prejudice”
  ➢ Can be brought again
• June 2018: Statute of limitations ran out

US v. McIntosh, 833 F.3d 1163 (9th Cir. 2018)
Louisiana Medical Marijuana
LA MEDICAL MARIJUANA OVERVIEW

• Act 261 was passed in 2015 which allows physicians to recommend medical marijuana to patients with certain debilitating conditions
• The anticipated date that medical will be available is May 2019
• The legislature named the agricultural centers at Louisiana State University and Southern University as the ONLY legal growers of marijuana from which medicines will be extracted
• The Louisiana Department of Health as NO authority to regulate medical marijuana in any way:
  › Cannot determine what entities can or cannot grow, process or manufacture marijuana
  › No authority to decide what conditions may be prescribed medical marijuana

http://ldh.la.gov/index.cfm/page/2892
PHYSICIAN REQUIREMENTS TO RECOMMEND

• Licensed and in good standing with the Louisiana State Board of Medical Examiners to practice medicine in the state
• Domiciled in the state
• Shall review the patient’s information in the database of the prescription monitoring program established in R.S. 40:1001 et seq. prior to recommending and dispensing

See LSA-R.S. 40:1046
DEBILITATING CONDITIONS (ACT 261; 2015)

- Cancer
- Positive status for HIV, AIDS
- Cachexia or wasting syndrome
- Seizure disorders
- Epilepsy, spasticity
- Crohn’s disease
- Muscular dystrophy
- Multiple sclerosis
DEBILITATING CONDITIONS (ACT 708; 8/1/2018)

• Glaucoma
• Parkinson’s disease
• Severe muscle spasms
• Intractable pain*
• Post traumatic stress disorder
Any of these conditions associated with autism spectrum disorder:

- repetitive or self-stimulatory behavior of such severity that the physical health of the person with autism is jeopardized;
- avoidance of others or inability to communicate of such severity that the physical health of the person with autism is jeopardized;
- self-injuring behavior; and
- physically aggressive or destructive behavior.*
PERMITTED/PROHIBITED FORMS OF MEDICAL MARIJUANA

• Any form as permitted by the rules and regulations of the Louisiana Board of Pharmacy

• The different acceptable forms are oils, extracts, tinctures, sprays, capsules, pills, solutions, suspension, gelatin-based chewables, lotions, transdermal patches and suppositories.

• Any form of inhalation is prohibited

See LSA-R.S. 40:1046
During their November 14, 2018 meeting, the Board approved the following guidance document for the benefit of its licensees, particularly those holding state controlled substance (CDS) licenses and federal registrations from the U.S. Drug Enforcement Administration (DEA).

Guidance Document re Cannabidiol (CBD) Oil

The Board continues to receive questions about cannabidiol (CBD) oil, derived from hemp or derived from marijuana. Act 261 of the 2015 Legislature, which established the state medical marijuana program, made no exception for possession or sale of CBD oil. Louisiana's controlled substance law includes CBD oil in the definition of marijuana.

All marijuana products shall comply with the rules adopted for the state medical marijuana program; they must have a known source as well as known quantities of active ingredients. Further, they may only be dispensed by marijuana pharmacies licensed by the Board of Pharmacy.

Since marijuana is listed in Schedule I of the state’s list of controlled substances, no one, including board licensees, may possess or sell CBD oil. Violations of the Louisiana Revised Statutes or Louisiana Administrative Code can subject a person to criminal and/or administrative action.

Frequently Asked Questions re CBD Oil

1. Is CBD (cannabidiol) oil legal under Louisiana law?
   No. The Louisiana Controlled Dangerous Substances Law defines marijuana as: “all parts of plants of the genus Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin, but shall not include the mature stalks of such plant, fiber produced from such stalks, oil, or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of such plant which is incapable of germination, or cannabidiol when contained in a drug product approved by the United States Food and Drug Administration.” CBD is a compound of marijuana and therefore is considered marijuana under Louisiana law. Marijuana is listed in Schedule I of the state controlled substance list. There is no lawful possession of a substance listed in Schedule I, except for the marijuana products authorized in the state medical marijuana program.

2. Is CBD oil legal under federal law?
LA MEDICAL MARIJUANA STATISTICS

- Currently 43 licensed physicians who are authorized to recommend medical marijuana within the state of Louisiana
- Currently 9 licensed pharmacies allowed to sale medical marijuana within the state of Louisiana
  - The legislation places a maximum of no more than 10 permits active at the same time in the entire state

http://ldh.la.gov/index.cfm/directory/category/386
Approved Physicians for Medical Marijuana

Andre Alber Bonnecaze, MD
5000 Hennessy Blvd., Baton Rouge LA 70808 | (225) 765-4050

Chad Rossitter, MD
927 E Prudhomme St., Opelousas LA 70570 | (337) 251-6000

Anand Krishnalal Roy, MD
780 East Bayou Pines, Lake Charles LA 70601 | (337) 433-0313
Directory

Approved Pharmacies for Medical Marijuana

Capitol Wellness Solutions, LLC d/b/a Capitol Wellness Solutions (Region 2 - Capitol)
7491 Picardy Avenue, Baton Rouge LA 70809-3536

Delta Medmar, LLC d/b/a Delta Medmar (Region 8 ~ Northeast)
111 McMillan Road, West Monroe LA 71291-5319

Green Leaf Dispensary, LLC d/b/a Green Leaf Dispensary (Region 3 ~ Teche)
6048 W. Park Avenue, Houma LA 70364-1608
Mississippi Medical Marijuana
MS MARIJUANA OVERVIEW

• Marijuana in Mississippi is illegal for recreational and medical purposes.
• While possession in small amounts is decriminalized, it is still a misdemeanor and only decriminalized in the sense that one will not be jailed for a first offense.

