WHEN A PATIENT COMMITS SUICIDE, WHO IS TO BLAME? CAUSATION, CAUSATION, CAUSATION!

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Please write a brief abstract of the article to be placed here.

As stated by Jamison, "The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description" (1). This "confusion and devastation" can also be a consequence for psychiatrists and other health professionals involved in the treatment of the suicidal patient.

Suicide, derived from the Latin *sui (*oneself) and *cidium (*a killing) is a behavior known from the beginning of recorded history and has continued to be a major psychiatric and public health problem, now the eleventh leading cause of death in the United States, accounting for 29,350 deaths in 2000 (2). In the U.S. someone commits suicide approximately every 20 minutes with a suicide rate averaging 12.5 per one hundred thousand over the last one hundred years.

This is, by any measure, a staggering mortality statistic. U.S. suicide rates are near the middle of those rates reported by other industrialized countries, which range from 25 per one hundred thousand persons in Austria, Germany, Switzerland, Denmark, Sweden, Eastern European countries and Japan, to less than 10 per one hundred thousand in Italy, Spain, Ireland, The Netherlands and Egypt. Over the last ten years in the U.S., New Mexico and Nevada had the highest reported suicide rates for men, and Wyoming and Nevada the highest for women. The lowest suicide rates for men and women were reported in New Jersey. An interesting statistic showed that, with 800 suicides since its opening in 1937, the Golden Gate Bridge in San Francisco remains the primary site for suicide in the world (3).

The pioneer studies of Robbins et al. (4) and of Barraclough and colleagues (5) demonstrated that a significant majority of individuals who

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committed suicide expressed their suicidal intent and had been seen by physicians a short time before they successfully completed the act. It would, therefore, seem that a majority of suicides might be preventable. Thus, it seems reasonable to presume that psychiatrists have the most important and primary role in suicide prevention. Fifty-one percent of psychiatrists report having had a patient who committed suicide (6). Although a psychiatrist's risk of being sued for malpractice is still quite low (7), lawsuits brought against them when a patient commits suicide constitute the largest number of malpractice suits against psychiatrists (8). In the continuing and prevalent litigious atmosphere in which medicine and psychiatry are practiced, it is obviously important that clinical psychiatrists effectively evaluate suicide risk, understand the potential legal liability and, moreover, that forensic psychiatrists asked to testify as expert witnesses in such cases have the necessary skills and expertise to effectively perform their roles.

Although it is reassuring for mental health professionals that, even when sued, they win up to 80% of cases involving suicide, it is essential that clinicians should have a full understanding of their potential liability in preventing suicide and the basic principles behind the malpractice claim.

In cases of persons who commit suicide and the psychiatrist is sued by the family for not acting pursuant to the standard of care and hence "causing" the death, it is always a concern that the jury will be left asking, "So what if the psychiatrist was negligent [or in Pennsylvania, grossly negligent], it was the patient who decided to take his own life." Therefore the overall question that a jury may very well be left with is, "Who is to blame?"

The "who is to blame" question is called "causation" by lawyers. Any negligence action requires proof by the plaintiff of three general elements: negligence (the breach of standard of care), that damage was suffered, and that the negligence caused the damages.

Pennsylvania juries are given the following standard instruction on the law of causation:

a) The defendant-physician is legally responsible or liable for the injuries suffered by his or her patient if the defendant's conduct is a factual cause of those injuries. Conduct is a factual cause of harm when the harm would not have occurred absent the con-

duct. If the injuries in question would have been sustained even if the physician had not been negligent, the negligent conduct of the defendant physician would not be a factual cause in causing the injuries in question. Stated differently, the negligent conduct of the defendant is a factual cause in causing the patient's injuries if those injuries would not have been sustained had the physician not acted in a negligent manner.

b) When a defendant physician negligently fails to act, or negligently delays in taking indicated diagnostic or therapeutic steps, and his or her negligence is a factual cause in causing injury to the patient, the plaintiff does not have to prove to a certainty that proper care would have, as a medical fact, prevented the injuries in question. If a defendant physician's negligent action or inaction has effectively terminated the patient's chances of avoiding injuries, he or she may not raise conjectures as to the measure of the chances that have been put beyond the possibility of realization. If there was any substantial possibility of avoiding injuries and the defendant has destroyed that possibility, he or she is liable to the plaintiff.

