

A quarterly newsletter designed to address legal and risk related issues that child and adolescent psychiatrists encounter.

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This newsletter is published in support of the American Professional Agency's child and adolescent psychiatrist insurance program, exclusively for members of the American Academy of Child and Adolescent Psychiatry.

Dear AACAP Member,

Welcome to the inaugural issue of Allied World's newsletter focusing on risk management concerns for child and adolescent psychiatrists. I am pleased to have joined Allied World as the Vice President of Healthcare Risk Management where my focus is on providing psychiatric risk management services.

It is to this position that I bring experience as an attorney, having worked in medical malpractice defense, mental health law and representation of facilities on general health law issues including advance directives/guardianship matters. I have also worked as a clinical social worker and have provided care in both inpatient and outpatient settings. It is through these experiences that I appreciate the risks and challenges that you may face. I look forward to working with you on the risk concerns you may encounter.

As the AACAP-endorsed medical malpractice insurance program, Allied World is committed to building a comprehensive risk management program for members of the AACAP who are Allied World policyholders, including providing resources such as:

- **"In Session with Allied World for AACAP,"** a quarterly newsletter designed to address legal and risk related issues that child and adolescent psychiatrists encounter. The newsletter will feature articles written by legal professionals specializing in mental health matters as well as by child and adolescent psychiatrists. We aim to provide legal and risk analysis on topics germane to your practice.
- **Risk management consultation services** with 24-hour hotline access providing immediate access to information whenever the need arises.
- **Risk management seminars** on topics which are timely and applicable to your practice needs.
- **Individual CME Education** through our strategic relationship with Medical Risk Management, Inc. to provide specific on-line risk management educational courses for psychiatrists at a discounted fee.
- **Access to our library** of risk management resources.

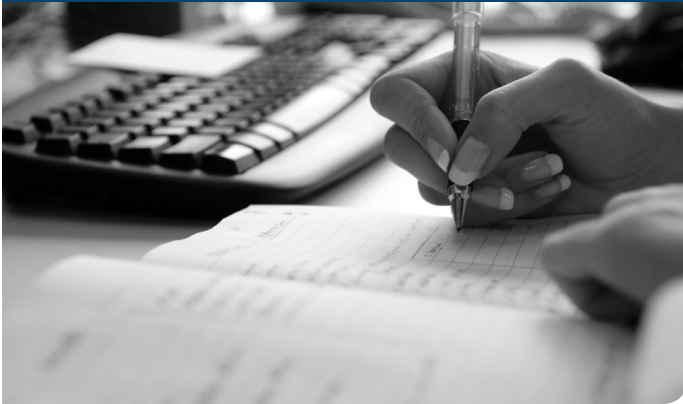
To make this the best program possible, we welcome your input and feedback. In addition, we are seeking contributions to future newsletters and development of educational resources. I look forward to working with you in support of your risk management needs. I can be contacted at **(857) 288-6036** or by email at kristen.lambert@awac.com.



Kristen M. Lambert, JD, MSW, LICSW
Vice President Healthcare Risk Management
Co-Editor, *In Session with Allied World for AACAP*



Boundary Violation Issues and Risk Management Concerns In Child and Adolescent Psychiatry



By Jonathan D. Rubin
Kaufman Borgeest & Ryan, LLP

The issue of boundary crossing violations and dual relationships (undue familiarity) between patients and their psychiatric care providers is one of continuing professional and ethical concern. Inherent in the often close and emotional relationships between psychiatrists and their patients are the risks and dangers of professional boundaries being crossed and violated by the caregiver in connection with the provision of services. Especially pertinent to the issues involved in analyzing boundary violations and how they impact a psychiatrist's treatment of their patients are how these issues affect the doctor patient relationship for child and adolescent psychiatrists. This article addresses the key issues that are frequently seen in the context of these relationships, many of which have led to complaints to state licensing boards and/or claims of psychiatric malpractice.

