Going outside your area of expertise: How far is too far?

Douglas Mossman, MD and Christina G. Weston, MD

Dear Dr. Mossman:

I am an adult psychiatrist practicing in a geographically isolated area. I am working with the family of 10-year-old "Bobby" who is struggling with attention problems. Top notch neuropsychologic testing recommends a stimulant trial, but the local pediatrician is too busy to give Bobby adequate follow-up and attention.

I am an experienced psychopharmacologist but have not prescribed medication to children since residency. My relationship with the family is excellent, and the local pediatrician said that she would supervise me. If I choose to treat Bobby, what are the possible liability issues I should be aware of, and how can I address them?

Submitted by "Dr. F"

Dr. F's question raises issues that come up whenever patients need treatment for conditions outside the few with which you are highly familiar. Although you can't be an expert on every aspect of every patient's treatment, psychiatrists shouldn't practice outside their area of competence.

Thus, the main liability-related issue that Dr. F should ask herself is, "Can I treat Bobby competently?" Of course, whenever you decide to treat any patient, you should be able to answer "yes" to this question. When thinking about potential liability related to treating Bobby, Dr. F might also ask, "If a lawsuit occurred, how would my treatment of Bobby appear?" This article discusses key issues that arise when general psychiatrists treat children and the steps general psychiatrists can take to show that they are practicing prudently.

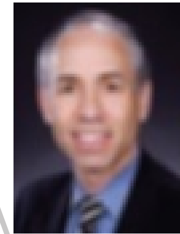
Copyright® Dowden Health Media
For personal use only

Problem: Not enough clinicians

Child and adolescent psychiatrists (CAPs) are in short supply.[1,2] In 2001 the United States had 8.67 CAPs per 100,000 youths and 1.6 CAPs for every 1,000 youths with severe mental disorders.[1] Studies suggest that the United States needs nearly twice that many CAPs.[3] The shortage is especially severe in rural areas, but approximately one-half of metropolitan counties with populations of >250,000 have no CAPs.[1] In much of the nation, finding CAPs who are accepting new patients is difficult, and child and adolescent psychiatric treatment often is delivered by pediatricians, family practitioners, psychiatric nurse practitioners, and general adult psychiatrists.

Children's special medical issues

General psychiatrists know that children aren't just little adults. CAPs develop skills and thinking styles during their 2 years of subspecialty fellowship training that are quite different from those used by their general psychiatric colleagues.


Douglas Mossman, MD

DO YOU HAVE A QUESTION ABOUT POSSIBLE LIABILITY?

- Submit your malpractice-related questions to Dr. Mossman at douglas.mossman@dowdenhealth.com.
- Include your name, address, and practice location. If your question is chosen for publication, your name can be withheld by request.
- All readers who submit questions will be included in quarterly drawings for a $50 gift certificate for Professional Risk Management Services, Inc's online marketplace of risk management publications and resources (www.prms.com).

Dr. Mossman is director, Glenn M. Weaver Institute of Law and Psychiatry, University of Cincinnati College of Law, and volunteer professor of psychiatry and associate program director, Institute for Psychiatry and Law, University of Cincinnati College of Medicine. Dr. Weston is assistant professor and associate director, division of child and adolescent psychiatry, Wright State University Boonshoft School of Medicine, Dayton, OH.

continued

For mass reproduction, content licensing and permissions contact Dowden Health Media.

Malpractice minute

At CurrentPsychiatry.com we give you facts of an actual malpractice case. Submit your verdict online and see how your colleagues voted.

Could a child's suicide have been prevented?

THE PATIENT. A 9-year-old boy was undergoing psychiatric treatment.

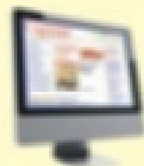
CASE FACTS. A psychiatrist prescribed bupropion. The child committed suicide.

THE PARENTS' CLAIM. The psychiatrist was negligent because he did not diagnose suicidal behavior during the initial visit and prescribed bupropion without proper warnings and follow-up.

THE DOCTOR'S DEFENSE. He did not receive information from the patient's family that would have indicated suicidal behavior, bupropion was an appropriate treatment and was unrelated to the suicide, the family received proper warnings about the drug, and the suicide was unforeseeable.

What's your verdict?

- LIABLE
- NOT LIABLE



Submit your verdict, find out how the court ruled, and see how your colleagues voted in August's Malpractice Minute at CurrentPsychiatry.com. Click on "Have more to say about this topic?" to comment.

Cases are selected by CURRENT PSYCHIATRY from *Medical Malpractice Verdicts, Settlements & Experts*, with permission of its editor, Lewis Laska of Nashville, TN (www.verdictslaska.com). Information may be incomplete in some instances, but these cases represent clinical situations that typically result in litigation.

Clinical Point

Child and adolescent psychiatrists are leery of giving kids the same medications that adult psychiatrists readily prescribe

Communication. Children and adolescents who need psychiatric care often have limited verbal abilities. Working and communicating with these patients requires a different interactive style.

Information sources. CAPs learn to seek and assimilate clinically important information from many settings—especially a child's home—where their patients interact with others.

