UDK 347.56:614.253 ; 616.895.8-008.441.44
Originalni naučni rad
Primljeno: 21. 3. 2011.

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SUICIDE AND SOME OF ITS LEGAL PROBLEMS WITH PARTICULAR REFERENCE TO THE SHIZOPHRENIA PATIENT***

Abstract. Suicide is one of the world's largest public health problems. Suicidal behavior as a whole is a complex phenomenon often resulting from the interplay of many factors. Despite efforts to predict and prevent it, inroads toward the reduction of completed and attempted suicide rates remain modest. Both biological and psychological models have been employed to better understand this behavior. Another question about suicide is it's legal aspect. Consideration of the legal implications of malpractice is of main concern to practitioners and insurance companies, which cover them. The legal complaints in malpractice cases involving suicide are the same for schizophrenic and non-schizophrenic populations. The courts have applied various theories in imposing liability on mental health practitioners in suicide cases.

Key words: suicide, factors, malpractice, schizophrenia, negligence, duty, breach of duty, cause in fact, proximate cause

THE BURDEN OF SUICIDE•

Suicide has stolen lives around the world and across the centuries. Meanings attributed to suicide and notions of what to do about it have varied with time and place, but suicide has continued to exact a relentless toll. Only recently the approach

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*** Some paragraphs of this chapter were published as Andalibian H, Howe LLS, Milner MW, Eudy K, Bongar B, Packman W. Medical-Legal Aspects of Treating Suicidal Schizophrenic Patients. In: R. Tatarelli, M. Pompili, Girardi P (Eds). Suicide in Schizophrenia. Nova Science Publishers, Inc., Hauppauge, N.Y. 2007, p. 83–98. The material is reprinted by permission.

• Primedba Redakcije: Samoubistvo kao fenomen ima brojne aspekte kao što su religiozni, moralni i pravni. Među njima poseban značaj imaju krivičnopravni i kriminološki naročito kada se radi o faktorima samoubistva. To je i razlog zbog kojeg je Redakcija odlučila da objavi ovaj rad.

to suicide as a preventable problem with realistic opportunities to save lives, using a methodology based on standardized tools, is becoming widely used.

Suicide is one of the world's largest public health problems, accounting for approximately 1 million lives lost annually; this represents a global mortality rate of 16 per 100,00 or one death every 40 seconds (World Health Organization, 1999; World Health Organization, 2002). Other sources estimate that there are ten to 25 non-fatal suicide attempts for every completed suicide, and these numbers rise to 100–200 for adolescents.[1] Suicide is one of the leading causes of death worldwide, particularly in younger people; it profoundly affects individuals, families, workplaces, neighborhoods and societies. In the last 45 years suicide rates have increased by 60% worldwide. Suicide is now among the three leading causes of death among those aged 15–44 years (both sexes); these figures do not include suicide attempts that are up to 20 times more frequent than completed suicide. Suicide worldwide is estimated to represent 1.8% of the total global burden of diseases in 1998, and estimates are that it will be the 2.4% in countries with market and former socialist economies in 2020.

Although traditionally suicide rates have been highest among the male elderly, rates among young people have been increasing to such an extent that they are now the group at highest risk in a third of countries, in both developed and developing countries. Mental disorders (particularly depression and substance abuse) are associated with more than 90% of all cases of suicide in Western societies; however, suicide results from many complex sociocultural factors and is more likely to occur particularly during periods of socioeconomic, family and individual crisis situations (e.g. loss of a loved one, employment, honour).

The economic costs associated with completed and attempted suicide are estimated to be in the billions of dollars. One million lives lost each year are more than those lost from wars and murder annually in the world. It is three times the catastrophic loss of life in the tsunami disaster in Asia in 2005. Every day of the year, the number of deads by suicide is equivalent to the number of lives lost in the attack on the World Trade Center Twin Towers on 9/11 in 2001.

It is acknowledged that since killing oneself is against nature, no normal person would commit such an act, therefore those who commit suicide are considered mentally ill; however the vast majority of mentally disordered people even if faced by the same dramatic situations encountered by suicides do not actually kill themselves. Suicide should not be considered a symptom of the various psychiatric disorders otherwise proper suicide assessment is generally impaired.