See Miss. Code Ann. § 41-29-130
HOUSE BILL 1231 ("HARPER GRACE’S ACT")

- House Bill 1231 ("Harper Grace’s Act") signed into law April 2014
  - Allows use of low-THC/high-CBD products for severe seizure disorders (intractable epilepsy)
  - Allows processing cannabis plant extract, oil or resin that contains more than 15% cannabidiol (CBD) and no more than 0.5% tetrahydrocannabinol (THC)
  - CBD oil may only be obtained by the order of a physician who is licensed to practice in MS
  - Administering CBD oil to a patient must be done by or under the direction or direct supervision of a physician
  - CBD oil must be obtained from or tested by the National Center for Natural Products Research at the University of Mississippi and dispensed by the Department of Pharmacy Services at the University of Mississippi Medical Center

See Miss. Code Ann. § 41-29-136
HOUSE BILL 1231 ("HARPER GRACE’S ACT")

• The only entities authorized to produce or possess cannabidiol for research:
  › The National Center for Natural Products Research at the University of Mississippi,
  › the Department of Pharmacy Services at the University of Mississippi Medical Center
  › Mississippi Agricultural and Forestry Experiment Station at Mississippi State University
FAILED MEDICAL MARIJUANA EFFORTS

• An initiative failed in 2015 when voters were unable to collect enough signatures to make the 2016 ballot (86,000 required)
  › However, this initiative also sought to legalize recreational marijuana
MEDICAL MARIJUANA 2020

• Campaign initiated by Ashley Durval, Harper Grace’s mother
• Medical Marijuana 2020 is funded and operated by Mississippians for Compassionate Care.
• Campaign is backed by a steering committee of medical health care professionals, law enforcement representatives, leaders in the faith community, and veterans.
• Must collect signature of 86,000 Mississippians by September 2019 to qualify for November 2020 ballot.
  › Proponents reported collecting 35,000 signatures as of January 2019.

www.medicalmarijuana2020.com/
MEDICAL MARIJUANA 2020

- Individuals with a *debilitating medical condition* could seek a certification from a Mississippi-licensed physician to obtain medical marijuana

- Cancer
- Epilepsy or other seizures
- Parkinson’s disease
- Huntington’s disease
- Muscular dystrophy
- Multiple sclerosis
- Cachexia
- Post-traumatic stress disorder
- Positive status for human immunodeficiency virus
- Acquired immune deficiency syndrome
- Chronic or debilitating pain
- Amyotrophic lateral sclerosis
- Glaucoma
- Agitation of dementias

- Crohn’s disease
- Ulcerative colitis
- Sickle-cell anemia
- Autism with aggressive or self-injurious behaviors
- Pain refractory to appropriate opioid management
- Spinal cord disease or severe injury
- Intractable nausea
- Severe muscle spasticity
- or another medical condition of the same kind or class to those herein enumerated and for which a physician believes the benefits of using medical marijuana would reasonably outweigh potential health risks
MEDICAL MARIJUANA 2020

• Would require a physician examine a patient in person and determine he or she meets one or more of the allowable diagnoses.
  › Parent of a minor must be present at the examination and provide written consent.

• The Mississippi Department of Health would regulate the process by which medical marijuana is grown, processed, and made available to patients.

• Proposes that the Mississippi Department of Health have the program up and running no later than August 15, 2021.
Jan. 12, 2017

FOR IMMEDIATE RELEASE

Nearly 100 Conclusions on the Health Effects of Marijuana and Cannabis-Derived Products Presented in New Report; One of the Most Comprehensive Studies of Recent Research on Health Effects of Recreational and Therapeutic Use of Cannabis and Cannabis-Derived Products

WASHINGTON – A new report from the National Academies of Sciences, Engineering, and Medicine offers a rigorous review of scientific research published since 1999 about what is known about the health impacts of cannabis and cannabis-derived products – such as marijuana and active chemical compounds known as cannabinoids – ranging from their therapeutic effects to their risks for causing certain cancers, diseases, mental health disorders, and injuries. The committee that carried out the study and wrote the report considered more than 10,000 scientific abstracts to reach its nearly 100 conclusions. The committee also proposed ways to expand and improve the quality of cannabis research efforts, enhance data collection efforts to support the advancement of research, and address the current barriers to cannabis research.

GOAL –
GET FAMILIAR WITH MEDICAL MARIJUANA

Specifically:
• Understand medical marijuana
• Know the side effects
• Know how it can worsen other medical conditions
GOAL –
GET FAMILIAR WITH MEDICAL MARIJUANA

Recommended reading list - for all:

• *Contemporary Routes of Cannabis Consumption: A Primer for Clinicians*

• *Medical Marijuana: Do the Benefits Outweigh the Risks?*
  > Gupta and Phalen, Current Psychiatry, Jan. 2018

• *Marijuana and the Psychiatric Patient*
  > Woodward, Psychiatric Times, Apr. 10, 2017
KEEP AT LEAST THESE POINTS IN MIND

• Little scientific literature to support benefits
  ➢ Potential drug interactions are unknown
  ➢ BIG problem for psychiatrists

• Drug is unregulated
  ➢ Purity?
  ➢ Potency?

• With minors:
  ➢ Effects on brain development
  ➢ Very risky

• Potential for abuse

• Potential for psychiatric and other side effects
LIABILITY OVERVIEW:
MEDICAL MALPRACTICE LAWSUITS

Currently, no *reported* cases

• Cases could exist

• 4 elements of medical malpractice:
  ➢ Duty of care
    • Likely to be recognized
  ➢ Breach of duty (negligence)
    • Ex: failing to take adequate history
  ➢ Harm
    • Ex: drug interaction
  ➢ Causation (harm was caused by negligence)
“Authorizing physicians to certify or recommended medical marijuana does not, in any way, absolve them from rendering competent and scientifically informed medical care. Physicians...must understand that...they are recommending or certifying a non-FDA approved treatment that is not supported or recognized by the large majority of their professional colleagues. Doing so may expose them to malpractice liability no differently than if they prescribed any other potentially hazardous and scientifically controversial experimental treatment.”

