

Research Article

Are Medical Records Truly Prepared for Malpractice Liability in Cases of Suicide?

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Abstract

The most common reason for a malpractice claim is suicide or attempted suicide. It is argued that suicide can be prevented if the danger is recognized and proper and timely treatment is provided. Failure to make an informed decision as to whether to admit an individual to a psychiatric unit generally constitutes the initial breach in a claim of negligence. The present study was designed to identify exactly what essential data was missing from files of completed suicides, using 39 medical case records of the risk-management files of the state-owned malpractice insurance company between 2004 and 2022 in Israel. We found that a great deal of important information was missing from those files (e.g., records of previous suicide attempts, documentation of disagreement between the emergency department and the patient as to whether the individual should be hospitalized, and information regarding a history or lack thereof of suicidal tendencies in the individuals immediate family). Our study demonstrates that lacking the proper documentation of vital patient history, allegations of negligence would be very difficult to disprove.

INTRODUCTION

Suicide is a major public health concern, and mental health professionals are often tasked with identifying and managing the care of individuals at risk for suicidal behavior. One high-risk population is comprised of individuals who have a history of prior psychiatric admission. An Israeli study found a much higher rate of suicides among Jews and other minority ethnic groups with a history of or current psychiatric hospitalization, the rates were 17.6 times higher than for those who were never hospitalized, and that among Arabs the corresponding rates were about 30 times higher [1].

Another high-risk population is made up of individuals who had been evaluated for suicide in an emergency department (ED) and then discharged [2]. Individuals who have recently been discharged from the ED of a general hospital, particularly those who have been treated for a mental health or substance abuse disorder, are at an increased risk of suicide. A comprehensive 30-year record linkage, UK-based study reports on a large dataset of individuals who died by suicide (n = 16,411), which indicates that among those last discharged from a general hospital, the rate was 3.1 times higher as compared to those last discharged from a psychiatric hospital, and that 24% of the deaths occurred within 3 months of discharge [3].

The percentage of suicides that occur within a specific time frame after ED discharge can vary depending on the population

of concern and the specific study. This is difficult to ascertain because the risk of suicide after ED discharge can vary depending on a number of factors, including the individual's psychiatric and medical history, the presence of co-occurring substance abuse disorders, and access to social support and follow-up care. Several studies have examined the risk of suicide after ED discharge in specific populations (e.g., suicidal youth, bipolar individuals, older adults) [4-6], or when evaluating intervention programs [7]. Other outcome studies deal with suicide as a (tangential) adverse event after ED discharge such as delays in care, etc. [2].

Those evaluated for suicide in an ED and subsequently were discharged comprise a non-homogenic group. Many generally mentally competent individuals resist psychiatric hospitalization; others can be potentially treated in a community setting; and in many instances, there are administrative and legal considerations that preclude immediate hospitalization.

In Israel, there were 60,000 visits to the psychiatric ED in 2021 for one reason or another, of which 24,033 were admitted to a psychiatric unit in the hospital and the rest referred for further treatment in an outpatient setting [8]. However, many of those referred for further treatment in the community drop out during the process, Owing either to inadequate outpatient accessibility (long waiting lists, etc.) or to difficulties in compliance and cooperation.

It is important to note that longitudinal studies tracking the

trajectories of suicidal patients use different methodologies and populations, so the results may not be relevant to all individuals who are discharged from an ED. Many studies have investigated the outcomes among hospitalized suicidal patients, that is, those who were not discharged from the ED after only a brief evaluation and intervention [9,10].

The Impact of the Reduction of Inpatient Psychiatric Beds

During the last 30 years, decision makers have been promoting mental health settings and interventions based in the community as opposed to institutional settings [11]. This worldwide trend is particularly evident in Israel, where the number of psychiatric beds has decreased by 50% in this period.

Owing to the reduction on the number of inpatient psychiatric beds along with the stated policy of favoring outpatient settings over inpatient treatment, the question of whether to admit a potentially suicidal individual has become an acute psychiatric and risk-management dilemma. For this reason, various standardized interviews and clinical scales are potentially available in the ED to identify individuals who should be hospitalized based on the risk of suicide [12]. Unfortunately, the specificity and sensitivity of these tools are limited [13-15]. In Pokorny's classic prospective study of 4800 patients treated in a psychiatric clinic in Houston, Texas, individuals were divided into high and low risk for suicide. Sixty-seven individuals within the group committed suicide during the period of the study. All attempts to identify specific subjects were unsuccessful, including the use of individual items, factor scores, and a series of discriminant functions [16]. Furthermore, 96.3% of the high-risk predictions in the Houston study were false positives and more than half of the suicides occurred in the low-risk group and were thus false negatives. Yet, the risk for committing suicide among those that were classified as high risk was approximately 4 times higher.

