THE PSYCHIATRY EDITION 2015 VOLUME 23 ISSUE 1

Rx for Risk

Addressing risk management issues and concerns in the field of psychiatry

PRMS℠ Professional Risk Management Services, Inc.
the psychiatrists' program®

Since the 1980's, The Psychiatrists' Professional Liability Insurance Program has reviewed and managed tens of thousands of claims and lawsuits against psychiatrists with one of, if not the most frequently identifiable cause of loss being patient suicide. The only upside to these otherwise tragic cases is the wealth of important risk management lessons to be gleaned by scrutinizing the specific types of allegations made in suicide related lawsuits. This issue of Rx for Risk focuses on preventing and managing the risks associated with the treatment of the suicidal patient.

Lessons to Be Learned: A Review of Post-Suicide Malpractice Lawsuits

The Standard of Care

An impression shared by many psychiatrists is that in order to avoid liability related to patients with suicidal behaviors, treating psychiatrists are expected to be able to predict whether a particular patient will attempt suicide and prevent all suicide attempts however unforeseeable. Thankfully, however, courts recognize that psychiatrists are only human and do not expect impossible powers of prediction.

What is expected, as in any psychiatrist-patient interaction, is that the psychiatrist will meet the standard of care, i.e. will exercise that degree of skill, care and diligence exercised by members of the same profession/specialty practicing in light of the present state of medical science. In a lawsuit involving a suicide, the psychiatrist's actions will be assessed by reviewing certain factors, including:

- Whether there was adequate identification and evaluation of suicide risk indicators and protective factors for the patient with suicidal behaviors
- Whether a reasonable treatment plan was developed based on the assessment of the patient's clinical needs
- Whether the treatment plan was appropriately (i.e., not negligently) implemented and modified based on an ongoing assessment of the patient's clinical status
- Whether the psychiatrist was professionally current regarding the assessment and treatment of patients with suicidal behaviors (i.e., knew suicide risk indicators and protective factors, knew current treatment options/interventions including medications, therapy, hospitalization, etc.)
- Whether documentation in the patient record was adequate to support that appropriate care was provided in terms of the assessment, treatment and ongoing monitoring of the patient

In a medical malpractice lawsuit, the plaintiff has the burden of proving that the physician was negligent. One element that must be shown is that the physician breached his legal duty to treat the patient within the standard of care. It is significant to note that the standard of care is not a static concept. In any

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particular instance, the standard of care encompasses a range of acceptable treatment options and requires the exercise of the psychiatrist's professional judgment. The standard of care in a particular case is determined by and based on that specific patient's clinical needs. Just as there is no such thing as a blanket treatment plan applicable to every patient with a given diagnosis, there is no such thing as a blanket standard of care. "When a psychiatrist chooses a course of treatment, within a range of medically accepted choices for a patient after a proper examination and evaluation, the doctrine of professional medical judgment will insulate such psychiatrist from liability."[1]

Lawsuits and Risk Management

When a plaintiff files a lawsuit, it is filed in the form of a "complaint," The complaint is a legal document that lists all the allegations upon which the medical malpractice case, or "claim," is based. These allegations are the way that a plaintiff asserts that there was a duty of care on the part of the psychiatrist, that there was a departure from accepted standards of care, that the departure caused legal injuries to the plaintiff, and that the plaintiff is entitled to money damages for those injuries.

At the time that an initial complaint is filed, the allegations listed are unproven. During the course of litigation, the plaintiff must prove that everything he alleges is true in order to prevail. Whether ultimately proven or not, the allegations which are commonly asserted in lawsuits resulting from a patient suicide, or suicide attempt, provide insight into what the plaintiff will try to claim is the standard of care. Thus, risk management strategies for avoiding a breach of that standard can be derived from close evaluation of the allegations and the facts of any given case.

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Standard of Care Factors, Related Allegations, and Risk Management Strategies

In this section, the most commonly asserted allegations are grouped with specific standard of care factors; this is done in order to illustrate how allegations and the standard of care are directly related. However, many of the allegations listed could relate to several of the standard of care factors or considerations.

Standard of Care Factor One: Adequate identification and evaluation of suicide risk indicators and protective factors

Allegations related to this standard of care factor are concerned with the failure to take an adequate patient history, the failure to adequately assess the patient, and the failure to make an accurate diagnosis.

