Bibliography for Slide Presentation
Legal Liability in Suicide Care
and the Courage to Change Institutional Culture

Susan Stefan March 25, 2021

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Indiana's State Suicide Infrastructure Plan, Jan. 2021 emphasizes improving the quality of suicidal people's lives rather than solely preventing suicide. On Jaspr website.

"The vision of suicide prevention in Indiana will move beyond a focus on Zero suicide to a broader endeavor: improving the quality of life for as many Hoosiers as possible." Slide 7. Chris Drapeau, State Suicide Prevention Director, slide presentation available on JASPR website.

Slide 4

Most people with suicidal thoughts don't kill themselves

99.6% of people with suicidal thoughts don't kill themselves. In 2019, 12 million people thought seriously about killing themselves, and 47,500 people killed themselves. 3.5 million planned. 1.4 million attempted. Even with attempts 97% of people who attempt don't die by suicide.

U.S Dept. of Health and Human Services, Centers for Disease Control and Prevention, "Fast Facts," https://www.cdc.gov/suicide/facts/index.html

Most suicides cannot result in malpractice cases

Of the people who do kill themselves, the majority are not receiving treatment from a mental health professional.

Massachusetts Violent Death Reporting System Suicide 2018, https://www.mass.gov/doc/2018-mavdrs-suicide-data-table/download (45.7% receiving treatment from either mental health or substance abuse professionals; note that the percentage is much higher for females than males0

Very few physicians account for most malpractice cases

1% of physicians accounted for 32% of claims; psychiatrists are 4% of all MDs but only 1% of malpractice claims.

David M. Studdert, Marie M. Bismarck, Michelle M. Mello et al, "Prevalence and Characteristics of Physicians Prone to Malpractice Claims," 374 New England Journal of Medicine 354 (Jan. 28, 2016), https://www.nejm.org/doi/full/10.1056/NEJMsa1506137

Very few suicide malpractice cases overall

I looked at all reported cases over 3 years, including settlements before trial, jury verdicts, about 70 a year.

Lexis + search in "Jury Verdicts and Settlements" search terms "suicide" and "malpractice" between January 1, 2018 and Dec. 31, 2020 brought 207 results.

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Successful litigation around suicide malpractice involves mind-boggling levels of malpractice.

Johnston v. Kim Barkley Webster, No. 9905-05704, Moltnomah County Trial, Jury verdict $3,025,000, 2001 Jury Verdicts LEXIS 81665 (Oregon, June 2001).

Edwards v. Tardif, 240 Ct. 610 (1997) (covering doctor responded to call from patient who was depressed by prescribing large amount of medication without checking her chart or asking her to come in for an assessment, despite the fact she had not been seen for ten months; jury found her suicide on the medication was foreseeable result of the doctor's negligence)

Schmitter v. Samaritan Health Services, No. 15CV26120, 2017 Ore.JuryVerdicts&Sett.LEXIS 69, March 9, 2017, Plaintiff counsel: James Huegli.

Doe v. Hospital, 2011 UT Jury Verdicts & Sett. LEXIS 908 (March 2011) Plaintiff counsel: G. Eric Nielson.

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D.C. v. Cimpeanu, No. 10-00830H (Mass. Super. Offer of Proof, 12/2011) Plaintiff counsel: Scott Heidorn.

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Lane v. Provo Rehab & Nursing, 414 P.3d 991 (Utah App. 2018)

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The rights of parents in Oregon to be involved in their teenager's safety planning:

Relevant Oregon Statute is ORS 109.675, which states (in summary) that:

- A minor who is 14 years or older may access outpatient mental health, drug or alcohol treatment (excluding methadone) without parental consent.
- These services may include: • Seeking help from a psychiatrist or psychologist; • Seeking mental health therapy from a doctor or social worker; and • Seeking help for drug or alcohol use.
- Providers are expected to involve parents by the end of the minor's mental health, drug or alcohol treatment unless: • The parent refuses involvement; • Clear clinical indications to the contrary exist and are documented in the treatment record; • There is identified sexual abuse; or • The minor has been emancipated and/or separated from the parent for at least 90 days.
- For mental health and chemical dependency services, the provider may disclose health information to a minor's parent or guardian per ORS 109.680 if: • It is clinically appropriate and in the minor's best interests;
    - The minor must be admitted to a detoxification program; or
    - The minor is at risk of committing suicide and requires hospital admission.