There are important ethical issues when treating children and adolescents. Children and adolescents undergo significant developmental changes in physical, cognitive, affective, communicative and interpersonal spheres.¹ These changes may occur during the duration of your treatment with the patient. The level of independence for a 7 year old as opposed to a sixteen year old can be very different. (Sondheimer, 2010). However, similar legal rules do apply to anyone under 18 who is under the treatment of a mental health professional. Parents or guardians must consent to treatment and children may assent or dissent.

(Sondheimer, 2010).² Thus, confidentiality and the role of a parent or guardian is a frequent issue of treatment in this realm.

Many practitioners recommend a "family based" model where practicable which includes continued communication with parents or guardians to make sure that all are involved in treatment. (Citing-Macbeth, 2002). Notwithstanding the foregoing, autonomy and privacy must be balanced with the issues involved in the therapy and the age of the patient. Parents or guardians will want to know about the progress of therapy and the issues discussed therein. With younger children, parents or guardians are typically more involved than with adolescents; however, privacy should be respected and followed where appropriate. When there are issues of safety and imminent danger, confidentiality can be set aside and issues can be revealed to parents or guardians.

The rights of the child must be balanced with the involvement of the parents or guardians in the treatment of the child. Thus, there is an underlying tension between the rights of the privacy of the child or adolescent and the parent's or guardian's involvement in treatment.

Child and adolescent psychiatrists must be especially aware of any pressures and inappropriate behaviors by parents or guardians in trying to direct or manipulate therapeutic relationships. Treatment issues related to a child's or adolescent's feelings (emotions, how they are doing on a daily basis or how they are dealing with a family trauma such as divorce or a death), are issues where the child or adolescent should expect to have a right to privacy within the doctor-patient relationship. Again, this must be evaluated and considered on a case-by-case basis with the patient's age and maturity of paramount importance.

Boundary violations can occur in the relationships between the patient and the provider and between the patient's parents and/or guardians and the provider. Any attempts by a parent or guardian to invade this relationship by seeking to improperly undermine the overall confidentiality of this relationship needs to be strongly avoided and resisted by the psychiatrist. Any sexual contact, of any kind, with the child or adolescent is strictly forbidden and not only would detrimentally affect a provider's license, but could also lead to criminal charges with allegations of rape, child abuse, etc. Further,

any sexual relationship with a parent or guardian is strictly forbidden. Such a relationship could completely undermine the trust between a provider and the child/adolescent and is unethical. Although a strong point for a family-based approach in therapy is advocated, this means that the same lines that should not be crossed in adult psychiatry should not be crossed when treating children/adolescents. For example, having a family dinner with a patient and his/her parents would be an exercise in poor judgment and could create a confusing dual relationship.

We realize that these directives are easy to put on paper but are sometimes hard to follow in practice. Whether there are dual relationships between present or former patients and/or issues related to boundary violations, it is again our consistent and firm advice to psychiatrists that these relationships be avoided. The relationship between a psychiatrist and his/her patient is unique and very involved. Anything that occurs that might blur or confuse the professional relationship between the doctor and his patient is fraught with peril. These relationships are different, for example, than a relationship that a patient might have with her pediatrician or family practitioner because the bulk of the psychiatric treatment involves issues related to the patient's subjective complaints and deep seated feelings and emotions. As such, the psychiatric relationship is especially unequal between the provider and the patient. The nature of this relationship is why boundary violations are especially problematic for the psychiatric provider.

Boundary Violations

Transference and counter-transference are inherent in the issues related to boundary violations that occur in therapy. Psychiatrists will encounter patients who frequently exhibit borderline and narcissistic personalities. These patients can be prone to manipulate the relationship between the psychiatrist and patient and often view the relationship with their psychiatrist as involving issues of control and power.³ This dual phenomenon, which can occur together or apart in psychiatric treatment, needs to be recognized and promptly addressed in therapy. When it occurs, the ability of the psychiatrist to remain objective can be dangerously impacted and weakened if not handled correctly.