LIABILITY OVERVIEW:
MEDICAL MALPRACTICE LAWSUITS

Professional liability insurance
• Policies exclude coverage for
  ➢ Criminal acts
  ➢ Statutory violations
  ➢ Illegal acts
DORA summarily suspends four Colorado physicians

DENVER (July 19, 2016) - The Colorado Medical Board summarily suspended the licenses of four Colorado physicians, meaning they may not practice medicine in Colorado unless or until such time as the suspension is lifted by the Board. The Colorado Medical Board resides within the Division of Professions and Occupations (DPO), part of the Department of Regulatory Agencies (DORA).

According to the Orders of Suspension, the Board found reasonable grounds to believe that the public health, safety or welfare imperatively requires emergency action and/or that the Respondents were guilty of a deliberate and willful violation of the Medical Practice Act, the state law that regulates the practice of medicine in Colorado. All four physicians were recommending the medical use of marijuana, each authorizing high plant counts (e.g., the possession of at least 75 plants) for hundreds of individuals without medical necessity. The Board found such conduct falls below generally accepted standards of medical practice and violates § 12-36-117(1)(p) and (mm), C.R.S. and Colo. Const. art. XVIII, § 14(4).

The Board summarily suspended the medical licenses for the following physicians:

- Gentry Dunlap M.D., recommended the medical use of marijuana, which authorized the possession of at least 75 plants for at least 700 individuals without medical necessity.
- Robert Malocco, M.D., recommended the medical use of marijuana, which authorized the possession of at least 75 plants for at least 190 individuals without medical necessity.
- Deborah Parr, M.D., recommended the medical use of marijuana, which authorized the possession of at least 75 plants for at least 300 individuals without medical necessity.
- William Stone, D.O., recommended the medical use of marijuana, which authorized the possession of at least 75 plants for at least 400 individuals without medical necessity.

Copies of the disciplinary actions are linked and will also be available later today to view online through the Division’s licensing system. The Division of Professions and Occupations encourages consumers to verify licenses and check for discipline when selecting a physician. If you

https://www.colorado.gov/pacific/dora/DORA-summarily-suspends-four-physicians-medical-marijuana
LIABILITY OVERVIEW: LICENSING BOARD ACTIONS

MANY reported cases

• Involved physicians who
  ➢ Work in offices whose sole purpose is to sign medical marijuana certificates
  ➢ Recommended for pregnant women
  ➢ Recommended without medical necessity
  ➢ Recommended without a legitimate doctor-patient relationship
  ➢ Acted incompetently – recommended medical marijuana
    • Without appropriate examinations
    • Without creating appropriate medical records
    • After seeing patients at marijuana dispensaries instead of an office
Lewiston OB/GYN Surrenders Medical License

Timothy Terranova, Assistant Executive Director
Board of Licensure in Medicine
137 State House Station
Phone: (207) 287-6930. Fax: (207) 287-6590.
Tim.E.Terranova@maine.gov

AUGUSTA, ME – Keng-cheong Leong, M.D., surrendered his medical license to the Board of Licensure in Medicine in a Consent Agreement signed December 9, 2014. Dr. Leong, who had his practice limited to office-based gynecology in 2011, was issuing medical marijuana certificates to male patients. Dr. Leong practiced in Lewiston.

In 2011, Dr. Leong’s practice was limited after he stated he was “naive” when it came to patients requesting narcotics and admitted the Board had sufficient evidence from which it could conclude he engaged in unprofessional conduct by prescribing narcotic pain medication without conducting and documenting appropriate medical histories, examinations and plans.

In 2014, the Board received information that Dr. Leong had been issuing medical marijuana certificates to male patients, had not been performing appropriate examinations, had not been creating appropriate medical records, and had been seeing patients at marijuana dispensaries instead of an office. Dr. Leong admitted the Board had sufficient evidence from which it could conclude that he engaged in unprofessional conduct, incompetent medical care, and that he violated the terms of his previous agreement.

This action means that Dr. Leong cannot practice medicine in the State of Maine.

All Board disciplinary actions are reported to the National Practitioner Data Bank, the Health Integrity and Protection Data Bank, and the Federation of State Medical Boards Action Data Bank. These reports are regularly reviewed by every state licensing board in the country.

The Board is made up of 6 physicians and 3 public members appointed by the Governor. Disciplinary actions taken by the Board are available to the public either by telephone at (207) 287-3601, or on the Board’s website at www.docboard.org/me/me_home.htm.

The Board of Licensure in Medicine is the State of Maine agency charged to protect the health and welfare of the public by verifying the qualifications of physicians to practice, and disciplining physicians for unprofessional conduct and incompetence. Any citizen can request an investigation of a physician or physician assistant by contacting the Board office by telephone at (207) 287-3608, by letter, or by visiting the Board’s web site.

https://www.maine.gov/md/discipline/releases.html?id=633295
How to minimize professional liability risk

Utilize three risk management strategies to provide good clinical care

Strategy #1: COLLECTING INFORMATION

Strategy #2: COMMUNICATING

Strategy #3: CAREFULLY DOCUMENTING

Copyright © 2012 Professional Risk Management Services, Inc. (PRMS). All Rights Reserved.
RISK MANAGEMENT STRATEGIES TO ↑ INCREASE PATIENT SAFETY AND ↓ PROFESSIONAL LIABILITY

Strategy #1: COLLECT INFORMATION

- About the patient
  - History
  - Examination
  - Check the PMP

- About the medication
  - Including APA statement

- About treatment standards
  - FSMB
  - CA
FSMB: MODEL GUIDELINES FOR THE RECOMMENDATION OF MARIJUANA IN PATIENT CARE