Caution. Only a small subset of psychotropic medications that adult psychiatrists prescribe are FDA-approved for use in children.[4] Because we don't know how psychotropic drugs affect brain development, CAPs sometimes are leery of giving kids the same medications that adult psychiatrists readily prescribe.

Different drugs. Some medications commonly taken by children are not often prescribed for adults, although this is changing as attention-deficit/hyperactivity disorder (ADHD) is better recognized in adults.[5,6]

Dosages. Dosing psychotropics in adults is fairly standardized, but in children and adolescents dosages vary with age, body weight, and physical maturity.

Adverse effects. The side effects kids experience and the way they report them can differ markedly from adults and will vary with age and developmental maturity. Some issues related to monitoring children—such as appropriate cardiac screening before starting stimulants—are controversial and remain unsettled.[7,8]

Consider alternatives

Dr. F may be tempted to treat Bobby because of her preexisting, positive relationship with the child's family and a laudable desire to help. But Dr. F needs to ask, "Is there really no other workable alternative

for Bobby?" Some possibilities include:

- Refer Bobby to a CAP in another community for initiation of treatment. Dr. F or Bobby's pediatrician might safely continue care once a CAP establishes an effective treatment regimen.
- Find another pediatrician who might have more time to provide the follow-up that Dr. F feels is necessary.
- Decline to treat Bobby. Before doing this, Dr. F should consider what effect this refusal might have on her relationship with the family and the consequences for Bobby if his problems go untreated.
- Consult a CAP from another community, describing the situation and clinical factors in detail without naming or identifying the patient, and then ask, "Is this really the best thing to do?"

From a liability standpoint, this last point may be crucial. If the CAP answers "yes," Dr. F can document the alternatives she has considered and her consultation and discussion with the CAP colleague as evidence of prudent practice. Dr. F can also document any advice that she has received and her plans to follow it.

If you choose to treat

Presumably, Dr. F would not perform thoracic surgery or provide any treatment that is far outside a general psychiatrist's competence except under the most dire circumstances. General psychiatrists receive child psychiatry training during residency, and treating children is within their scope of practice. Similarly, most elderly patients are treated by general psychiatrists, rather than graduates of geropsychiatry fellowships. Prescribing medication for Bobby is not grossly different from Dr. F's other duties, and she might provide services that a pediatrician might not.

Ask yourself 4 questions to determine if you are competent to provide medical treatment outside your usual area of expertise (***Table***). In Bobby's case, Dr. F can consider these additional questions:

- Am I comfortable doing this? Would I be comfortable with this scenario if Bobby were my child?
- How extensive was my general residency training in child psychiatry?
- How long ago was my last CAP experience?
- Have I treated ADHD in adults, and am I familiar with stimulant medications?
- What kind of supervision could I arrange, such as regular phone consultation with a CAP or pediatrician?
- How helpful are other information sources, such as recent texts, journals, and medical Web sites?

Table

Should you provide treatment? 4 questions to ask yourself

How sure am I that I know what I *don't* know?
How will I know when I should ask for help?
Do I have colleagues readily available for consultation if I need help?
Do I have a good track record for seeking consultation when I need it?

Clinical Point

Document the alternatives considered and a consultation with a qualified colleague as evidence of prudent practice

Bottom Line

Few if any physicians know everything about every illness they treat. When you treat problems that stretch your competence, ask yourself, "Under the circumstances, am I providing good care for this patient?" If the answer is "yes," you've met your legal and ethical obligation to your patient.

continued

- What is my relationship with the family, and how would treating Bobby affect it?

Advantages and benefits

So far, we've emphasized cautions, but Dr. F also should remember that she may offer patients services that general psychiatrists provide but that pediatricians might not do routinely. Among the possibilities:

- Performing a diagnostic assessment that incorporates biopsychosocial factors.
- Taking time to foster a strong doctor-patient relationship with the family.
- Reserving time for medication-related psychoeducation.
- Scheduling longer visits to discuss a child's psychiatric problems and explore solutions.
- Utilizing knowledge of and existing relationships with nonphysician therapists who could provide additional psychotherapy.

Want to know more?

Visit this article at CurrentPsychiatry.com to read more about FDA-approved drugs and dosages for treating ADHD in children and adults.

References

1. Thomas CR, Holzer CE III. The continuing shortage of child and adolescent psychiatrists. *J Am Acad Child Adolesc Psychiatry* 2006;45:1023-31.
2. U.S. Department of Health and Human Services. Mental health: a report of the Surgeon General. Rockville, MD: National Institute of Mental Health; 1999. Available at: http://www.surgeongeneral.gov/library/mentalhealth/home.html. Accessed August 20, 2008.
3. Levin A. Rural counties suffer from child psychiatry shortage. *Psychiatr News* 2006;42(14):4-41.
4. National Institute of Mental Health. Treatment of children with mental disorders. 2004. Available at: http://www.nimh.nih.gov/publicat/childqa.cfm. Accessed August 2, 2008.
5. Wilens TE, Biederman J, Spencer TJ. Attention deficit/hyperactivity disorder across the lifespan. *Annu Rev Med* 2002;53:113-31.
6. Greenhill LL, Pliszka S, Dulcan MK, et al, and American Academy of Child and Adolescent Psychiatry. Practice parameter for the use of stimulant medications in the treatment of children, adolescents, and adults. *J Am Acad Child Adolesc Psychiatry* 2002;41(2 suppl):26S-49S.
7. Perrin JM, Friedman RA, Knilans TK. Cardiovascular monitoring and stimulant drugs for attention-deficit/hyperactivity disorder. *Pediatrics* 2008;122:451-3.
8. Vetter VL, Elia J, Erickson C, et al. Cardiovascular monitoring of children and adolescents with heart disease receiving medications for attention deficit/hyperactivity disorder: A scientific statement from the American Heart Association Council on Cardiovascular Disease in the Young Congenital Cardiac Defects Committee and the Council on Cardiovascular Nursing. *Circulation* 2008;117:2407-23.