Related Allegations:

- Failure to obtain an adequate history
- Failure to contact the prior physician
- Failure to obtain history from the family, including past suicidal behaviors
- Failure to determine what treatments had previously failed
- Failure to review prior medical records
- Failure to perform a full mental status exam
- Failure to properly evaluate and record patient's risk for suicide
- Failure to reach a rational diagnosis based on careful examination and history of the patient
- Failure to weigh psychodynamic factors
- Failure to diagnose medication intoxication and dependency
- Failure to diagnose suicidality

Risk Management Strategies:

- Explore the patient's clinical history and past treatment, if any. Obtain prior treatment records where possible and document attempts to get records and information. Telephone consultation with past treaters may be necessary when records cannot be timely obtained. While treatment recommendations might not be altered based on previous information, past records can give the psychiatrist a more comprehensive and nuanced context in which to understand the patient. Additionally, the psychiatrist may benefit from the experiences of previous providers.
- Consult with family members and others close to the patient for information about the patient's history, presenting condition and life circumstances.
- Assess the patient's suicide risk at significant points in the treatment, including, but not limited to:
  - At the outset of treatment

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- With the occurrence of suicidal or self-destructive ideation or behavior
- When significant clinical changes occur
- When a change in supervision or observation level is ordered
- At the time of discharge or transfer from one level of care to another
- Be alert for, and respond to, developments in a patient's life that may increase the risk of suicide.

Standard of Care Factor Two: A reasonable treatment plan was developed based on the assessment of the patient's clinical needs

and

Standard of Care Factor Three: The treatment plan was implemented appropriately and modified as needed based on the patient's clinical condition

Generally, these allegations have to do with decisions about appropriate treatment modalities and settings and the correct implementation of the treatment plan.

- Related Allegations:
- Failure to take reasonable steps to ensure the patient's safety
- Failure to take protective measures (such as placing the patient on constant observation)
- Failure to remove dangerous objects (such as shoelaces, sharps, firearms/weapons)
- Failure to develop a comprehensive treatment plan
- Failure to hospitalize for suicidality
- Failure to communicate with other providers involved in the patient's care (for example, psychiatrist failed to communicate clinical concerns to other physicians involved in the patient's care)
- Failure to communicate with the patient's family or significant others (for example, the family alleged that the psychiatrist failed to alert them to the patient's suicidal ideation)
- Improper reliance on "no-harm" contract
- Failure to weigh the benefits of ECT in a timely manner
- Negligent psychopharmacologic management
- Improper medication prescribing
- Failure to provide adequate post-discharge care

Risk Management Strategies:

- Address the need for a safe environment for patients with suicidal behaviors. The accessibility of firearms/other weapons should be assessed and an appropriate plan for safety instituted. This should include obtaining information from and instructing the patient's family/significant others about this issue.
- Facility policies and procedures should be in place and followed to ensure patient safety. The standard of care is largely established by the opinion of other psychiatrists, and since policies and procedures often are the result of a consensus of practitioners, the policies and procedures may be a close approximation to the standard of care.
- Frequently reassess the patient's risk of suicide and the safety of the patient's environment and make adjustments in the treatment plan, as needed.
- Even though a patient at risk for suicide does not meet the criteria for hospitalization at one point in treatment, assessment should be ongoing to determine when and if that assessment changes. Know the criteria and procedures for involuntary hospitalization in your state.
- Involve and educate the patient's family and significant others, when appropriate, about the patient's situation and treatment. The patient, other healthcare providers, and the patient's family should be appropriately warned about the potential for suicide and significant risk factors. If the patient will consent to communication with significant others, consider discussing the following: Do they know what behaviors to be

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From Our LinkedIn Blog

Do Your Patients With Suicidal Ideation Have a Lifeline Number?–posted 08-28-14

I know you've instructed your patients (and parents of minor patients) to call you in the event of a crisis, and you've also instructed them to call 9-1-1 or go to the emergency department in the event you cannot be reached. In addition to those instructions, have you considered providing the telephone number of a suicide prevention lifeline? If not, consider the following:

- The National Suicide Prevention Lifeline:
- 800-273-TALK (8255) or 800-SUICIDE (784-2433)
  - Trained counselors are available 24/7
  - *www.suicidepreventionlifeline.org*
  - TTY: 800-799-4TTY (4889)
  - Launched in 2005 by SAMHSA and the Mental Health Association of New York City
- For Veterans and Active Military:
  - 800-273-8255 and Press 1
  - VA professionals are available 24/7
  - *www.veteranscrisisline.net*
  - Partnership between the VA and the National Suicide
  - Prevention Lifeline
    - If 1 is not pressed, calls are routed to the National Suicide Prevention Lifeline
- The Trevor Lifeline: 866-488-7386
- For lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24
- Trained counselors are available 24/7
- *www.thetrevorproject.org*

(Lessons to Be Learned from page 3)

on the lookout for that may indicate increased risk? Do they know what to do if they notice these symptoms or behaviors? If the patient will not consent to communicating with family or others, remember, there are some exceptions to patient confidentiality, such as when a patient is in danger of harming himself or others.[2] Accordingly, even without patient consent, consider alerting family members and significant others to the risk of outpatient suicide when:

  - the risk is significant,
  - the family members do not seem to be aware of the risk, and
  - the family might contribute to the patient's safety.