Guidelines
• Physician-Patient Relationship
• Patient Evaluation
• Informed and Shared Decision Making
• Treatment Agreement
• Qualifying Conditions
• Ongoing Monitoring and Adapting the Treatment Plan
• Consultation and Referral
• Medical Records
• Physician Conflict of Interest
GUIDELINES FOR THE RECOMMENDATION OF CANNABIS FOR MEDICAL PURPOSES

Guidelines
- Physician-Patient Relationship
- Patient Evaluation
- Informed and Shared Decision Making
- Treatment Agreement
- Qualifying Conditions
- Ongoing Monitoring and Adapting the Treatment Plan
- Consultation and Referral
- Medical Records
- Physician Conflict of Interest

www.mbc.ca.gov/Publications/guidelines_cannabis_recommendation.pdf
RISK MANAGEMENT STRATEGIES TO ↑ INCREASE PATIENT SAFETY AND ↓ PROFESSIONAL LIABILITY

Strategy #2: COMMUNICATE

- With patient
  - Risks and benefits
    - Including risk of addiction
    - Side effects
  - Do not drive while intoxicated
- With others
  - Other prescribers
RISK MANAGEMENT STRATEGIES TO ↑ INCREASE PATIENT SAFETY AND ↓ PROFESSIONAL LIABILITY

Strategy #3: CAREFULLY DOCUMENT

- Medical record
- Informed consent
- Treatment plan/agreement
- Assessments
- Checking the PMP
# Medical Marijuana Certifications

## Established physician-patient relationship?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DRUG “PUSHER”</strong></td>
<td><strong>LEGITIMATE PATIENT CARE</strong></td>
</tr>
<tr>
<td>Outside of established treatment relationship</td>
<td>Within established treatment relationship</td>
</tr>
<tr>
<td>Failure to follow established standards</td>
<td>Established standards are followed:</td>
</tr>
<tr>
<td>▪ No history</td>
<td>• History</td>
</tr>
<tr>
<td>▪ No physical exam</td>
<td>• Physical exam</td>
</tr>
<tr>
<td>▪ No informed consent discussion</td>
<td>• Informed consent discussions</td>
</tr>
<tr>
<td>Clinically inappropriate</td>
<td>✓ Documented</td>
</tr>
<tr>
<td>▪ No diagnosis</td>
<td>• Sufficient clinical basis</td>
</tr>
<tr>
<td>▪ No evidenced-based support</td>
<td>✓ Diagnosis and evidenced-based support</td>
</tr>
<tr>
<td>▪ Pregnant women</td>
<td>✓ Documented</td>
</tr>
</tbody>
</table>

---

Copyright © 2018 Professional Risk Management Services, Inc. (PRMS)
CONCLUSION AND CLINICAL PEARLS

• Federal law
  ➢ Marijuana is Schedule I, so illegal to prescribe
  ➢ Federal enforcement is unclear
  ➢ Health systems may prohibit medical marijuana discussions with patients

• State law
  ➢ Ensure compliance with all requirements
  ➢ Watch for changes to requirements
CONCLUSION AND CLINICAL PEARLS

• Clinically
  ➢ Get up to speed with marijuana
    • Even if you don’t certify, your patients may be on it
  ➢ If you want to certify:
    • May be difficult in psychiatry
      ➢ Need evidence-based support
    • Must be within physician-patient treatment relationship
    • In the absence of state guidelines, follow those from FSMB
    • Utilize the 3 Cs – practice good medicine
      ➢ Collect information
      ➢ Communicate
        • Consider a treatment plan
      ➢ Carefully document

• Professional liability exposure
  ➢ Licensing board action more likely than med mal lawsuit
  ➢ Med mal insurance policies exclude coverage for illegal acts
AGENDA

- Professional liability overview
- Psychopharmacology
  - Typical pitfalls
  - Opiates
  - Non-adherent patients, driving, and telepsychiatry
  - Medical marijuana
- Forensic practice exposures
- Child and adolescent practice exposures
HIPAA AND CONFIDENTIALITY IN FORENSIC PRACTICE
DISCLAIMERS

1. Risk management review – not legal advice
2. Cases – illustrative examples only
3. Law is evolving
AGENDA

1. HIPAA
2. Professional liability exposure
3. Confidentiality expectations
AGENDA

1. HIPAA
2. Professional liability exposure
3. Confidentiality expectations
“It’s a baby. Federal regulations prohibit our mentioning its race, age, or gender.”
HIPAA
Health Insurance Portability and Accountability Act of 1996

Administrative Simplification Provisions
Compliance required by providers who electronically transmit the following transactions:
1. claims
2. payment/remittance advice
3. coordination of benefits
4. claim status
5. enrollment/disenrollment
6. eligibility
7. premium payments
8. referral certification/authorization
9. first report of injury *
10. claims attachments *
11. other transactions per HHS may prescribe by regulation

Other Titles
(such as Fraud and Abuse, Health Insurance Portability, etc.)

* HHS has stated that only electronic transmission of the transactions for which HHS has adopted standards will make a provider covered by the Administrative Simplification regulations. HHS has not yet adopted standards for these two transactions, but has indicated that standards for these two transactions will be promulgated in the future.
ADMINISTRATIVE SIMPLIFICATION PROVISIONS OF HIPAA

Regulations related to the ELECTRONIC TRANSMISSION of health insurance claims data

TRANSACTION RULE
Final Rule; compliance due 10-16-02, unless 1-year extension received

IDENTIFIER CODES

CLAIMS ATTACHMENT STANDARDS
Only Proposed Rule

PRIVACY RULE
Final Rule and modifications; compliance due 4-14-03

SECURITY RULE
Final Rule; compliance due 4-05

ENFORCEMENT RULE
Final Rule

HEALTH PLANS
No Proposed Rule yet

EMPLOYERS
Final Rule; compliance due 7-04

PROVIDERS
Final Rule; compliance due 5-07

PATIENTS
On hold indefinitely

For information about all Administrative Simplification regulations under HIPAA, see HHS' website http://aspe.hhs.gov/admnsimp