Moreover, a patient often considers the tools used in the ED evaluation to be non-empathetic and counterproductive in the effort to enhance cooperation in order to deter suicidal behavior. Apart from any standardized tool, every competent mental health professional should be able to obtain the basic information to make a risk-management decision to admit or to discharge (e.g., previous attempts, reason for visiting the ED, use of alcohol/psychoactive substances, etc.). Be that as it may, for a qualified mental health professional in the ED, the overall clinical impression of the patient is still the determining factor in the decision to hospitalize.

The present study was designed to identify exactly what essential data might be missing from files of completed suicides. We believe our approach is novel in that our database consisted of the records of the risk-management division of a state-owned malpractice insurance company. (In a similar study, Choi et al., investigated the connection between life insurance and suicidal behavior) [17].

Data from 30 years of psychiatric malpractice suits administered by a prominent psychiatric malpractice insurer in the United States reveal that the most common cause of a malpractice claim is suicide or attempted suicide [18]. Many assume that suicide can be prevented if the danger is recognized and timely treatment is provided.

We examined cases brought to the attention of a state-owned malpractice insurance company of individuals who committed suicide after being evaluated by Israeli ED personnel during a suicide crisis and were not admitted for inpatient care. We focused on determining the completeness of the relevant medical files.

STUDY POPULATION AND METHODS

The data from 39 cases of completed suicide events in governmental hospitals which cover 85% of the 3570 psychiatric beds in Israel, in both psychiatric and general hospitals were collected. We believe that the present sample provides good insight regarding the data, or lack thereof, recorded in the patient's medical chart.

The study population comprised individuals aged between 22 and 77 from the years 2004 to 2022 who died by suicide, that is, with an International Classification of Diseases (ICD)-10 code X60-X84 or Y87.0 as underlying cause of death, after having been examined by a psychiatrist in the ED but not hospitalized. Twenty-six were male and thirteen female. All the medical records were reviewed by a senior psychiatrist (G.L.), who extracted the relevant data.

STATISTICAL ANALYSIS

Data analysis was performed using JASP software. We used the non-parametric chi-square test to determine a significant association between two categorical variables. The p-value was considered statistically significant at $p < 0.05$.

Ethics Statement

The study protocol was approved by the ethics committee of the investigators' institution and abided by Declaration of Helsinki guidelines.

RESULTS

Table 1 lists the description of the sample and socio-demographic data. Two-thirds of the sample were male and a majority of 59% were seen in the ED of a general hospital. In 15 cases (38.5%), there was no information about prior suicide attempts. No statistical relationship was found between the individuals' demographic characteristics and the previous suicidality or method of suicide (Table 2).

Figure 1 depicts the time and method of suicide in relation to the discharge of the individual from the ED. We found a statistically significant association ($p < 0.05$) between minimal time elapsed between the ED discharge and the suicide.

Table 1: Description of the sample (N=39)

	Number	Percent
Gender	39	
Men	26	66.7
Women	13	33.3
Average age	45	
Min. age	22	
Max. age	77	
Method of suicide		
Other	11	28.2
Jumping	2	5.1
Hanging	11	28.2
Poisoning	15	38.5
Previous suicidality		
Unknown	15	38.5
None	6	15.4
Suicidal thoughts only	2	5.1
Multiple suicide attempts	9	23.1
One suicide attempt only	7	17.9
Type of emergency department		
Emergency department of general hospital	23	59.0
Psychiatric emergency department	14	35.9
Unknown	2	5.1