- Additionally, some clinicians, wishing to zealously protect a patient's confidentiality, erroneously believe they cannot listen to what family members have to tell them about a patient. Listening to others does not constitute a breach of confidentiality and may provide invaluable information and insight into the patient's suicide risk.
- Office staff should have guidelines about the symptoms and conditions/issues that patients and families may call about that require immediate referral to the psychiatrist or another clinician. The threshold for obtaining a physician's response should be relatively low—any uncertainty in this area means the matter is discussed with the doctor.
- Communicate with other treaters, especially when the patient is being treated in a split treatment or collaborative treatment situation. In order for the care given by an individual treater to be as effective as possible, the patient's overall care must be coordinated. Pertinent treatment team information should be taken into consideration when assessing, formulating a diagnosis, and putting a treatment plan into place. On an inpatient unit, read the documentation of other treaters and address conflicting information or assessments. This demonstrates that you are aware of the information, took steps to clarify it, and factored the information into your assessment and treatment recommendations. Obtain patients' consent to communicate with other treatment providers, if such consent is needed, at the outset of treatment.[3]
- Do not rely solely on a patient agreeing to a "no-harm" or suicide prevention contract as a guarantee of patient safety. These "contracts" have no legal force and cannot take the place of an adequate suicide risk assessment. Although it may be appropriate for a "no-harm" contract to be one part of a comprehensive treatment plan, it is the clinicians' responsibility to evaluate the patient's overall suicide risk and the patient's ability to participate in the treatment plan. Over reliance on such contracts may lessen a clinician's awareness or observation of a patient's suicide risk.
- Appropriate baseline laboratory testing, a comprehensive patient history, and any necessary physical examinations should be completed before medications are prescribed. Monitor medication levels and all ongoing laboratory testing regularly. Make informed decisions about the type and amount of medication given to a patient at risk for suicidal behaviors. The decision should reflect the extent of your experience with the patient, your knowledge of this patient, the severity of the risk, and the extent to which prescribed medications may be of significance to the patient. Avoid telephone refills without assessing the patient, particularly when you are covering for a colleague. As always, obtain the patient's informed consent for medications prescribed.
- Avoid terminating treatment with a patient in outpatient treatment who is in crisis. Ideally, the psychiatrist should continue treating until the crisis is resolved. If the patient's condition requires hospitalization, the psychiatrist may terminate safely while the patient is hospitalized. The patient and the in-patient treatment providers should be informed so that planning for alternative treatment arrangements after discharge can begin as soon as possible.
- Patients are at increased risk of suicide after discharge from hospitalization. An assessment of the patient's status should be done prior to discharge and a reasonable discharge plan should be in place to provide adequate support and care at this vulnerable time.

Standard of Care Factor Four: Be professionally current regarding the assessment and treatment of patients with suicidal behaviors (know suicide risk indicators and protective factors, know current treatment options/interventions including medications, therapy, hospitalization, etc.)

Related Allegations:

Many of the allegations previously cited could be asserted to support a claim that a psychiatrist did not meet the standard of care because the psychiatrist was not professionally current about assessing and prescribing treatment for patients with suicidal behaviors. For example, an allegation of failure to diagnose suicidality could result because a plaintiff believes the psychiatrist was negligent for not knowing the suicide risk associated with specific psychiatric disorders. Or, an allegation of negligent psychopharmacologic management could be related to the belief that a psychiatrist was not up-to-date regarding the effectiveness of certain medications on decreasing potential suicide risk.

Risk Management Strategies:

- Stay current with the field. It is imperative that psychiatrists maintain competency with regard to the medications and other forms of psychiatric treatment they are providing.
- Do not hesitate to consult with or refer to colleagues when appropriate.

Standard of Care Factor Five: Document adequately to support that appropriate care was provided in terms of the assessment, treatment, and ongoing monitoring of the patient

Documentation problems that have been noted in malpractice cases run the gamut from no chart notes to poor or incomplete chart notes to wildly inconsistent and self-serving entries made after an adverse event.

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Related Allegations:

- Failure to maintain hospital records showing dual diagnoses, full diagnostic evaluation, and adequate clinical notes
- Failure to record a full mental status examination
- Failure to document adequate suicide assessment

Risk Management Strategies:

- The written treatment record stands as a testament of treatment provided and the reasoning behind it. The record comprises a significant and substantial part of the defense against any claim of malpractice against the psychiatrist. Highly defensible cases where the psychiatrist delivered seemingly flawless treatment have been lost or settled because of poor documentation by the psychiatrist.

