



Law and Psychiatry

Avoiding the Malpractice Snare: Documenting Suicide Risk Assessment

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This month's column was written by two highly ethical plaintiffs' attorneys. No, that's not an oxymoron. Most experienced psychiatrists understand that not all our colleagues do a good job all the time, and that even when they do, tragedies can occur. When our negligence causes damage to patients, those patients and their families deserve to have their complaints heard and their problems addressed. That's one role of plaintiffs' lawyers.

When our work is misunderstood in the process of malpractice litigation, such as through poor documentation, things get complicated at best. At worst, this can lead to a second tragedy—an erroneous verdict or unduly high settlement against the caregiver(s). Stacy and Simpson spend considerable time trying to improve mental health care and the communication that is so important to it, by teaching psychiatry residents about documentation and by writing articles such as this. This column should dispel forever the old myth, still taught in some training seminars, that detailed documentation should be avoided because "lawyers can hang you with it."

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While psychiatrists are less likely to be sued than other physicians, we are witnessing a surge in the number of malpractice suits filed against psychiatrists and other mental health care professionals. Causes of action for misdiagnosis, negligent treatment, sexual exploitation, and the implanting of false memories are all examples of potential suits. Suicide, however, is the most common cause of action against mental health care professionals.

Documentation is a cornerstone of the defense of a potential suicide case. Please do not misconstrue this statement. It goes without saying that there is no substitute for good care. However, good care combined with good documentation is the surest way to avoid being a

defendant in a malpractice action. From the perspective of attorneys who review suicide-related matters for prospective plaintiffs on a weekly basis, the quality of documentation can determine whether a malpractice attorney accepts or declines a suicide case.

More often than not, the core of a suicide case is whether the mental health care professional properly assessed the patient's suicide risk and whether the suicide was "foreseeable."* A proper assessment generally reveals the severity of a patient's risk for suicide, which leads to critical treatment plan determinations. Decisions such as whether to hospitalize, whether to use ECT, or whether a patient can be treated on an out-patient basis (and the procedures associated with each) all depend on the foreseeable risk of suicide. Naturally, the lawyer, and jury if a lawsuit is filed, will seek to determine just how thorough the clinician was in assessing the patient's risk for suicide. Although most lawyers don't understand all the clinical subtleties, a smart lawyer reads the literature and retains good experts to educate him or her on the subject.

When a lawyer initially reviews a potential case, all he or she typically has are the medical records. Accordingly, nothing will stop a malpractice lawyer dead in his or her tracks quicker than a well-documented chart reflecting careful and thoughtful suicide assessments. A well-documented case reflecting good care means a plaintiff's lawyer is likely to lose the case. Losing a malpractice case means the lawyer will lose hundreds, possibly thousands of hours of attorney time preparing the case (for no fee), along with approximately \$40,000–\$100,000 in expenses the lawyer has advanced for the cost of the lawsuit. Lawyers expect no sympathy from physicians, but like other people investing their own money, we want good investments, not chancy ones.

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*Foreseeability is a legal term of art generally defined as the reasonable anticipation that some harm or injury is likely to result from certain acts or omissions. Foreseeing a result is not the same as predicting that an event will occur. Foreseeability is a matter of probabilities. Prediction, on the other hand, adds an element of certainty that is inherently absent from the legal concept of causation.



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In reviewing the case for potential negligence, the lawyer can determine whether or not there is a defense that is based upon physician competence. The lawyer knows the clinical record will be the doctor's most persuasive evidence to prove competence and care. He or she also knows the importance juries attach to the written record. We spend hours combing through the medical charts of potential cases and pay close attention to details such as the dates of discharge summaries and progress notes. When done properly, the suicide risk assessment is recorded in the chart contemporaneously (that is, recorded when it is done, not as an afterthought). A timely dictated note is more reliable and credible to a jury than a later one, since it is recorded before the doctor can be alleged to have motive to enhance, or even fabricate, a suicide assessment. Conversely, post-suicide entries in a medical chart are looked upon with great suspicion by both lawyers and jurors.

