Bullet Proofing your Documentation: Forensic Issues in Suicide Assessments

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Learning Objectives

- Review elements of Malpractice as they relate to suicide management
- Identify community and legal expectations of psychiatry in suicide prevention
- Address issues of "foreseeability" and Suicide prediction and prevention
- Use of clinical tools for suicide detection and statistical limitations of prediction
- Identify weakness of current documentation practices and "best practice" strategies for Bulletproofing documentation to minimize accusations of medical malpractice in psychiatric care of suicidal patients

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Case Examples

- 28 year old man with diagnosis of Bipolar Mood Disorder reported to his outpatient psychiatrist suicidal ideation subsequently shot himself 20 days after medication management appointment.
- 43 year old man presented to ED at local Hospital with c/o depression and suicidal ideation. Seen by psychiatric consultant and discharged. One day later man killed his sister's family and himself in sister's home.
- 35 year old woman with diagnosis of Borderline personality disorder fatally overdosed 2 weeks after the latest of several hospitalizations for suicidal ideation.
- 55 year old man hung himself on inpatient psychiatric unit 30 minutes after completed diagnostic interview with psychiatrist.

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Keeping Perspective

- Psychiatry is not rocket science—it's a lot harder!
- No two patients are alike.
- No two clinicians are alike.
- From a forensic perspective each case is unique and must be judged solely on the facts as they were known at the time of the incident.
- Monday morning quarterbacking can be an issue in forensic evaluations.

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Suicide

- Over course of their careers most psychiatrists will experience a patient suicide.
- Managing suicidal patients' risk is one of the most stressful endeavors a psychiatrist can face. Grief and guilt felt by the psychiatrist may be profound.
- Post-suicide lawsuits account for the largest percentage of suits against psychiatrists.

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Suicide

- Suicide constitutes one arena in which tort claims will be brought by parties attempting to focus civil responsibility on someone other than the beloved decedent.
- Attorneys and suicide prevention organizations also promote an expectation that if an at risk individual is assessed by a psychiatrist suicide will be averted.
- Attorneys specializing in in tort actions against psychiatrists emphasize "foreseeability" and negligent diagnosis.
- Tension between failure to detain vs. false imprisonment in suicide.

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The Law Office of Skip Simpson

- **SUICIDE OR WRONGFUL DEATH DUE TO NEGLIGENCE OR MALPRACTICE**
- **GET THE HELP YOU NEED**
- **CLICK HERE FOR MORE INFORMATION**
- Nationally recognized expert in inpatient suicide law
- CLICK HERE TO CALL US TOLL-FREE
- **214-618-8222**
- **Suicide Malpractice Lawsuit**
- **How to bring a lawsuit as a result of suicide**
- It may be necessary to pursue a malpractice lawsuit if the healthcare provider was negligent and a suicide occurred. While a family may be reluctant to pursue a suicide malpractice lawsuit, taking legal action may be the best way to hold a negligent provider accountable. Your actions may also help to save the lives of others experiencing the same suffering.
- A psychiatrist or a psychologist may be negligent for failing to properly assess the patient's suicide risk. The following are factors that may be precursor to a malpractice lawsuit:
- Failure to learn about and document prior suicide attempts or feelings of hopelessness and anxiety.
- Failing to take into account input from the patient's family.
- Failing to take into account the patient's behavior prior to discharge from the hospital.
- Failing to properly assess a patient for suicide.
- Failing to protect a patient from suicide.
- **Healthcare provider's duty to protect the patient**
- Suicide is difficult to predict, but prediction is never the issue. Foreseeability is the issue. Psychiatrists have a duty to protect a patient by properly assessing the suicide risk. Reasonable precautions, such as appropriate frequent monitoring of the patient, need to be taken after the risk is identified.
- A doctor should document signs of improvement before discharging the patient. Too often, patients are discharged simply because their insurance no longer pays for their care.

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Standard of Care

- The standard of care in medicine is traditionally defined as “that degree of skill and learning that is ordinarily possessed and exercised by members of that profession in good standing”
- This standard is also know as the ”average practitioner” or “customary practice” standard and generally applied nationally.
- Physicians range in skill levels, though most over-rate their skills
  - A, B, C, D, F practitioners
- For malpractice to be established 4 Elements need to be proven

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Elements of Malpractice

- Psychiatrist has **duty** of care;
- Psychiatrist **deviated** from standard of care;
- Which led to **damage** to the patient;
- as a **direct** result of the deviation from standard care.
- For a plaintiff to prevail in a malpractice case all elements must be proved by a “preponderance of the evidence”- “more likely than not” – or 51% or greater probability.
- Psychiatry malpractice often hinge on (1) “Foreseeability” or
- (2) precautions taken to prevent the suicide once the risk was acknowledged.
- Two basic types of error:
- 1. Errors of fact
- 2. Errors of judgement

