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Suicide and Civil Litigation

The responsibility of hospitals and physicians for suicide prevention continues to be a major problem confronting the health care professions. Suicide induced litigation was reviewed in 1960 and 1965 [*1,2*] and my purpose now is to bring up to date some of the conflicting issues characteristic of this problem.

Suicide occurring in an institution may result in a claim for wrongful death based on alleged negligence of the physician or the hospital or both. A hospital owes to its patients a specific standard of care as dictated by current practice; it must exercise such reasonable care and appropriate attention for the safety of its patients as their mental and physical condition, if they were known or should have been known, would require. The physician is obligated to use a degree of skill comparable to that possessed by others in his profession or specialty in accord with the current state of medical knowledge. Theoretically, a physician is not liable for injurious consequences if he exercises the required degree of skill and care. Where there are several accepted methods of treatment, the physician may adopt any one of them even though the one chosen is not the one most generally used.

In suicide cases, the negligence claimed in litigation is a lack of watchfulness on the part of the hospital either due to delinquency on the part of its personnel or to inappropriate medical instruction and supervision. In keeping with the principles of negligence law, the key words reflecting the degree of responsibility imposed are "reasonable," "anticipated," "foreseeable," "preventable," and "controllable."

Suicide may occur in a wide variety of clinical situations. As a result we would expect to encounter difficulties in foreseeability and problems in controllability. Suicide cases also focus on other factors such as the various modes of current treatment programs and the trend to using day care units and open hospitals. In the past such cases have reflected a legalistic chaos because of conflicting decisions arising from similar fact situations. As a result, physicians and hospitals are unable to practice with the comfort of security based on consistent precedent. Numerous bizarre cases cluttering the law books have imposed liability and have resulted in a fearfulness on the part of hospitals and physicians. This may result in a tendency to overhospitalize and prolong patient stay without having a significant effect on the incidence of suicide.

Despite all the clinical work, the research, and the establishment of suicide prevention programs, suicides have remained constantly with us. Good intentions have had only limited effect statistically on what in essence is the act of the suicidal person, not that of another person who finds himself often judged blameworthy. It must be remembered that there is an immense number of potentially suicidal individuals compared to the few who

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succeed. While there are 25,000 to 50,000 suicides a year, the pool of potential suicides probably numbers in the millions. The problem of suicide prediction was raised many years ago by Rosen [*3*]; more recently Brown and Sheran [*4*] pointed out that suicide predictive signs "are equivocal in that neither single signs, standard psychological tests, specially devised tests, clinical judgments, nor scales are found to be able to predict suicide at useful levels."

In an analogous situation, some say that the potentially violent individual should be institutionalized to protect society against destructive behavior. The problems of statistical error, combined with the evils of preventive detention and the denial of freedom based on the possibility of unacceptable behavior, are relevant to the suicide dilemma. Criticism of civil detention through commitment to prevent dangerous behavior has been expressed by various legal authors [*5,6*]. The inadequate basis for dogma and rigidity in the use of enforced hospitalization was noted in the *Santa Clara Lawyer* [*7*]. It was questioned whether involuntary hospitalization does in fact prevent eventual suicide and whether the hospitalization procedure itself might be quite harmful and misused. It was noted that "recent articles discussing treatment for the suicide prone are of significance in that they do not stress the use of hospitalization, voluntary or involuntary. Rather, emphasis is laid on person-to-person contact and continued sympathetic support for the individual."

The problem of suicide control is also reflected in the rapidly accumulating data from the many suicide prevention centers established in the United States in the last ten years. Though these centers have acted as crisis intervention units, they have not affected suicide rates [*8*].

Clearly physicians, psychiatrists, and hospitals, both general and psychiatric, are concerned with suicide. Part of this preoccupation and anxiety is based on a feeling of helplessness because there is little control or predictability as to what will happen, when, where, how, or by whom. Extreme restraint certainly lessens the immediacy of a suicidal occurrence; however, restraint may not be the best approach to the underlying psychiatric problem. Restraint may be antitherapeutic in long-term effects, causing disrupted personal relations, feelings of guilt, lost jobs, removal from the community, etc. Nevertheless, many courts and legal writers continue to be preoccupied with the role of controls which, of course, do have a place in the immediacy of a crisis situation. Morse [*9,10*], reviewing this topic, discussed the techniques of suicide prevention at a Chicago hospital. Some law cases have been decided on the basis of whether or not there had been an attempted suicide (as compared to a threat of suicide) and whether there should be constant supervision, periodic scheduled supervision, or altered observation in which the staff is alerted generally to devote a close degree of attention to a given patient. *Kent v. Whitaker* [*11*] and *Stallman v. Robinson* [*12*] imposed a standard of constant supervision where there was an attempted suicide. *Van Eye v. Hammes* [*13*] imposed liability for failure to observe closely even though the patient was not identified as a potential suicide.