Imagine for a moment a psychiatrist who fails to properly document a suicide assessment. Inevitably, the doctor tells the jury, "I did assess the patient for suicide, but I just failed to document it." This is not an ideal situation for a physician who really has done a good evaluation. Such a scenario usually turns into a swearing match (literally) between the lawyers for the plaintiff and defendant. In a legal sense, "if it isn't written down, it didn't happen." More importantly, fair or not, juries almost always take this position when it comes to suicide assessments. The reason is clear: there is always information that a physician felt compelled to enter into the chart that is far less critical than a dialogue regarding suicide. Since suicide is one of the worst possible outcomes for a psychiatric patient, most juries conclude that if a psychiatrist actually conducted a suicide assessment, he or she surely would have documented it.

Lawyers look to the medical literature for direction on the standard of care. This holds true for the requirements of documentation as well. Experts for over 20 years have underscored the importance of properly documenting the chart. They consistently conclude that all suicide assessments need to be recorded in the patient's chart at the time of evaluation.

Defendant physicians and their attorneys often argue that it's impossible and/or too time-consuming to document everything. While there is some truth to that position, one thing is clear: vital information must be documented, and it is difficult to come up with something more vital for a psychiatric patient than suicide risk. Documenting properly will take some extra time,

but this intelligent use of time can pay huge dividends. In the big picture, taking an extra 5 minutes to properly document a suicide assessment can save years of stress and hundreds of hours dedicated to defending a lawsuit. Shawn Shea, a nationally recognized expert on suicide assessments, has found that

careful documentation of suicide assessment issues over the course of a busy day as an outpatient psychiatrist in a busy community mental health center used to cost me about 20 minutes a day, unless there were some unusually complex assessments (p. 256).¹

Is Good Documentation Merely Defensive?

Lawyers have heard more than once from physicians that they must waste precious time creating a document for no other purpose than to avoid litigation. Do not lose sight of the fact that there is a higher purpose for documenting than simply keeping the lawyers away. Smart charting will not only keep lawyers away, it helps prevent suicide. Accurate and complete medical records can help subsequent clinicians make better decisions. The process of creating a sound document can also push a mental health professional to review the quality and comprehensiveness of his or her own database, as well as lead him or her to reformulate the clinical assessment based on that database. Once a clinician has developed the habit of addressing key elements of suicide assessment in each and every suicide assessment note written, the act of documentation itself becomes a built-in checklist for good care.

When should the chart reflect a suicide assessment? The answer should be no surprise: every time an assessment is made. Lawyers review medical charts to determine whether or not assessments were made at critical times such as the initial visit, in the emergency room, in outpatient psychotherapy when treating a potentially suicidal patient, during medication checks with a patient who may be having suicidal thoughts, before a pass or discharge from an inpatient unit or rehabilitation center, and when the level of observation of a hospitalized patient is being changed. For instance, we know that, for a psychiatric patient, the time immediately following discharge from hospitalization is a high risk period (especially when a suicide attempt precipitated the admission). Even so, we often find that a comprehensive assessment was not performed just prior to discharge.

The next question is what needs to be documented? The short answer is that the medical record must

reflect a *proper* suicide assessment. In most cases, simply asking a few rote questions such as “Are you suicidal,” “Do you have a plan,” and/or “Do you have the means” is grossly inadequate for defending against allegations of negligence. Likewise, documentation which implies that these rote questions were the extent of the assessment (or the clinician’s considerations) is tantamount to admitting that poor care was provided.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) speaks directly to documenting information about the potentially suicidal patient:

Documentation of the assessment and care of the potentially suicidal individual presents considerable challenges for clinicians... Both positive and negative assessment findings should be carefully documented, as should immediate plans for intervention and rationale for not choosing alternative interventions. (p. 8)²

