Suicide Risk Assessment: What Is the Standard of Care?

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It is said that there are two kinds of psychiatrists: those who have had patients commit suicide and those who will. Suicides of patients are the most frequent source of malpractice claims against psychiatrists. An examination of the parameters of what constitutes acceptable suicide risk assessment finds marked disagreement among respected clinicians, academics, and researchers who testify as experts in suicide cases.

Studies of suicide in adults indicate that more than 90 percent of individuals who commit suicide are mentally ill.[1] More than 30,000 people die by suicide each year. Many of these individuals will have seen a physician or a mental health professional the day of or a few days before committing suicide. In 1999, the Surgeon General's "Call to Action to Prevent Suicide" emphasized that identification of "suicide risk and protective factors and their interactions form the empirical base for suicide prevention."[2]

Psychiatrists cannot predict with certainty which patients will commit suicide. Suicide is a rare event. Attempts to predict suicide produce many false-positive and false-negative results. Thus, there is no professional standard of care for the prediction of suicide. No competent expert will disagree on this point. Moreover, few experts would disagree that the psychiatrist must gather sufficient information about the patient to perform an adequate suicide risk assessment that informs clinical interventions and management. The question is, what constitutes an adequate, clinically informative suicide risk assessment? My answer is that an adequate suicide risk assessment systematically considers the interplay between risk and protective factors. By systematic, I mean the identification and weighing of patient-specific risk and protective factors. Systematic suicide risk assessment is an inductive process, reasoning from patient-specific data to a clinical judgment about appropriate treatment and management. Systematic does not mean perfect or exhaustive assessment. When patients are at risk for suicide, nothing less than systematic risk assessment will do.

Why do so many psychiatrists not perform or, having performed, not document even the semblance of a systematic (formal) suicide risk assessment? When posed to colleagues, this question receives a variety of answers: the psychiatrist never learned during training how to perform a systematic suicide risk assessment (I believe this to be true of many psychiatrists); the psychiatrist simply does not perform a systematic suicide risk assessment (the majority of cases); patients at risk for suicide evoke anxiety and denial in the psychiatrist who then minimizes or overlooks the risk; the psychiatrist actually performs a systematic suicide risk assessment but is rushed and fails to document it; the psychiatrist is fearful that documenting his or her thought processes creates legal exposure if the assessment is wrong and the patient commits suicide; or the psychiatrist delegates risk assessment and patient management to the treatment team or others, usually in managed-care settings. All of the above can play some role in the lack of performance or documentation of systematic suicide risk assessments. However, depending on the patient or in clinical situations such as ongoing psychotherapy, systematic suicide risk assessment may not be indicated.

In the experience of one hospital quality assurance committee, which mandates documented assessment of suicide risk as a marker for review, there has been a complete lack of compliance. Repeated requests to perform risk assessments go unheeded by the attend-

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ing psychiatrists. In desperation, a trial period requiring psychiatrists to use suicide risk assessment forms or, as an alternative, to document the psychiatrist's suicide risk assessment in the patient's chart is currently being tried. It remains to be seen whether this entrenched resistance to perform even minimally acceptable suicide risk assessments can be overcome. I doubt that this problem is unique to just one hospital.

In reviewing psychiatric records of suicide cases in litigation, I find that what usually passes for suicide risk assessment is the following: "Patient denies HI, SI, CFS" (homicidal ideation, suicidal ideation, contracts for safety). At most, the record contains a note that "The patient denies suicide ideation, intent, or plan." A talismanic "no-harm contract" often is relied on in lieu of performing an adequate suicide risk assessment. Laypersons also can ask these questions and obtain a perfunctory no-harm contract.

The Courts

Clinicians and the courts should have little disagreement that the standard of care requires that suicide risk assessments be performed to guide the treatment and management of patients at risk of suicide. However, if clinicians cannot agree among themselves about what constitutes an adequate, clinically informative suicide risk assessment, how much more difficult must it be to arrive at a professional and legal consensus on this question?