  Documenting the decision-making processes underlying treatment decisions is key to building a supportive record (i.e., what actions were taken and why, as well as what actions were rejected and why). The major aspects of patient care should be documented.
- Information to include in the patient record:
  - initial and ongoing assessments of suicide risk;
  - treatment recommendations/plan and modifications;
  - the informed consent process;
  - medication information (medication name, dosage and size of prescription, refills, effectiveness of medication, any side effects reported or medication allergies/ sensitivities, changes of medication or dosage and the basis for such modifications, etc.);
  - patient history and examination;

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From Our LinkedIn Blog

New Suicide Prevention Resource–Get the App! –posted 03-13-15

Having defended cases brought against our insured psychiatrists since the 1986, we know that patient suicide / attempted suicide is one of the top two allegations brought against psychiatrists in medical malpractice cases, the other being medication-related issues.

We also know that assessing for suicide risk is critical to understanding the patient's condition and developing an adequate treatment plan. Moreover, in the event of subsequent litigation, contemporaneously documented risk assessments go a long way in showing that the psychiatrist met the standard of care.

And we unfortunately know that how to assess for suicidality is not well addressed in psychiatric training. With this educational gap in mind, PRMS was more than happy many years ago to fund the printing and distribution of the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) card, originally conceived by Dr. Doug Jacobs, to the nation's psychiatric residency programs.

Since that time, I've been very pleased to see that SAMSHA has taken over the SAFE-T card. And I just learned today that SAMSHA increased its distribution of the assessment tool via a new mobile app, Suicide Safe. According to the website (*http://store.samhsa.gov/apps/suicidesafe/*), this free app helps providers:

- Learn how to use the SAFE-T approach when working with patients
- Explore interactive sample case studies and see the SAFE-T in action through case scenarios and tips
- Quickly access and share information, including crisis lines, fact sheets, educational opportunities, and treatment resources
- Browse conversation starters that provide sample language and tips for talking with patients who may be in need of suicide intervention
- Locate treatment options, filter by type and distance, and share locations and resources to provide timely referrals for patients.

While we're on the topic of suicide risk assessment, here are my three top risk management points:

- In many of our suicide cases, appropriate risk assessments were done, but not documented. To some degree, the old adage "if it wasn't documented, it wasn't done" applies and it becomes a "he said—she said" issue. Document the assessments!
- In other cases, the initial assessment was done and documented well. But there were no additional assessments done. Assessing risk is not a one-and-done thing. There are many clinical junctures after the first contact that require additional assessment (for example, the SAFE-T card lists "with any subsequent suicidal thoughts, increased ideation, or other pertinent change; for inpatients, prior to increasing privileges and at discharge.") We know that immediately after discharge can be a high risk period, so risk should be assessed as close to the time of discharge as possible.

We know from our cases as well as from patient safety literature that standardization in suicide risk assessment is beneficial. Having a framework ensures that important issues do not get overlooked. The SAFE-T card is one example of several assessment tools available. Find the tool that works best for you—and use it!

If you don't already have an assessment tool that works for you, check out the Suicide Safe app now! Download the free app now from google play or apple's app store.

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- laboratory test results and patient monitoring, reports from psychological testing, physical examinations, laboratory data, etc.;
- instructions to patient and family;
- consultations;
- dates (and length) of service;
- initial assessment, diagnosis, and subsequent re-assessments of the patient's needs;
- any signed informed consents for treatment and authorizations for release of information, including releases to third-party payors;
- names, addresses, and telephone numbers of the patient and designated others, if the patient has granted appropriate authorization to communicate with others;
- consultations with other health care providers;
- what treatment options/actions were considered, what options/actions were chosen and why, and what options/actions were rejected and why;
- documentation of the termination process;
- a discharge summary (if relevant), including patient's status relative to goal achievement, prognosis, and future treatment considerations; and
- copies of relevant correspondence concerning the patient.

- Never alter a treatment record. The strength of the treatment record as evidence in a malpractice case is based on the idea that a contemporaneous record of actions and observations can reasonably be relied upon to be true and unbiased. Altering the record undermines this assumption and can result in an otherwise defensible case being rendered totally indefensible. Correcting mistakes does not constitute "altering" a record; always use accepted methods when correcting mistakes or omissions.
- Some state legislatures and/or licensing boards require certain minimum information to be made part of the treatment record. Psychiatrists should be familiar with the requirements in their states.
- As stated by an attorney on the Program's defense panel, "Generally, a jury will ultimately decide whether the psychiatrist departed from the standard of care. That determination will be made after the jury is presented with the testimony of the psychiatrist; the experts for the psychiatrist and the patient; and other relevant witnesses.
- A chart that carefully documents the psychiatrist's reasoning process and suicide assessments is a powerful defense tool in that it (1) allows the psychiatrist and his expert to testify as to specifics; (2) makes the psychiatrist's testimony more believable; and (3) places the psychiatrist's attorney in a better position to convince the jury that the patient's expert is engaging in second-hand guessing after the fact."

