Current PSYCHIATRY

MALPRACTICE VERDICTS

Involuntary admission

The challenge of weighing patient rights vs. appropriate care

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Widower denies suicidal thoughts in hospital, but acts on them at home

DuPage County (IL) Circuit Court

A 77-year-old man was hospitalized after complaining of chest pain. He reported attempting suicide the night before by taking pills. His wife had died 5 months previously.

When the psychiatrist evaluated the patient the next day, the patient assured him that he was no longer suicidal, refused inpatient admission, but agreed to enter outpatient therapy. The patient repeated this intent to the hospital social worker.

The psychiatrist arranged visits by a home health care nurse. The patient was discharged after a 2-day stay, and the nurse visited the following day. The patient assured the nurse that he was not suicidal and called the psychiatrist to make an appointment for the next week. Two days later, the patient stabbed himself to death at home.

The estate claimed the psychiatrist should have kept the patient hospitalized. The psychiatrist claimed that involuntary admission was not possible because the patient was not dangerous to himself or others. The patient's toxicology screen was negative except for his prescription drugs.

- **The jury decided for the defense**

Alcoholic promises to attend AA, but takes his life on Christmas Day

Davidson County (TN) Circuit Court

A 44-year-old man with a long history of alcohol abuse and failed rehabilitation was involuntarily admitted to a hospital after threatening suicide. His blood alcohol level was 0.393, and he had threatened suicide at the same facility 8 months before. A court order gave the hospital authority to involuntarily detain him until a hearing the following week.

The next day, the patient was transferred from the detoxification center to the psychiatric unit and evaluated by the psychiatrist. The patient disavowed suicidal thoughts, and the psychiatrist discharged the patient the following day (Christmas Eve, 48 hours after admission). The psychiatrist based this decision partially on the patient's promise to enter inpatient alcohol treatment and attend an Alcoholics Anonymous meeting within 2 days.

Cases are 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

On Christmas Day, the patient shot himself and died. His blood alcohol content at the time of death was 0.303.

The patient's estate charged that the final discharge was negligent, the discharge instructions were inadequate, and the psychiatrist and hospital's assessments were inaccurate.

The hospital argued that it deferred to the psychiatrist in the discharge decision. The psychiatrist argued that state law defined holding an individual without "immediate risk of substantial harm" as a felony.

- **The jury decided in favor of the defendant psychiatrist. A directed verdict was granted for the hospital.**

Plaintiff: Discharge led to hemiplegia

Broward County (FL) Circuit Court

Police took into custody a 27-year-old woman who had been wandering a public road, apparently under the influence of illegal substances. The officers transported her to a hospital, where the emergency room staff admitted her for psychiatric evaluation.

The psychiatrist determined that involuntary admission was not appropriate. When the patient refused the psychiatrist's recommendation for voluntary admission, she was discharged.

The patient then went to her mother's house, began drinking, and became combative. She started brandishing a rifle. The next day, the weapon discharged and a bullet lodged in her spine at the L2 vertebra. The patient is now hemiplegic and has no bladder or bowel control. She alleged that the hospital and psychiatrist were negligent in not admitting her.

- **The hospital reached a $50,000 settlement before trial; the jury returned a $190,007 award, with 90% of fault apportioned to the plaintiff and 10% to the psychiatrist. After setoffs, the plaintiff's net award was $80.**

Dr. Grant's observations

These cases illustrate suicide risk factors psychiatrists must consider even when a patient denies suicidal thoughts or intent. Suicide risk factors these patients showed include:

- recent discharge from psychiatric facilities[1]
- recent suicide attempt with fairly high lethality potential (overdosing on pills)
- depressive turmoil and psychological isolation (recent loss of spouse)
- older widowed male[2-3]
- history of dangerous behavior when intoxicated[4]
- possible "holiday effect."[5]

These cases reflect one of psychiatry's more troubling job requirements: assessing whether a patient is safe to discharge or should be admitted involuntarily. Such situations force us to balance the civil liberties of the mentally ill with our responsibility to care for those who lack insight into their illnesses. This tension often weighs heavily on psychiatrists[6] and is, unfortunately, rather common. A study at one hospital found that approximately 8.5% of emergency department visits resulted in involuntary admission.[7]

As the verdicts in these cases suggest, the legal system recognizes that psychiatrists cannot predict suicide.[8] Mistakes in clinical judgment are not the same as negligence, however, and failure to assess suicide risk or intervene appropriately for the level of risk may result in successful negligence claims.

Standards for emergency short-term hospitalization vary from state to state, so familiarize yourself with your state's standards. Although one standard for involuntary admission is often imminent threat of harm to self, do not base the threat of danger only on a patient's self-report. One study of patients who committed suicide while hospitalized found that 78% denied suicidal thoughts at their last communication.[9] However, "locking up" suicidal patients to prevent a malpractice suit is equally inappropriate.

Table

Documenting suicide risk assessment

Include in patient's chart…	Examples…
Short-term factors	Current suicidal ideation/plan, lethality potential, current stressors (bereavement, illness, loss of job), recent discharge from a psychiatric facility, time of year (holiday effect, anniversaries)
Long-term factors	History of suicidal behavior/attempts, personality factors (agitation, hopelessness), gender, age, marital status, substance abuse history, psychiatric illness (depression, bipolar disorder, schizophrenia)
Appropriate psychiatric interventions based on the assessed degree of risk	Involuntary admission, intensive monitoring, outpatient visits, home healthcare nursing, residential placement, substance abuse treatment
Sources of information used	Medical records, patient self-report, family report, observation

Assess suicide risk during a thoroughly documented psychiatric examination with particular attention to the patient's history of suicidal behavior. Record details of the assessment in the patient's chart *(Table)* at the time of evaluation, and document how these clinical factors influence your final decision.

Involuntary hospitalization provides the immediate benefit of supervision in a safe environment, and patients can gain short-term therapeutic benefits from inpatient treatment whether or not the admission was voluntary.[10] Patients may eventually recognize admission was helpful, but their attitudes about the process often do not become more positive. To ease the stress of involuntary admission:

- acknowledge the patient's disapproval
- tell the patient why he's being hospitalized
- inform the patient about his or her legal rights.

Carry out this discussion with respect for the patient's dignity and wishes.

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