U.S. Postal Service

STATEMENT OF OWNERSHIP, MANAGEMENT, AND CIRCULATION

(Required by 39 U.S.C 3685)

1. Publication Title: Current Psychiatry
2. Publication Number: 022-622
3. Filing Date: 09/12/08
4. Issue Frequency: Monthly
5. Number of Issues Published Annually: 12
6. Annual Subscription Price: $106.00
7. Complete Mailing Address of Known Office of Publication (*Not printer*) (*Street, city, county, state, and ZIP+4®*): Contact Person: Deborah O'Brien, Telephone: 813-627-6722, Dowden Health Media, 110 Summit Avenue, Montvale, Bergen County, NJ 07645-1712
8. Complete Mailing Address of Headquarters or General Business Office of Publisher (*Not printer*): Dowden Health Media, 110 Summit Avenue, Montvale, NJ 07645-1712
9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor: Kenneth A. Sylvia, Publisher, Dowden Health Media, Inc, 110 Summit Avenue, Montvale, NJ 07645-1712; Alice V. Luddington, ELS, Editor, Dowden Health Media, Inc, 110 Summit Avenue, Montvale, NJ 07645-1712
10. Owner (*If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.*): Dowden Health Media, 110 Summit Avenue, Montvale, NJ 07645-1712
11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities: None
12. (*Must be completed if the publication title shown in item 2 is a publication published and owned by a non-profit organization.*) The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: n/a
13. Publication: Current Psychiatry
14. Issue Date for Circulation Data: September 2008

	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
15. Extent and Nature of Circulation		
a. Total Number of Copies (Net Press Run)	41,698	41,208
b. Legitimate Paid and/or Requested Distribution (*By Mail and Outside the Mail*)		
(1) Outside County Paid/Requested Mail Subscriptions Stated on PS Form 3541 (*Include direct written request from recipient, telemarketing and Internet requests from recipient, paid subscriptions including nominal rate subscriptions, employer requests, advertiser's proof copies, and exchange copies*)	22,352	21,924
(2) In-County Paid/Requested Mail Subscriptions Stated on PS Form 3541 (*Include direct written request from recipient, telemarketing and Internet requests from recipient, paid subscriptions including nominal rate subscriptions, employer requests, advertiser's proof copies, and exchange copies*)	none	none
(3) Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid or Requested Distribution Outside USPS®	34	42
(4) Requested Copies Distributed by Other Mail Classes through the USPS (eg, First-Class Mail®)	none	none
c. Total Paid and/or Requested Circulation (*Sum of 15b (1), (2), (3), and (4)*)	22,386	21,966
d. Nonrequested Distribution (*By Mail and Outside the Mail*)		
(1) Outside County Nonrequested Copies Stated on PS Form 3541 (*include Sample copies, Requests Over 3 years old, Requests induced by a Premium, Bulk Sales and Requests including Association Requests, Names obtained from Business Directories, Lists, and other sources*)	18,429	18,630
(2) In-County Nonrequested Copies Distributed Stated on PS Form 3541 (*include Sample copies, Requests Over 3 old, Requests induced by a Premium, Bulk Sales and Requests including Association Requests, Names obtained from Business Directories, Lists, and other sources*)	none	none
(3) Nonrequested Copies Distributed Though the USPS by Other Classes of Mail (*e.g., First-Class Mail, Nonrequestor Copies mailed in excess of 10% Limit mailed at Standard Mail® or Package Service Rates*)	none	none
(4) Nonrequested Copies Distributed Outside the Mail (*Include Pickup Stands, Trade Shows, Showrooms and Other Sources*)	233	100
e. Total Nonrequested Distribution (*Sum of 15d (1), (2), and (3)*)	18,662	18,730
f. Total Distribution (*Sum of 15c and e*)	41,048	40,696
g. Copies not Distributed (*See Instructions to Publishers #4, (page #3)*)	650	512
h. Total (*Sum of 15f and g*)	41,698	41,208
i. Percent Paid and/or Requested Circulation (*15c divided by f times 100*)	54.5%	54.0%

16. Publication of Statement of Ownership for a Requester Publication will be printed in the October 2008 issue of this publication.
17. I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).
—Daniel J. Mills, Executive Vice President/CFO, 9/12/08