Current PSYCHIATRY

Caring for your patient after discharge

Improper treatment of depression and psychosis blamed for suicide

Kings County (NY) Supreme Court

A 52-year-old patient with a history of mental illness was hospitalized for treatment of major depression with recurrent psychotic features. After release she underwent counseling with a psychiatrist at a mental health center. One month after discharge the patient was rehospitalized for 2 weeks. After this release she resumed counseling at the mental health center. Six months later the patient's husband telephoned the center and reported that the patient needed further treatment. The husband was instructed to bring the patient to a hospital, but he did not do so. The next day the patient committed suicide by jumping from a fourth-floor window.

The case went to trial against the psychiatrist, a social worker, and the mental health center. The patient's family claimed that she should have been prescribed antidepressant medication, enrolled in family therapy, and received immediate care when her husband telephoned the mental health center with concerns. The psychiatrist, a social worker, and the mental health center argued that the patient was properly treated and medication was prescribed. They counterclaimed that the husband was negligent toward his wife by failing to take her to the hospital as instructed.

A $75,000 settlement was reached with the social worker prior to the verdict. Remaining parties reached a $650,000/$250,000 high/low agreement.

> A defense verdict was returned

A woman with prescription drug abuse commits suicide 19 days after discharge

Floyd County (GA) Superior Court

A patient, in her early 40s, was under a psychiatrist's care and admitted to an acute care psychiatric facility for prescription drug abuse. The patient was discharged from the psychiatric facility with instructions to continue outpatient therapy with the psychiatrist. The patient committed suicide 19 days later.

The patient's family alleged that the psychiatrist failed to properly diagnose and treat the patient's mental condition, arguing that the clinician should not have discharged the patient from the acute care psychiatric facility while she experienced drug withdrawal symptoms and depression. The psychiatrist claimed that the patient was treated properly for substance abuse, and depression was secondary and related to drug abuse. The psychiatrist also said that the patient received a comprehensive discharge plan, which included follow-up treatment with him and counselors.

> A defense verdict was returned

continued

Jon E. Grant, JD, MD, MPH

Dr. Grant's observations
Page 76

Cases are selected by CURRENT PSYCHIATRY 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.

Dr. Grant is associate professor of psychiatry, University of Minnesota Medical Center, Minneapolis

continued from page 75

Dr. Grant's observations

Suicide rates are highest immediately after hospital discharge.[1,2] Inadequate follow-up care or discharge planning may increase the risk for suicide.[3] A recent study of 121,933 psychiatric patients at VA hospitals found that 481 (0.4%) died of suicide within 1 year of discharge; 46% of those deaths occurred within the first 3 months. Patients who stayed less than 14 days or had poor continuity of care had a higher risk of suicide.[4]

Discharge may form the basis for a negligence claim if the release is not a valid exercise in professional judgment. In Bell vs New York City Health and Hospitals Corporation, a patient attempted suicide after hospital discharge. He was released despite suicidal ideation and psychosis. Citing the lack of a well documented psychiatric examination, the court found the hospital negligent because the psychiatrist failed to investigate the patient's psychiatric history and delusions or an incident when the patient was restrained the night before.[5,6]

The courts have not found psychiatrists negligent when they perform a risk assessment and reasonably conclude that the benefits of release outweigh the risks.[7]

Clinical Point

Discharge may form the basis of a negligence claim if the release is not a valid exercise in professional judgment

Reasonable protection

When a doctor-patient relationship is established, the psychiatrist has a duty of care to the patient. The psychiatrist must act affirmatively to protect the patient from violent acts against himself. This becomes a duty to reasonably attempt to prevent patient suicide. Negligence occurs when this duty is breached. A negligence claim can be established if the breach was proximately related to a suicide.

Two factors determine liability in suicide cases: forseeability and reasonable care.

Forseeability refers to the reasonable evaluation of suicide potential based on a risk assessment. Failure to perform and document this assessment may be evidence of negligence.

Box 1

Short-term suicide risk factors

- Panic attacks
- Anxiety
- Loss of pleasure
- Diminished concentration
- Depressive turmoil
- Insomnia

Source: Reference 12

Document in your risk assessment the patient's:

- short-term suicide risk factors (***Box 1***)
- suicidal thoughts, plans, intents, and actions
- feelings of hopelessness
- substance abuse
- evidence of poor impulse control[8,9]
- protective factors such as coping and survival skills, family responsibilities, child-related concerns, and moral/religious beliefs.[10,11]

Reasonable care indicates a systematic approach to treatment within the profession's standards. Appropriate suicide precautions—which are part of reasonable care—must be performed based on a risk assessment. In the first case, instructing the family to bring the patient to the hospital constituted reasonable care. If the family refused over the phone to bring the patient to the hospital, the psychiatrist would have had to assess the risk of suicide and deliver reasonable care, which might have included summoning emergency services to the patient's home.

