Limits of care: What events can you prevent?

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Psychotic patient declines hospital admission, drives into an office building

Cook County (IL) Circuit Court

The patient, age 43, had been treated for mental illness for many years. He was voluntarily admitted to a hospital under the care of his psychiatrist, and was discharged at his own request a few days later. He had improved and was not considered a candidate for involuntary admission because he was not a danger to himself or others.

The patient then informed the psychiatrist that he did not want to continue treatment and said he had an appointment with a new psychiatrist within 2 weeks.

Five days later, the patient went to another hospital for voluntary admission. He was seen by an emergency room physician, who determined the patient was a candidate for voluntary admission. The patient, however, decided to leave the hospital while a bed was being arranged.

Two days later, the patient began having auditory and visual hallucinations. He then drove his car through the glass doors of an office building. No one was injured, but the patient was arrested and convicted of felony damage to property.

In his suit, the patient alleged his longtime psychiatrist was negligent and failed to properly treat him to avoid development of hallucinations. The psychiatrist argued that involuntary admission was not indicated and that the care given was appropriate.

• A defense verdict was returned

Patient commits suicide after discharge

Cook County (IL) Circuit Court

A patient, age 45, committed suicide by taking lethal doses of medication prescribed by her psychiatrist. The patient had suffered from severe depression, personality disorder, and substance abuse. The day before her death, she went to a hospital emergency room, where she was assessed for suicide and released without the psychiatrist having been notified.

The patient's family claimed that the psychiatrist was negligent because he did not adequately assess or monitor the patient's clinical condition at sufficient intervals over the 3 months preceding her suicide. The family also alleged that the psychiatrist prescribed oxycodone inappropriately.

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The psychiatrist argued that proper care was given and that the patient failed to provide a complete, accurate medical history at the emergency room visit and did not to consent to admission.

• A defense verdict was returned

Could admission have prevented patient's suicide?

Douglas County (NE) District Court

A patient in his mid-60s with a history of depression committed suicide with a gunshot wound to the head. Before his suicide, the patient was seeing a psychiatrist and psychologist for depression and emotional problems.

The patient's family alleged the psychiatrist failed to diagnose the severity of the patient's problems and admit him to a hospital for treatment and observation. The psychiatrist and psychologist denied negligence.

• A defense verdict was returned

Dr. Grant's observations

Medical malpractice law is constantly evolving to determine what constitutes "negligent care." The legal standard requires a patient who brings a negligence claim against a psychiatrist to prove:

- a relationship between patient and psychiatrist such that a duty of care exists
- the duty was breached—meaning the standard of care was not met
- the breach of duty caused the injury.

RELATIONSHIP RULES

The first case highlights issues surrounding the patient-psychiatrist relationship. In general, once you have agreed to treat a patient, a doctor-patient relationship and duty of care exists.

In the first case, the patient informed his longtime psychiatrist that he no longer wanted to continue care after discharge. A psychiatrist who terminates a doctor-patient relationship should provide written notice, an explanation of termination, and referrals and continue to care for the patient for a reasonable period.[1] No such duty exists, however, when the patient ends treatment. Courts have found that the patient has not been abandoned when he or she voluntarily and unilaterally terminates the relationship.[2,3]

The relationship ends the moment the patient terminates care, unless the patient is not competent to make that unilateral decision. In that situation, your duty of care to the patient continues.[2] When a competent patient terminates care, document the date and time of termination and the patient's competence.

WHEN RELATIONSHIPS BEGIN

The patient in the first case had an appointment with a new psychiatrist within 2 weeks. Is the new psychiatrist liable for what happens in the intervening period or does the relationship begin when the patient has been examined or treated? The legal question of when a physician-patient relationship is created remains problematic. Standards vary from state to state, but general principles offer some guidance.

The physician-patient relationship is a contract. The court would examine parties' actions to ascertain their intent to determine if the patient reasonably believed that the physician—by actions or words—agreed to provide necessary medical care. Additionally, whether a relationship exists depends on the specific facts and circumstances of each situation.

There is some authority, across many jurisdictions, that a physician-patient relationship is established only when a physician conducts the initial history and physical examination. In some cases, however, the relationship has been found to exist at an earlier point, such as when a physician gave a referred patient an appointment for a consultation. When in doubt, assume the relationship exists.[4]

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DUTY OF CARE

These cases raise areas where possible duty of care was breached:

- negligent prescription of medication
- failure to assess suicidal thinking.

Ethical prescribing. In the second case, the patient's family claimed that oxycodone was prescribed inappropriately. It is unclear from the case why the psychiatrist prescribed oxycodone. Because psychiatrists generally do not prescribe narcotics, the physician may have been prescribing outside of his or her area of professional competence. A psychiatrist who regularly does this is considered to have acted unethically.[5]

Assessing suicide risk. Negligence in the second and third cases is based upon failure to assess suicidal thoughts. The legal system recognizes that psychiatrists cannot predict suicide,[6] and mistakes in clinical judgment are not the same as negligence. Psychiatrists, however, are required to assess suicide risk and intervene appropriately.

When defending a negligence claim, the profession's custom—reflected by the standard of care common to others with the practitioner's training—is the benchmark against which the courts measure negligence. Therefore, take steps determined appropriate by the profession and document this risk assessment.[7] For example, ask the patient about:

- suicidal thoughts and intent
- stressors
- history of suicidal behavior/attempts
- substance use
- signs and symptoms of depression
- bipolar disorder
- psychosis.[8]

Patient dishonesty. Patients who do not disclose their suicidal thoughts might be seen as contributing to negligence. This means that despite the psychiatrist's mistakes, the harm would not have occurred without the patient's actions—which could include not being honest about his or her emotional condition. Contributory negligence might relieve the psychiatrist of liability or have an effect on resulting damages.[9]

Prescriptions. No clear line defines negligence when potentially dangerous medications are prescribed to a suicidal patient. Some psychiatrists dispense limited quantities of medications and see the patient weekly to monitor mood and medication. But even then a psychiatrist cannot prevent suicide—for example, the patient may have multiple prescribers or hoard medications. The concept of "sufficient intervals" to see a patient is determined case-by-case.

Documentation. Make suicide assessments an ongoing process. Document all aspects of the patient's care, stability, and suicide risk, and reasons for the visit intervals. Indicate in the records your risk-benefit assessment in making treatment decisions.

References

1. American Medical Association Code of Medical Ethics, Opinion 8.115.
2. Knapp v. Eppright, 783 SW2d 293 (Tex 1989).
3. Saunders v. Tisher (Maine Sup. Jud. Ct. 2006).
4. Physicians Risk Management Update. The physician-patient relationship: when does it begin? Available at: http://www.phyins.com/pi/risk/updates/mayjun04.html. Accessed December 28, 2006.
5. American Psychiatric Association. *Principles of medical ethics with annotations especially applicable to psychiatry*. Washington, DC; 2006. Available at: http://www.psych.org/psych_pract/ethics/ppaethics.cfm. Accessed December 28, 2006.
6. Pokorny A. Prediction of suicide in psychiatric patients. Report of a prospective study. *Arch Gen Psychiatry* 1983;40(3):249-57.
7. Packman WL, Pennuto TO, Bongar B, Orthwein J. Legal issues of professional negligence in suicide cases. *Behav Sci Law* 2004; 22:697-713.
8. 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.
9. Maunz v. Perales, 276 Kan. 313, 76 P.3d 1027 (Kan 2003).

DRUG BRAND NAME

Oxycodone • Percocet