LESSONS TO BE LEARNED: A REVIEW OF POST-SUICIDE MALPRACTICE LAWSUITS

Introduction

Since the 1980's, The Psychiatrists' Professional Liability Insurance Program has reviewed and managed tens of thousands of claims and lawsuits against providers with one of, if not the most frequently identifiable cause of loss being patient suicide. The only upside to these otherwise tragic cases is the wealth of important risk management lessons to be gleaned by scrutinizing the specific types of allegations made in suicide related lawsuits. The following is a review of allegations frequently made in lawsuits filed after a suicide attempt or a completed suicide and a discussion of risk management strategies that emerge from an examination of this information.

The Standard of Care

An impression shared by many providers is that in order to avoid liability related to patients with suicidal behaviors, treating providers are expected to be able to predict whether a particular patient will attempt suicide and prevent all suicide attempts however unforeseeable. Thankfully, however, courts recognize that providers are only human and *do not* expect impossible powers of prediction.

What *is* expected, as in any provider-patient interaction, is that the provider will meet the standard of care, i.e. will exercise that degree of skill, care and diligence exercised by members of the same profession/specialty practicing in light of the present state of medical science. In a lawsuit involving a suicide, the provider's actions will be assessed by reviewing certain factors, including:

- Whether there was adequate identification and evaluation of suicide risk indicators and protective factors for the patient with suicidal behaviors
- Whether a reasonable treatment plan was developed based on the assessment of the patient's clinical needs
- Whether the treatment plan was appropriately (i.e., not negligently) implemented and modified based on an ongoing assessment of the patient's clinical status
- Whether the provider was professionally current regarding the assessment and treatment of patients with suicidal behaviors (i.e., knew suicide risk indicators and protective factors, knew current treatment options/interventions including medications, therapy, hospitalization, etc.)
- Whether documentation in the patient record was adequate to support that appropriate care was provided in terms of the assessment, treatment and ongoing monitoring of the patient

In a medical malpractice lawsuit, the plaintiff has the burden of proving that the physician was negligent. One element that must be shown is that the physician breached his legal duty to treat the patient within the standard of care. It is significant to note that the standard of care is not a static concept. In any particular instance, the standard of care encompasses a range of acceptable treatment options and requires the exercise of the provider's professional judgment. The standard of care in a particular case is determined by and based on that specific patient's clinical needs. Just as there is no such thing as a blanket treatment plan applicable to every patient with a given diagnosis, there is no such thing as a blanket standard of care. "When a provider chooses a course of treatment, within a range of medically accepted choices for a patient after a proper examination and evaluation, the doctrine of professional medical judgment will insulate such provider from liability."[1]

Lawsuits and Risk Management

When a plaintiff files a lawsuit, it is filed in the form of a "complaint," The complaint is a legal document that lists all the allegations upon which the medical malpractice case, or "claim," is based. These allegations are the way that a plaintiff asserts that there was a duty of care on the part of the provider, that there was a departure from accepted standards of care, that the departure caused legal injuries to the plaintiff, and that the plaintiff is entitled to money damages for those injuries.

At the time that an initial complaint is filed, the allegations listed are unproven. During the course of litigation, the plaintiff must prove that everything he alleges is true in order to prevail. Whether ultimately proven or not, the allegations which are commonly asserted in lawsuits resulting from a patient suicide, or suicide attempt, provide insight into what the plaintiff will try to claim is the standard of care. Thus, risk management strategies for avoiding a breach of that standard can be derived from close evaluation of the allegations and the facts of any given case.

Standard of Care Factors, Related Allegations, and Risk Management Strategies

In this section, the most commonly asserted allegations are grouped with specific standard of care factors; this is done in order to illustrate how allegations and the standard of care are directly related. However, many of the allegations listed could relate to several of the standard of care factors or considerations.

Standard of Care Factor One: Adequate identification and evaluation of suicide risk indicators and protective factors

Allegations related to this standard of care factor are concerned with the failure to take an adequate patient history, the failure to adequately assess the patient, and the failure to make an accurate diagnosis.