In Conclusion

There are important lessons to be learned by reviewing malpractice claims and understanding the types of allegations that are frequently asserted. Risk management strategies emerge from the information about past lawsuits that can effectively reduce the risk of professional liability and put psychiatrists into a better position to defend a lawsuit, should it occur.

(Endnotes)

[1] Durney v. Terk, 42 AD3d 335 (2007)

[2] The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry, 2013 eEdition states in Annotation 8 under Section 4: "When, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be significant, the psychiatrist may reveal confidential information disclosed by the patient."

[3] Under the Federal Health Insurance and Portability and Accountability Act of 1996 (HIPAA), covered providers have regulatory permission to discuss patients' protected health information for treatment purposes. Some states, however, may have more stringent requirements to obtain permission from patients before releasing protected health information for this purpose. From a risk management perspective, it is recommended that psychiatrists obtain consent to talk to other treaters whenever possible and clinically reasonable. This is also consistent with the APA's holding in the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry that the patient's consent should be obtained before disclosing protected health information.

Be sure to watch for the e-mail alerting you when new issues of *Rx for Risk* are available!

New issues of *Rx for Risk* will be posted quarterly to the Psychiatrists' Program website (*www.psychprogram.com*). Don't miss a thing! For your convenience, an e-mail notification is sent alerting you when each new issue is available. The e-mail includes a direct link to the new issue, along with a brief description of its content. To receive these e-mail notifications, you need only to be registered (and validated) to access the "My Program" section of the website.

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Practical Pointers for Managing Risk When Treating Patients With Suicidal Behaviors

1. Include specific exploration of suicidal potential in examinations at the outset of treatment and at other points of decision during treatment. Suicidal potential should be re-assessed at least: 1) whenever there is an incidence of suicidal or self-destructive ideation or behavior; 2) when significant clinical changes occur; 3) when any modification in supervision or observation level is ordered; and 4) at the time of discharge or transfer from one level of care to another. Based on these reassessments, make adjustments to the treatment plan as needed.
2. Explore past treatment. Obtain treatment records where possible for new or returning patients. Record attempts to obtain records if they cannot be obtained.
3. Review patient records prior to lifting precautions or otherwise reducing the nature or intensity of treatment. Review the entries of other professionals as well as your own.
4. Conduct follow-up discussions with staff members whose record entries may be inconsistent with treatment options under consideration. Include the basis for resolution of the inconsistency in a record entry of the decision.
5. Instruct staff to notify you immediately if they are concerned about a patient's potential for suicide.
6. Communicate with other treaters, especially when the patient is being treated in a split or collaborative treatment arrangement.

From Our LinkedIn Blog

Suicides Are Increasing Among Yound Females (10-24) posted 03-26-15

This week's MMWR from the CDC addresses suicide trends among persons aged 10-24 years from 1994-2012. The study's findings include:

- Suicide is the second leading cause of death among 10-24 year olds in the US
- There were 5,178 suicides in this age group in 2012
- The three most common methods are firearm, suffocation (including hanging), and poisoning (including drug overdose)
- Consistent with prior research, and with reports of suicide in older age groups, the rate of suffocation suicides in this age group is increasing
  - This is concerning given the high lethality rate – typically 69% - 84%
- During 1994-2012, suicide rates by suffocation increased on average by 6.7% annually for females and 2.2% annually for males
- Suicide by males in this age group were consistently higher than females
- For males:
  - 1994 rate = 15.7 per 100,000
  - 2012 rate = 11.9 per 100,000
  - 2012 ranking of methods, in order of frequency:
    - Firearm
    - Suffocation
    - Poisoning
- For females:
  - 1994 rate = 2.7 per 100,000
  - 2012 rate = 3.2 per 100,000
  - 2012 ranking of methods, in order of frequency:
- Suffocation
- Firearm
- Poisoning

The authors referenced the CDC's High School Youth Risk Behavior Survey, 2013, which is replete with statistics showing female high school students have greater suicide concerns than males. From the 13,583 responses, during the prior 12 months:

- Those reporting feeling so sad or hopeless almost every day for two or more weeks in a row that they stopped doing some usual activities:
  - 39.1% females vs. 20.8% males
- Those reporting seriously considering attempting suicide:
  - 22.4% females vs. 11.6% males
- Those reporting having made a plan about how they would commit suicide:
  - 16.9% females vs. 10.3% males
- Those reporting an attempted suicide:
  - 10.6% females vs. 5.4% males
- Those reporting an attempted suicide resulting in an injury, poison, or overdose that had to be treated by a doctor or nurse:
  - 3.6% females vs. 1.8% males

For more information:

CDC's MMWR, 3/6/15: *www.cdc.gov/mmwr/preview/mmwrhtml/mm6408a1.htm?s_cid=mm6408a1_x*

