Commentary: Think Fast, Act Quickly, and Document (Maybe)

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The article by Elbogen *et al.*[1] makes a valuable contribution to the little-studied connection between documentation of violence risk information and risk management. Some clinicians neither take the time nor have the inclination to document violence risk assessments adequately. When the clinician is confronted with a patient at imminent risk of becoming violent toward others or himself, the clinical focus is on rapid intervention. Documentation of the clinician's risk assessment rationale is often an afterthought, if it is done at all. It is my experience that even unhurried clinicians rarely document evidence of violence adequately in their risk assessments and clinical decision-making. However, asking busy, harried clinicians in today's managed-care environment to complete time-consuming risk assessment protocols is a fool's errand.

The authors cite the work of Malone *et al.*[2] regarding the documentation of suicide risk assessments. This provides an opportunity to discuss the parallel topic of documenting the assessment and management of patients at risk for suicide. Malone *et al.*[2] studied clinicians, including psychiatrists, who performed routine intake and discharge assessments of 50 patients identified by systematic research evaluations as having attempted suicide and as having a current major depressive episode. They found that the clinicians failed to document adequately the presence of a lifetime history of suicide attempts in 24 percent of cases at admission and in 28 percent of cases in the discharge summary. In 38 percent of the patients, the physician's discharge summary did not document the presence of recent suicidal ideation or planning behavior. The authors conclude that a significant degree of past suicidal behavior is not recorded during routine clinical assessment. They recommend the use of semistructured screening instruments to improve documentation and to detect lifetime suicidal behavior. For outpatient clinicians responsible for follow-up, adequate documentation identifies the high-risk population at time of discharge. The study underscores the importance of systematic suicide risk assessment.

Documentation is an essential part of patient care. It encourages the practitioner to sharpen clinical focus and clarify decision-making rationale. The record comes alive as an active clinical tool, not just an inert document. The clinician treats the patient, not the chart. Documentation as a risk management tool supports good clinical care.

When patients are at risk of suicide, it is necessary to document all interventions as well as the rationale for such actions. Documentation should contain answers to the following basic questions: what was done, the reason(s) for doing it, and the rationale for rejecting alternative interventions or treatments.[3] Suicide risk assessments should be recorded when performed. Psychiatrists who do adequate suicide risk assessments may not always record them.

Suicide risk assessment and documentation in outpatient settings are usually performed during the initial interview, at the emergence of suicidal ideation or behavior, and when a significant change occurs in the patient's condition. In inpatient facilities, important points of documentation of suicide risk assessment occur at admission, changes in supervision level, ward changes, the issuance of passes, marked changes in the patient's clinical condition,

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and evaluation for discharge.[4] Suicide risk assessment is a process, not a one-shot event.

If a malpractice claim is brought against the psychiatrist, documentation of suicide risk assessment assists the court in evaluating the many clinical complexities and ambiguities that exist in the treatment and management of patients at risk for suicide. In *Abille v. U.S.*,[5] a psychiatrist failed to maintain contemporary notes, orders, or other records that adequately explained the management decisions for a patient who committed suicide. The psychiatrist transferred the patient from suicide status to a status appropriate for less dangerous patients. At the time of the transfer, no notation was made by the psychiatrist explaining the transfer, even though he usually made such notes. This documentation was also required by hospital regulations. The court acknowledged that a reasonable psychiatrist might have determined that the patient could be reclassified with safety, but without notes, there was concern that the decision was made negligently. *Abille* underscores the court's need to know the decision-making process of the psychiatrist. A psychiatrist's best friend in court is a carefully documented record that contemporaneously details the provision of adequate care.