- Involvement does not mean that adults always have access to a minor's mental health or chemical dependency records.

This statute is itself controlled by federal regulation 42 CFR 2.14, which states that if a minor is able to self-consent for drug or alcohol treatment, the minor's treatment records cannot be disclosed without the minor's written consent (including to the parent or guardian).

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Environmental Audit is crucial

Joint Commission National Patient Safety Goal 15.01.01, EP 1:

PSG 15.01.01, EP 1:

BHC: The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the organization takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). HAP: For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). Published for Joint Commission-accredited organizations and interested health care professionals, R3 Report provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, R3 Report goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement.:

Noninpatient behavioral health care settings and unlocked inpatient units do not need to be ligature-resistant. The expectation for these settings is that they conduct a risk assessment to identify potential environmental hazards to individuals served; identify individuals who are at high risk for suicide; and take action to safeguard these individuals from the environmental risks (for example, removing objects from the room that can be used for self-harm and continuous monitoring in a safe location while awaiting transfer to higher level of care.) For nonpsychiatric units in general hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital.

Note: Nonpsychiatric units in general hospitals are not expected to be ligature-resistant environments. Nevertheless, these facilities should assess clinical areas to identify objects that could be used for self-harm and should be routinely removed when possible from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible). Rationale The health care

environment, including patient rooms, patient bathrooms, corridors, and common patient care areas can contain features that patients can use to attempt suicide. The most common hazards for suicide risk are ligature anchor points that can be used for hanging. However, there are many other types of hazards, so it is important to do a thorough assessment of the environment to minimize all potential suicide risks. For nonpsychiatric units that are not required to be ligature-resistant, the focus should be on rigorous implementation of protocols to keep patients safe, especially one-to-one monitoring.

Resources to assist in compliance with this goal
For more information, see The Joint Commission Perspectives article, November 2017, Volume 37, Number 11. The Veteran's Health Administration showed that use of a Mental Health Environment of Care Checklist to facilitate a thorough, systematic environmental assessment reduced the rate of suicide from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions. There was no loss of effect over seven Reference* Watts BV, et al. Sustained Effectiveness of the Mental Health Environment of Care Checklist to Decrease Inpatient Suicide. Psychiatric Services, 2017 Apr 1;68(4):405- 407.

pages-from-suicide_prevention_compendium_5_11_20_updated-july2020_ep1.pdf (jointcommission.org)

The Joint Commission recommends the *Design Guide for the Built Environment of Behavioral Health Facilities*, published by the Facility Guidelines Institute; there are also the design guidelines published by the International Association of Healthcare Safety and Security, which feature a great deal of information regarding prevention of patient suicide and harm.

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Difficulty of being agents of cultural change

One of the people who first used anesthesia in the United States was a dentist named Horace Wells, who was driven to suicide by the hostility of the medical profession. When anesthesia was first employed in London in 1846, it was labeled a "Yankee dodge" because "Most of the characteristics the surgeons had developed--the indifference, the strength, the pride, the sheer speed--were suddenly irrelevant,". Using anesthesia felt like cheating, so few doctors did it--at least at first.

David Wootton, Bad Medicine: Doctors Doing Harm Since Hippocrates, (Oxford University Press 2006).

Ignatz Semmelweis discovered that women were dying in childbirth in hospitals were dying because of infections that could be stopped by doctors washing their hands. He proved this was true, and was fired for his pains, and when he continued insisting on it, was thrown into a mental asylum where he died two weeks later at the age of 47.

David Wootton, Bad Medicine: Doctors Doing Harm Since Hippocrates, (Oxford University Press 2006).