States define the standard of care required of physicians. The specific legal language is applied to the facts of a case to determine whether the patient's treatment was negligent. For example, in *Stepakoff v. Kantar*, the standard of care applied by the court in a suicide case was the "duty to exercise that degree of skill and care ordinarily employed in similar circumstances by other psychiatrists" (473 N.E.2d 1131 (Mass. Ct. App. 1987)). The court held that the duty of care was that of the "average psychiatrist."

If most psychiatrists do not perform or document a systematic suicide risk assessment, does that become the standard of care when the "ordinarily employed" legal frame is applied to suicide cases? To pursue this reasoning as a defense strategy in a malpractice case would be foolhardy. Some states establish that the standard of care be judged by the practice of the reasonable, prudent practitioner. Does the "prudent" standard require that psychiatrists perform and document systematic suicide risk assessments?

The standard of care "ordinarily employed" by the average psychiatrist must be something more than a statistical head count. If 99 of 100 therapists were to have sex with their patients, it still would be negligent and harmful behavior. Courts have held that negligence cannot be excused because others practice the same kind of negligence. Although the "reasonable, prudent" physician is a higher legal standard, even a majority of reasonable and prudent practitioners can be wrong. Just recall the massive scale of unnecessary tonsillectomies performed on children not so long ago. If, in fact, reasonable and prudent psychiatrists do not perform systematic suicide risk assessments to inform the treatment of patients at risk of committing suicide, a resultant standard of care not requiring systematic risk assessment would be clinically wrong and harmful. This conclusion is unavoidable when actual practice bears little or no relationship to a reasonable and prudent standard of care.

Courts scrutinize the psychiatrist's management of the patient who attempts or commits suicide to determine the reasonableness of the risk assessment process and whether the patient's suicide was foreseeable. The law tends to assume that suicide is preventable if it is foreseeable. There is, however, an imperfect fit between legal and medical terminology. Foreseeability is a legal term of art—a common sense, probabilistic concept rather than a scientific construct. Foreseeability is the reasonable anticipation that harm or injury is likely to result from certain acts or omissions. For example, if the psychiatrist assesses the patient to be at moderate to high risk for suicide, he or she is on notice to take appropriate clinical action.

However, the law does not require the defendant to "foresee events which are merely possible but only those that are reasonably foreseeable" (*Hairston v. Alexander Tank & Equipment Co.*, 311 S.E.2d 559 (N.C. Ct. App. 2000)). It is only the risk of suicide that can be assessed, and therefore only the risk of suicide that is reasonably foreseeable. Prediction of suicide remains opaque to the clinician, even with the best of risk assessments. Thus, the performance and documentation of systematic suicide risk assessment that informs patient treatment and management should meet foreseeability criteria.

Foreseeability is not to be confused with predictability, for which no professional standard exists.

Foreseeability must be distinguished from preventability. A suicide may have been preventable in hindsight but was not foreseeable at the time of assessment. Based on expert testimony, courts generally have held the psychiatrist liable in a patient's suicide if she or he failed to assess the patient's risk of suicide adequately and to implement an appropriate treatment plan.

Courts are likely to dismiss incomplete assessments such as the assessment of isolated risk factors (e.g., demographic factors) as "simply insufficient" in establishing foreseeability. In *Williamson v. Liptzin* (548 S.E.2d 734 (N.C. 2001)), the psychiatrist was sued by his former patient for not foreseeing the violence perpetrated by the patient during a murderous rampage that occurred eight months after the termination of treatment. The appellate court held that: "Furthermore, evidence of 'risk factors' for potential violence, such as gun ownership, being under a certain age, or being of a certain gender, implicates a large portion of our population and is simply insufficient in and of itself to prove foreseeability." However, the court did not directly address whether systematic risk assessment would have established foreseeability. A history of violence or violent threats may have "individualized" the risk assessment and led to a conclusion that the violence was foreseeable, which was not possible with demographic factors alone.

Williamson is a case about the foreseeability of violence toward others. However, the court's comments could be applied just as easily to suicide cases and suicide risk assessment. When systematic suicide risk assessments are performed and documented, the clinician is not only able to identify and treat modifiable risk factors, but to give the court guidance in litigation. It also provides the clinician with a sound legal defense.