Collaboratively, other experts have said, in part,

It is the duty and responsibility of the clinician to make reasonable and prudent efforts to obtain as much data as possible. Failure to attempt to obtain some data (current level of lethality, access to means, response to prior therapeutic interventions) is below the standard of care. (p. 88)³

Shea has written an excellent book which details the general principles of writing a sound assessment document.¹ Common sense dictates that the ideal situation for a physician is to do such a good job documenting a suicide assessment that the record, *on its face*, proves that the physician met the standard of care. We can tell you that every good plaintiff’s lawyer will ask the defendant physician or therapist about the patient’s risk factors and which specific questions were asked regarding suicidal thoughts, intentions, and plan(s). A chart reflecting an understanding and appreciation for the patient’s particular risk factors and reflecting that the physician or therapist elicited critical information regarding specific suicidal thoughts and methods, and the extent of planning and action taken with regard to these methods, will go a long way toward dissuading a good plaintiff’s lawyer from taking the case.

We also search the record for pertinent *negative* findings concerning the patient’s suicidal ideation, planning, and intent. Notes indicating that the clinician ruled out certain risk factors support the conclusion that the clinician performed a proper assessment. Essentially, the plaintiff’s lawyer is trying to determine whether the clinician uncovered both positive and negative findings

using a systematic approach, such as the Chronological Assessment of Suicide Events (CASE), a four-step strategy of sensitively probing for suicidal ideation, or a similar method (for a description see Shea 1998, Chapter 8⁴). For instance, when you ask about risk factors and the patient denies them, write down the response. If you don’t, there is no evidence you even knew to ask, and you end up resorting to the “swearing match” mentioned above. Patient comments such as, “I would never kill myself” or good reasons that the patient is unlikely to kill himself should be set off in quotes and described in detail. The patient’s own words can be persuasive to jurors considering whether your judgments were solid or were made without careful reasoning.

In addition to the obvious need to assess and document current suicidal ideation, intent, or plan, we believe failure to obtain a proper history of the patient’s present illness leads to many lawsuits. *A suicide assessment that focuses solely on the here and now is very likely to fall below the standard of care.* Consider a patient who attempted suicide by overdose 2 weeks prior to evaluation. He was later found to have continued to plan suicide during the 10 days prior to evaluation, but he denied active suicidal ideation, intent, or plan during the assessment. We look to see if the clinician described all suicidal ideation and events that occurred during the current episode of the illness, including suicide-related events that may have unfolded in the previous several months (p. 275).¹

The Record As Communication to Others

When documenting a suicide assessment, remember that you are not the only person who may visit or revisit the chart entry in the future. If the entry is made in a hospital or a rehabilitation unit, the “team” will be reading your comments. If the assessment is written in outpatient records, subsequent treaters may be calling on you or your records for important observations recorded while the patient was under your care.

Patients always come to us with a history, often with a history of prior evaluations and treatment... Few mental health practitioners would underestimate the value of taking an adequate history of the patient. Yet it is surprising how lax therapists may appear... if they fail to consider the observations and judgments other professionals have made in the past contacts with their patients... Here, it is not uncommon to find that there may be an over reliance on patient or family self-report and no evident imperative to secure records from past care givers. (pp. 20–21)⁵



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Subsequent treaters may be rushed or inexperienced. Your good charting alerts the hurried clinician to important information and risk factors, such as past suicidal behavior, that need careful attention. Subsequent treaters can also (and often should) use your observations as a check on the reliability of the patient's current statements about suicide and other important topics (see below).

Patient Reliability and Veracity

Patients are not always reliable sources of information, especially about their suicidal wishes and impulses. When a suicide has occurred, one of the things our experts look for is evidence that the caregivers relied solely on the patient for information about suicide risk. We commonly read in the record, or hear in later testimony, that caregivers were satisfied by the patient's reassurances alone, or that they failed to try to obtain information from other sources. This is music to our ears.