Copyright © 2003 by Professional Risk Management Services, Inc. All rights reserved. No part of this document may be reproduced, transmitted, or utilized in any form or by any means, electronic or mechanical, including photocopying, recording, or by any information storage and retrieval system, without permission in writing.
COVERED ENTITIES UNDER HIPAA

- All health plans
- All healthcare clearing houses
- Healthcare providers that *electronically* transmit the specific transactions *with health plans*
HIPAA
Health Insurance Portability and Accountability Act of 1996

Administrative Simplification Provisions
Compliance required by providers who electronically transmit the following transactions:
1. claims
2. payment/remittance advice
3. coordination of benefits
4. claim status
5. enrollment/disenrollment
6. eligibility
7. premium payments
8. referral certification/authorization
9. first report of injury *
10. claims attachments *
11. other transactions per HHS may prescribe by regulation

Other Titles
(such as Fraud and Abuse, Health Insurance Portability, etc.)

* HHS has stated that only electronic transmission of the transactions for which HHS has adopted standards will make a provider covered by the Administrative Simplification regulations. HHS has not yet adopted standards for these two transactions, but has indicated that standards for these two transactions will be promulgated in the future.
Who must comply with HIPAA privacy standards?

Answer:

As required by Congress in HIPAA, the Privacy Rule covers:

- Health plans
- Health care clearinghouses
- Health care providers who conduct certain financial and administrative transactions electronically. These electronic transactions are those for which standards have been adopted by the Secretary under HIPAA, such as electronic billing and fund transfers.

These entities (collectively called “covered entities”) are bound by the privacy standards even if they contract with others (called “business associates”) to perform some of their essential functions. The law does not give the Department of Health and Human Services (HHS) the authority to regulate other types of private businesses or public agencies through this regulation. For example, HHS does not have the authority to regulate employers, life insurance companies, or public agencies that deliver social security or welfare benefits. See our business associate section and the frequently asked questions about business associates for a more detailed discussion of the covered entities’ responsibilities when they engage others to perform essential functions or services for them.

Learn more about health information privacy.
HIPAA PENALTIES
(As increased by HITECH)

Civil Penalties

• Can exceed $50,000 per violation

• Up to $1.5 million per violation in one calendar year

• “Violation” = breach of one person’s info

• No private right of action
HIPAA PENALTIES

Criminal Penalties

“A person who knowingly obtains or discloses individually identifying health information shall be punished”

- Up to $50,000 and one (1) year imprisonment
- False pretenses - up to $200,000 and five (5) years
- For commercial advantage, personal gain, or malicious harm” -- up to $250,000 and ten (10) years
HIPAA’ S PRIVACY RULE

• Applies to all uses and disclosures of covered entity’s PHI, regardless of the type of service rendered or the existence of a physician-patient relationship

• CE must get BUSINESS ASSOCIATE AGREEMENT from third party who receives PHI to perform function or service for CE

• §164.508(b)(4)(iii): specifically allows IME providers to require the evaluatee to sign an authorization for the release of PHI to the third party requesting the IME as a condition of performing the IME
HIPAA’S PRIVACY RULE

• Evaluatees would have access to the covered entity’s PHI

  › Access to covered entity’s PHI is one of only two mandatory disclosures under the Privacy Rule

  › The federal Privacy Rule pre-empts other laws that are less stringent (provide less rights of access to individual)
Compliance and Enforcement

Private Practice Revises Process to Provide Access to Records

Covered Entity: Private Practices
Issue: Access

9. At the direction of an insurance company that had requested an independent medical exam of an individual, a private medical practice denied the individual a copy of the medical records. OCR determined that the private practice denied the individual access to records to which she was entitled by the Privacy Rule. Among other corrective actions to resolve the specific issues in the case, OCR required that the private practice revise its policies and procedures regarding access requests to reflect the individual's right of access regardless of payment source.

www.hhs.gov/ocr/privacy/enforcement/allcases.html#case9
STATE LAW

From the New Hampshire Board of Medicine newsletter (November 2001):

“Medical Records: Notice to all physicians – Another issue which generates many avoidable complaints to the Board of Medicine involves patient efforts to retrieve their medical records. It appears that some physician offices may not fully understand obligations to make these records available. When patients request medical records from your office, please be advised that you are required by law to promptly release a copy of all medical records in your possession, including medical records received from other providers... Also, patients are entitled to a copy of IME medical records...”

AGENDA

1. HIPAA
2. Professional liability exposure
3. Confidentiality expectations
FORENSIC LIABILITY RISK IN PERSPECTIVE

• Overall – not high professional liability risk

• But – be aware of possibilities of
  Administrative actions, such as board complaints
  › Peer review of expert testimony
  › Litigation
    • Courts are imposing more duties on IME physicians
    • If there is an event, IME physician may be named
Liability For Breach of Confidentiality

Regulatory Investigation

Federal
- HHS
- FTC
  - OCR
  - SAMSHA / US Attorney

State
- Licensing Board
  - Attorney General

Litigation
- Civil
- Criminal

Professional Association Investigation
“We medical practitioners do our very best, Mr. Nyman. Nothing is more sacred to us than the doctor-plaintiff relationship.”
AGENDA

1. HIPAA
2. Professional liability exposure
3. Confidentiality expectations
CONFIDENTIALITY

THE LAW IS EVOLVING – THERE IS NO UNIFORMITY!
DUTIES OWED TO IME EVALUVEES

Courts agree – physician’s duty in performing an IME is not the same duty as owed to the physician’s patients.