Suicidal behavior as a whole is a complex phenomenon often resulting from the interplay of many factors. Despite efforts to predict and prevent it, inroads toward the reduction of completed and attempted suicide rates remain modest. Both biological and psychological models have been employed to better understand this behavior. Several neuroimaging studies have suggested possible biological markers for suicidal behaviour.[2]

1 R. W. Maris, A. L. Berman & M. M. Silverman /2000/: *Comprehensive textbook of suicidology*, New York: The Guildford Press

2 E. P. Ahearn, K. R. Jamison, D. C. Steffens, F. Cassidy, J. M. Provenzale, A. Lehman, *et al.*/2001/: MRI correlates of suicide attempt history in unipolar depression, *Biological Psychiatry,* 50, pp.

PSYCHOBIOLOGY OF SUICIDE

Several studies have also shown that dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis can be found in suicide victims. That disturbances in these two systems may share a common pathophysiological mechanism is not surprising, inasmuch as we know from animal studies that they interact extensively and that they are related in a variety of ways: The hippocampus, in particular, is an anatomical region in which components of the HPA and the 5-HT systems have a rich representation. This region is part of the limbic system, an area implicated in the regulation of several vegetative functions (arousal, sleep, appetite, and hedonic capacity) as well as in the control of cognitive function and of mood. Therefore, the hippocampus provides an ideal anatomical substrate to study the HPA axis, the serotonin system, and their potential role in suicide. It is clear that neurobiological abnormalities can be found in suicide victims, irrespective of diagnosis. However, not all suicides have a common underlying psychiatric condition. An important question is whether the biological abnormalities that have been found in suicide victims are characteristic of a subpopulation or if there is a neurobiological precursor common to all suicides. For example, although disturbances in the 5-HT and HPA systems have been identified in suicide victims, they have also been implicated in affective disorders. This is particularly relevant, because, depending on the population, 40 to 60% of suicide victims have a history of affective disease. Given this neurobiological link, an understanding of the relationship between these two circuits can give us clues to the pathophysiology of both suicide and affective illness. Other insights on the neural bases of suicide behavior are been developed by the funtional neuroimaging.

Oquendo et al.[3] compared 16 depressed patients with a high lethality suicide attempt and 9 depressed patients with low-lethality attempts. These authors involved the positron emission tomography (PET) to study regional brain metabolic responses to a serotonergic challenge and lethality of attempts in major depression. They found that depressed high-lethality suicide attempters had lower regional cerebral uptake of fludeoxyglucose F18 in ventral, medial and lateral prefrontal cortex compared with low-lethality attempters.

Suicidal behavior is a complex phenomenon often resulting from the interplay of many factors. One model[4] proposed a stress-diathesis combination in the precipitation of a suicidal act. A stressor such as a psychiatric disorder or a psychosocial crisis may lead to suicidal ideation; if the individual has specific personality traits, vulnerability due to genetic, biology and early unfavorable experiences a suicidal act becomes most probable. A typical stressor includes the acute worsening of a psychiatric disorder, but often an acute psychosocial crisis seems to be the most proxi-

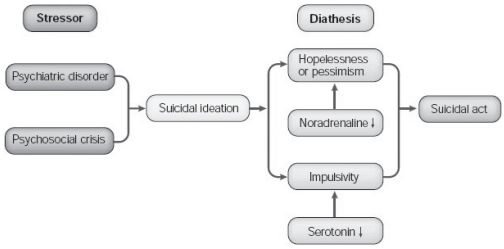
266–70. M. A. Oquendo, B. Halberstam, & J. J. Mann /2003/: Risk factors for suicidal behavior: utility and limitations of research instruments. In Standardized Evaluation in Clinical Practice (ed. M. B. First), pp. 103–130. Washington, DC: American Psychiatric Publishing.

3 M. A. Oquendo, B. Halberstam, & J. J. Mann, *op. cit*., pp. 103–130.

4 J. J. Mann, C. Waternaux, G. L. Haas, et al. /1999/: Toward a clinical model of suicidal behavior in psychiatric patients. *Am. J. Psychiatry*, 156:181–9.

mal stressor or 'the straw that broke the camel's back', leading to suicidal behaviour. Pessimism and aggression/impulsivity are components of the diathesis for suicidal behaviour. Sex, religion, familial/genetic factors, childhood experiences and various other factors, including cholesterol levels, influence the diathesis (Fig. 1).

Fig. 1 – The stress-diathesis model proposed by Mann et al (1999)



These risk factors are not independent. For example, there is a relationship between aggressive/impulsive traits, substance abuse, depression and cigarette smoking.[5] Also, head injuries occur more frequently in aggressive, impulsive subjects and in people with a history of alcohol and substance abuse. This particular relationship is bidirectional because alcoholism, substance abuse and aggressive behaviours can follow head injuries. Scholars found that head injuries in childhood are more common in aggressive children, and that the impact of the head injury on future aggression is greater in children who were more aggressive before the head injury.[6] As aggressive behaviours and alcoholism are more common in males than in females this might partly explain the higher suicide rates that are reported in males.

