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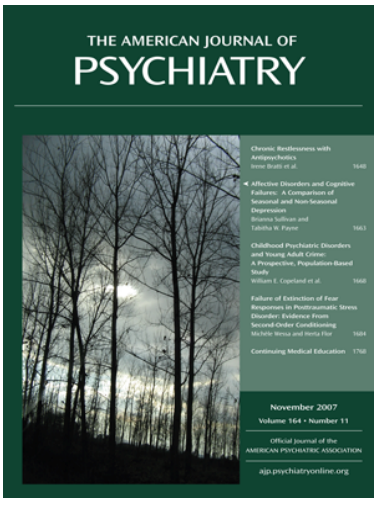

The following is an interview with Paul S. Appelbaum, M.D., on "Legal Considerations in Psychiatric Patient Suicide," conducted by Anna Gross, M.D. Dr. Appelbaum is the Elizabeth K. Dollard Professor of Psychiatry, Medicine, and Law and the Director of the Division of Law, Ethics, and Psychiatry at Columbia University. Dr. Gross is a fourth year psychiatry resident at Columbia University and the Resident Editor for this issue.

Dr. Gross: **What lessons can we learn from malpractice litigation after a patient attempts or commits suicide?**

Dr. Appelbaum: Examining the reasons why psychiatrists are sued can help identify major areas of litigation risk that need to be managed appropriately. Although we lack broad-based studies of suicide litigation, in my experience the most frequent areas in which problems arise are: 1) appropriate initial assessment of suicide risk, 2) continuing attention to the presence of suicidal ideation, and 3) proper documentation of the basis for decisions about patient care.

Dr. Gross: **From a legal perspective, is there a "standard of care" for suicide assessment, documentation, and management?**

Dr. Appelbaum: The law does not require psychiatrists to be guarantors of patients' safety. So if a suicide occurs, liability is not automatically assumed. However, the law does expect psychiatrists to live up to the standard of care set by the profession, i.e., to do what a reasonable psychiatrist in a similar situation would have done to manage the case. Entire books have been written attempting to describe what is required by the standard of care. In brief, psychiatrists should be screening for suicide risk in initial patient encounters, with the extent of the evaluation depending on the presence and extent of suicidal ideation. Treatment should be focused on responding to suicide risk when present, including treating depression and other disorders, addressing situational precipitants, ensuring an appropriate level of safety (e.g., continuous observation or periodic checks in an inpatient service), and periodically reevaluating patient suicidality, especially when changes in privileges or discharge are being considered. Not only should medical records document *what* was done, but psychiatrists should record *why* these decisions were made. Although the details of management differ for inpatient and outpatient settings, the principles are the same.

Dr. Gross: **What are the key elements to a systematic suicide risk assessment?**

Dr. Appelbaum: All new patients should be screened for past suicidal behavior (e.g., "Have you ever tried to hurt yourself?") and current ideation (e.g., "Do you ever think about hurting yourself?"). For patients who respond in the negative and give no reason to doubt their replies, the psychiatrist has discharged his or her obligation. If past suicidal behavior is reported, psychiatrists should explore its nature and precipitants and determine the extent to which such precipitants are currently present in the patient's life or may recur in the foreseeable future. Current ideation should be probed to ascertain its strength, whether it has evolved into a discrete plan, whether steps have been taken to further the plan, and the likely imminence of implementing the plan. Good references exist for psychiatrists who want to know more about suicide risk assessment.

Dr. Gross: **How does the law view suicide prevention contracts or "contracts for safety"?**

Dr. Appelbaum: The consensus in the literature is that "contracts for safety" do not reduce the risk of suicide. Moreover, they may mislead clinicians into believing that suicide risk has been appropriately dealt with and that further evaluation and management are not needed. The legal system has become extremely skeptical of such contracts, and even clinicians who take all other appropriate steps in treating suicidal patients may find themselves raked over the coals about their use. Given that these contracts seem to have no beneficial clinical impact and that they may actually increase the risk of liability, I would avoid them entirely.

Dr. Gross: **From a clinical and risk management perspective, what do you recommend regarding patients at risk for suicide who unilaterally terminate outpatient treatment?**

Dr. Appelbaum: If the terminating patient appears likely to act on the suicidal ideation in the near future, involuntary commitment may be needed. If the risk is less intense or less imminent, efforts should be made to encourage the patient to return to treatment or to accept referral to another clinician. From a risk management perspective, letters are better than phone calls, since they are easier to document. For those patients whom one is genuinely worried about, more than one attempt should be made. But if the patient cannot be committed and is not interested in returning to treatment, the psychiatrist should not be liable in the case of future suicide.