A psychiatric record that carefully documents the psychiatrist's suicide assessments and reasoning process provides a formidable legal defense by providing the defendant psychiatrist and the expert specific information on which to base their testimony. Also, the psychiatrist's testimony is made credible and the expert's testimony is shown not to be based on second guessing.[6]

Generally, in the absence of corroborating records, an assertion in court that certain actions were taken is a question for the factfinders, who must consider the matter of proof. When an adequate record exists, the possibility of proving that a treatment or procedure was reasonably provided is significantly enhanced. Moreover, lawsuits are brought within months or several years from the time of the alleged negligence. Without an adequate record, the clinician is less able to mount an effective legal defense. Some courts have concluded that what is not recorded has not been done.[5,6]

Integrated behavioral records are used in many clinical settings. On inpatient units, notes by the treatment team members, consultants, and other medical health professionals are documented sequentially. It is important for the hospital staff to be able to review the psychiatrist's ongoing rationale in the management of the suicidal patient. It is equally important for the psychiatrist to review regularly the patient's records throughout the hospital stay. It is good clinical practice to write a progress note at each hospital visit. Hospital by-laws and regulations usually require that the psychiatrist enter daily progress notes. At the time of patient discharge from the hospital, the decision to discharge, including the risk-benefit assessments for both continued hospitalization and discharge should be documented. Detailed follow-up arrangements for the patient's outpatient care also should be recorded.

In high-volume, inpatient units with rapid patient turnover, adequate documentation may be given short shrift. In addition to the clinical setting, documentation may be influenced by diagnostic factors, the assessment process, the patient's clinical condition, and his or her ability to cooperate with the examiner. Patients who are severely ill and at heightened risk for harm toward themselves or others are often poor historians. Information must be obtained quickly from other sources and duly documented.

Whether the patient is treated as an outpatient or inpatient, the psychiatrist should document the treatment plan, the clinical reasoning as it pertains to specific treatments and interventions, and any communication with prior treaters and significant others. Pertinent telephone calls from the patient or family should be documented. Detailed medication records should be kept. Consultations requested and obtained should be noted. Written consultations should be requested and included in the patient's record. When the psychiatrist is away, coverage instructions for the patient should be documented. This litany of "shoulds" is well established clinical practice that supports good patient care, while also providing clinically based risk management.

The failure to document adequately all assessments, treatment, and safety interventions for patients at risk for suicide is not usually the cause of a patient's suicide. The standard of care requires clinicians to maintain adequate patient records. Adequate documentation of suicide risk assessments assists utilization reviewers in substantiating the need for additional hospital days. Moreover, adequate documentation permits the treatment team to review the psychiatrist's clinical reasoning across staff shift changes. Psychiatric inpatients are often seen briefly by psychiatrists. Much of the treatment and manage-

ment of the patient is performed by the multidisciplinary treatment team. When the psychiatrist does not verbally communicate with the staff about the patient and does not document suicide risk assessments and treatment interventions, a claim of malpractice after the patient commits suicide is much more difficult to defend. Although inadequate documentation by itself may not be the cause of a patient's committing suicide, it may be part of an overall pattern of substandard care. However, careful documentation of substandard care can be disastrous if a claim of malpractice is filed against the psychiatrist.

Clinically, keeping a record during the course of the patient's treatment serves a number of purposes. The clinician is able to review the patient's record between sessions. Summarizing treatment sessions may permit a better understanding of the patient and the treatment process. If the patient interrupts or terminates treatment but later decides to return, the previous record will be helpful in refreshing the therapist's memory about the patient. Accurate record keeping can also help resolve billing disputes. Adequate records are important for quality assurance, for accreditation, for financial reimbursement, and for legal purposes.[8]

Generally, state laws and administrative regulations require that patient records be kept. Professional organizations may provide specific guidelines for record keeping. State licensing and certification laws may incorporate record-keeping guidelines and principles of a state or national professional organization.

The standard of care—as well as legal, administrative, and professional regulations—requires clinicians to document adequately and maintain patient records. In critical situations where patients threaten violence, clinicians not only have to think fast and act quickly, but then must also efficiently document their violence assessment and intervention rationale. There can be no "maybe" about it, not even for the busiest clinician. Rushed or not, clinicians must document their work.

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