Shneidman[7] coined the term „psychache" to describe this pain. Psychache is „the hurt, anguish, or ache that takes hold in the mind...the pain of excessively felt shame, guilt, fear, anxiety, loneliness, angst, and dread of growing old or of dying badly. Suicide is functional because it abolishes the pain for the individual. Suicide occurs when the psychache is deemed by that individual to be unbearable. It is an escape from intolerable suffering". Shneidman[8] (1993b) believes that in suicide, 'death' is not the key word. Suicide is best understood not so much as a movement toward death but more as a movement away from an intolerable emotion, unendurable, or unacceptable anguish. If the level of suffering is reduced the individual will choose to live.

Each of us has an idiosyncratic disposition made up of psychological needs, and the weights we give to these psychological needs is a window into our persona-

5 J. J. Mann /2003/: Neurobiology of suicidal behavior. *Nat. Rev. Neurosci.*, 4:819–28.

6 M. A. Oquendo, B. Halberstam, & J. J. Mann, *op. cit.,* pp. 103–130.

7 E. S. Shneidman /1993a/: *Suicide as psychache: a clinical approach to self-destructive behaviour*, Jason Aronson: Northvale. E. S. Shneidman /1993b/: Suicide as psychache, *The Journal of Nervous and Mental Disease* 181, pp. 145–147.

8 E. S. Shneidman /1993b/, pp. 145–147.

lity.[9] Among the various psychological needs we can distinguish at least two kinds: those that characterize the functioning, that is the modal needs. These are the needs the person lives with. On the other hand, there are the needs that the individual focuses on when he or she is under duress, suffering, heightened inner tension and in mental pain. These are the needs an individual is willing to die for, also called vital needs. In suicidal individuals the focus is on frustrated or thwarted need. These are the needs deemed by the individual as vital for continuing living. The frustration of these needs might lead to suicide. This special disposition of needs can be elicited by asking an individual about precise reactions to the failures of losses or rejections or humiliations previously in his life.

Suicide is the result of an interior dialogue. A dialogue takes place in the mind where options to solve the pain are scanned and suicide occurs after a length of time when efforts to find amelioration of psychache failed. At the beginning the mind scans its options; the topic of suicide comes up, the mind rejects it, scans again; there is suicide, it is rejected again, and then finally the mind accepts suicide as a solution, then plans it fixes it as the only answer. It is therefore an escape from intolerable suffering. Suicidal individuals experience constriction as tunnelling, or focusing or narrowing the range of options usually available to that individual's consciousness and dichotomous thinking, that is, wishing either some specific (almost magical) total solution for their psychache, or cessation, in other words suicide.[10] According to this view, suicide occurs when perturbation and lethality exist in the same individual: perturbation refers to how upset (disturbed, agitated, discomposed) the individual is; lethality refers to the likelihood of an individual's being dead by his/her own hand in the future. Lethality is a synonym for suicidality. Perturbation supplies the motivation for suicide, lethality is the fatal trigger. To reduce lethality and therefore dealing with perturbation we need to ask the person „Where do you hurt?", „How may I help you?" and so forth. Before dealing with lethality we need to deal with perturbation (psychache) which energizes lethality. Shneidman[11] has proposed the following definition of suicide: 'Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution'.

Anyone dealing with suicidal individual should be empathic and resonate to the patient's private psychological pain; be aware of the uniqueness of „patient's suffering"; change from „unbearable" and „intolerable" to „barely bearable" and „somewhat tolerable"; pay attention to frustrated psychological needs considered by the person to be vital to continued life.[12]

9 H. A. Murray /1938/: *Explorations in personality*, New York: Oxford University Press.

10 E. S. Shneidman /1996/: *The suicidal mind*, New York: Oxford University Press.

11 E. S. Shneidman /1985/: *Definition of suicide*, Aronson: Northvale.

12 E. S. Shneidman /2004/: *Autopsy of a suicidal mind*. (Tr. It: Autopsia di una mente suicida, Fioriti Editore, 2006), New York: Oxford University Press. E. S. Shneidman /2005/: Anodyne Psychotherapy: A Psychological View of Suicide, *Clinical Neuropsychiatry* 2, pp. 7–12.