CDC's High School Youth Risk Behavior Survey, 2013:*www.cdc.gov/healthyyouth/yrbs/index.htm*

(Practical Pointers from page 7)

7. At the outset of treatment, or after breaks in treatment, consult family members or others close to the patient, as appropriate, for information about the patient's history, presenting condition, and life circumstances.
8. Address the need for a safe environment for patients with suicidal behaviors. The accessibility of firearms or other weapons should be assessed and an appropriate plan for safety should be instituted, including getting information from and instructing family/significant others about this issue.
9. Record all potentially relevant information provided by family and close friends.
10. Know the criteria and procedures for involuntary hospitalization in your state.
11. Do not rely solely on "no-harm" contracts as a guarantee of patient safety. These "contracts" have no legal force and cannot take the place of an adequate suicide risk assessment. It may be appropriate for a "no-harm" contract to be one part of a comprehensive treatment plan but it is the clinician's responsibility to evaluate the patient's overall suicide risk and ability to participate in the overall treatment plan.
12. Be alert for—and respond to—developments in a patient's life that may increase the risk of suicide.
13. Address financial constraints directly. If recommended treatment is not financially possible, then attempt to find equivalent alternatives. Document the adequacy of the alternative that is ultimately chosen.
14. Document all relevant information about a patient's condition, treatment options considered, risk/benefit analysis performed, and the rationales for choosing or rejecting each option.
15. Never alter or destroy a patient record after an adverse incident.
16. Develop a follow-up treatment plan for discharge or for transfer from one level of care to another that is consistent with a patient's situation and abilities. You may need to take steps to monitor patient compliance if another psychiatrist or professional has not yet assumed care.
17. Familiarize yourself with the policies of all hospitals or other institutions/organizations where you provide treatment. Practice accordingly.
18. The decision about type and amount of medication given to a suicidal patient—and the resulting record entry—should reflect the extent of your experience with the patient, your knowledge of the patient, the severity of the patient's suicidality, and the extent to which physician prescribed medications may be of significance to the patient.
19. Refill prescriptions for other psychiatrists' patients with care. Review such refills with the psychiatrist if possible. Where such review is not possible, consider prescribing only enough medication to cover the patient until the psychiatrist returns or can be consulted.
20. Terminate treatment with potentially suicidal patients with extreme care. Avoid terminating during periods of crisis. Consider termination during inpatient treatment, if termination is necessary.
21. Prepare patients for scheduled absences and make provisions for coverage.
22. Consider alerting family members to the risk of outpatient suicide when:
    - the risk is significant,
    - the family members do not seem to be aware of the risk, and
    - the family might contribute to the patient's safety.
23. Consistently use an authoritative guideline to assess the level of suicide risk and facilitate the development of a reasonable intervention and treatment plan based on the assessed risk level.

Risk Management After a Suicide: Confidentiality and Related Matters

Psychiatrists are well aware of their duty to maintain patient confidentiality while a patient is alive; however, the continuing obligation to protect confidentiality after the death of a patient

is not always appreciated. Many psychiatrists, acting on the mistaken belief that confidentiality does not survive a patient's death or that suicide negates confidentiality, disclose protected patient information without proper authorizations. Such improper disclosure leaves the psychiatrist vulnerable to allegations of ethical and statutory violations as well as investigations by the relevant state licensing body.

How strong is confidentiality after death? According to AMA Ethics Opinion 5.5051, Confidentiality of Medical Information Postmortem, "At their strongest, confidentiality protections after death would be equal to those in force during a patient's life."

Most states agree with this position and make no distinction between confidentiality before or after the death of a patient; they merely transfer the ability to control disclosure of protected information from the patient to another individual or set of individuals.

The following are examples of questions frequently received by The Program and represent common situations faced by psychiatrists after a patient suicide.

Question One:

A patient I'd been treating for over a year recently committed suicide. The patient's wife is distraught and is desperately trying to understand this tragic event. She has asked for a copy of the

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patient's records. Should I release it to her? I also received a message from the patient's mother asking that I call her. I'm concerned that she will want to discuss confidential patient information. The patient was separated from his wife and living with his parents for the last few months before his death. There is a great deal of animosity between the patient's wife and his parents. What are my obligations under these circumstances?

Answer:

A psychiatrist's obligation to preserve patient confidentiality continues even after death. This well-established ethical and legal responsibility sometimes conflicts with the family's or significant other's understandable desire for information. Reaching out to the family can be an important clinical and compassionate act, and risk management recommendations after a suicide usually support such a response. Specific confidential treatment information, however, cannot be disclosed to the family members without valid authorization from the person authorized to give consent after death. Applicable state laws govern who may legally give consent for the release of patient information. In most states it is the executor or personal representative of the estate who has this authority.

