Current PSYCHIATRY

MALPRACTICE VERDICTS

How to avoid 'foreseeable' harm

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

When a psychiatrist is sued for negligence, the legal system asks, "Did the doctor depart from the standard of care, and—if so—did that departure proximately cause the harm?" To determine proximate cause, the legal system then asks whether the harm was a "reasonably foreseeable" result of the negligent act.

Inadequate evaluation leads to patient's suicide, plaintiff alleges

Dallas County (TX) District Court

In 1997, 1 year after suffering a stroke, a 56-year-old man was admitted to a rehabilitation center and seen by a psychiatrist for depression. In February 2000, the patient died after jumping from the center's fifth-floor window.

The patient's estate charged that the psychiatrist was negligent and did not adequately evaluate or treat the patient. The defense disputed the charge.

• **The jury found for the defense.**

Dr. Grant's observations

In this case, the psychiatrist presumably assessed the patient, determined whether he was depressed, and made appropriate treatment interventions. Three years later, the patient killed himself.

Although 3 years passed between the consultation and the suicide, under the law an intervening act that is the reasonably foreseeable result of negligence does not break the causal chain. For example, if the psychiatrist told the patient he needed no treatment and did not need to follow-up with another clinician, the causal chain arguably would still exist. Thus, proper care, not time, will prevent such a suit.

To win a negligence case, the plaintiff must show that the psychiatrist's actions proximately caused the harm. In order to defend your treatment decisions, document and discuss with the patient:

- the diagnosis and illness severity
- possible illness course based on patient history and the illness in question
- the need to monitor mood symptoms
- basis for treatment recommendations
- the possible need for continued treatment and to arrange follow-up care.

Plaintiff: Improper treatment caused fatal altercation

Cuyahoga County (OH) Court of Common Pleas

A man in his early 30s was admitted to the hospital's psychiatric unit for depression, mood disorder, and

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adjustment disorder secondary to myasthenia gravis. He was estranged from his wife, who was dating another man. The treating psychiatrist discharged the patient after 5 days.

Approximately 40 hours after discharge, the patient went to the other man's home and confronted him about his relationship with the patient's wife. The two men then fought, and the other man fatally shot the patient. During the fight, the patient stabbed the other man in the neck with a knife; this man required care and subsequently developed a scar.

The other man and the patient's estate charged that the psychiatrist did not appropriately evaluate and treat the patient. They claimed that a more thorough evaluation would have resulted in continued hospitalization and prevented the fight.

The defendant argued that the evaluation was thorough, that the discharge met the guidelines of appropriate care, and that the patient posed no risk to himself or others when he was discharged.

• **The jury decided for the defense.**

Dr. Grant's observations

This case raises the clinically difficult issue of assessing a patient's danger to self or others and whether this danger is reasonably foreseeable. Although Hughes reports that 17% of psychiatric emergency room patients are homicidal,[1] the American Psychiatric Association notes that 2 of 3 predictions of patient violence are wrong.[2]

In *Tarasoff v Regents of the University of California*, the California Supreme Court ruled that clinicians must warn potential victims of, and protect them from, a patient's intent to harm.[3] You should become familiar with the Tarasoff-type legislations in your state. But even if the patient shows no violent intent, the possibility of future violence cannot be ruled out.

During admission, assess and document an inpatient's risk of violence.[4] Factors that may increase a depressed patient's risk of becoming homicidal include:

- past violence
- current substance abuse
- psychopathy
- having suffered physical abuse as a child
- violent thoughts.[4-6]

If sexual infidelity, real or fantasized, precipitated the depression—as it might have in this case—a depressed patient may be at increased risk for homicide.

Check the patient's records for a history of recurrent violence. Culling this information from the chart is necessary because:

- past violent behavior may predict future violence
- patients rarely reveal homicidal thoughts or behavior spontaneously.[6]

Knowing a patient's violent past may aid in treatment. For example, you might order a longer hospitalization or establish more-intensive outpatient services focusing on avoiding aggression and violence. Make sure that follow-up care meets the patient's needs after discharge.[7]

A psychiatrist may be found negligent after a patient's violent act if the violence was foreseeable. However, after having seen the patient for 5 days in an inpatient setting, the psychiatrist in this case apparently could clearly document that the patient was not dangerous to himself or others before discharge.

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