Examples of Boundary violations can include:

- frequent changing of appointments
- increasing appointments
- setting up appointments at the end of session days
- exchanging of gifts, going for coffee or meals outside of the session
- hugging, holding hands, kissing, massaging the patient
- treatment of friends and relatives
- waiving of fees
- allowing the patient and/or his family to find out personal information about the provider (such as schools attended, vacations taken, and whether he/she is married or has children).

Other violations can include:

- telling a client that you are angry at them
- using self-disclosure as a therapy technique
- having a client address you by your first name
- accepting gifts
- asking for favors
- lending money
- inviting clients to a party or social event
- disclosing details of current personal stress to a client
- making house calls to patients

These issues are also frequently seen, for example, in the topics related to whether sessions run over time and when patients request additional time for treatment. Of course, sexual relations and sexual intercourse of any kind during treatment are among the most serious boundary violations. This list is by no means exhaustive but certainly highlights the areas where violations have and can occur.⁴

It is a difficult situation where the provider wants to present a humane and humanistic environment in which the patient feels secure and comfortable in order that he can talk and share issues related to his current problems. This is a difficult balance of which the psychiatrist must always be aware and try to deal with in a way to keep professional boundaries at all times. Nevertheless, this balance is one that cannot be minimized, compartmentalized or compromised by crossing boundaries like the ones previously listed.

Where prescribing medications to patients can be a large component of the care, it is essential to stay consistent and keep a record of the dosages and what is being done. It is also important that there be frequent face-to-face treatment with the patient, especially with a patient on psychotropic medications.

Psychiatric Litigation

Psychiatric litigation is on the rise as are board complaints. As such, a standard of boundary maintenance is critical to each psychiatrist in the provision of care to his/her patients. A bright line approach of course cannot always be kept in place, but that is why a psychiatrist must have a support network and be willing to reach out to his/her insurance carrier or hotline where he can talk about troubling and difficult issues within the context of the client/patient relationship **as these issues arise, rather than after a problem occurs.** Boundary violations may be seen as a departure from traditional psychiatric care. In order to avoid dual relationships and boundary violations, it is critical that the provider develop a treatment care plan for the provision of care. It is important that a diagnosis be arrived at, and that the provider is aware of what this diagnosis means in the context of patient vulnerability and the patient's attempts to manipulate or control the session or the doctor.

While every case is different, the standard of care remains the same and must be followed by the psychiatrist where

Allied World's Experienced Claims

Team: As the largest insurer for mental health providers, Allied World's analysts understand the intricacies of psychiatric claims, including the unique challenges associated with patient complexities, patient rights and various state regulations. Possessing both the legal and clinical backgrounds that are critical for handling psychiatric claims, each team member has experience handling claims specific to child and adolescent psychiatrists.

he/she is aware of transference, counter-transference and boundary maintenance. As new doctor-patient relationships commence and proceed with treatment, the efforts by certain patients and/or their parents or guardians to test boundaries may occur. In our experience, borderline patients are especially prone to test boundaries in an effort to control situations and manipulate the psychiatrist. The psychiatrist should not shy away from appropriate termination of a patient when a patient or his parent/guardian continually refuses to respect boundaries. Records maintained by the provider must indicate that conversations occurred regarding boundary maintenance. In the event of litigation, these records are critical to pointing out that boundary maintenance was something that the psychiatrist was aware of and attempted to maintain. These records are also critical in defending against claims of patient abandonment.

Termination

In terms of present versus former patients, once there is a termination or an ending to the therapeutic relationship, it is easier for a dual relationship to commence and boundary violations can become less paramount and important. However, even in these situations, it is always best to take a strict approach and try to avoid these relationships.