Dr. Gross: **After a patient commits suicide, clinicians have an understandable urge to reach out to the family to express sympathy and regret. Mindful of both clinical and legal concerns, what is the best way to approach this difficult task?**

Dr. Appelbaum: It is both natural and commendable for a psychiatrist to want to contact the family

and express sympathy. Many experienced clinicians believe that outreach at this point reinforces the bond with the family and decreases the risk of subsequent lawsuits. But psychiatrists should avoid the impulse to express guilt over their own behavior or to in any way suggest that the family shares responsibility for the outcome. The message should be something like: "I'm so terribly sorry about Jane's death. We all did everything we could, but sometimes that is not enough." Families experiencing guilt over a loved one's suicide may respond by projecting that guilt onto the psychiatrist—with a lawsuit as an ultimate result.

Supporting Residents After Patient Suicide

Christina Mangurian, M.D., PGY 5

Department of Psychiatry, Columbia University

When I started my internship, I actually thought I would be able to avoid having a patient of mine die. That, of course, was a fantasy and a denial of the severity of some medical illnesses, as I had to cope with the death of a couple of my patients that first year. It was a similar defense that allowed me to not consider the possibility of a patient of mine committing suicide during my psychiatry residency. But, like my internship, I had to struggle with this reality as well.

In the beginning of my third year, one of my patients committed suicide. I developed a confusing array of feelings after hearing the news. I was numb, shocked, and filled with disbelief. I felt guilty that I had not done enough and ashamed that I was a "bad resident." I felt angry. I had intrusive images and dreams for about a month. At the time, these responses were disturbing because I thought that there was something wrong with me. Later I learned that I was experiencing the typical reactions to patient suicide (1–2).

After a patient commits suicide, residents often feel like they do not receive the support they need, especially from those in positions of authority (1–3). This was true for me but fortunately, with support from others in my life and by reading the literature and contacting other clinicians around the country, I was able to turn this unfortunate experience into something productive. In the *Textbook of Suicide Assessment and Management*, contributor Dr. Gitlin outlines "optimal coping strategies" to consider after patient suicide (1). I used several of these coping strategies (particularly decreasing isolation, acknowledging that suicide can be part of the natural course of severe mental illness, acknowledging that clinical failures are not personal failures, and instituting reparative and constructive behaviors) to achieve my goal of better supporting fellow residents after patient suicide. My work thus far includes:

• Starting a committee of faculty and residents with the goal of better supporting residents after patient suicide

• Presenting at the first Morbidity and Mortality conference at my institution

• Developing anticipatory courses about responses to patient suicide for PGY-1 and PGY-2 residents

• Developing an informational packet for residents including typical responses to patient suicide, suggestions for coping, supportive peer/faculty contact information, details of different administrative procedures on various services after a patient suicide, listing of risk management organizations/terms, legal questions/answers, and a listing of references

• Chairing and presenting a workshop at the 2007 APA annual meeting at which Columbia University residents and faculty members presented personal accounts of patient suicide.

• Collaborating with residents at my institution who have experienced patient suicide so that they too could take leadership in some of these endeavors.

Finally, I have been given the opportunity to contribute to this important series of papers. I hope this information is helpful to readers and that my experience helps residents improve patient care and better support other clinicians who have also experienced patient suicide.

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Coping With Patient Suicide: A Novel Approach

Allison Nitsche, M.D., PGY4

Department of Psychiatry, Emory University School of Medicine

An estimated 15% to 68% of psychiatrists and one-third of trainees have experienced patient suicide. Studies reveal that a significant proportion of those affected show strong negative reactions, including symptoms of anxiety and depression. Residents are particularly at risk of increased distress following patient suicide due to their relative youth and limited experience (1).

During my adult psychiatry training in the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine, I observed residents in the program attempting to cope with patient suicides and other traumatic clinical encounters. During my third year, I was touched when Dr. Glen Gabbard courageously presented at grand rounds on his personal experience with patient suicide. During this presentation, Dr. Gabbard described a response team that provided support to employees in the aftermath of patient suicide when he was director of Menninger Hospital. After hearing this presentation, I wondered if we could design a similar response in my program. I approached Dr. Gabbard and several other faculty members with this idea and was happily surprised when it was met with enthusiasm and encouragement.

In December 2006, a group of residents and faculty from my program began a series of discussions to design and implement a crisis response team. This team consists of the chief resident, training directors, and representatives from each of the clinical sites within the department and is activated whenever a patient under the care of a resident commits suicide. In addition, the same team is activated when a patient under a resident's care commits an act of homicide or engages in assaultive or stalking behavior. The chief resident is the central figure of the team, as the one who is first notified and who subsequently activates the team. The team provides a two-part response: 1) a clinical response, in which the chief resident, a representative of the clinical site, and the director of the service offers support, including time away from work, and 2) an administrative response, in which the training directors meet with the resident to determine what

additional support would be helpful, including 1) recommendations on how to interact with the patient's family, 2) whether to attend funeral services, and 3) where to receive further assistance. The clinical and administrative aspects of the response are separated so that residents can speak openly, without concern of repercussions in terms of training.

Other key issues that have been raised include making notification of the response team mandatory, so as to avoid residents' tendency to deny the need for help, and assuring that discussions with the response team are protected under peer review in the event of litigation. While the team is still in its infancy, it has been activated and utilized by several residents who have greatly valued the support.

References

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