Systematic Suicide Risk Assessment

The assessment of risk for suicide is one of the most complex, difficult, and challenging evaluative procedures in psychiatry. Similar to other important psychiatric procedures, knowledge and training are required to perform it correctly. Assessment can identify acute, modifiable, and treatable risk factors, essential to the psychiatrist's treatment and management of suicidal patients. When systematic assessment is not performed, it is easy to overlook important risk and protective factors.

Systematic suicide risk assessment examines individual (unique), clinical, interpersonal, situational, and demographic factors that increase or decrease suicide risk. The overall assessment of suicide risk is a judgment call that is clinically informed and supported by sufficient information gathered from the patient, from prior treaters and treatment records, and usually from those who live with or know the patient. Performing a systematic suicide risk assessment that informs treatment should more than meet the criteria for a reasonable, prudent standard of care. The use of reasonable professional judgment is a mainstay defense in suicide cases in which it is alleged that the psychiatrist was negligent in the treatment and management of the patient.

Suicide risk assessment is a process, not an event. Time rapidly diminishes the clinical usefulness of suicide risk assessments. Assessments must be updated frequently. For example, the clinician performs a systematic suicide risk assessment at the patient's inpatient admission. Throughout the hospitalization, the clinician assesses the course of the acute risk factors for suicide that precipitated the hospitalization. A chronic (static) risk factor can change during the hospitalization—such as the unexpected dissolution of a marriage or a sudden financial crisis—abruptly becoming an acute risk factor. At discharge, a systematic suicide risk assessment is performed to assess relevant risk and preventive factors. The suicide risk assessment process is similar for outpatients.

Whether a patient actually attempts or commits suicide has multiple determining aspects, depending largely on the complex interaction between risk and protective factors. An internal battle rages for life or death. Assessing only risk factors addresses just one side of the patient's psychic struggle and is therefore insufficient.

There are a variety of suicide risk assessment methods available to the clinician. No suicide risk assessment method has been empirically tested for reliability and validity. Psychiatrists and other mental health professionals are free to devise suicide risk assessment methods based on their training, clinical experience, and the psychiatry literature that adequately inform patient treatment and management. Suicide assessment forms, structured and semistructured suicide scales, questionnaires, and checklists may complement but should not substitute for the psychiatrist's suicide risk assessment. The reliance on checklists

creates the danger that the clinician will robotically suspend clinical skills and judgment in assessing suicide risk. Checklists cannot capture the dynamic interplay between suicide risk and protective factors. Moreover, plaintiffs' attorneys are quick to point out any omissions on the checklist that were relevant to the patient's suicide.

The standard of care requires the documentation of suicide risk assessments. However, the absence of documentation is rarely the proximate cause of suicide. Documentation of suicide risk assessments that serve both important clinical and risk-management purposes can be done in a concise, time-efficient manner. The failure to document suicide risk assessments contemporaneously may permit the court to conclude that they were not performed. Also, when the clinician fails to describe her or his decision-making process in the patient's record, the court may not be able to evaluate the complex issues involved in the assessment of the risk. The lack of documentation may allow the court to focus narrowly on simpler aspects of the case, while overlooking the clinical complexities and ambiguities that exist with every patient who attempts or commits suicide.

Official Practice Guidelines

Practice guidelines usually indicate the degree of importance or certainty of each recommendation. For example, minimal-standards recommendations are based on substantial empirical evidence (such as well-controlled, double-blind studies), or overwhelming clinical consensus, or legal and regulatory requirements, or all of these. Minimal standards are recommendations that are expected to apply more than 95 percent of the time. I believe that performing and documenting systematic suicide risk assessments on patients at risk for suicide would meet the "overwhelming clinical consensus" criterion for minimal standards of practice.

The argument will be made by some that clinical guidelines are more appropriate for psychiatry than setting minimal standards. Clinical guidelines are recommendations that are based on empirical evidence such as open trials and clinical studies, or on strong clinical consensus, or on both. Clinical guidelines are relevant approximately 75 percent of the time. The clinician should always consider these recommendations, but there are exceptions to their applicability.

Options are pragmatic recommendations that are acceptable but not required. Insufficient empirical evidence is available to support recommending options as minimal standards or clinical guidelines. In some cases, the practice may be entirely appropriate, whereas in other situations it should be avoided.

