Current PSYCHIATRY

MALPRACTICE VERDICTS

Liability when patients die after treatment

How to manage requests for pain medication and post-discharge suicide risks

Jon E. Grant, JD, MD, MPH
Assistant professor of psychiatry and human behavior
Brown Medical School, Providence, RI

Can a psychiatrist legally and safely prescribe medication to reduce pain and, if so, when? How can a psychiatrist avoid a negligence charge if the patient commits suicide after discharge?

This article offers answers to those questions.

Methadone prescription for pain blamed for overdose death

Richmond (VA) Circuit Court

The patient had been receiving psychiatric treatment for approximately 1 year and also sought care for chronic pain during that time. The psychiatrist prescribed a pain medication and advised the patient to find a physician specializing in pain management, which the patient did.

Later, the patient and her husband told the psychiatrist during an emergency visit that no other physician was willing to treat her pain and requested pain medication. The psychiatrist viewed this request as possible drug-seeking behavior but considered the incident a crisis. She gave the patient a 2-week prescription of methadone for both pain and withdrawal.

Five days later, the patient's husband found her dead; her autopsy showed a high level of methadone and two other medications.

The plaintiff's estate claimed that the psychiatrist was negligent and that the patient died from methadone intoxication. The defense argued that the prescription was appropriate, and that amitriptyline, which the patient also had been taking, caused the sudden cardiac arrest that led to her death.

• **The jury found for the defense.**

Dr. Grant's observations

A physician can prescribe any medication for a legitimate purpose. When prescribing outside your psychiatric expertise—such as medication for this patient's chronic pain—the following recommendations can help you prevent a negligence claim:

• **Document your physical examination.** Assess the physical and psychological aspects of a pain condition before treating it. Then document the condition and the rationale behind your treatment choice based on the medical assessment.

If you are uncomfortable examining and diagnosing a medical condition, avoid prescrib-

Cases were selected by CURRENT PSYCHIATRY's editors from *Medical Malpractice Verdicts, Settlements & Experts,* with permission of its editor, Lewis Laska of Nashville, TN (www.verdictslaska.com). Information may be incomplete in some instances, but these cases represent clinical situations that typically result in litigation.

continued

ing pain medication. Instead, refer the patient to a physician specializing in pain management.

• If prescribing pain medication, document the type, location, and severity of pain. Also document your discussion of pain management options with the patient, and ask about previous pain-reduction interventions.

• Assess type, quantity, and frequency of prescription drug use as well as illicit drug and alcohol use. Order urine and serum toxicology tests if you suspect or need to document substance abuse.

As in this case, refer patients with chronic pain to their primary care physicians or to another specialist for appropriate pain management. Pain reduction may require psychological and behavioral interventions (such as cognitive–behavioral therapy, relaxation therapy, hypnosis, biofeedback, stress management, educating patients and their families about pain management) as well as physical therapy, anesthetic treatments, or surgical evaluation.[1]

• Assessing pain in the ER. A different level of chronic pain assessment may be necessary in the emergency room, and the law recognizes that resources—such as information from other providers—are limited in the ER.[2] In this case, the patient reported that no one was willing to treat her, and the psychiatrist feared she was seeking a prescription for illicit use. In such cases, consider contacting the patient's previous pain specialist or hospitalizing the patient if you fear he or she will go into withdrawal.

Plaintiff: Premature discharge caused alcohol-related suicide by drowning

Lucas County (OH) Common Pleas Court

The patient, age 41, had a longstanding, treatment-refractory alcohol use disorder.

He was admitted to the hospital after he was dismissed from a halfway house; upon admission, his blood alcohol level was 0.41%.

When assessed by a psychiatrist several days later, the patient showed suicidal behavior. The psychiatrist evaluated him three additional times. After the final visit, the patient renounced suicide, and the psychiatrist decided that he had improved. The patient's discharge was planned—with aftercare housing and outpatient program particiption arranged—and he left the hospital in a taxi.

Three days later, the patient was found dead in a creek. An autopsy showed that the patient died by drowning and that his blood alcohol level was 0.32%. The death was ruled a suicide secondary to excessive alcohol consumption.

Managed care rules that shorten hospital stays increase risk of premature discharge claims.

The plaintiff—the patient's estate—charged that the psychiatrist was negligent in discharging the patient from the hospital and claimed that lack of a post-discharge recovery plan made the suicide likely.

The defense argued that the patient's history of suicide attempts was known and that a discharge plan—which included housing and participation in an outpatient program—was in place before he was discharged.

• The jury found for the defense.

Dr. Grant's observations

Many factors associated with managed care—such as cost-containment policies that shorten hospital stays, shorter visits that limit opportunity to develop a therapeutic alliance with patients, and limited ability to communicate with patients—have increased the risk of malpractice suits alleging premature discharge of patients who later kill themselves.[3]

To avoid such a suit:[4]

• Document the patient's risk factors for suicide as well as specific suicidal thoughts and methods

expressed, extent of planning and action taken toward a suicide attempt, access to means, and response to prior therapeutic interventions.

• **Explain in your notes why specific risk factors were ruled out.** This supports the conclusion that you properly assessed the patient.

• **Obtain a proper history** of the patient's current illness. Understanding how a patient's substance use is affecting his mood may influence plans for care after discharge.

• **Do not rely solely** on a patient's statements about suicidality. Document information from other sources (old records, previous providers, or family members) and note that you tried to contact collateral sources or get permission to talk with the patient's family

• **Arrange** outpatient services that focus on substance addiction (for example, support groups such as Alcoholics Anonymous [*see page 56*], and therapy with an addictions specialist). Schedule timely visits for therapy and medication management. A medical follow-up may be needed if health concerns are associated with a mental health issue. A patient may need to be placed in a sober house or residential facility if he cannot stay sober on his own.

References

1. Bronheim HE, Fulop G, Kunkel EJ, et al. The Academy of Psychosomatic Medicine practice guidelines for psychiatric consultation in the general medical setting. *Psychosomatics* 1998;39:S8-S30.
2. Gutheil TG, Appelbaum PS. *Clinical Handbook of Psychiatry and the Law (3rd ed)*. Philadelphia: Lippincott Williams & Wilkins, 2000.
3. Simon RI. Psychiatrists' duties in discharging sicker and potentially violent inpatients in the managed care era. *Psychiatr Serv* 1998;49:62-7.
4. Simpson S, Stacy M. Avoiding the malpractice snare: documenting suicide risk assessment. *J Psychiatr Pract* 2004;10:185-9.