Courts disagree – what exact duty, if any, the physician does owe to the evaluatee.
Courts are shifting away from the traditional view (no physician-patient relationship, so no duty) toward imposing a duty, even if limited

*Trend is to impose malpractice liability without the traditional physician-patient relationship*
STANDARD OF CARE FACTORS

- Statutes – federal and state
- Regulations – federal and state
- Case law – federal and state
- Other materials from federal and state regulatory agencies – guidelines, policy statements, etc.
- Authoritative clinical guidelines
- Policies and guidelines from professional organizations
- Learned treatises
- Journal articles
- Research reports
- Accreditation standards
- Facility’s own policies and procedures
- Drug manufacturer recommendations
- Etc.
LIABILITY FOR PERFORMING IMES

Four possible duties owed to evaluatee

#1 Duty to not harm the evaluatee during the evaluation
   - Majority view

#2 Duty properly diagnose
   - Minority view

#3 Duty to inform evaluatee of serious medical conditions
   - Majority view
DUTY #4: MAINTAIN CONFIDENTIALITY

General obligation

- Majority view
- Required by state and federal statutes and regulations
  - 42 CFR Part 2
  - HIPAA
- Recognized in case law
  - Ex: Pettus v. Cole
- Required by ethics codes, including
  - AMA
  - AOA
  - APA
  - AAPL
Even in the context of forensic activities, physicians are ethically and legally obligated to maintain confidentiality.
Pettus v. Cole

Appellate court ruled that two psychiatrists violated state law (California Confidentiality of Medical Information Act) when they disclosed to the employer information from the psychiatric disability evaluation they performed at the employer’s request.

Neither psychiatrist obtained a written authorization for disclosure of medical information, as required by state law.
AMA CODE OF MEDICAL ETHICS
OPINION 1.2.6

WORK-RELATED & INDEPENDENT MEDICAL EXAMINATIONS

“Physicians who are employed by businesses or insurance companies, or who provide medical examinations within their realm of specialty as independent contractors, to assess individuals’ health or disability face a conflict of duties. They have responsibilities both to the patient and to the employer or third party. Such industry-employed physicians or independent medical examiners establish limited patient-physician relationships...In keeping with their core obligations as medical professionals, physicians who practice as industry-employed physicians or independent medical examiners should:

(a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.
(b) Explain that the physician’s role in this context is to assess the patient’s health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.
(c) Protect patients’ personal health information in keeping with professional standards of confidentiality.
(d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.”
INDUSTRY-EMPLOYED PHYSICIANS & INDEPENDENT MEDICAL EXAMINERS

“Physicians may obtain personal information about patients outside an ongoing patient-physician relationship. For example, physicians may assess an individual’s health or disability on behalf of an employer, insurer, or other third party. Or they may obtain information in providing care specifically for a work-related illness or injury. In all these situations, physicians have a responsibility to protect the confidentiality of patient information.

When conducting third-party assessments or treating work-related medical conditions, physicians may disclose information to a third party:

(a) With written or documented consent of the individual (or authorized surrogate).
(b) As required by law, including workmen’s compensation law where applicable.

..."
PROFESSIONAL ORGANIZATIONS’ ETHICS CODES AND NON-MEMBERS

Sugarman v. Board of Registration in Medicine

Courts may expect even non-members to follow relevant professional ethics codes
Disclosure only of relevant information

- **Statute**
  - Ex: GINA

- **Regulation**
  - Ex: New Jersey §13:35-6.5

- **Case law**
  - Ex: *McGreal v. Ostrov*

- **Ethics codes / guidelines**
  - AAPL’s *Practice Guideline for the Forensic Evaluation of Psychiatric Disability*
  - AMA Ethics Opinion 5.09
GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA)

- Title II - protects employees, potential employees, and former employees from an employer’s discrimination based on genetic information
- “Genetic information” is defined to include *family history*
- When requesting medical information, employers should direct the healthcare provider not to include genetic information
  - EEOC provided “safe harbor” language
When disclosing information to third parties, physicians should:

(c) Restrict disclosure to the minimum necessary information for the intended purpose.

(d) Ensure that individually identifying information is removed before releasing aggregate data or statistical health information about the pertinent population.”
DUTY TO MAINTAIN CONFIDENTIALITY

Other issues

• Dangerous evaluatees
  › But see Elijah v. Superior Court
DUTY TO MAINTAIN CONFIDENTIALITY

Other issues

• Duty to report child abuse?
  › Ex: *Elijah v. Superior Court*

• Release of IME reports in unrelated cases
  › Ex: *Graham v. Dacheikh*
IME LIABILITY – RISK MANAGEMENT ADVICE

Protect confidentiality:

• Inform evalee to whom information will be disclosed

• Obtain evalee’s written authorization to release to the retaining party prior to performing IME

• Obtain evalee’s written authorization prior to releasing information

• Let hiring party know you may have to release information to the evalee
AGENDA

- Professional liability overview
- Psychopharmacology
  - Typical pitfalls
  - Opiates
  - Non-adherent patients, driving, and telepsychiatry
  - Medical marijuana
- Forensic practice exposures
- Child and adolescent practice exposures
How to minimize professional liability risk

Utilize three risk management strategies to provide good clinical care

Strategy #1: COLLECTING INFORMATION

Strategy #2: COMMUNICATING

Strategy #3: CAREFULLY DOCUMENTING
RISK MANAGEMENT STRATEGY #1: COLLECTING INFORMATION

Do you know what your patients **CAN** do online?
THEY CAN FORM SOCIAL NETWORKS
... SOME OF IT POTENTIALLY HARMFUL
... SOME OF IT POTENTIALLY HARMFUL
Teen whose throat was punctured after copying a YouTube video dies

15-year-old's throat was slashed by broken glass

CHEVRON IS PUTTING OVER 6,000 PEOPLE TO WORK IN THE SAN JOAQUIN VALLEY.

