



# ‘Med check’ appointments: How to minimize your malpractice risk

## The safety and efficacy of these appointments depend on how they are set up

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**M**edical malpractice claims can arise in any type of health care setting. The purpose of this article is to discuss the risk of medical malpractice suits in the context of brief “med checks,” which are 15- to 20-minute follow-up appointments for psychiatric outpatient medication management. Similar issues arise in brief new patient and transfer visits.

### **Malpractice hinges on ‘reasonableness’**

Malpractice is an allegation of professional negligence.<sup>1</sup> More specifically, it is an allegation that a clinician violated an existing duty by deviating from the standard of care, and that deviation caused damages.<sup>2</sup> Medical malpractice claims involve questions about whether there was a deviation from the standard of care (whether the clinician failed to exercise a reasonable degree of skill and care given the context of the situation) and whether there was causation (whether a deviation caused a patient’s damages).<sup>3</sup> These are fact-based determinations. Thus, the legal resolution of a malpractice claim is based on the facts of each specific case.

The advisability of 15-minute med checks and the associated limitation on a clinician’s ability to provide talk therapy are beyond the scope of this article. What is clear, however, is that not all brief med check appointments are created equal. Their safety and efficacy are dictated by the milieu in which they exist.

Practically speaking, although many factors need to be considered, the standard of care in a medical malpractice lawsuit is based on



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**The reasonableness of a clinician's actions during a brief med check visit depends on the specific patient**

reasonableness.<sup>46</sup> One strategy to proactively manage your malpractice risk is to consider—either for your existing job or before accepting a new position—whether your agency's setup for brief med checks will allow you to practice reasonably. This article provides information to help you answer this question and describes a hypothetical case vignette to illustrate how certain factors might help lower the chances of facing a malpractice suit.

### Established patients

In med check appointments for established patients, consider the patient population, the availability of pre- and postvisit support services, and contingency plans (*Table, page 29*).

Different patient populations require different levels of treatment. Consider, for example, a patient with anxiety and trauma who is actively engaged with a therapist who works at the same agency as their psychiatrist, where the medication management appointments are solely for selective serotonin reuptake inhibitor refills. Compare that to a dual-diagnosis patient—with a psychotic and substance use disorder—who has had poor medication compliance and frequent rehospitalizations. The first patient is more likely to be reasonably managed in a 15-minute med check. The second patient would need significantly more pre- and postvisit support services. This consideration is relevant from a clinical perspective, and if a bad outcome occurs, from a malpractice perspective. Patient populations are not homogeneous; the reasonableness of a clinician's actions during a brief med check visit depends on the specific patient.

Pre- and postvisit support services vary greatly from clinic to clinic. They range from clerical support (eg, calling a pharmacy to ensure that a patient's medication is available for same-day pickup) to nursing support (eg, an injection nurse who is on site and can immediately provide a patient with a missed injection) to case manager support (eg, a case manager to facilitate coordination of care, such as by having a patient fill out record releases and then working to ensure that relevant hospital records are received

prior to the next visit). The real-world availability of these services can determine the feasibility of safely conducting a 15-minute med check visit.

Regardless of the patient population, unexpected situations will arise. It could be a patient with posttraumatic stress disorder who was recently retraumatized and is in the midst of disclosing this new trauma at the end of a 15-minute visit. Or it could be a patient with dual diagnoses who comes to the agency intoxicated and manic, describing a plan to kill his neighbor with a shotgun. A clinician's ability to meet the standard of care, and act reasonably within the confines of a brief med check structure, can thus depend on whether there are means of adequately managing such emergent situations.

Some clinics have fairly high no-show rates. Leaving no-show slots open for administrative time can provide a means of managing emergent situations. If, however, they are automatically rebooked with walk-ins, brief visits become more challenging. Thus, when assessing contingency plan logistics, consider the no-show rate, what happens when there are no-shows, how many other clinicians are available on a given day, and whether staff is available to provide support (eg, sitting with a patient while waiting for an ambulance).

### New and transfer patients

Brief visits for new or transfer patients require the same assessment described above. However, there are additional considerations regarding previsit support services. Some clinics use clinical social workers to perform intake evaluations before a new patient sees the psychiatrist. A high-quality intake evaluation can allow a psychiatrist to focus, in a shorter amount of time, on a patient's medication needs. An additional time saver is having support staff who will obtain relevant medical records before a patient's first psychiatric visit. Such actions can greatly increase the efficacy of a new patient appointment for the prescribing clinician.