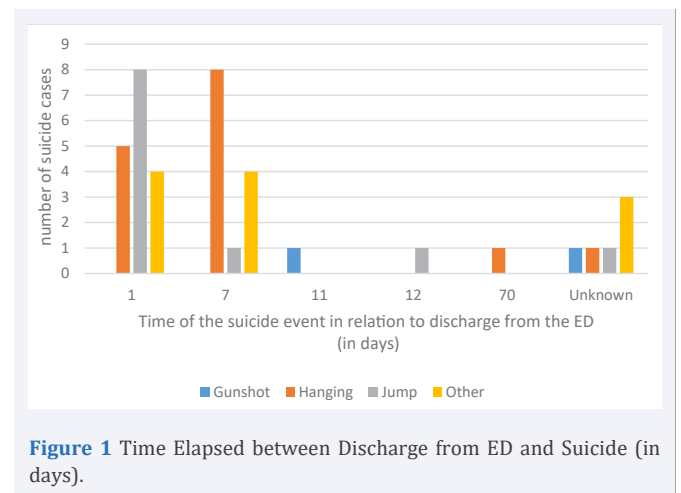
Table 2: Pertinent data missing in the medical files (n=39)

Missing information	Number of files with missing data	Percent of 39
Age	2	5.1
Marital status	5	12.8
Type of emergency department	2	5.1
Reason for going to the ED	3	7.7
Previous psychiatric diagnosis noted	3	7.7
Attitude regarding psychiatric hospitalization	16	41.0
Data relating to stressors	17	43.6
Alcohol use noted	35	89.7
Substance use noted	30	76.9
Disagreement to be hospitalized between the emergency department and the patient documented	25	64.1
The time of the suicide event in relation to the time of discharge from the ED	6	15.4
Expressions of physical violence in the past documented	21	53.8
Suicidal background in the immediate family noted	35	89.7
Previous treatment with psychotropic medication noted	13	33.3

DISCUSSION

The dilemma of whether to admit an individual to a psychiatric ward during a suicidal crisis has clinical, ethical, and legal perspectives. There is a consensus that an educated decision can only be made if the clinician has all the necessary data upon which to make a competent determination. Good documentation and clear treatment records are crucial [18].

According to data from the National Practitioner Data Bank (NPDB), psychiatrists account for approximately 4% of all active

**Figure 1** Time Elapsed between Discharge from ED and Suicide (in days).

physicians but account for only 1% of all paid medical malpractice claims in the United States many of which involve suicide [19].

Our approach is novel in that we examined the records of the Israeli state-based malpractice liability insurance company, which insures most of the country's psychiatric hospitals, to check if the medical notes in cases of suicide are complete. We have not seen a similar method of investigation anywhere in the literature.

We found that in nearly all of the 39 cases, which involved individuals aged between 22 and 77, in the years 2004 to 2022 who died by suicide, a great deal of important information is missing (Table 2). The record of previous suicidal attempts is absent in 15 cases (38%); documentation of disagreement between the ED and the patient about hospitalization was missing in 25 cases (64.1%); and there was no note as to whether or not there was suicidal background in the immediate family in 35 cases (89.7%). There was no documentation as to whether there were episodes of previous physical violence in 21 cases (53.8%).

We also found that most of the suicides occurred within a week of the ED discharge to a statistically significant degree. This is consistent with many previous studies using different methodologies, including a recent South Korean study of 74,741 suicide deaths from 2009 to 2013 that indicated that 7.9% of suicides of individuals who had any mental health contact occurred within a week [20].

Our findings have limitations. Although we reviewed the cases of the major state-owned insurance company, there remain roughly 15% of the psychiatric care not covered in our study. Admittedly, the study is modest in scope and was specifically designed to determine whether or not medical records are up to standard and prepared for malpractice suits, as well as to demonstrate what information might be missing.

In terms of suicide prevention, the age-standardized suicide rate for an individual examined in an ED and admitted was 17.6 times higher than that of the non-hospitalized) [1]. In this respect, the ED clinician serves as a gatekeeper, who must determine who

is at high-risk and should be hospitalized and who is at a low risk and should be discharged. This determination also sets the basis for the means of intervention and suicide prevention in the short and long term.

In Israel, the age adjusted mortality rate per 100,000 persons aged 18 and over for persons with past psychiatric hospitalization in 2020 was 109.3.8 The persons hospitalized would be considered to be high risk. Alternatively, a person discharged from the ED is considered to be at a low-risk for suicide. Our study suggests that these critical decisions to discharge or hospitalize may be made without access to all the necessary information.

It is therefore essential that the ED medical records document all relevant information, record the patients' understanding and cooperation with the treatment plan, and note any intervention. Our study clearly demonstrates that allegations of negligence brought to the insurers would be very difficult to disprove if proper documentation of vital patient history of an acceptable standard of care is lacking.

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