A causal connection between the injuries suffered and the defendant's failure to use reasonable care may be proved by evidence that the risk of incurring those injuries was increased by the defendant's negligent conduct.

The law recognizes that it is rarely possible to demonstrate to an absolute certainty what would have happened in circumstances that the wrongdoer did not allow to come to pass (9).

In representing the family of the person who committed suicide, one would emphasize and argue that principle as stated in section B is most applicable. This section is commonly understood to memorialize the holding of the Pennsylvania Supreme Court in the case of *Hamil v. Bashline* (10). These legal standards can be reduced to the question of whether the physician's negligence increased the risk of the patient's injury.

Compounding the problem for a jury in determining the "who is to blame" question is that the jury will be entitled to consider whether the patient who committed suicide was also negligent. After all, it is reasonable to

suggest that one who takes his own life is responsible therefore for his own death. Also, creating difficulty for Pennsylvania lawyers representing plaintiff's in these cases, is that the defendant psychiatrist's actions will be judged under the standard of "gross negligence." The jury, however, will be asked to evaluate whether the patient was contributorily negligent under any ordinary care standard.

The Mental Health Procedures Act requires proof of gross negligence or willful misconduct to hold a physician, hospital, or any authorized person who participate in mental health decisions, liable for his decisions or any of its consequences (11). Following are examples of real cases in which these issues must be anticipated.

CASE 1

Joe Smith was an unemployed 22yearold African American male. On Saturday, at about noon, he was taken by family members to a local hospital emergency room. He had no prior history of having received psychiatric treatment. He told the physician that he had a two year history of depression, poor concentration, reduced energy and social withdrawal. He expressed having a poor appetite and being unable to eat for the past two days. He admitted to being a drug user. A urine drug screen was positive for benzodiazepines, opiates, phencyclidine and cannabinoids. He was noted to have paranoid ideation, depressed with a blunt affect. He was diagnosed with having a psychosis, not otherwise specified. He refused hospitalization and was discharged with a referral for outpatient treatment.

Fourteen hours later, at 2 a.m. on Sunday, he returned to the same local hospital. He told the physician, "I am gay" and "I am scared." He admitted having a drug problem and asked for help with it. His aunt and mother described him to the physician as being increasingly suspicious and paranoid. He remained under continuous observation and was noted at 7 a.m. to be bizarre but calm and cooperative. He was noted to have suicidal ideation and homicidal ideation, as well as auditory hallucinations. He was observed to be feeling not like himself and "out of control," and noted to be displaying dangerous and impulsive behavior. When asked if he owned a weapon, he said he owned a knife. He was discharged by late morning with advice to receive outpatient treatment.

After being home for several hours, he calmly walked into the kitchen, obtained a large butcher knife and walked with it up to his room. His mother followed, obviously concerned. When Joe refused to come out of his room, another male family member broke down the door to see Joe holding the knife to his stomach. The family was then successful in wrestling the knife away from Joe. They immediately rushed him to a different hospital, concerned that the first hospital did not properly care for him.

With his mother present with him while being evaluated in the psychiatric emergency room of this big city hospital by a resident psychiatrist, he reported that "I held a knife to my stomach. I gave up." The resident noted that he had been seen twice the day before at another hospital. Joe denied he had suicidal ideation and verbally agreed to "contract for safety" but when presented with a form, "contract for safety," to sign, he refused.

Joe was discharged from the emergency room. His mother took him home. Because his family continued to be concerned they began to drive with him to yet a third hospital. While stopped at a red light, just by a highway overpass, Joe sprang from the car, climbed the cyclone fence on the overpass and leaped to his death on the highway below.