Pompili et al (2008) recently investigated the role of psychache in the determination of suicide risk in 88 psychiatric inpatients. They used the Psychological Pain Assessment Scale[13] that involves direct questions about the level of current and worst-ever psychache using a linear rating scale and a checklist for the emotions experienced, along with pictorial stimuli. These authors found that patients currently at risk for suicide reported significantly higher current psychache and higher worst-ever psychache. The rating of current psychache was high, 6.7 on a scale of 1–9, but lower than the rating the worst psychache ever experienced – 8.6. It appears, therefore, that the patients had experienced severe psychache and were still suffering intense psychache. Most of our patients considered their worst-ever psychache unresolved. They had been hurt so much that they felt that the pain associated with those adverse events in their life could not be relieved and that they were condemned to face this pain forever. This suggests that, for suicidal psychiatric patients, amelioration of symptoms is not sufficient.

Everyone should be aware of the warning signs for suicide: Someone threatening to hurt or kill him/herself, or taking of wanting to hurt or kill him/herself; someone looking for ways to kill him/herself by seeking access to firearms, available drugs, or other means; someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person. Also, high risk of suicide is generally associated with hopelessness; rage, uncontrolled anger, seeking revenge; acting reckless or engaging in risky activities, seemingly without thinking; feeling trapped – like there's no way out; increased alcohol or drug use; withdrawing from friends, family and society, anxiety, agitation, unable to sleep or sleeping all the time; dramatic mood changes; no reason for living; no sense of purpose in life.[14]

Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems. Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them. Talking about suicide does not cause someone to be suicidal; on the contrary the individual feel relief and has the opportunity to experience an empathic contact.

Ways to be helpful to someone who is threatening suicide:

1. Be aware. Learn the warning signs.
2. Get involved. Become available. Show interest and support.
3. Ask if he/she is thinking about suicide.
4. Be direct. Talk openly and freely about suicide.
5. Be willing to listen. Allow for expression of feelings. Accept the feelings.
6. Be non-judgmental. Don't debate whether suicide is right or wrong, or feelings are good or bad. Don't lecture on the value of life.

13 E. S. Shneidman /1999/: The Psychological Pain Assessment Scale, *Suicide & Life-Threatening Behavior* 29, pp. 287–294.

14 R. Tatarelli /1992/: *Suicidio. Psicopatologia e prevenzione*, Il Pensiero Scientifico Editore, Roma.

7. Don't dare him/her to do it.
8. Don't give advice by making decisions for someone else to tell them to behave differently.
9. Don't ask 'why'. This encourages defensiveness.
10. Offer empathy, not sympathy.
11. Don't act shocked. This creates distance.
12. Don't be sworn to secrecy. Seek support.
13. Offer hope that alternatives are available, do not offer glib reassurance; it only proves you don't understand.
14. Take action! Remove means! Get help from individuals or agencies specializing in crisis intervention and suicide prevention.

Be aware of feelings, thoughts, and behaviors:

Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis is temporary, but death is not. On the other hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently, they:

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat or work
- Can't get out of the depression
- Can't make the sadness of away
- Can't see the possibility of change
- Can't see themselves as worthwhile
- Can't get someone's attention
- Can't see to get control

Strategies involving restriction of access to common methods of suicide have proved to be effective in reducing suicide rates; however, there is a need to adopt multi-sectoral approaches involving other levels of intervention and activities, such as crisis centres. There is compelling evidence indicating that adequate prevention and treatment of depression, alcohol and substance abuse can reduce suicide rates. School-based interventions involving crisis management, self-esteem enhancement and the development of coping skills and healthy decision making have been demonstrated to reduce the risk of suicide among the youth. Worldwide, the prevention of suicide has not been adequately addressed due to basically a lack of awareness of suicide as a major problem and the taboo in many societies to discuss openly about it. In fact, only a few countries have included prevention of suicide among their priorities. Reliability of suicide certification and reporting is an issue in great need of improvement. It is clear that suicide prevention requires intervention

also from outside the health sector and calls for an innovative, comprehensive multisectoral approach, including both health and non-health sectors, e.g. education, labour, police, justice, religion, law, politics, the media. With a highly suicidal person, our task is to serve as an anodyne, that is a substance or process that relieves pain.[15] In suicidology we must redefine the kind of pain we are dealing with, a concept not always completely understood.