CHULA VISTA, Calif. - A 15-year-old Chula Vista boy has died in a freak accident after he fell onto a drinking glass, puncturing his neck while playing a pass out game with friends in his bedroom, police said Wednesday.

The teen, whose name was withheld, was bleeding profusely when officers arrived at his home on Old Janai Ranch Road shortly after 7 p.m. Tuesday, according to Chula Vista police.
The largest group of internet pornography consumers is children ages 12-17

90% of kids ages 8-16 have seen online pornography

31% of kids ages 12-18 have lied about their age in order to access a website

70% of kids ages 7-18 have accidentally encountered online pornography

www.guardchild.com/statistics/
(Accessed August 28, 2017)
THEY CAN POST SEXUALLY SUGGESTIVE CONTENT

➢ Say they posted nude or semi-nude photos or videos of themselves online
  • 22% of teenage girls
  • 18% of teen boys
  • 11% of teen girls between the ages of 13 and 16

➢ 71% of teen girls and 67% of boys who sent or posted sexually suggestive content say they sent it to a boyfriend or girlfriend

www.guardchild.com/statistics/
(Accessed August 28, 2017)
THEY CAN SEXT

➢ Say they have sexted:
  • 37% of teen girls
  • 40% of teen boys
➢ 48% of teens say they received sexts

www.guardchild.com/statistics/
(Accessed August 28, 2017)
They can be targeted for sex

➢ 20% of teenaged internet users have been the target of unwanted sexual solicitation
➢ 41% of unwanted sexual solicitations, 29% of unwanted exposure to sexual materials, and 31% of harassment occurred when kids were online with their friends
➢ Law enforcement estimates that more than 50,000 sexual predators are online at any given moment
➢ 89% of sexual solicitations of youth were made in chat rooms or through instant messaging

www.guardchild.com/statistics/
(Accessed August 28, 2017)
Girls are more likely than boys to be the target of cyber bullying

65% of 8-14 year olds have been involved in a cyber-bullying incident

www.guardchild.com/statistics/
(Accessed August 28, 2017)
In most countries it is illegal for anyone under the age of 18 to gamble. Although a few underage gamblers certainly manage to sneak into land-based casinos, they are generally quite good at stopping teens at the door.

With internet gambling however, there is little to stop a teen from placing bets online. In general, if they are able to get their hands on a credit card they can easily register at an online gambling website. The research tends to support the theory that it is simple for teens to gamble online and adolescents (especially boys) are often over-represented among online problem gamblers.
THEY CAN ENGAGE IN ONLINE GAMING

Do you know what the term “MMORPG” means?
THEY CAN MASK THEIR IDENTITIES

“CATFISHING”

“Catfish” = someone who pretends to be someone they’re not using Facebook or other social media to create false identities, particularly to pursue deceptive online romances.

www.urbandictionary.com/define.php?term=catfishing
Accessed 12 February 2013
“On the Internet, nobody knows you’re a dog.”
GENERAL OBSERVATIONS

The virtual social world

- Difficult to determine true identities
- You can be whomever you want
- “Online disinhibition effect”
RISK MANAGEMENT STRATEGY #2: COMMUNICATION

Do you know what your patients **ARE** doing online?
Do you currently ask your patients about their online lives?

Communicate with
- Patients
- Parents
RISK MANAGEMENT STRATEGY #3
CAREFULLY DOCUMENTING

Document so another professional can read your record and understand what happened in treatment and why

➢ Treatment options/actions considered
➢ Options/actions were chosen and why
➢ Options/actions were rejected and why
COMPETING INTERESTS

- Ethical
- Clinical
- Legal
REMINDER:

Patient safety, and safety of others, are exceptions to confidentiality.
FACTORS TO CONSIDER

➢ Negative nature of the behavior
  • How severe is the risky behavior
  • Potential for negative consequences

➢ Maintaining the therapeutic relationship
  • Importance of continuing treatment
  • Effect of disclosure on adolescent and on family

➢ Dangerousness of the risk behavior
  • Intensity and seriousness of behavior
  • Desire to protect patient

➢ Legal protections
  • Upholding the law
  • Patient’s safety
  • Legal consequences for clinician
GENERAL FRAMEWORK

Protect minor patient’s confidentiality, unless:

- Mandated report
- Safety of patient
- Safety of third party
- Valid legal compulsion
  - Court order
WOULD YOU TELL THE PARENT(S)?
WOULD YOU TELL THE PARENT(S)?

Your soon-to-be 16 year old patient tells you that she is sneaking out of the house most nights to “roam around town” with her 19 year old boyfriend. She assures you that they are not yet having sex.

YES OR NO?
WOULD YOU TELL THE PARENT(S)?

Your 15 year old patient tells you that she has had sex once with her 15 year old boyfriend. Do you alert the parents?

YES OR NO?
WOULD YOU TELL THE PARENT(S)?

Your 16 year old male patient with ADHD and anxiety tells you that he is using marijuana and getting high before classes, several times per week. He also admits to having sold marijuana at least three times at school. He disclosed this information because he believes it will stay confidential and it is helping him stay focused in class. Do you alert the parents?

(MODIFIED FROM GOLDSMITH M AND JOSHI S., ETHICAL CONSIDERATIONS IN CHILD AND ADOLESCENT PSYCHIATRY, FOCUS, SUMMER 2012, VOL. X, NO. 3:3125-322)

YES OR NO?
Your 17 year old female patient admits to you that her boyfriend is in a gang and was recently non-fatally stabbed in a gang fight.
WHAT DO YOU DO?

➢ Nothing – the patient wasn’t harmed
➢ Tell the parents – she is clearly in danger
➢ Let the patient know that parents need to be told – and that she gets to determine/control who tells the parents – you or the patient
Your developmentally disabled minor patient just told you that she is purposely trying to get pregnant.
WHAT DO YOU DO?

