Bullet Proofing your Documentation: Forensic Issues in Suicide Assessments

Michael Farnsworth MD, DFAPA
Farnsworth Forensic Psychiatry, PA
Medical Director, Blue Earth County Mental Health

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

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.
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.

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.

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.
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 lawsuit if the healthcare provider was negligent and a suicide occurred. While the 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 precipitate an institute's civil liability:
- Failure to base a diagnosis on a thorough assessment of the patient’s risk.
- 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

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.

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 known 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

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” or 51% 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
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 judgment 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.

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

If we know all the risk factors can suicide be predicted?
Methods of Risk Prediction

Clinical or “Educated Guess”

Actuarial or “Scientific”

Methods of Risk Assessment

Linear Regression Model

\[ y = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \ldots + \beta_k x_k \]

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

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%
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 outperform clinical predictions.

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

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.

Prediction methods

How well do these methods perform?
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.
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.

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

- 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.
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.

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

Sir William Osler
Acquaintance: 1889

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