LEGAL CAUSES OF ACTION

Common allegations in complaints among mental health practitioners, suicide is among the most common causes of action in lawsuits.[16] Claims brought against psychiatrists report post-suicide lawsuits as accounting for both the largest number of claims as well as the largest amount of monetary settlement.[17] Similarly, among psychologists, suicide of a patient is the sixth most common category for a claim, but still ranks second for percentage of total costs.[18] Thus, a consideration of the legal implications of malpractice is of main concern to practitioners and insurance companies, which cover them. The legal complaints in malpractice cases involving suicide are the same for schizophrenic and non-schizophrenic populations. The courts have applied various theories in imposing liability on mental health practitioners in suicide cases.[19] The following are the most common allegations in a complaint for malpractice following a patient's suicide:

(1) Failure to take proper tests and evaluations of the patient to establish suicide intent.
(2) Failure to medicate properly.
(3) Failure to observe the patient continuously (24 hours) or on a frequent enough basis (e.g., every fifteen minutes).
(4) Failure to take an adequate history.
(5) Inadequate supervision and failure to remove dangerous objects, such as a patient's belt.
(6) Failure to place the patient in a secure room.

We will revisit the above common allegations following a discussion of negligence law in order to clarify the element of the law to which they relate.

15 E. S. Shneidman /1993c/: Some controversies in suicidology: toward a mentalistic discipline, *Suicide & Life-Threatening Behavior* 23, pp. 292–298.

16 S. Simpson and M. Stacy /2004/: Avoiding the malpractice snare: Documenting suicide risk assessment, *Journal of Psychiatric Practice,* 10 (3), pp. 185–189.

17 D. R. Baerger /2001/: Risk management with the suicidal patient: Lessons from case law, *Professional Psychology: Research and Practice,* 32(4), pp. 359–366.

18 *Ibidem*. B. Bongar, R. W. Maris, A. L. Berman and R. E. Litman /1998/: *Outpatient standards of care and the suicidal patient,* in: B. Bongar, A. L. Berman, R. W. Maris and M. M. Silverman., E. A. Harris and W. L. Packman (Eds.): *Risk management with suicidal patients*, New York, New York: Guilford, pp. 4–33.

19 J. D. Robertson /1988/: *Psychiatric malpractice: Liability of mental health professionals*. New York: Wiley.

MALPRACTICE AND NEGLIGENCE LAW

The main legal theory in medical malpractice complaints is negligence. Negligence is „the failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation.[20]„ The area of negligence law falls under the broader scope of tort law. A „tort" is a civil wrong committed by one individual (the defendant), which has caused some injury to another individual[21] (the plaintiff). Unlike intentional torts, negligence does not require any intent on the part of the defendant. This means that in a tort case of battery (the use of force against another resulting in harmful or offensive contact[22], for example, the defendant must intend to commit the battery for liability to occur. In a negligence case, on the other hand, the defendant may bear no intentions of harm and still be held liable. This area of law essentially provides compensation for people when harm is done unto them because someone (the defendant) did something they should not have done (act of commission) or failed to do something they should have done[23] (act of omission). The lack of a requirement of intent is of crucial importance because it leaves health care practitioners vulnerable to liability even when they have the best intentions. Specifically, to recover on a claim of negligence the plaintiff must prove five elements[24]. These are: *duty, breach of duty, cause in fact, proximate cause* and *damages.*[25] It should be noted that the plaintiff must show all five elements. By refuting just one element the defendant can safeguard him or herself from liability. Indeed, attempting to refute one or more elements of the claim is the primary method practitioners and their legal counsel will employ in preventing liability. The other form of defense that is used is referred to in a legal sense as an affirmative defense. Affirmative defenses are legal defenses which can essentially excuse the defendant from liability even after all the elements of the tort have been met.[26] Affirmative defenses for negligence causes of action do exist; however, they rarely prevent full liability and serve mainly to mitigate it. Affirmative defenses include assumption of the risk and comparative liability. The former relates to the theory that the defendant assumed some or all of the risk going into the treatment and as such, the clinician should not be held liable.[27] Comparative liability is more commonly used as a

20 H. C. Black /1996/: *Black's law dictionary*, pp. 1405.

21 W. L. Packman and E. A. Harris /1998/: Legal issues and risk management in suicidal patients: in B. Bongar A. L., Berman R. W., Maris M. M., Silverman E. A., Harris and W. L. Packman (Eds.), *Risk management with suicidal patients*, New York: Guilford, pp. 150–186.

22 H. C. Black /1996/, *op. cit.*

23 R. I. Simon /1992/: *Concise guide to psychiatry and the law for clinicians,* Washington, DC: American Psychiatric Press.