Documentation

It is extremely important that the provider keep thorough, up-to-date notes of each treatment session and maintain these notes carefully. Note taking of sessions is required by state licensure and is something that there is no short cut in doing. In cases where there is transference, counter-transference and/or a blurring and crossing of boundaries, the lack of notes can make the defense of these cases extremely difficult. Over the years, we have encountered many providers who kept no notes of their sessions and said they rely only on their good recall. We once thought that it was only veteran psychiatrists who were more apt not to keep notes of their sessions and to maintain a lot of the care and treatment in their head. However, this phenomenon occurs with psychiatrists of all ages and experiences. Not taking notes is dangerous, unpermitted, and unethical. This can lead to license revocation and can certainly lead to an inability to defend a malpractice case.

Not taking notes is dangerous, unpermitted, and unethical. This can lead to license revocation and can certainly lead to an inability to defend a malpractice case.

Records need to be kept by all psychiatric providers, not just for provision of psychotropic medications but with an explanation as to why medications are being given, what changes in dosages are being made and why, what follow-up there might be with other mental health providers and the need for any hospitalizations, etc. A clear, consistent and chronological record is critical both for the treatment by any subsequent providers and hospitalizations for the patient, and to assist family members (parents or guardians). When problems arise with boundary issues, they need to be reflected in the patient's records. This can be very important for termination and to fend off any claims of abandonment. If a patient persists in pushing boundaries, this must be reflected in the records and will again set up a good defense as to why a patient was terminated.

Support of Colleagues

We recommend that child and adolescent psychiatrists have mentors and supervisors and stay in contact with professional colleagues to obtain feedback and have a sounding board when a provider feels that a transference or counter-transference of some kind is about to occur or is occurring. We also encourage providers to seek counsel from their insurance companies, professional organizations and, if need be, attorneys as potential problems arise. It is best to be proactive in these situations.

Conclusion

This article is a summary of some of the key issues that can occur with boundary violations and the problems that we have seen arise in connection to claims brought against child and adolescent psychiatrists. There is an abundance of literature and articles on this issue and it is one that will continually be important for psychiatrists.

About the Author



Jonathan D. Rubin is a partner with Kaufman Borgeest & Ryan LLP in New York City. His practice areas include Medical Malpractice Defense. He has particular expertise in the defense of mental

health providers and has lectured extensively in this area. Mr. Rubin represents hospitals, nursing homes, physicians and all health professionals in civil litigation matters in state and federal courts. In addition, Mr. Rubin represents physicians and other medical professionals in disciplinary actions before the New York State Department of Education, Office of Professional Discipline. Mr. Rubin has given numerous presentations on topics including the litigation of complex medical malpractice matters and a variety of risk management issues for health professionals. Mr. Rubin is admitted to practice in New York; The United States District Court for the Southern and Eastern Districts of New York as well as the District of Columbia. He is the author of several articles related to health care issues including *"Confidentiality Issues in the Treatment of Couples in Marital Therapy;"* *Medical Malpractice Law and Strategy 2000*, and *"Defense of Record Keeping Issues for Mental Health Care Professionals in New York:"* *'The Ugly, the Bad and the Good'*; *AHRMNY News 2009*. Mr. Rubin served as a New York County District Attorney prior to entering civil practice. He is the current President Elect and Board Member of The Association for Healthcare Risk Management of New York, Inc. and a member of the New York State Bar Health Law section. He is a graduate of Vassar College (B.A., *cum laude*) and the George Washington University (J.D.) and is a former Assistant District Attorney in the New York County District Attorney's office (1991-1996).

Culture Corner



By Kristen M. Lambert

Psychiatrists often encounter patients and family members from diverse cultures and backgrounds. Although there are many differences and variations within a culture, we will feature different cultural groups which may be of interest to you in your daily practice as well as some relevant legal issues which you may encounter. It is important not to stereotype a person from a specific culture into thinking he has the same beliefs as someone else from that same culture. Learning whether a patient considers himself typical or different from others in his cultural group is important as there are many factors which influence how an individual views his own culture/beliefs. You may never encounter some of the featured cultures in your practice; however, we hope you find the information interesting nevertheless. Our first featured culture is American Indians.