The reliability of and level of detail assessed in prior evaluations can be



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## Relevant considerations when assessing a med check appointment structure

Factor	What to consider
Patient population	The prevalence of serious mental illnesses and dual diagnoses
Clinical support services	The availability and quality of pre- and postvisit clerical, nursing, and case manager support
Contingency plans	The ability to use no-show slots to address unexpected patient care issues, and the availability of other clinicians and staff to provide support in case of an emergency

particularly relevant when considering a job providing coverage as locum tenens, when all patients will be new to you. Unfortunately, if you are not employed at a clinic, it can be hard to assess this ahead of time. If you know colleagues in the area where you are considering taking a locum position, ask for their opinions about the quality of work at the agency.

### Case vignette

Mr. J is a 30-year-old man with schizoaffective disorder. For several years, he has been followed once every 4 weeks at the local clinic. During the first year of treatment, he had numerous hospitalizations due to medication noncompliance, psychotic episodes, and threats of violence against his mother. For the past year, he had been stable on the same dose of an oral antipsychotic medication (risperidone 2 mg twice a day). Then he stopped taking his medication, became increasingly psychotic, and, while holding a butcher knife, threatened to kill his mother. His mother called 911 and Mr. J was hospitalized.

While in the hospital, Mr. J was restarted on risperidone 2 mg twice a day, and lithium 600 mg twice a day was added. As part of discharge planning, the hospital social worker set up an outpatient appointment with Dr. R, Mr. J's treating psychiatrist at the clinic. That appointment was scheduled as a 15-minute med check. At the visit, Dr. R did not have or try to obtain a copy of the hospital discharge summary. Mr. J told Dr. R that he had been hospitalized because he had run out of his oral antipsychotic, and that it

had been restarted during the hospitalization. Dr. R—who did not know about the recent incident involving a butcher knife or the subsequent medication changes—continued Mr. J's risperidone, but did not continue his lithium because she did not know it had been added.

Dr. R scheduled a 4-week follow-up visit for Mr. J. Then she went on maternity leave. Because the agency was short-staffed, they hired Dr. C—a locum tenens—to see all of Dr. R's established patients in 15-minute time slots.

At their first visit, Mr. J told Dr. C that he was gaining too much weight from his antipsychotic and wanted to know if it would be OK to decrease the dose. Dr. C reviewed Dr. R's last office note but, due to limited time, did not review any other notes. Although Dr. C had 2 no-shows that day, the clinic had a policy that required Dr. C to see walk-ins whenever there was a no-show.

Dr. C did not know of Mr. J's threats of violence or the medication changes associated with his recent hospitalization (they were not referenced in Dr. R's last note). Dr. C decreased the dose of Mr. J's risperidone from 2 mg twice a day to 0.5 mg twice a day. He did not do a violence risk assessment. Two weeks after the visit with Dr. C, Mr. J, who had become increasingly depressed and psychotic, killed his mother and died by suicide.

The estates of Mr. J and his mother filed a medical malpractice lawsuit against Dr. R and Dr. C. Both psychiatrists had a duty to Mr. J. Whether there was a duty to Mr. J's mother would depend in part on the state's duty to protect laws. Either way, the malpractice case would hinge on whether the

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**The availability of pre- and postvisit support services can determine the feasibility of safely conducting a med check visit**



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Leaving no-show slots open can provide a means of managing emergent situations

### Related Resources

- Mossman D. Successfully navigating the 15-minute 'med check.' *Current Psychiatry*. 2010;9(6):40-43.
- Olfson M, Marcus SC. National trends in outpatient psychotherapy. *Am J Psychiatry*. 2010;167(12):1456-1463.

#### Drug Brand Names

Lithium • Eskalith, Lithobid    Risperidone • Risperdal

psychiatrists' conduct fell below the standard of care.

In this case, the critical issues were Dr. R's failure to obtain and review the recent hospital records and Dr. C's decision to decrease the antipsychotic dose. Of particular concern is Dr. C's decision to decrease the antipsychotic dose without reviewing more information from past records, and the resultant failure to perform a violence risk assessment. These deviations cannot be blamed entirely on the brevity of the med check appointment. They could happen in a clinic that allotted longer time periods for follow-up visits, but they are, however, more likely to occur in a short med check appointment due to time constraints.

The likelihood of these errors could have been reduced by additional support

services, as well as more time for Dr. C to see each patient who was new to him. For example, if there had been a support person available to obtain hospital records prior to the postdischarge appointment, Dr. R and Dr. C would have been more likely to be aware of the violent threat associated with Mr. J's hospitalization. Additionally, if the busy clinicians had contingency plans to assess complicated patients, such as the ability to use no-show time to deal with difficult situations, Dr. C could have taken more time to review past records.

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## Bottom Line

When working in a setting that involves brief med check appointments, assess the agency structure, and whether it will allow you to practice reasonably. This will be relevant clinically and may reduce the risk of malpractice lawsuits. Reasonableness of a clinician's actions is a fact-specific question and is influenced by multiple factors, including the patient population, the availability and quality of an agency's support services, and contingency plans.