Professional organizations recognize the need for developing evidence-based and clinical consensus recommendations to be applied to the management of various diseases, including such behavioral states as suicide. The American Academy of Child and Adolescent Psychiatry has published "Practice Parameters for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior."[3] The American Psychiatric Association has organized a Work Group on Suicidal Behaviors that will recommend practice guidelines for treatment and management of patients at risk for suicide.

Official practice guidelines are not static but evolve and change according to new developments in practice and science, requiring frequent updating. Studies show that no more than 90 percent of practice guidelines are valid at 3.6 years.[4] At 5.8 years, half of the guidelines are outdated. Thus, sponsoring organizations issue disclaimers that practice guidelines do not represent the standard of care, much less for a fact-specific case in litigation.

The T. J. Hooper Case and the Standard of Care

Is it too much to expect psychiatrists and other mental health practitioners to gather sufficient information to perform and document systematic suicide risk assessments, especially in the managed care era of rapid patient turnover and limited treatments? Some clinicians believe that the initial psychiatric evaluation is sufficient to determine suicide risk without the added necessity of conducting a systematic assessment, much less an ongoing, evolving one. Others will no doubt complain that setting a standard of care requiring systematic suicide assessments is an unrealistic standard, is contrary to current clinical practices, and is reflective of this author's personal views. Some will say that the standard proposed herein would unnecessarily burden psychiatrists who do not have time to perform systematic suicide risk assessments in the real world of managed care. Still others will point out that there is no research showing that such assessments prevent suicide attempts or successful suicides. The standard "ordinarily employed" by

clinicians does not require systematic assessment of risk for suicide—so goes this line of reasoning.

Courts, however, may impose their own standards. In *The T. J. Hooper* case (60 F.2d 737 (2d Cir. 1932)), two barges towed by the tugs *Montrose* and *T. J. Hooper* were lost off the New Jersey coast during a gale in March 1928. The court upheld the finding that the tugs were unseaworthy because they did not have radios with which they could receive weather reports, even though at the time such equipment was not standard in the industry.

There are comparable cases of judicially imposed standards of care in medicine. A few courts have rejected the standard of the profession, finding negligence as a matter of law rather than by a jury determination. In *Helling v. Carey* (519 P.2d 981 (Wash. 1974)), the court held that tonometry examinations were required as a matter of law on all patients younger than 40 years, not withstanding the testimony by ophthalmologists that glaucoma in patients less than 40 years of age had an incidence of 1 in 25,000. In *Tarasoff v. Regents of the University of California* (551 P.2d 334 (Cal. 1976)), the court imposed a duty to warn and protect individuals potentially endangered by therapists' patients, despite unanimous testimony by leading authorities and the American Psychiatric Association that the accurate prediction of violence is not possible. The court in *Canterbury v. Spence* (464 F.2d 772 (D.C. Cir. 1972)) imposed the "reasonable man" standard in informed-consent litigation, even though the professional-custom standard was the prevailing standard. In *Tarasoff*, *Helling*, and *Canterbury* the courts imposed their own versions of professional practice standards, regardless of professional opinion to the contrary. Moreover, in the legal regulation of psychiatry, legislatively imposed standards of care can be found, for example, in civil statutes governing confidentiality, in therapist-patient sexual misconduct, and in immunity statutes defining the duty to warn and protect.

It is well that we should heed the words of Justice Learned Hand who wrote the opinion in *The T. J. Hooper* case:

> There are, no doubt, cases where courts seem to make the general practice of the calling . . . the standard of proper diligence. Indeed in most cases reasonable prudence is in fact common prudence, but strictly it is never its measure; a whole calling may have unduly lagged in the adoption of new and available devices. It may never set its own tests, however persuasive be its usages. Courts must in the end say what is required; there are precautions so imperative that even their universal disregard will not excuse their omission [60 F.2d at 740].

A systematic suicide risk assessment is a basic, essential clinical tool to inform the practitioner about the safety requirements, treatment, and management of patients at risk for suicide. It is akin to tonometry for the diagnosis of glaucoma or x-rays for the demonstration of fractures. If there is a "universal disregard" for "precautions so imperative" as systematic suicide risk assessment, then administrative, legislative, or judicial directives may mandate it.

References

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