CASE 2

Robert was a 55-year-old married, unemployed carpenter. He had been laid off from work for approximately two months. He had suffered psychiatric problems for which he had received both inpatient and outpatient treatment for eight years. He had been seeing the same psychiatrist on an outpatient basis for about six years. Three years ago he had been admitted as an inpatient to a psychiatric hospital after having attempted suicide by hanging from a dog's leash in his basement. Soon after being laid off, he admitted himself into a psychiatric hospital complaining that he was thinking of hanging himself in his basement. He spent two weeks as an inpatient. A week after discharge, he followed up with his outpatient psychiatrist. He reported that he still felt depressed and still thought about hanging himself in the basement but told his physician that he would not act on those thoughts and would call him if he felt that he was. The psychiatrist scheduled him to return in six weeks. Eleven days later, Robert hung himself from a dog's leash in the basement.

In order to win a malpractice claim, the plaintiff must demonstrate four things (12):

1) That *duty to care* for the patient existed based on the provider's relationship with the patient. This means that in an emergency room, on a hospital floor, or in a psychiatrist office, once a doctorpatient relationship has been established, the provider agrees to provide non-negligent care.
2) *Negligence*. The part of civil law known as negligent torts includes malpractice. The central issue here is based upon a "standard of care" which is established by case law or by statutes. Simply described, the standard of care is what the average psychiatrist would have done at the time under the same circumstances. It is the role of expert witnesses to inform and educate judges and juries as to what constitutes average practice.
3) *Harm*. Even if a psychiatrist has acted negligently there is no malpractice unless harm has been suffered and demonstrated.
4) *Causation*. The negligent act must be proved to have caused the harm.

Since it has been demonstrated that mental health professionals, including psychiatrists, are unable to accurately predict suicide (13), the psychiatric "standard of care" remains the gold standard of malpractice, and deviation from that standard has to be demonstrated for a malpractice case to be successful.

In negligence actions in which it is alleged that suicide is the harm caused, the general rule is that the suicide acts as an intervening force that breaks the line of causation from the alleged negligent act, if the suicide victim knew and understood the nature of his or her act or the act resulted from a moderately intelligent power of choice. This view is based upon the theory that suicide is not an ordinary, foreseeable result of injury. For example, where a teenager finds a gun, loads it and puts the gun to his head, the homeowner whose gun the teenage used would not have been the "proximate" of legal cause of death.

However, when the wrongful act of a tortfeasor causes an injury that leads the injured person to become "insane" or bereft of reason, and the person involuntarily commits suicide, then it can be said that the wrongful act was a legal cause of the suicide. This rule is called the "irresistible impulse rule" in which the wrongdoer's act is caused by mental illness which results in an uncontrollable impulse to commit suicide.

There are essentially two issues running side by side in looking at these two legal rules; whether the suicide is foreseeable and whether the act of suicide was voluntary. Therefore, the key to answering the riddle of "who is to blame" boils down to these two concepts. If a mental health treater can present enough facts to show either that the suicide was not foreseeable or predictable, or that the person who committed suicide was able to understand the nature and consequence of the act of suicide, then the plaintiff will not have proven causation.

It is therefore suggested, that for any lawyer reviewing a potential psychiatric malpractice case, or in asking any expert to offer an opinion regarding the conduct of another psychiatrist in a suicide case, that attention be directed first, not to whether the psychiatrist deviated from the standard of care, but instead to the mental state of the person who committed suicide and to whether, given the facts, the psychiatrist should have been able to predict that this person was going to commit suicide unless something different is done.

In fact, these are the only two questions that the jury will really care about. If the suicide was not predictable, the jury is not going to blame the psychiatrist. Also, if the person who committed suicide was not insane or bereft of reason, regardless of how predictable the suicide was, the jury will blame the person who committed suicide for their own death.

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