SUMMARY

DR. KEITH HENRY ANDERSON (CPSO# 24237)

1. Disposition

On May 14, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required psychiatrist Dr. Anderson to appear before a panel of the Committee to be cautioned with respect to discharging a patient without adequately assessing and documenting the patient's suicidal risk.

2. Introduction

Patient A was placed on a Form 1. A few days later, Dr. Anderson was assigned to provide Patient A with ongoing care. After seeing Patient A, Dr. Anderson discontinued the Form 1 and discharged Patient A home. Approximately two weeks later, Patient A committed suicide.

The complainant, a family member of Patient A, contacted the College expressing concern that Dr. Anderson discharged Patient A prematurely and without consulting Patient A's previous treating physician. The complainant also expressed concern that Dr. Anderson failed to conduct himself in a professional manner in that he said, "there are no guarantees in life" when she asked for reassurance of Patient A's safety post-discharge.

Dr. Anderson responded that he reviewed all chart documentation, discussed Patient A's case with nursing staff, and met with Patient A to conduct a thorough assessment. Dr. Anderson explained that Patient A denied being suicidal, that he believed Patient A was not in acute distress, and that he reached a clinical diagnosis for Patient A. He indicated that he discharged Patient A because he concluded that Patient A did not meet the criteria for involuntary admission and that continuation on a voluntary basis was not warranted.

Dr. Anderson also explained that in saying there were "no guarantees in life", he was using the phrase the complainant used when she asked him if he could guarantee that Patient A would not attempt to commit suicide again. The Respondent apologized, acknowledged that he should have chosen his words more carefully, and indicated that he would do his best to be more empathetic in the future.

3. Committee Process

A Mental Health Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee concluded that Dr. Anderson erred in discharging Patient A without adequately assessing and documenting Patient A's suicidal risk himself (including obtaining a detailed history and collateral information from the complainant). The Committee explained that while Dr. Anderson's colleagues had recently assessed Patient A and anticipated a short stay in hospital (and similarly did not see clinical value in more than a brief admission), Dr. Anderson should not have simply relied on and accepted the assessments of his colleagues. Rather, the Committee was of the view that Dr. Anderson should have properly evaluated Patient A's mental state himself to rule out clinical conditions and determine the degree of Patient A's suicidal risk, including taking a complete history himself when he took over Patient A's care.

The Committee was also of the view that Dr. Anderson erred in relying so heavily on Patient A's statement of not feeling suicidal, and failed to appreciate and adequately explore other important factors. The Committee stated that Dr. Anderson should have placed greater weight

on the fact that Patient A had made some repeated attempts at committing suicide, and that Patient A had sought help on multiple occasions in a short period of time.

With respect to the complainant's concern that Dr. Anderson discharged Patient A without consulting Patient A's previous physician, the Committee noted the record indicated that Dr. Anderson encouraged Patient A to continue seeing the university counsellor, appropriately followed up with Patient A's family physician, and that the other psychiatrists who saw Patient A at the hospital were also of the view that Patient A's stay would be brief.

In the Committee's view, Dr. Anderson's response did not clearly demonstrate that he had insight into the deficiencies in his cursory assessment of Patient A. The Committee's concern was heightened by the fact that Dr. Anderson was the subject of a prior complaint to the College, where he was cautioned in person on failing to conduct an appropriate suicide risk assessment. The Committee concluded that it was appropriate to caution Dr. Anderson in person again to impress upon him the importance of conducting a thorough suicide risk assessment prior to discharge. The Committee also asked Dr. Anderson to submit a written report about how he could have handled this case better, so as to ensure that he learns from this tragic situation.

With respect to communications, the Committee was of the view that Dr. Anderson provided a reasonable explanation for why he decided to use the phrase there are "no guarantees in life." While it was understandable why the complainant would have perceived Dr. Anderson's comment as insensitive, the Committee appreciated that Dr. Anderson showed insight into how his choice of words was less than optimal, and that he was committed to communicating more effectively in the future. As a result, the Committee took no action on that aspect of the complaint.