American Indians

There are over five hundred tribes, nations, bands and native villages recognized by the federal government with two hundred more not federally recognized.⁵

Major Language/Dialects: Most speak English. Long pauses are part of conversation. When asking a question that requires more than a yes/no answer, be patient and allow time for careful consideration before an answer is received.

Nonverbal Communication: Respect is communicated by avoiding contact and respectful distance.

Tone of Voice: Tone expresses urgency. Loudness is associated with aggression while requests made in a personable, polite manner are welcomed.

Consents: To obtain consent, have a conversation with the patient explaining the treatment and everyone's role including the patient and his family. Ask if the patient needs to talk with anyone before consenting to treatment. Some patients may be unwilling to sign written consents based on personal/political history of documents being misused. Thorough documentation is key.

- *Advance Directives:* Consent to advance directives may be unsuccessful. There may be a preference for natural processes. Some cultures may prefer not to openly discuss DNR status because negative thoughts might hasten the loss.

Concept of Health: Traditional health beliefs are holistic and wellness oriented.

- *Invasive Procedures:* Patients may be skeptical of procedures but will allow if treatment is needed; however it may be a last resort.

Mental Illness: Mental illness is a culturally specific concept and beliefs may include ghosts, breaking taboos, or loss of harmony with environment.

As compared to other ethnic groups, American Indian/Alaska Native youth have more serious problems with mental health disorders relating to suicide including anxiety, substance abuse and depression.⁶ Suicide ranked as the second leading cause of death in those aged 10-34.⁷ Statistics such as these may become important in the event that a patient or family member files suit following a suicide or attempted suicide. Family members may claim that you should have been aware of the increased risk and that you should have monitored the patient more closely. Therefore, it is important to be aware of the cultural differences that you may experience when treating Native American patients.

Mental health services are not often easily accessible and Native Americans tend to underutilize mental health services and discontinue therapy.⁸

- *Depression:* Depression is generally recognized. Depression may be described as vague physical complaints such as having 'heart problems,' 'being out of harmony,' or having problems with the social/physical universe.

- *Substance Abuse*: Culturally sensitive programs which strengthen family ties, including addressing substance abuse, could protect against suicide among Native American adolescents.⁹

Children within the family unit: Children often assume the role of caring for elders. Children are expected to respect their elders and take pride in their culture. Autonomy is generally valued, however, independence is tempered by responsibility to community, tribe and family. Children are not encouraged to seek help from persons outside the family. This may be problematic in a therapeutic context.

A Patient's Right to Refuse Treatment



By Kristen M. Lambert

Our society is built upon the fundamental value of an individual's right to choose — where to live, whom to marry, how to worship, and the right to choose medical treatment. In the context of psychiatric treatment, there can often be a delicate balance between protecting a person from harm (or harm to others) with their right to choose medical treatment. Psychotropic medications may be seen as a violation of bodily integrity and a patient may elect not to take prescribed medications. It is important for a physician to recognize a patient's right to choose and the legal issues involved. Although this article may be germane to psychiatrists treating adult patients, the information may be important as your adolescent patients reach the age of majority, given that they may be making decisions with respect to their psychiatric and medical treatment.

The right to refuse treatment can be a difficult situation for a psychiatrist to encounter when treating a patient. There are various instances where a physician may be faced with a challenging issue weighing the benefit of treatment versus a patient's right to choose a specific treatment. As a psychiatrist, you may not agree with a patient's decision not to take a specific medication and it may be highly beneficial if he did agree to do so. For example, a patient with Bipolar Disorder may clearly benefit from treatment with a specific medication to stabilize his mood; however he will not consent to the medication.

