Commentary: Medical Errors, Sentinel Events, and Malpractice

Robert I. Simon, MD

Medical errors do not necessarily represent negligence. Even when a mental health professional deviates from the standard of care, minor injury to a patient is unlikely to result in a lawsuit. The standard of care is not the same as the quality of care. Quality of care refers to the total care a patient receives, the patient's health care decisions, and the available mental health services. As defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), "sentinel events," such as a patient's suicide, do not necessarily imply that a deviation in the standard of care occurred. Psychiatrists and hospital staff are held to an "ordinarily employed" standard of practice. The Institute of Medicine (IOM) guidelines recommend evidence-based care related to patient needs and values. Both JCAHO and IOM promote best practices. Experts err when they testify to a best practice standard in malpractice cases.

J Am Acad Psychiatry Law 34:99–100, 2006

In the case example in Dr. Steiner's article regarding adverse hospital incidents,[1] the senior nurse made a serious mistake in allowing a patient on one-to-one observation to possess a razor. The error was not intentional, it was negligent. The patient's self-inflicted injuries were minor. A lawsuit is unlikely, even though the senior nurse deviated from the standard of care. Lawyers are fond of saying, "no harm, no fault."

The standard of care should be distinguished from the quality of care.[2] The standard of care is a legal concept, normatively defined, that is applied to the specific fact pattern of a case in litigation.[3] The definition of standard of care differs among states. Quality of care is defined as the adequacy of total care the patient receives from health care professionals, including third-party payers. The quality of care is further influenced by the patient's health care decisions and the allocation and availability of psychiatric services. The quality of care provided by the psychiatrist may be below or equal to or may even exceed the acceptable standard of care. Medical errors that diminish the quality of care may not necessarily violate the standard of care.

The Institute of Medicine (IOM)[4] guidelines recommend evidence-based and individualized care based on patients' needs and values. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)[5] places emphasis on Root Cause Analysis through the process of identifying and analyzing "sentinel events." The IOM and JCAHO guidelines promote best practices. In a malpractice case, however, the psychiatrist and hospital staff members are held to the "ordinarily employed" standard of practice—a minimally acceptable standard of care. Unfortunately, some plaintiffs' experts who testify in malpractice cases erroneously impose a "best practices" standard of care on mental health professionals.[6]

The case example in Dr. Steiner's article[1] does not provide the senior nurse's explanation for her error. Many factors can adversely affect inpatient care, placing psychiatrists and other mental health professionals in legal jeopardy. Restriction or denial of mental health benefits by third-party payers has reduced hospital length of stay dramatically—usually to less than a week. Close scrutiny by utilization reviewers permits only brief hospitalization.[7] Seriously mentally ill patients who are at high risk of committing suicide, homicide, or both, are admitted. Admission to a psychiatric unit is a useful indicator of increased risk of suicide.[8] Comorbidities, especially substance abuse disorders, increase the risk of suicide. Adequate suicide risk assessments may not be performed or, if performed, may not be documented.[2] Many of these patients cannot be adequately stabilized within a few

Dr. Simon is Clinical Professor of Psychiatry and Director, Program in Psychiatry and the Law, Georgetown University School of Medicine, Washington, DC. Address correspondence to: Robert I. Simon, MD, 8008 Horseshoe Lane, Potomac, MD 20854. E-mail: risimonmd@aol.com

days. Patients at continuing high risk for violence against self or others may be prematurely discharged.[9] Also the hospital administration may press for early discharge to maintain patient length of stay statistics within predetermined goals.

On inpatient units, rapid patient turnover usually does not allow the mental health staff and psychiatrists sufficient time to provide care that meets a "best practices" standard. Units are often understaffed. Psychiatrists' time spent with patients is limited. The treatment team can become overwhelmed and exhausted by rapid patient admissions and discharges. Moreover, it is not possible to provide 5- or 10-minute safety checks on patients requiring close supervision by an overburdened staff. Patients are usually placed on either 15-minute checks or on some form of one-to-one observation. Most third-party payers do not pay for "sitters," requiring an already overextended staff to provide close supervision or to devise some alternative safety management. Completed suicides occur on inpatient units, even when patients are on arms-length, one-to-one supervision.[10] Psychiatric hospitalization is not a guarantee of safety.

Inpatient units may require temporary closure to new admissions when very ill or disruptive patients overwhelm the staff's ability to provide safety. Seclusion and restraint may be inappropriately utilized. These conditions are rife for medical errors. Nonetheless, psychiatrists, inpatient staff, and the hospital must maintain a minimally acceptable standard of care.

In the case example, the director of human resources and the director of nursing recommended "serious disciplinary action" against the senior nurse. Disciplinary action by itself, however, does not establish that malpractice occurred. Mistakes alone are not a basis for malpractice, if the minimally acceptable standard of care is not breached. If, however, the senior nurse's negligence had caused serious injury or death, citing all of the vicissitudes and limitations of inpatient treatment would not provide a viable defense against a malpractice suit. Providing adequate and timely care for patients according to their clinical needs and situations is the best malpractice defense. Mental health professionals who practice inpatient psychiatry should carry good professional liability insurance.

References

1. Steiner JL: Managing risk: systems approach versus responsibility for hospital incidents. J Am Acad Psychiatry Law 34:96–8, 2006
2. Simon RI: Assessing and Managing Suicide Risk: Guidelines for Clinically Based Risk Management. Arlington, VA: American Psychiatric Publishing, Inc., 2004
3. Simon RI, Shuman DW: The standard of care in suicide risk assessment: an illusive concept. CNS Spectrum, in press
4. Committee on Quality Health Care in America, Institute of Medicine: Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy of Sciences, 2001
5. Joint Commission on Accreditation of Healthcare Organizations: Sentinel Event Statistics: Root Causes of Inpatient Suicide, 1995–2002. http://www.jcaho.org/accredited+organizations/ambulatory+care/sentinel+events/rc+inpatient+suicides.htm (accessed July 21, 2003)
6. Simon RI: Standard-of care testimony: best practices or reasonable care. J Am Acad Psychiatry Law 33:8–11, 2005
7. Wickizer TM, Lessler D, Travis KM: Controlling inpatient psychiatric utilization through managed care. Am J Psychiatry 153: 339–45, 1996
8. Bostwick JM, Pankratz VS: Affective disorders and suicide risk: a reexamination. Am J Psychiatry 157:1925–32, 2000
9. Simon RI: Discharging sicker, potentially violent psychiatric patients in the managed care era: standard of care and risk management. Psych Ann 27:726–33, 1997
10. Fawcett J, Busch KA, Jacobs DG: Clinical correlates of inpatient suicide. J Clin Psychiatry 64:14–19, 2003