➢ Make appropriate referrals for parenting classes, reproductive education, ob-gyn care
➢ Discuss the issues with the patient and consider notifying the patient’s parents
➢ Both of the above
➢ Nothing
Riley, a 16-year-old 11th grader, shares with you at the beginning of treatment that she’s felt “bummed on and off” for 3 years. She says its hard to sleep at night and she has trouble concentrating on schoolwork. She denies suicidal ideation. The only thing that helps her is marijuana – she smokes once or twice nearly every day. She denies using tobacco or other recreational drugs. She admits to drinking alcohol 3 times but didn’t like the effect because she felt “too out of control.” She denies smoking marijuana while driving or at school.

WHAT DO YOU DO?

- Tell her parents about the illegal drug use
- Do not tell her parents – due to the adverse impact on the treatment relationship
WHAT ARE YOU BASING YOUR DECISION ON?

Your own personal beliefs or experience with marijuana?

The discussion at the beginning of treatment with the patient and her parents regarding the patient’s confidentiality rights and limitations?
Riley (16) tells you she’s sleeping with her 17 year old boyfriend Jake. She takes birth control pills and reports that the relationship is consensual and a source of support for her. She will tell her mother that she is at a friend’s house and stay over at Jake’s house sometimes. Jake’s mother is aware that Riley is over, but she things that Riley’s mother has given her permission.
WHAT DO YOU DO?

➢ Tell Riley you need to let her mother know about her sexual activity for safety reasons
➢ Call Jake’s mother to advise that Riley's mother is unaware
➢ Make no comment to Riley's mother or Riley about her risky behavior
➢ Talk to Riley about her risky behavior; express concern that she’s making poor choices
Your 15-year-old patient admits self-harm. He was sniffing glue, and burning cigarettes on his skin. He disclosed having attempted to choke himself with a rope on three occasions and of attempting to drown himself in the bath. He reports doing these things to feel something, to escape from feeling numb. He reported no current plans or intentions regarding suicide. He did, however, acknowledge ongoing thoughts regarding risky behaviors. His mother is aware that he’d cut himself before, but that’s all she is aware of.

WHAT DO YOU DO?

➢ Tell his mother of his risky behavior
➢ Don’t’ tell his mother for fear he’ll drop out of treatment
➢ Give him a week to tell his mother himself
RELEASE OF INFORMATION
The parents of one of your minor patients are currently in a nasty custody battle. The court has appointed a guardian ad litem (GAL) to represent the minor’s best interests. The GAL would like to set up a time to speak about the patient and she has provided a copy of the court order that grants her access to your patient’s records.
WHAT DO YOU DO?

➢ Provide a record copy as requested and schedule an appointment to discuss the patient’s case
➢ Refuse to release the record copy but schedule an appointment to discuss the patient’s case
➢ Provide a record copy if requested but decline to discuss the patient’s case
➢ Ignore the request
Your female patient turns 18 in four weeks. All along, her parents have agreed not to seek a copy of the record. Now dad has submitted a written request for her record and is threatening to sue if you refuse to provide him with what he has a right to see. The patient is begging you not to release.
WHAT DO YOU DO?

- Release – dad is correct that he’s entitled to his minor daughter’s record
- Refuse to release the record copy given how close to 18 she is
- Discuss your concerns with dad
- Stall until she turns 18 – relying on your board’s statement that records are to be released within 30 days
Your female patient turns 18 in six weeks. All along, her parents have agreed not to seek a copy of the record. Now dad has submitted a written request for her record and is threatening to sue if you refuse to provide him with what he has a right to see. The patient is begging you not to release.
WHAT DO YOU DO?

➢ Release – dad is correct that he’s entitled to his minor daughter’s record
➢ Refuse to release the record copy given how close to 18 she is
➢ Discuss your concerns with dad
➢ Stall until she turns 18
You have received a request for records from a minor patient’s father. The father has not been involved in the patient’s life or treatment for the past five years, and he also lives in another state far away. However, due to financial limitations, the patient’s mother has not been able to update the custody order, and the patient’s father still has access to medical records. Both the patient and her mother are adamant that they do not want the record to be released. The prospect of the release is beginning to negatively impact the minor patient’s therapy as she’s unwilling to reveal any information about herself in treatment that might ultimately be disclosed to her father.
WHAT DO YOU DO?

➢ Release the record copy
➢ Refuse to release the record copy
➢ Discuss with the patient and mother the possibility of a limited release of information
➢ Ignore the request
KEY CONCEPTS
#1: MANAGE EXPECTATIONS OF ALL PARTIES

#2: THERE ARE EXCEPTIONS TO CONFIDENTIALITY
#3: EVEN IF THEY SAY THEY WON’T, PARENTS CAN ALWAYS CHANGE THEIR MINDS AND DEMAND A COPY OF YOUR RECORD
#4: WITH FEW EXCEPTIONS, PARENTS GENERALLY HAVE THE RIGHT TO ACCESS THE RECORD OF THEIR MINOR CHILD
#5: DOCUMENT KNOWING THAT THE RECORD MAY HAVE TO BE RELEASED TO THE PARENT(S)
#6: WHAT YOU BELIEVE IS THE “RIGHT” APPROACH MAY BE CONSIDERED THE “WRONG” APPROACH BY OTHER CHILD AND ADOLESCENT PSYCHIATRISTS
#7: YOUR CLINICAL JUDGMENT IS THE DETERMINING FACTOR
Welcome to the website of the Louisiana State Board of Medical Examiners

Established in 1894, the Louisiana State Board of Medical Examiners (LSBME) protects the health, welfare and safety of Louisiana citizens against the unprofessional, improper, and unauthorized practice of medicine by ensuring that those who practice medicine and other allied health professions under its jurisdiction are qualified and competent to do so. In addition, the Board serves in an advisory capacity to the public and the state with respect to the practice of medicine.
QUESTIONS?

www.prms.com/rmtalks