When asked for protected information, the psychiatrist should require the requesting individual to put her request in writing and cite her authority to obtain the information. If the authority derives from her status as personal representative, she should also provide a copy of the appointment or assignment papers. The psychiatrist should not take an individual's word for it that she is the personal representative. Keep in mind, however, that some states permit the decedent's spouse or other immediate family members to authorize disclosure when a personal representative has not been appointed; thus, physicians need to be familiar with the relevant state law.

The family should be made to understand that requiring proper authorization for release of records is not just being done in an attempt to keep information from them, but, rather, an obligation imposed by the law and by professional ethics because of the nature of the psychiatrist-patient relationship. In addition, situations do arise in which conflicts among the patient's various family members develop over the deceased's estate. When family members are in conflict, the potential increases for the physician to be accused of breaching confidentiality by releasing information to the opposing party. This risk is mitigated by always following the proper legal steps for the release of patient information.

An appreciation of confidentiality obligations need not, however, prevent the psychiatrist from offering support and expressing care and concern for the patient's family. The psychiatrist can also inform them of appropriate resources and/or recommend and refer family members for counseling or treatment—all without disclosing confidential patient information. Fortunately, most families usually understand that the doctor must follow legal and ethical requirements for releasing patient information when it is tactfully explained and discussed with them.

Question Two:

I am clear in my understanding that in speaking to family members I must protect my patient's confidentiality. However, I'm still somewhat anxious about talking to the family at all. I would like to reach out to them. I know how distraught they are and I'm

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Resource List: Suicide Prevention

The National Suicide Hotline—1-800-SUICIDE (1-800-784-2433)

American Association of Suicidology (AAS)—*www.suicidology.org*, 1-202-237-2280

National Depression Screening Day website—*www.mentalhealthscreening.org/programs/ndsd*

American Foundation for Suicide Prevention (AFSP)—*www.afsp.org*

National Institute of Mental Health (NIMH)—*www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml*

National Association of Psychiatric Hospital Systems (NAPHS)— *www.naphs.org*

Office of the Surgeon General National Strategy for Suicide Prevention (Goals and Objectives for Action)—*www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention*

Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Prevention—*www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp*

Stop A Suicide Today! (a program of Screening for Mental Health, Inc.)—*www.stopasuicide.org*

Centers for Disease Control and Prevention (CDC): Injury Prevention & Control: Division of Violence Prevention—*http://www.cdc.gov/ViolencePrevention/suicide/index.html*

American Psychiatric Association (APA)—1-888-357-7924, *www.psych.org*

American Psychological Association (APA)—1-800-964-2000, *www.apa.org*

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worried about the impact of this event—especially the patient's teenage son. But could something that I say be used against me at a later time if the family decides to sue over this event? Would it be appropriate to send a card of condolence instead? Should I attend the funeral?

Answer:

Different psychiatrists have different comfort levels when it comes to dealing with the family. It can be very stressful to talk with grieving relatives candidly and compassionately while striving to avoid breaching confidentiality and/or making a statement that may later be construed as an admission of liability.

Reaching out to the family by means of a note or care of condolence or attendance at a funeral may beneficial to the psychiatrist, as well as the family, in dealing with the patient's death. Before doing so, however, the psychiatrist should consider a variety of factors. What is his or her current relationship with the family? Are family members blaming the psychiatrist or expressing appreciation of the care the patient received? What are the psychiatrist's own feelings about the patient's suicide?

We are not suggesting that family members should necessarily be viewed as adversaries but rather that the psychiatrist treat this situation with a realistic degree of caution. It is not possible to know whether a patient suicide will ultimately generate a lawsuit or if a family's feelings about the psychiatrist's care will change over time. Therefore, as in all other interactions with patients' families, the psychiatrist must use his professional judgment in providing empathy and support. The focus of any discussions should be on maintaining a respectful, supportive environment. It will not be helpful to the family or the psychiatrist if the psychiatrist becomes defensive should his care of the patient be questioned or if the psychiatrist expresses self-doubts to the family about the care he provided.

Question Three:

After a recent patient suicide, I received calls from the police officer investigating his death and from the medical examiner requesting information about the patient and his treatment. I know that they are involved in official investigations for the state but is it permissible to release confidential patient information to these individuals? The police officer said it was urgent that I provide the requested information and wanted to stop by my office to get a copy of my records the next day.

Answer:

Applicable laws and regulations (usually your individual state's) govern the release of patient information, even to law enforcement and investigatory entities. Some states allow information to be released to the medical examiner or police investigators pursuant to certain procedures. This means, of course, that applicable laws must be consulted and the proper

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2015 Risk Management Seminars–Save the Date!