Some courts have placed great stress on whether or not patients had expressed suicidal thoughts, yet it is clear that such findings alone are insufficient to dictate a standard of care. Paykel et al record the findings of a New Haven study [*14*] in 1971 which indicated that in the general population, 7.8 percent reported having thoughts of life not worth living, 5.0 percent wished they were dead, 2.3 percent had thoughts of attempting suicide, 1.5 percent had seriously planned suicide, and 0.5 percent had made a suicide attempt during the preceding year. Schwab's study [*15*] of 1645 people in northern Florida indicated that 15.9 percent had had suicidal thoughts (22.9 percent of those under 30 ad-

mitted to such thoughts) and that 2.7 percent had attempted suicide. Where is the dividing line requiring restraint?

Rauenhorst's recent study [*16*] reported a generally good prognosis in the treatment of women who attempted suicide. The unexpected finding was that the severity of the suicide attempt did not reflect the long-term psychiatric maladjustment; rather, such suicide attempts "can best be viewed as a short-lived crisis which is subsequently resolved." This finding contradicts many other studies, which should lead us to recognize the difficulties inherent in broad generalizations about suicide.

These comments provide a background to more recent cases involving suicide and professional liability, some of which have been reviewed by Beresford [*17*]. In the *National Training School v. Perotti* case [*18*], the hospital argued that close confinement and restraint were antitherapeutic and that the taking of calculated risks was necessary to deal with the crises in patient's lives. Judge Bazelon recognized this factor but nonetheless indicated that the hospital could be liable if it was negligent in allowing the patient to leave the closed ward. (The patient had jumped from the 7th floor after leaving the closed ward unattended.) He further indicated that expert testimony was not necessary to prove negligence, since the hospital itself had established a standard of restricting the movement of patients into and out of the closed ward. The patient had committed suicide the day after admission, having been admitted with orders for only sleep medication and observation, under the diagnosis of paranoid depression. This was not considered to be a case where a determined patient managed to commit suicide "in a mysterious or unexpected fashion" [*19,20*]; nor was this a case where a calculated risk was taken for therapeutic purposes with a patient of known suicidal tendencies [*21–23*]; nor where a hospital had concluded after examination that a patient was not suicidal and, hence, did not require precautions [*24–26*]. In all of the latter cases, liability may be denied.

In the Dmitrijevic case [*24*], involving a suicide five days after hospital admission, the court indicated that it must be shown affirmatively that the defendant was unskillful or negligent (proof of the bad result alone is insufficient to constitute liability). Generally a plaintiff must show by expert testimony not only that the injury occurred, but that such event does not ordinarily occur in the normal course of events without negligence. In that case, a resident had recorded that the patient had "suicidal thoughts," and noted an impression of psychotic depression on admission. The diagnosis of the attending and department chairman on the other hand, was acute anxiety state. The attending physician, in his testimony, stated that "a suicidal risk means a medical determination that a patient could possibly take his life and a certain procedure should be instituted immediately. When someone expresses suicidal thoughts, we cannot institute this rigorous procedure. Many people have suicidal thoughts. Suicidal thoughts are not equivalent to a patient being a suicidal risk." In the *Kent v. Whitaker* and the *Stallman v. Robinson* cases [*11,12*], the court decided that, despite no affirmative testimony of negligence, there was no question that the patients were suicidal risks. Generally, unless an attending physician recommended special precautions against suicide, the hospital is under no duty to take precautions.