Related Allegations:

- Failure to obtain an adequate history
- Failure to contact the prior physician

- Failure to obtain history from the family, including past suicidal behaviors
- Failure to determine what treatments had previously failed
- Failure to review prior medical records
- Failure to perform a full mental status exam
- Failure to properly evaluate and record patient's risk for suicide
- Failure to reach a rational diagnosis based on careful examination and history of the patient
- Failure to weigh psychodynamic factors
- Failure to diagnose medication intoxication and dependency
- Failure to diagnose suicidality

Risk Management Strategies:

- Explore the patient's clinical history and past treatment, if any. Obtain prior treatment records where possible and document attempts to get records and information. Telephone consultation with past treaters may be necessary when records cannot be timely obtained. While treatment recommendations might not be altered based on previous information, past records can give the provider a more comprehensive and nuanced context in which to understand the patient. Additionally, the provider may benefit from the experiences of previous providers.

- Consult with family members and others close to the patient for information about the patient's history, presenting condition and life circumstances.

- Assess the patient's suicide risk at significant points in the treatment, including, but not limited to:
    - At the outset of treatment
    - With the occurrence of suicidal or self-destructive ideation or behavior
    - When significant clinical changes occur
    - When a change in supervision or observation level is ordered
    - At the time of discharge or transfer from one level of care to another

- Be alert for, and respond to, developments in a patient's life that may increase the risk of suicide.

Standard of Care Factor Two: A reasonable treatment plan was developed based on the assessment of the patient's clinical needs

and

Standard of Care Factor Three: The treatment plan was implemented appropriately and modified as needed based on the patient's clinical condition

Generally, these allegations have to do with decisions about appropriate treatment modalities and settings and the correct implementation of the treatment plan.

Related Allegations:

- Failure to take reasonable steps to ensure the patient's safety
- Failure to take protective measures (such as placing the patient on constant observation)
- Failure to remove dangerous objects (such as shoelaces, sharps, firearms/weapons)
- Failure to develop a comprehensive treatment plan
- Failure to hospitalize for suicidality
- Failure to communicate with other providers involved in the patient's care (for example, provider failed to communicate clinical concerns to other physicians involved in the patient's care)
- Failure to communicate with the patient's family or significant others (for example, the family alleged that the provider failed to alert them to the patient's suicidal ideation)
- Improper reliance on "no-harm" contract
- Failure to weigh the benefits of ECT in a timely manner
- Negligent psychopharmacologic management
- Improper medication prescribing
- Failure to provide adequate post-discharge care

Risk Management Strategies:

- Address the need for a safe environment for patients with suicidal behaviors. The accessibility of firearms/other weapons should be assessed and an appropriate plan for safety instituted. This should include obtaining information from and instructing the patient's family/significant others about this issue.

- Facility policies and procedures should be in place and followed to ensure patient safety. The standard of care is largely established by the opinion of other providers, and since policies and procedures often are the result of a consensus of practitioners, the policies and procedures may be a close approximation to the standard of care.

- Frequently reassess the patient's risk of suicide and the safety of the patient's environment and make adjustments in the treatment plan, as needed.

- Even though a patient at risk for suicide does not meet the criteria for hospitalization at one point in treatment, assessment should be ongoing to determine when and if that assessment changes. Know the criteria and procedures for involuntary hospitalization in your state.

- Involve and educate the patient's family and significant others, when appropriate, about the patient's situation and treatment. The patient, other healthcare providers, and the patient's family should be appropriately warned about the potential for suicide and significant risk factors. If the patient will consent to communication with significant others, consider discussing the following: Do they know what behaviors to be on the lookout for that may indicate increased risk? Do they know what to do if they notice these symptoms or behaviors? If the patient will not consent to communicating with family or others, remember, there are some exceptions to patient confidentiality, such as when a patient is in danger of harming himself or others.[2] Accordingly, even without patient consent, consider alerting family members and significant others to the risk of outpatient suicide when:
    - the risk is significant,
    - the family members do not seem to be aware of the risk, and
    - the family might contribute to the patient's safety.

