SUICIDE
IN THE
COURTROOM

Lessons Learned from Malpractice Litigation

Mace Beckson, M.D.

- Health Sciences Clinical Professor of Psychiatry & Biobehavioral Sciences at University of California, Los Angeles
- Medical Director of the Psychiatric Intensive Care Unit of the VA Greater Los Angeles Healthcare System
- Core faculty, UCLA Psychiatry Residency Training Program
- Email: mbeckson@ucla.edu

Learning Objectives:

To understand *legal issues* in malpractice lawsuits involving patient suicide

To learn *clinician* approaches to:

- *reducing the risk of litigation*
- *increasing the likelihood of successfully defending* suicide malpractice lawsuits

Suicide and Malpractice Litigation

Common settings for suicides resulting in litigation

- Psychiatric inpatient units
- Correctional settings (e.g., jail; prison)
- Outpatient mental health treatment

Malpractice: Negligence by Professional

"Four Ds"

- **Dereliction** of
- **Duty** that
- **Directly** causes
- **Damages**

Duty: to the Patient

- Doctor-patient relationship
- Psychotherapist-patient relationship
- Consultant/evaluator

Dereliction of Duty

Standard of Care

"A [clinician] is *negligent* if [he/she] fails to use the level of skill, knowledge, and care in diagnosis and treatment that other *reasonably careful* [clinicians] would use in similar circumstances.

This level of skill, knowledge, and care is sometimes referred to as 'the standard of care.'"

- "Prudent Practitioner" standard
- National Standard

Causation

"Proximate" cause

- *Directly* causes the damages
  - No intervening event "breaks the chain" of causation

Does not need to be the *sole* cause

- May be a "substantial" cause
  - "But for" the acts or failure to act, the damages would *not* have occurred

Damages

- Pain and suffering of decedent
- Loss of financial support for family members (e.g., children)
- Loss of consortium (relationship) for spouse

May Increase Litigation

Strong survivor feelings of anger or guilt

- Displacement
- Projection

May Increase Litigation

Lack of communication between clinician and survivors prior to suicide*

- Psychoeducation re: patient's clinical condition and suicide risk
- Suicide safety plan: involvement of family
- Availability of clinician: management of expectations

*Patient confidentiality issues

May Increase Litigation

Lack of communication between clinician and survivors *following* the suicide

- Reaching out to family with expression of sympathy
- Offer of support and availability
- Meeting to discuss the suicide
- Defensiveness

Litigation Following Suicide

Complaint

- Legal bases for lawsuit

  (e.g., wrongful death; malpractice)

Complaint

Failure to meet the standard of care

- Inadequate suicide risk assessment
- Failure to protect the patient

Complaint

The suicide was "foreseeable":

"Foreseeable" that a patient at that patient's high risk for suicide would commit suicide in the very near future without appropriate intervention

Foreseeable

- Suicide risk can be assessed
- "Knew or *should have* known" that there was a high risk for suicide

Predictable

Who of a group of 100 patients equally at high risk will commit suicide in the *very near future* without appropriate intervention?

- Very low base rate
  - Vast majority will not be deceased in the near future without any interventions
- Cannot predict a particular patient's suicide

Suicide Risk Assessment

- Review of *reasonably* available records
- Access *reasonably available* collateral sources of history*
  - *Emergency exception to confidentiality
- Personal Interview and Examination
  - History
  - Mental Status Examination
- Diagnosis

Suicide Risk Assessment

- Risk Factors
  - Static
  - Dynamic
- Protective Factors
- Clinical Judgment: Overall Level of Risk

Interventions to Mitigate Suicide Risk

- Suicide safety plan
- Increase frequency of outpatient visits
- Psychopharmacological interventions
  - e.g., reduce agitation or psychosis, improve sleep, etc.
- Involve family members
  - with patient's permission or emergency exception
- 911 or psychiatric emergency team evaluation

Interventions to Mitigate Suicide Risk

Psychiatric Hospitalization

- Voluntary or involuntary
- Environment of care
  - e.g., no anchor points, no sharps
- Nursing monitoring
  - e.g., 1:1 arm's length nursing observation; frequency, etc.
- Psychopharmacological interventions
  - e.g., reduce agitation, improve sleep, etc.

Reducing Likelihood of Patient Suicide & Guarding Against Malpractice Litigation

Meet the standard of care: Clinical Evaluation

- Diagnostic assessment
- Suicide risk assessment
  - Re-assessment
    - change in clinical condition
    - transition of level of care

Reducing Likelihood of Patient Suicide & Guarding Against Malpractice Litigation

Meet the standard of care: Treatment Planning

- Additional diagnostic assessment
  - e.g., collaterals, psychodiagnostic testing)
- Treat the psychiatric disorder and relevant symptoms
- Involve family members in the psychoeducation & treatment plan
- Suicide safety plan

Reducing Likelihood of Patient Suicide & Guarding Against Malpractice Litigation

Meet the standard of care: Treatment Planning

- Appropriate level of care
- Obtain relevant consultation as necessary

Consultation:
High risk, challenging, confusing cases

- Discussion of the case (assessment and plan) with colleague or supervisor
- Referral of patient for second opinion
- Voluntary inpatient evaluation
- Consult risk management of malpractice carrier

Documentation

- Sources of information
- History and Mental Status Examination
  - Patient quotes
- Diagnosis and differential diagnosis

Documentation

- Suicide risk assessment
- Suicide safety plan
- Treatment Plan

“Meta-Documentation”

- Discussion of thought process and rationale for:
  - Clinical judgment of risk level
  - Actions taken
  - Actions considered but not taken