A recent Ohio case [*27*] reflects an opposing theory in ruling that the duty of a hospital requires it to use reasonable care to prevent a patient from committing suicide, if the hospital knows the patient's emotional and mental condition is such that a reasonably prudent person would anticipate that the patient would commit suicide unless prevented. Here the diagnosis was schizophrenic reaction, schizoaffective type, and the patient had spent the night in a locked security room. The court used a standard of a reasonably

prudent person test and stated that the question of negligence was within the "ordinary, common, and general experience and knowledge of mankind. It does not appear to be a highly technical question of science." A dissenting judge stated that there should be a distinction between crisis intervention and professional treatment. In *Bannon v. U.S.* [*28*], a schizophrenic patient committed suicide after escape from a V.A. Hospital where he had been a patient for more than ten years. The court ruled that his suicide was not foreseeable in view of a history of no suicide attempts despite repeated threats over the years. The plaintiff's expert stated there was insufficient surveillance in view of his excitability and poor judgment under stress. (Are these valid criteria for predictability of suicide?) Similarly, no liability was found in the Weglarz case (where a patient eloped from an open ward and hanged himself) [*29*] and in the Hirsh case (where a patient somehow obtained 12 seconal and killed himself) [*19*]. In the latter the court stated, "The State could not have provided an employee to watch every move by this unfortunate man during 24 hours of the day. We are not persuaded that it is evidence of negligence that he was not repeatedly awakened and his bed searched during the night. If institutions for the mentally ill are required to take all of the precautions contended for in this case, and are to be held liable for such delicate mistakes in judgments, patients would be kept in straitjackets or some other form of strict confinement which would hardly be conducive to recovery . . . an ingenious patient harboring a steady purpose to take his own life cannot always be thwarted."

The type of testimony which may be presented for the plaintiffs in these cases is exemplified by the following "expert" utterances: "I would have instructed my attendants to search Irving from head to foot before they put him to sleep and to search him several times during the day and to examine his person and every part of his personal effects, and because of these suicidal tendencies, I would have reminded and especially alerted the personnel and also the fact that he was a potentially barbiturate suicide, and if I may say so, counsel, I would have alerted them to the fact that they can't be sure that they have checked carefully unless they searched him repeatedly, and unless they did a thorough search and I mean a thorough searching by means of palpating every part of his body, all of his clothing." In *Fernandez v. Baruch* [*30*] a patient was taken to a hospital where he was noted to display violent and homicidal tendencies. His wife, who ultimately sued, refused to sign commitment papers. Therefore, after 18 days, when he was "calm and rational," he was returned to the custody of the police and later killed himself. The court dealt with the question of whether the health professionals should have known that there was a suicidal risk requiring special precautions. Apparently no suicidal tendencies had been noted though the patient had been markedly assaultive. The defendant's witness stated that homicidal tendencies and suicidal tendencies were usually antithetical, that most homicidal patients are not suicidal. The plaintiff's expert, on the other hand, testified that one cannot differentiate between homicidal and suicidal tendencies and that hostility was common to both. This expert also testified that 24 to 36 h after the last dosage of chlorpromazine, an "explosive feeling" and "tension" would develop. Despite such testimony, the court properly found in favor of the defense.

In *Boyce v. State of California* [*31*] a lower court awarded $125,000 when a patient killed himself 36 h after discharge from a state hospital. He had attempted suicide on previous occasions, had a diagnosis of paranoid schizophrenia, and had been hospitalized 17 times for alcoholism. The four defendant doctors stated that he had shown marked improvement, was competent on discharge, and that it was impossible to tell whether a paranoid schizophrenic would commit suicide.

In other recent cases, hospitals were not held responsible for suicides within the hospital [*32,33*]. In one case [*32*], the court found it necessary to consider a report from a previous hospital which stated that nine years earlier the patient had been preoccupied with suicide.

Conclusion

Reviewing litigated suicide cases reveals lack of consistency, the ignorance of some of the decision makers, and the poor quality of testimony affecting the lives and fortunes of people as well as policies of health care. We need to sympathize with those defendants who have performed in accordance with usual medical standards which, unfortunately, may not coincide with the often arbitrary rules established by some courts. Most courts do rule appropriately, demonstrating their awareness of the very great problems in foreseeability and prediction; however, this is not good enough when one considers the haphazard nature of the cases, the insecurity of health professionals in dealing with depressed patients, and the conflict which may develop when they must choose between planned therapeutic programs and planned security programs. The law, despite good intentions, may have done a disservice to society by creating such an atmosphere of fear that immediate hospitalization must be resorted to as the "safest" of alternative choices. Such a defensive reaction seems counterproductive to the evolutionary trend in psychiatric and medical practice of utilizing office treatment, day care, and short-term hospitalization. Therefore, the pressures imposed by some of the court decisions may result in a lowering of the quality of care of the mentally ill.

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