In the second case, reasonable care encompasses a discharge plan and continuity of care. Discharge plans should include safety precautions and treatment. Follow-up after discharge ensures that the treat-

Box 2

Issues to discuss with previously suicidal patients and their families

- **Emphasize** the need for follow-up therapy and/or medication adherence
- **Inform** the patient and family of crisis management procedures and steps. Patient needs to know how to the contact treatment provider and what to do when the clinician is not immediately accessible in an emergency
- **Obtain the patient's** permission for you to talk with family members as is clinically necessary
- **Instruct the family to monitor** the patient and communicate changes or concerns to the outpatient providers
- **Enlist** the family to help safeguard the home, for example, removing firearms
- **Evaluate** the patient's understanding and acceptance of the aftercare plan. Family members should be aware of any problems in the patient's understanding or acceptance of the plan.

Source: Reference 9

ment plan has been carried out. Educate family members about monitoring the patient, communicating observations about changes or concerns, and safeguarding the home, such as removing firearms (*Box 2*).[13]

The discharge records should indicate:

• information sources (such as patient report, family report) the psychiatrist used when deciding to discharge the patient

• factors that went into the decision to discharge (such as response to medications)

• how these factors were balanced against the option of keeping the patient in the hospital.

Consider and record the risks and benefits of discharge versus continued hospitalization. Patient anxiety about leaving the security of the hospital can precipitate a crisis and should be part of the risk-benefit analysis.[14]

Comparative negligence. In some suicide cases, courts have allowed a comparative negligence defense, either against the family or the patient. In Maunz vs Perales, the psychiatrist instructed the patient's family to remove all guns from the home, referred the patient to an outpatient clinic, advised the family to make an appointment 1 week later, and then discharged the patient. The next day, the patient bought a gun and shot himself.

The court held that "people generally have a duty to exercise ordinary care for their own safety. To rule otherwise would make the doctor the absolute insurer of any patient exhibiting suicidal tendencies. The consequence of such a ruling would be that no health care provider would want to risk the liability exposure in treating such a patient, and, thus, suicidal persons would be denied necessary treatment."[5,15]

Clinical Point

Patient anxiety about leaving the security of the hospital can precipitate a crisis and should be part of the risk-benefit analysis

References

1. Geddes JR, Juszczak E, O'Brien F, et al. Suicide in the 12 months after discharge from psychiatric hospital in Scotland, 1968-1992. *BMJ* 1995;311:357-60.
2. Roy A. Risk factors for suicide in psychiatric patients. *Arch Gen Psychiatry* 1982; 39:1089-95.
3. Oquendo MA, Kamali M, Ellis SP, et al. Adequacy of antidepressant treatment after discharge and the occurrence of suicidal acts in major depression: a prospective study. *Am J Psychiatry* 2002;159:1746-51.
4. Desai RA, Dausey DJ, Rosenheck RA. Mental health service delivery and suicide risk: the role of individual patient and facility factors. *Am J Psychiatry* 2005;162:311-18.
5. Packman WL, Pennuto TO, Bongar B, et al. Legal issues of professional negligence in suicide cases. *Behav Sci Law* 2004;22:697-713.
6. Bell v. New York City Health and Hospitals Corporation 456 NYS2d 787 (1982).
7. Johnson v. United States, 409 F. Supp. 1283 (D Fla 1981).
8. Simon RI. Commentary: medical errors, sentinel events, and malpractice. *J Am Acad Psychiatry Law* 2006;34:99-100.
9. Berman AL. Risk management with suicidal patients. *J Clin Psychol* 2006; 62:171-84.
10. Linehan MM, Goodstein JL, Nielsen SL, et al. Reasons for staying alive when you are thinking of killing yourself: the reasons for living inventory. *J Consult Clin Psychol* 1983;51: 276-86.
11. Simon RI. Suicide risk assessment: is clinical experience enough? *J Am Acad Psychiatry Law* 2006;34:276-8.
12. Fawcett J, Scheftner WA, Fogg I, et al. Time-related predictors of suicide in major affective disorder. *Am J Psychiatry* 1990;147:1189-45.
13. Abille v. United States, 482 F. Supp. 703 (ND Cal 1980).
14. Simon RI. The suicidal patient. In: Lifson LE, Simon RI, eds. *The mental health practitioner and the law: a comprehensive handbook*. Cambridge, MA: Harvard University Press; 1998:166-86.
15. Maunz v. Perales, 276 Kan. 313, 76 P.3d 1027 (Kan 2003).