Although it is important to check with your particular state laws / regulations impacting forcible administration of medication, typically, the issue hinges upon whether the person is in imminent danger to hurt himself or others versus the realization that he would clearly benefit from treatment with medication.¹⁰

Typically, a physician may not undertake any therapy, in a non-emergency context without a patient's consent.¹¹ Simply because a patient has mental illness does not mean he may not be able to make informed medical decisions. While it is true that a patient's refusal to consent to medications may be due to his underlying delusions, the patient may have a sound and rational reason why they will not consent to medication. For example, if a patient has a side effect to an antipsychotic medication such as Tardive Dyskinesia, he may not agree to continue taking the medications. As you know, these medications do not come without risks and they may have life-long and irreversible side effects which may be troublesome to the patient. Further, simply because a patient is involuntarily committed, does not necessarily mean that he is unable to make medical decisions.

What, in general, is incapacity? The Uniform Probate Code (UPC) has been adopted or followed by many states. The UPC defines an incapacitated person as, "...an individual who, for reasons other than being a minor, is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance."¹²

There are a number of landmark legal decisions that have been decided over the years concerning a patient's right to choose his own medical treatment. A few of these are as follows:

I. In Re Quinlan¹³

Many of you are familiar with this case as it gained national recognition in the patient's right to choose movement. In 1976, the Supreme Court of New Jersey decided this case in which a father was allowed by the court to authorize discontinuation of his comatose daughter's respiratory assistance on the basis that given her condition, she would not have wanted the respiratory assistance continued.¹⁴

II. Superintendent of Belchertown State School v. Saikewicz¹⁵

In 1977, the Massachusetts Supreme Judicial Court in the Saikewicz decision recognized the rights of competent and incompetent patients to refuse treatment. In the event of incompetence, the case discussed the substituted judgment doctrine: what the patient would have wanted if he were competent to choose. (See below Guardianship of Roe.) Mr. Saikewicz was a 67 year old man with profound mental retardation, who had a mental age of approximately 2 years, eight months. Mr. Saikewicz was diagnosed with acute myeloblastic leukemia and the recommended treatment was chemotherapy. The treatment would not have cured him, but rather would only have prolonged his life.

Mr. Saikewicz had a long-standing guardian appointed. The case concerned the recommended chemotherapy treatment. The Court recognized that a general right exists in all persons, both competent and incompetent, to refuse medical treatment in appropriate circumstances. The Court discussed the process for determining substituted judgment in treatment decisions. The Court concluded that Mr. Saikewicz, if he were competent, would have refused the treatment and that he could still do so even though he was previously determined to be incompetent. The Saikewicz case was important in determining the rights of a patient to refuse treatment.

III. Guardianship of Roe¹⁶

In 1981, the Massachusetts Supreme Judicial Court addressed a patient's right to refuse treatment for a mental illness, i.e., administration of treatment with antipsychotic medications. The Court placed the task of determining substituted judgment upon the courts, not the guardian.

Mr. Roe's father, previously appointed as his guardian, consented to the administration of antipsychotic medications over his son's objection and in absence of an emergency or institutionalization. The Court decided that even though Mr. Roe (the son) lacked capacity to make decisions, including treatment with antipsychotic medications, his stated preference was entitled to serious consideration. The Court mandated a set of factors to determine substituted judgment which included:

- the patient's stated preference
- religious beliefs
- impact on the patient's family
- side effects
- outcome and prognosis with treatment
- outcome and prognosis without treatment
- other factors that the court would deem appropriate

The Court held there was a constitutional right to privacy and that the patient had a right to free choice.

IV. Rennie v. Klein¹⁷

In 1983, the New Jersey Court of Appeals heard an issue pertaining to a suit involving involuntarily committed patients and their right to refuse treatment with antipsychotic medications. The core issue in the case concerned side effects of antipsychotic medications, the use of different antipsychotic medications at the same time and retaliation for complaints of side effects. The Court found that involuntarily committed patients have a legal right to refuse antipsychotic medications. The standard applied to override a patient's refusal was a determination of dangerousness to himself or others, made by a medical provider exercising professional judgment.

