# LIABILITY for SUICIDE

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Suicide is still a leading and growing cause of death in this country. Typically, it evokes extremely troublesome feelings in the family and friends of the deceased. Their grief is complicated by anger, guilt and blame. Increasingly, litigation is pursued against third parties who are said to be responsible. Although not exclusively so, these are most commonly psychiatrists, psychologists and other mental health providers. A clearer understanding of this trend requires a historical perspective on reactions to suicide and an analysis of whether suicide is predictable and preventable.

In English common law, suicide was considered a crime. The deceased and the deceased's heirs would both be punished. The body of the deceased was buried shamefully in the crossroads of a public highway with a stake through the heat and a stone on the face. The estate would often be forfeited. The criminal element was measured, much like in other types of criminal responsibility, by whether the individual knew right from wrong. In some jurisdictions in this country, until very recently, suicide was also considered a crime. With a greater recognition of mental illness, emotional disturbance replaced criminal responsibility in suicide and criminal penalties were abandoned.

In common law, there was no civil action for suicide because the right of action died along with the one who committed suicide. Later wrongful death and survivor statutes allowed families to bring an action for their loss or on behalf of the deceased. However, even if liability could be attributed to a third party, the act of suicide was considered an independent intervening cause breaking the chain of causation and, therefore, not foreseeable.

Modern developments in causation, however, have allowed liability in a number of instances for suicide. These include failure to prevent suicide, workers' compensation injuries leading to suicide, and intentional as well as negligent infliction of bodily injury or emotional distress resulting in suicide. Earlier requirements that the individual was psychotic, in a delirium or frenzy, acting on an uncontrollable impulse, or without conscious intent, have gradually given way to a much more liberal analysis where the presence of any mental disturbance is sufficient to shift the blame to a potential tortfeasor. In addition, the distinction between intentional and negligent torts, where the latter requires foreseeability, has often been blurred and a "but for" analysis is at times sufficient for liability. Typically, however, most jurisdictions still look to foreseeability and control to establish causation in negligence actions for the suicide of another. However, both of these elements should be considered in terms of their corresponding psychiatric concepts of predictability and preventability. There is reason to believe that both are more limited than may be assumed.

Although foreseeability and predictability are not synonymous, some attention should be drawn to statistical probabilities and the likelihood of particular events occurring, before determining whether something is, in fact, predictable. When events are frequent, they are more predictable; their parameters are more easily identified and variables leading to them more easily defined. On the other hand, when events are infrequent, they are difficult to distinguish from random happenings, and, therefore, the risk of occurrence may be beyond the scope of prediction.

In this regard, it is disappointing in the field of mental health, that in spite of a great deal of demographic data and identified risk factors, the majority of individuals who commit suicide have been seen within a short period of time prior to their act by a professional who did not

predict it. In addition, they have usually told someone about their suicidal thinking. Large patient studies have shown that the problem is while suicide is increasing statistically in the country, it is still relatively infrequent in the population even among emotionally disturbed individuals. So, for example, a mental health provider may see hundreds of patients in a year who express depressed mood with suicidal thinking, yet few if any will actually commit suicide. In essence, therefore, the mental health provider can assume that the treatment and management of those hundreds of patients was successful, so the approach can remain the same. It is not difficult in practice to identify a large pool of patients who are potentially suicidal and fit all the risk factors, but to decide which ones among those are actually a threat may be guesswork. Yet, to confine and protect all those who are potentially suicidal is impossible, especially when a fair number are chronically that way.

Control over a suicidal patient, or preventability, is also assumed by virtue of a mental health provider's expertise in tile treatment of disorders leading to suicide. Indeed, most mental health providers intuitively believe that they do prevent suicide by helping disturbed patients choose the alternative of living, or by initiating protective action in a suicidal crisis. And, modern treatment has certainly been successful in many difficult, formerly untreatable, mental illnesses. But, again, the suicide rate is increasing in frequency in spite of these modern treatment methods. In addition, numerous studies of suicide prevention centers indicate that they have been ineffective in preventing suicide. Routinely, individuals commit suicide on hospital wards using a variety of inventive means to do it. Contracts with patients to disclose suicidal intent to the mental health provider are used regularly, but with little empirical evidence of effectiveness.

In spite of these obstacles, mental health providers should not lose faith in their ability to help patients overcome such disturbing and hopeless feelings. Good judgment and conscientious attention to warning signs of suicide are not without merit. At times, however, even well-reasoned judgment and a caring treatment approach will not prevent a suicide. Control over a patient's behavior may be difficult if not impossible to achieve, especially when less restrictive alternatives in treatment are being demanded. Similarly, predicting a suicide may be much harder than our science would like to accept. In the aftermath of suicide, blame-casting is plentiful. Professionals often blame themselves. Survivors blame themselves too, as well as others; if the deceased is not to be blamed, then someone must be!

It is natural, therefore, for blame to be transferred to the courtroom. But, before liability is found, there needs to be a careful analysis that takes into account the limitations of predictability and preventability even by well-trained and conscientious practitioners. Breaches in standards of care should be clear and not dependent only on the authority of hind sights

(see Drukteinis, A.M.: Psychiatric perspectives on civil liability for suicide. Bull Am Acad Psychiatry Law, 13:1, 1985