

# Splitting treatment: How to limit liability risk when you share a patient's care

Dear Drs. Mossman and Weston:

In my psychiatric practice, I sometimes provide pharmacotherapy for patients treated by psychotherapists who practice independently. Am I liable for what these therapists do or don't do—for example, not contacting me if a patient is suicidal or experiences a medication side effect? How much communication should occur between us? Sometimes—after a patient signs a release—I call the therapist and leave messages, but my calls are not returned. What should I do?

Submitted by "Dr. B"

**P**harmacologic advances and altered reimbursement patterns have drastically changed how psychiatrists understand and manage mental problems. Not long ago, insight-oriented psychotherapy was the primary treatment—and often the only one—psychiatrists provided for outpatients. Nowadays, most visits to psychiatrists involve little or no in-depth psychotherapy,<sup>1</sup> and many patients receive "joint treatment"—a psychiatrist performs the diagnostic and medical assessment and prescribes medications where appropriate, and a nonphysician provides other treatment services.

Psychiatrists need to be clear about their responsibilities for patients whom they "share" with other mental health professionals. In this article, we'll discuss:

- forces that promote split treatment
- types of split-treatment relationships

- how to limit liability risk when you split treatment with a nonphysician mental health practitioner.

## Dollars and cents reasons

Since the 1980s, psychiatrists have spent less time with their patients, provided less psychotherapy, and prescribed medications more frequently.<sup>2</sup> An estimated 70% of outpatient visits to psychiatrists involve no psychotherapy.<sup>1</sup>

Market conditions are a major factor in these changes. Cost-containment policies and reduced private insurance payments for psychotherapy visits have incentivized psychiatrists to collaborate with less-well-paid psychotherapists. Combining medication and psychotherapy may be the best and most cost-effective treatment for mentally ill patients, but psychiatrists get paid more for three 15-minute "med checks" than for one 45-minute psychotherapy session.<sup>3-5</sup>

Although managed care payment patterns may be "perversely influencing" psychiatry (as one psychiatrist puts it)<sup>6</sup> other factors contributing to the decline of psychotherapy include:

- new medications with fewer side effects
- aggressive pharmaceutical company promotions of psychotropics
- greater public acceptance of mental illness and its treatment
- an increasingly cohort of psychiatrists trained by teachers and mentors who emphasized biologic therapies.<sup>1</sup>



Douglas Mossman, MD,  
and Christina G. Weston, MD

## DO YOU HAVE A QUESTION ABOUT POSSIBLE LIABILITY?

- Submit your malpractice-related questions to Dr. Mossman at [douglas.mossman@qhc.com](mailto:douglas.mossman@qhc.com).
- Include your name, address, and practice location. If your question is chosen for publication, your name can be withheld by request.

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### Clinical Point

Find out if the potential therapist is credentialed, and respectfully inquire about his or her training and clinical approaches

Table 1

### Types of split-care relationships

Type	Characteristics
Consultative	Develops when one licensed practitioner asks for the opinion of another
Informal ('curbside')	One practitioner describes clinical characteristics to another; patient's identity is unknown to consultant
Formal	Consultant documents findings after reviewing record and/or examining patient; consultant knows patient's identity
Supervisory	Mandated relationship between 2 professionals in which supervisee should follow supervisor's recommendations
Collaborative	Credentialed professionals share ongoing responsibility for care and complementary aspects of a patient's treatment
Same agency	Practitioners have distinct treatment roles (eg, therapist and prescriber) in several patients' care and may have regular contact with each other; shared medical record
Independent	Practitioners lack regular contact; scope of treatment duties is established for the individual shared patient

Source: Reference 7

### Forms of split treatment

Psychiatrists engage in several types of professional relationships that split the care provided to mentally ill patients (Table 1),<sup>7</sup> and Dr. B has asked us to focus on one type of split-care relationship: a physician and psychotherapist treat the same patient, ideally collaborating to provide good clinical care.

Split, collaborative care is common throughout medicine. Most of us see medical specialists who treat different illnesses, but each doctor is responsible for the care he or she provides. An allergist knows

what orthopedic surgery is, but we don't expect our allergist to provide follow-up after arthroscopic surgery—and neither does our orthopedist.

The same considerations apply when a psychiatrist's patient sees an independent nonphysician therapist. The psychiatrist provides the same care that a patient receiving only pharmacotherapy would need. The psychiatrist should not expect the collaborating therapist to monitor the patient's pharmacotherapy—for example, by checking lab tests or asking about medication side effects—although the therapist is welcome to tell the psychiatrist about pharmacotherapy matters or encourage the patient to do so.

### Limiting liability

Psychiatrists who share patients with independent nonphysicians can take several steps to promote better care and limit potential liability.