PRMS will be presenting a mock trial (full day of CME) in the following six cities:

- **July 25, Miami, FL**
  Sheraton Miami Airport Hotel & Executive Meeting Center, 3900 NW 21st Street, Miami, FL
- **August 8, Seattle, WA**
  Bell Harbor International Conference Center, 2211 Alaskan Way Pier 66, Seattle, WA
- **August 22, Philadephia, PA**
  The Hub Cira Centre (attached to 30th Street Amtrak Station) 2929 Arch Street, Mezzanine, Philadelphia, PA
- **October 26, San Antonio, TX**
  Hotel Contessa, 306 W Market Street, San Antonio, TX
- **November 7, Atlanta, GA**
  Georgian Terrace Hotel, 659 Peachtree Street NE, Atlanta, GA
- **December 5, Arlington, VA**
  Waterview Conference Center, 1919 North Lynn Street, Arlington VA

In today's litigious society, every psychiatrist faces the hard reality of possible malpractice litigation. We are presenting a mock medical malpractice trial in areas nationwide to illustrate the many stages of litigation, as well as lessons to help you avoid potential incidents or lawsuits.

Our mock trial will allow you to learn, among other things, how to document effectively in the medical record and the importance of communication with patients and families. You will also learn tips for working effectively with your defense counsel in the event you face a lawsuit.

Registration is free for PRMS clients who also may be eligible to receive a 5% premium discount!* We will send another email when registration is open.

If you have any questions please visit us online or call us at (800) 527-9181.

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procedures followed before information can be released. You should consult with a risk manager or personal attorney when you receive a request to release information after a patient's death.

Sometimes investigators pressure physicians into improperly releasing confidential information by convincing the physicians that they are obligated to talk to the investigators immediately. The following are some suggestions for managing the situation when an investigator becomes insistent — or perhaps even threatening — about the need to release patient information immediately.

- Remember that you should not release patient information over the telephone. You cannot verify who is calling.
- Assure the investigator that you are not trying to impede the investigation and explain that you have a professional and legal obligation to protect patient confidentiality.
- Request that the investigator provide identification, as well as documentation confirming the agency he is representing and specifically what information is requested. In other words, ask the investigator to put the request in writing and cite his authority to access protected information.
- State that you will process the request as quickly as possible.
- Consult with your risk manager or personal attorney about how to proceed.
- Make every effort to respond to the request as soon as possible.

Question Four:

I am having a variety of feelings and thoughts about a particular patient's treatment and suicide, but I'm worried about discussing them with others. What are the ramifications of talking to others about how I feel?

Answer:

The emotional impact that a patient's suicide can have on the psychiatrist and other treatment team members should not be minimized. Professionals are not immune to the natural onslaught of feelings that follow such a tragic event. When deciding how to manage this situation, the responsibility of maintaining patient confidentiality, as discussed above, still applies and it is important to use discretion. Unfortunately, discussing the situation with a spouse, friends, or colleagues outside the treatment team may very well violate patient confidentiality. Furthermore, if litigation results, statements made to others could be used against your interests. Some mental health professionals establish a therapeutic relationship as a patient with another therapist in order to deal with their personal crisis. The establishment of a formal treatment relationship allows the psychiatrist to claim the physician-patient or therapist-client privilege for themselves.

Question Five:

A patient of my private practice who recently committed suicide, was also attending an outpatient day program a few times a week. The risk manager from that facility requested that I write a report detailing my treatment of the patient, including the last time I assessed the patient for suicidality. The patient's insurance company has also advised me that it will be conducting a "quality review" as a result of this event and will need a report from me. Should I provide these reports?

Answer:

Do not give any written or verbal reports related to a patient suicide, or any other adverse event/outcome, prior to consulting with your malpractice carrier. Before proceeding, it is important to determine how the reports will be used and whether they are protected from discovery in a subsequent lawsuit. There have been cases where a facility has tried to avoid responsibility for potential malpractice by attempting to "point the finger" at the treating psychiatrist based on information provided in good faith by the psychiatrist about the event. Good risk management strategies after the event can help prevent the situation from spiraling out of control.

Question Six:

A patient called me two days before his suicide. I have not yet documented the call in the patient record. Should I do so now? If so, how should it be done?

Answer:

The patient record should be as accurate and complete as possible at all times. If there is important patient information that belongs in the record, such as a telephone consultation with the patient, you should contact your malpractice carrier for advice on how to document appropriately after the suicide. Of course, existing documentation should never be altered. Altering records can at a minimum result in a loss of credibility and may result in allegations being made against you for spoliation of evidence and carry possible ethical and criminal ramifications. Consult with your malpractice carrier or personal attorney if you have any questions or concerns about documentation after a patient suicide.

In conclusion, confidentiality continues after the death of a patient, regardless of how that death occurred. The psychiatrist is prohibited, legally and ethically, from releasing protected patient information without proper authorization.