- Additionally, some clinicians, wishing to zealously protect a patient's confidentiality, erroneously believe they cannot listen to what family members have to tell them about a patient. Listening to others does not constitute a breach of confidentiality and may provide invaluable information and insight into the patient's suicide risk.

- Office staff should have guidelines about the symptoms and conditions/issues that patients and families may call about that require immediate referral to the provider or another clinician. The threshold for obtaining a physician's response should be relatively low – any uncertainty in this area means the matter is discussed with the doctor.

- Communicate with other treaters, especially when the patient is being treated in a split treatment or collaborative treatment situation. In order for the care given by an individual treater to be as effective as possible, the patient's overall care must be coordinated. Pertinent treatment team information should be taken into consideration when assessing, formulating a diagnosis, and putting a treatment plan into place. On an inpatient unit, read the documentation of other treaters and address conflicting information or assessments. This demonstrates that you are aware of the information, took steps to clarify it, and factored the information into your assessment and treatment recommendations. Obtain patients' consent to communicate with other treatment providers, if such consent is needed, at the outset of treatment.[3]

- Do not rely solely on a patient agreeing to a "no-harm" or suicide prevention contract as a guarantee of patient safety. These "contracts" have no legal force and cannot take the place of an adequate suicide risk assessment. Although it may be appropriate for a "no-harm" contract to be *one part* of a comprehensive treatment plan, it is the clinicians'

responsibility to evaluate the patient's overall suicide risk and the patient's ability to participate in the treatment plan. Over reliance on such contracts may lessen a clinician's awareness or observation of a patient's suicide risk.

- Appropriate baseline laboratory testing, a comprehensive patient history, and any necessary physical examinations should be completed before medications are prescribed. Monitor medication levels and all ongoing laboratory testing regularly. Make informed decisions about the type and amount of medication given to a patient at risk for suicidal behaviors. The decision should reflect the extent of your experience with the patient, your knowledge of this patient, the severity of the risk, and the extent to which prescribed medications may be of significance to the patient. Avoid telephone refills without assessing the patient, particularly when you are covering for a colleague. As always, obtain the patient's informed consent for medications prescribed.

- Avoid terminating treatment with a patient in outpatient treatment who is in crisis. Ideally, the provider should continue treating until the crisis is resolved. If the patient's condition requires hospitalization, the provider may terminate safely while the patient is hospitalized. The patient and the in-patient treatment providers should be informed so that planning for alternative treatment arrangements after discharge can begin as soon as possible.

- Patients are at increased risk of suicide after discharge from hospitalization. An assessment of the patient's status should be done prior to discharge and a reasonable discharge plan should be in place to provide adequate support and care at this vulnerable time.

Standard of Care Factor Four: Be professionally current regarding the assessment and treatment of patients with suicidal behaviors (know suicide risk indicators and protective factors, know current treatment options/interventions including medications, therapy, hospitalization, etc.)

Related Allegations:

Many of the allegations previously cited could be asserted to support a claim that a provider did not meet the standard of care because the provider was not professionally current about assessing and prescribing treatment for patients with suicidal behaviors. For example, an allegation of *failure to diagnose suicidality* could result because a plaintiff believes the psychiatrist was negligent for not knowing the suicide risk associated with specific psychiatric disorders. Or, an allegation of *negligent psychopharmacologic management* could be related to the belief that a provider was not up-to-date regarding the effectiveness of certain medications on decreasing potential suicide risk.

Risk Management Strategies:

- Stay current with the field. It is imperative that providers maintain competency with regard to the medications and other forms of psychiatric treatment they are providing.

- Do not hesitate to consult with or refer to colleagues when appropriate.