Clinical decision makers know, or should know,[†] the many reasons patients often provide inaccurate information in assessments. Cognitive deficits or psychosis may make them incapable of giving a complete history. They may want to avoid hospitalization or restriction. If already hospitalized, they may want to be discharged or given a pass. They may try to be honest with the examiner but be unable to assess their own future impulses. They may simply want to mislead the clinician into believing they aren't suicidal so they will be free to kill themselves without interference. By the same token, so-called no-self-harm "contracts" are woefully unreliable and we know it. You should know it, too. We understand, as should you, that *it is not sufficient to rely solely on the patient's statements or promises not to kill him- or herself.*

There are virtually always other sources of information that one can at least try to consult, such as old records, previous treaters, or family members. Comments after the fact that one didn't call relatives or prior caregivers for information because of "confidentiality" ring hollow to a jury when it is obvious that the patient was in danger. We know that talking with prior caregivers doesn't generally require a release, and, in cases requiring a release, it is generally very easy to

obtain. Documenting that you tried (diligently, not just superficially) to contact collateral sources and/or attempted to get permission to talk with the patient's family will help. If little such information is available, the clinician should document that fact as well, and carefully describe his or her consideration of what to do next.

Just as patients are often unreliable about the suicide-related information they provide, they are often unreliable (or even incompetent) in their choices of whether or not to be hospitalized. When defendants tell us that they "offered" hospitalization to a patient who needed it but refused and later committed suicide, our next questions have to do with three things: how that "offer" was made, whether or not the patient was in a position to refuse competently, and whether or not the patient should have been detained involuntarily. If the patient refused hospitalization, the defendant's case is bolstered considerably if there is 1) clear documentation that the doctor or other clinician recommended hospitalization carefully, in a way designed to convince the patient; 2) detailed chart evidence that the clinician enlisted the support of family in convincing the patient to come into the hospital; and 3) a good description of how the doctor seriously considered and/or attempted involuntary hospitalization.

Documenting Clinical Thought Process

In a malpractice case, the plaintiff's attorney and expert(s) look for evidence that the clinician acted negligently. The point is not that the doctor or other evaluator should have done exactly what some expert might have done, but rather whether or not the clinician's actions were similar to what reasonable clinicians would do under the same or similar circumstances (that's part of the definition of "standard of care" in most jurisdictions). If one documents a reasonable and fairly complete thought process and clinical considerations—in addition to the final decision—it is difficult for a plaintiff's expert to criticize that final decision.

It is generally more important to document the details of decisions that increase risk than those that *decrease* it. For example, when one can get a patient into a safe environment such as a hospital (or one decides not to discharge a patient who is already there), a shorter assessment and documentation may be sufficient (since the patient is in a relatively safe setting, where further evaluation and treatment can reasonably be expected). On the other hand, if the decision is to allow the patient to remain (or go) to a relatively

[†]"Know or should know" is a phrase every lawyer uses and every clinician should remember. Your duty under the standard of care includes knowing everything you should know about your patient, not just what you *do* know.

unsupervised, unmonitored setting, such as home or a halfway house, more comprehensive consideration is generally required, with concomitant documentation of how the risks are being assessed and managed.

Consultation and Second Opinions

As already mentioned, the standard of care is largely defined by what reasonable psychiatrists would do under similar circumstances. That means that documenting discussions and consultations with other qualified professionals can be a substantial part of defending one's actions if a tragedy occurs. Notes about team meetings, and about the psychiatrist's actions after talking with the treatment team, are important indicators that the doctor is seeking and considering information from others involved in the patient's care. Consultation with another psychiatrist about whether or not to discharge a potentially suicidal patient (or whether or not to let him or her leave an outpatient assessment without being hospitalized) is a very good idea, documenting both good care and the original clinician's wish to do the right thing. Consultation should be legitimate, of course, and not merely a brief conversation with someone who will automatically agree and "clear" the patient.

The Last Word

Assuming good care, proper documentation of suicide assessments is a clinician's best defense against a potential lawsuit arising from a patient's suicide. Most importantly, proper documentation serves the higher purpose of promoting quality care.

References

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