V. Rogers v. Commissioner of Department of Mental Health¹⁸

In 1983, in another Massachusetts Supreme Judicial Court decision, the Court found that an involuntary commitment does not constitute incompetence to make treatment decisions. The Court held that only the court can adjudicate a person incompetent. This is a finding after a substituted judgment analysis and occurs prior to the administration of any forcible antipsychotic medications. The Court found that in a non-emergency situation no state interest is compelling enough to overcome a patient's decision to refuse treatment with antipsychotic medications. Forcible administration is

permitted in an emergency situation to prevent an immediate, substantial and irreversible deterioration of a serious mental illness.

VI. Department of Health & Mental Hygiene v. Kelly¹⁹

In a 2007 decision, the Maryland Court of Appeals upheld a Code requiring the state to prove that an involuntarily committed individual is dangerous to himself or others within an institution before it may forcibly administer medications.

Mr. Kelly was charged with multiple violent crimes. A court ordered him to undergo an evaluation on his competency to stand trial. He was subsequently ordered to an inpatient psychiatric hospitalization. To treat his mental illness, he was prescribed antipsychotic medications. Six months later, he refused the medications.

The Court did not consider his history of violence prior to his commitment or his potential violence after release. As a result, the standard in Maryland requires the state to prove that an involuntarily committed patient is dangerous to himself or others within the walls of the institution before it may forcibly administer medication.²⁰

Conclusion

Although these are some of the landmark decisions on forcible medications when treating adult patients, it is important to check with your specific state regulations and prevailing caselaw concerning forcible administration of medications and incapacity. However, the trend over the last thirty years is to allow patients autonomy and the ability to choose what medications they take.

In Session with Allied World for AACAP is provided, free of charge, as a benefit for participants of the AACAP-endorsed Psychiatrist Malpractice Insurance program.

Offered exclusively through the American Professional Agency, Inc.

What's New

Massachusetts SJC Amicus Brief

In our continued efforts to promote education, training and assistance, Kristen Lambert of Allied World had the pleasure to co-author an Amicus Brief with Ellen DiPaola, Esq. which was submitted to the Massachusetts Supreme Judicial Court. This Brief was prepared on behalf of the Massachusetts Guardianship Association, a non-profit organization which offers information and resources to individuals, families and professionals on guardianship, conservatorship and related matters. The issue was reviewed by the Court on February 10, 2011 and concerned an incompetent adult (under guardianship). She was prescribed the injectable antipsychotic medication, Prolixin, which the Probate Court approved against her objection. In July, 2009, Massachusetts underwent an overhaul whereby guardianship laws completely changed. This is likely why the Court sought to review this case. Although this case involves an adult with incapacity, as you know, at times when your patients reach the age of majority, they may not have the ability to make informed decisions concerning the psychiatric care and may require a guardian to do so on their behalf. As such, we will keep you posted on the outcome of this case, especially in light of some of the important right to choose decisions which have come out of Massachusetts over the years.

ASHRM Pearls for Psychiatric Care

Allied World's Kristen Lambert will be serving as the Chair of ASHRM's Psychiatric Pearls Task Force over the next year. This Task Force will be comprised of multi-disciplinary professionals who will revise the Pearls for Psychiatric Care pocket guides. These guides include essential tips and strategies on how to minimize healthcare liability exposures and are designed to assist with educational efforts. ASHRM publishes a variety of Pearls, including topics on Long Term and Continuing Care, Physicians Offices, Medication Safety, and Emergency Department. We will keep you updated on when this is published.

Upcoming Speaking Events

Kristen Lambert will be speaking at the following events:

APA Annual Meeting

**May
17**

9:00 – 10:30 a.m.

Honolulu, Hawaii

Topic: "Clinical Documentation after HITECH: It's back to risk management basics"

ASHRM Annual Conference

**October
19**

10:00 – 11:00 p.m.

Phoenix, AZ

Co-Presenting with Kelley Woodfin, R.N., B. S. DFASHRM, CPHRM & Dawn Cushman, Esq.