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Two Basic Types of Errors

- An **Error of Fact** is considered to be a "mistake about a fact that is material to a transaction"—for example an error of fact occurs when the psychiatrist bases a clinical judgement on erroneous beliefs, such as might occur if a patient's past history wasn't reviewed or lab results not checked before making a substantial clinical decision.
- **Psychiatrists are likely to be found negligent for errors of fact.**
- An **Error of Judgement** occurs when the psychiatrist makes an informed decision in good faith that turns out to have been a mistake
- **Psychiatrists are less likely to be held liable for mere error in professional judgement.**

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Clinical and mathematical limitations on Foreseeability

- Clinical vs. Actuarial assessments/regression modeling.
- False positive and false negative risks.
- Overstating clinical ability to foresee and potential consequences.
- Statistics regarding # of individuals never seen by psychiatry who commit suicide

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If we know all the risk factors can suicide be predicted?

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Methods of Risk Prediction

Clinical or "Educated Guess"

Actuarial or "Scientific"

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Methods of Risk Assessment

Linear Regression Model

$$y = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \ldots + \beta_n x_n$$

Risk= Base rate + impact of numerous variables of the individual to produce the individual's personal risk

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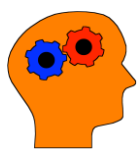
Prediction of Future Behavior



Clinical: Decision maker mentally processes information to make prediction.

- Clinicians generally have no idea of their accuracy rates.
- Clinicians generally overrate their skill.
- Most crisis, ER and courtroom decision making is clinical.

Best estimates of Clinical accuracy is 33%

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Prediction of Future Behavior

Actuarial: Statistical method which eliminates human judgment and bases conclusions solely on empirically established relationships between data and condition of interest.

Actuarial predictions always out-perform clinical predictions.

Actuarial models have to date have not exceeded 75%-85% accuracy

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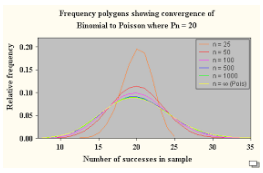
Clinical and mathematical limitations on Foreseeability



- Given the low incidence of suicide per 100,000 it is a rare event mathematically that makes it a stochastic variable that follows a Poisson or Binary probability distribution.
- That's fancy math talk for: It will be difficult to predict on an individual basis the risk of a specific act of suicide at a designated time-like trying to identify which specific electron of a radioactive element will undergo decay

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Prediction methods

How well do these methods perform?

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Prediction Contingency Table

PREDICTION	ACTUAL OUTCOME: suicide	ACTUAL OUTCOME: No suicide
suicide	True Positive	False Positive
No suicide	False Negative	True Negative

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Actuarial Judgment Contingency Table

Assumptions
Accuracy=95%
Base Rate=11/100K
N=300K (SCCBI Population)

PREDICTION	ACTUAL OUTCOME: suicide	ACTUAL OUTCOME: No suicide	
suicide	TP **31**	FP **14998**	
No suicide	FN **2**	TN **284969**	
Totals	**33**	**299967**	**300000**

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Suicide Prediction Tools

Despite extensive research and analysis of risk factors, no reliable tool has been developed to predict suicide that can be used clinically from a forensic perspective. It still comes down to evidence of careful consideration of factors and analysis by the practitioner determining the response to the risk.

Evidence boils down to clear documentation.

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Documenting Suicide Risk Assessments

- No national standard of care regarding suicide assessment protocol.
- Use of actuarial tools such as Columbia Protocol (**C-SSRS**)
- Deterioration of psychiatric documentation with advent of EMS.
- Importance of good record keeping:
- May stop a lawsuit early.
- Notes should be written in style ready to be exhibited in a court (and likely will if suit proceeds to trial).
- If charting is clear the case may be terminated once the plaintiff expert reviews the notes.
- Strive to document important clinical matters contemporaneously.
- When Psychiatrists do not document their reasoning there will be no evidence to show that they were thoughtful, prudent and used "reasonable" professional judgement.

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Documenting Suicide Risk Assessments- Critical Decision Points

- At initial assessment or admission
- With occurrence of any suicidal behavior or ideation
- Whenever there is a noteworthy clinical change
- Before increasing privileges, granting passes or discharging an inpatient
- Document all issues regarding firearms

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Documenting Suicide Risk Assessments- Critical Decision Points

- **Always, in noting an action taken in furtherance of risk management (i.e., committing or not, increase freq. of visits, change in medicine) include a statement of the rationale for the action.**
- **Always document communication with families and any directions given to patient, family or caregivers**-
- --unrecorded instructions or conversations with family members will likely become points of contention after a suit is filed.

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Conclusion

- All the best documentation and use of best practices—i.e. use of screening tools—may not prevent an accusation of malpractice but may prevent a successful suit against a practitioner

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"Errors in judgment must occur in the practice of an art which consists largely of balancing probabilities."

Sir William Osler
Aequanimitas: 1889

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