**Delegation.** Do not delegate essential aspects of medical care. For example, tell young patients starting antidepressants (and minors' legal guardians) about the risk of increased suicidal ideation, and provide close monitoring. Although it is acceptable for a patient to tell his or her therapist about worsening suicidal thoughts, instruct the patient to inform you as well.

**Check them out.** Before agreeing to split care, find out if the potential collaborator is credentialed, and respectfully inquire about his or her training and clinical approaches.<sup>8</sup> Because unlicensed or uncredentialed therapists might not be held to the same practice standards as physicians and often have little or no malpractice insurance, psychiatrists who work with them may be assuming most of the clinical and legal liability.<sup>9</sup> If a court is looking for a way to compensate an injured patient, it may hold the psychiatrist accountable for not knowing the therapist's qualifications, failing to supervise the

therapist, or failing to inform the patient of the therapist's lack of qualifications.<sup>7,10</sup>

**Establish the collaboration.** Psychiatrists have a duty to ensure that their patients receive good care. Split treatment can help patients—who get 2 pairs of eyes monitoring them, plus 2 clinicians' combined areas of skill—if the clinicians work together satisfactorily. Some psychiatrists recommend using initial consultation forms<sup>8</sup> or contracts to spell out mutual expectations and establish important components of the relationship (*Table 2, page 46*).<sup>11,12</sup> Other psychiatrists are comfortable with brief discussions with potential collaborators that cover:

- how the clinicians will divide treatment responsibilities
- circumstances when they will communicate
- patient coverage during each other's vacations

- availability to patients during crises
- types of problems that would prompt the patient to contact the psychiatrist or therapist first.

Be sure to document these discussions as well as written consent for initial and ongoing communication in the patient's medical record. Major treatment advances or setbacks, nonadherence, or termination of treatment by/with one clinician should prompt contact with the other clinician. Collaborating clinicians should communicate regularly even when treatment is going well, not only when big changes occur.<sup>8</sup>

### Back to Dr. B

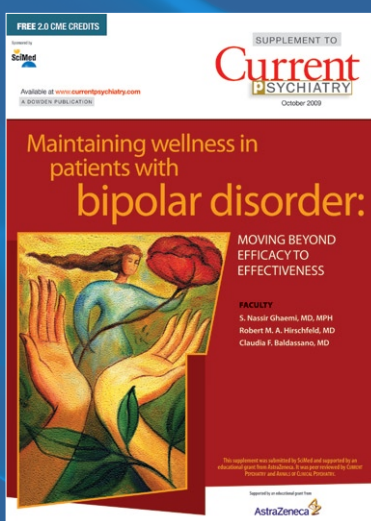
What should you do if a patient seeks pharmacotherapy and the therapist hasn't contacted you? First, you probably should speak with your patient about the absence of interclinician communication, explain that it

### Clinical Point

Treatment advances or setbacks, nonadherence, or termination of treatment should prompt contact between clinicians

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## Clinical Point

Get patients' written consent to share confidential information before you agree to a shared treatment relationship

Table 2

### 7 C's of effective collaborative treatment

**Clarity** about the relationship (collaborative, supervisory) and what each provider will do

**Contract.** A written agreement about duties and roles may help to dispel an assumption that the psychiatrist had supervisory responsibilities

**Communication** that occurs routinely between caregivers, even when treatment is going well

**Consent** by the patient, which requires that the patient knows, understands, and accepts each provider's role

**Comprehensive review** of what's happened in therapy, especially if the psychiatrist sees the patient infrequently

**Credentialing.** If the parties don't know each other well, they should check out each other's background

**Consultation.** Seek when problems arise in treatment or with the above arrangements

Source: References 11,12

is important, and get the patient's written permission to initiate contact. After contacting the therapist, you will be in a better position to determine how often you should see the patient and how often you need to share information with the therapist.

If you are uncomfortable sharing care with some or all nonphysician therapists, tell your patients. You might refer prospective patients to psychotherapists with whom you're comfortable providing collaborative care or to other psychiatrists who accept split relationships.

Ideally, get patients' written consent to share confidential information before you agree to participate in a shared treatment relationship. If patients refuse, you will not

have access to all treatment information. This may adversely affect the quality of care and increase your liability risk.

In some cases, your discomfort with a split-treatment situation may make you decide to decline or terminate the treatment relationship. This is permissible if you give the patient proper notice, suggest other psychiatrists who might see the patient, and remain available for urgent matters for a reasonable time—usually 30 to 60 days—to allow the patient to contact another psychiatrist.<sup>10</sup> When you discuss potential providers, explain that you don't know these clinicians (if that's the case) or whether they will agree to treat the patient.<sup>12</sup>

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## Bottom Line

Split treatment between psychopharmacologists and psychotherapists is common and can work well, but it has potential clinical and liability pitfalls. Some therapists might not be held to the same practice standards as psychiatrists and may have little or no malpractice insurance. Psychiatrists can limit their liability by establishing good and frequent communication with collaborating clinicians.