Topic: "Legal and Risk Considerations: Managing Age-Related Psychiatric Behaviors in LTC Residents"

If you have a topic of interest, **please contact Kristen Lambert at (857) 288-6036.**

End Notes

Boundary Violation Issues

¹ Ethics and Child and Adolescent psychiatry – “Avoiding Confidently Conflicts” by Adrian Sondheimer MD June 8, 2010, *Psychiatry Times*.

² Citing-Macbeth J. Legal Issues in the treatment of minors. In: Schetky D. Benedek E, eds Principles and Practice of Child and Adolescent Forensic Psychiatry. Washington, DC: American Psychiatric Publishing; 2002:309-323.

³ Psychiatry and Law for Clinicians, 3rd edition, Robert I. Simon MD., American Psychiatric Publishing, Inc. (2001).

⁴ Boundaries in Psychotherapy, The Concept of Boundaries in Clinical Practice: Theoretical and Risk-Management Dimensions, Thomas G. Gutheil and Glen O. Gabbard 1993.

Culture Corner

⁵ Lipson, J., Dribble, S., Minarik, P. (Ed.). Culture & Nursing Care: A Pocket Guide, USCF Nursing Press (1996), 3: 11-21 (B. Josea Kramer, Ph.D.).

⁶ Suicide Prevention Resource Center. <http://www.sprc.org/library/ai.an.facts.pdf> (citing Olson, L.M. & Wahab, S. (2006). American Indians and suicide: A neglected area of research. *Trauma, violence, and Abuse*, 7(1), 19-33.

⁷ Suicide Prevention Resource Center. <http://www.sprc.org/library/ai.an.facts.pdf> (citing Centers for disease Control and Prevention, National Center for Injury Prevention and Control. Web based Injury Statistics Query and Reporting System [WISQARS]).

⁸ Suicide Prevention Resource Center. <http://www.sprc.org/library/ai.an.facts.pdf> (citing Gone, J.P., (2004). Mental health services for Native Americans in the 21st century United States. *Professional Psychology: Research and Practice*, 35, 10-18).

⁹ Suicide Prevention Resource Center. <http://www.sprc.org/library/ai.an.facts.pdf> (citing Range, L.M., et al. (1999). Multicultural perspectives on suicide).

A Patient’s Right to Refuse Treatment

¹⁰ Rogers v. Commissioner of Dept. of Mental Health, 390 Mass.489, N.E.2d 308 (1983); Rogers v. Okin, 634 F.2d 650, 660 (1st Cir. 1980); People v. Medina, 705 P.2d 961, 974 (Colo. 1985).

¹¹ Dep’t of Health & Mental Hygiene v. Kelly, 918 A.2d 470 (2007).

¹² Uniform Probate Code, Section 5-102. National Conference of Commissioners on Uniform State Laws (2006).

¹³ In Re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976).

¹⁴ Appelbaum, Paul, S., Gutheil, Thomas, G., Clinical Handbook of Psychiatry & the Law. 4th Ed. (2007).

¹⁵ Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728; 370 N.E.2d 417 (1977).

¹⁶ In Re: Guardianship of Roe, 383 Mass. 415, 421 N.E. 2d 40 (1981).

¹⁷ Rennie v. Klein, 720 F.2d 266 (3rd Cir. 1983).

¹⁸ Rogers v. Commissioner of Dep’t of Mental Health, 390 Mass.489, N.E.2d 308 (1983).

¹⁹ Dep’t of Health & Mental Hygiene v. Kelly, 918 A.2d 470 (Md. 2007).

²⁰ Rolon, Yamilka, M.D., *Right to Refuse Treatment: Dangerousness Within the Institution Must Be Proven to Treat and Involuntarily Committed Individual Over His Objection.*, *J. Am Acad Psychiatry Law*, 36:2:252-255 (2008).

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In Session with Allied World for AACAP

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