Standard of Care Factor Five: Document adequately to support that appropriate care was provided in terms of the assessment, treatment, and ongoing monitoring of the patient

Documentation problems that have been noted in malpractice cases run the gamut from no chart notes to poor or incomplete chart notes to wildly inconsistent and self-serving entries made after an adverse event.

Related Allegations:

- Failure to maintain hospital records showing dual diagnoses, full diagnostic evaluation, and adequate clinical notes
- Failure to record a full mental status examination
- Failure to document adequate suicide assessment

Risk Management Strategies:

- The written treatment record stands as a testament of treatment provided and the reasoning behind it. The record comprises a significant and substantial part of the defense against any claim of malpractice against the provider. Highly defensible cases where the provider delivered seemingly flawless treatment have been lost or settled because of poor documentation by the provider. Documenting the decision-making processes underlying treatment decisions is key to building a supportive record (i.e., what actions were taken and why, as well as what actions were rejected and why). The major aspects of patient care should be documented.

- Information to include in the patient record:
    - initial and ongoing assessments of suicide risk;
    - treatment recommendations/plan and modifications;
    - the informed consent process;
    - medication information (medication name, dosage and size of prescription, refills, **effectiveness of medication, any side effects reported or medication** allergies/sensitivities, changes of medication or dosage and the basis for such modifications, etc.);
    - patient history and examination;
    - laboratory test results and patient monitoring, reports from psychological testing, physical examinations, laboratory data, etc.;
    - instructions to patient and family;
    - consultations;
    - dates (and length) of service;
    - initial assessment, diagnosis, and subsequent re-assessments of the patient's needs;

- any signed informed consents for treatment and authorizations for release of information, including releases to third-party payors;
- names, addresses, and telephone numbers of the patient and designated others, if the patient has granted appropriate authorization to communicate with others;
- consultations with other health care providers;
- what treatment options/actions were considered, what options/actions were chosen and why, and what options/actions were rejected and why;
- documentation of the termination process;
- a discharge summary (if relevant), including patient's status relative to goal achievement, prognosis, and future treatment considerations; and
- copies of relevant correspondence concerning the patient.

- Never alter a treatment record. The strength of the treatment record as evidence in a malpractice case is based on the idea that a contemporaneous record of actions and observations can reasonably be relied upon to be true and unbiased. Altering the record undermines this assumption and can result in an otherwise defensible case being rendered totally indefensible. Correcting mistakes does not constitute "altering" a record; always use accepted methods when correcting mistakes or omissions.

- Some state legislatures and/or licensing boards require certain minimum information to be made part of the treatment record. Providers should be familiar with the requirements in their states.

- As stated by an attorney on the Program's defense panel, "Generally, a jury will ultimately decide whether the provider departed from the standard of care. That determination will be made after the jury is presented with the testimony of the provider; the experts for the provider and the patient; and other relevant witnesses. A chart that carefully documents the provider's reasoning process and suicide assessments is a powerful defense tool in that it (1) allows the provider and his expert to testify as to specifics; (2) makes the provider's testimony more believable; and (3) places the provider's attorney in a better position to convince the jury that the patient's expert is engaging in second-hand guessing after the fact."

In Conclusion

There are important lessons to be learned by reviewing malpractice claims and understanding the types of allegations that are frequently asserted. Risk management strategies emerge from the information about past lawsuits that can effectively reduce the risk of professional liability and put providers into a better position to defend a lawsuit, should it occur.

[1] *Durney v. Terk,* 42 AD3d 335 (2007)
[2] The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry, 2013 eEdition states in Annotation 8 under Section 4: "When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient."
[3] Under the Federal Health Insurance and Portability and Accountability Act of 1996 (HIPAA), covered providers have regulatory permission to discuss patients' protected health information for treatment purposes. Some states, however, may have more stringent requirements to obtain permission from patients before releasing protected health information for this purpose. From a risk management perspective, it is recommended that psychiatrists obtain consent to talk to other treaters whenever possible and clinically reasonable. This is also consistent with the APA's holding in the *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* that the patient's consent should be obtained before disclosing protected health information.

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