24 It should be noted that the traditional view conceptualizes the legal concept of negligence as consisting of the four elements of duty, breach, causation, and damage. The element of causation is comprised of the two subparts of cause in fact and proximate cause. Newer and more modern approaches sometimes talk about negligence as being comprised of five or six elements. They break the element of causation into two separate elements and sometimes even add standard of care as a sixth element.

25 W. L. Prosser /1971/: *Handbook of the law of torts* (4th ed.), St. Paul, MN: West.

26 H. C. Black /1996/, *op. cit*.

27 *Ibidem.*

defense and refers to the idea that the plaintiff's own actions were also at fault and thus the liability of the defendant should be lessened.[28] Returning to the primary elements of negligence, we shall for the purposes of this chapter begin with the most basic element–damages–and end with duty and breach of duty.

UNDERSTANDING DAMAGES

Generally, when a plaintiff files a negligence lawsuit, the element of damages is usually satisfied. It essentially reflects the law's requirement that the plaintiff suffer some harm in order to be compensated. Simply put, a defendant may be negligent, but he or she is not liable unless it results in injury. If, for example, a practitioner's negligence leads to a patient's unsuccessful suicide attempt, and the attempt fortunately results in no psychological or physical harm, then the practitioner is not liable. In most cases, a completed suicide or physical and psychological injuries from a suicide attempt easily satisfy the damages requirement. Thus, a bigger issue in court becomes the *amount* of damages resulting from the negligence. The amounts are determined by the courts and are fact-specific to each case.

UNDERSTANDING CAUSATION: CAUSE IN FACT AND PROXIMATE CAUSE (FORESEEABILITY)

Causation refers to both the elements of *cause in fact* and *proximate cause*. Cause in fact refers to the basic requirement that the defendant's negligence must cause the damages to evoke liability. To determine this, courts traditionally applied the „but for" test. Essentially, a negligent act is said to be the cause in fact of the harm when „the result would not have occurred without the party's conduct.[29]" This analysis often found long chains of occurrences to pass the „but for" test. For instance, the mother of a child may have taken illegal drugs during her pregnancy, leading to mental retardation and behavioral problems in the child, a need for treatment, and possibly ending in suicide. Even though, in this hypothetical it is true that „but for" the mother's drug use, the suicide may not have occurred, it does not clearly follow that the drug use *caused* the suicide. Because of this flaw with the „but for" analysis, courts will often consider the substantial factor test. The substantial factor test requires merely that the act in question be a substantial factor of the harm.[30] This analysis helps remedy the problem of a long chain of events leading to unpredictable damages. In cases following an attempted or completed suicide, the courts consider 1) whether the practitioner providing adequate treatment would have prevented the suicide, and 2) whether the act or failure to act of the practitioner was a substantial factor in the suicide. Further limiting unforeseen

28 *Ibidem.*

29 *Ibidem.*

30 *Ibidem.*

damages is the element of *proximate cause*. Proximate cause deals mainly with the requirement that the harm be reasonably foreseeable. Often times the foreseeability of the suicide becomes the heated issue in court. If the court decides that the suicide was foreseeable, liability is often likely. On the other hand, if the court determines that the suicide was not reasonably foreseeable given the circumstances, then the practitioner may not be liable even when providing substandard care. In short, the practitioner is not responsible for harms which were not reasonably foreseeable. It is important to distinguish forseeability of suicide from predictability. Mental health practitioners cannot predict suicidal behavior reliably and validly without a high degree of false-positives.[31] Thus, forseeability involves a comprehensive and reasonable assessment of the risk. Nevertheless, once in court the difference between foreseeability and predictability may be blurred. „When a suicide is viewed through the lens of hindsight, it can take on a quality of apparent predictability.[32]„ This can give the plaintiff an advantage and is one reason why we recommend that practitioners practice within and even above the applicable standard of care. Since the law tends to assume that a foreseeable suicide is preventable in many cases, a clinician who either fails to reasonably assess risk level and/or implement appropriate preventative measures is potentially vulnerable if the patient is harmed.[33] As such, it is of crucial importance to carefully review the patient's history and determine the specific risk factors. In *Stallman v. Robinson* (1953)[34], the decedent's husband sued for the death of his wife who committed suicide while an inpatient at a private hospital. During her four-day stay at the hospital, the patient tore off strips of fabric from her nightgowns and successfully committed suicide by hanging and strangling herself. In finding the hospital liable, the court reasoned that „the most important single factor in determining whether a hospital was negligent in failing to prevent suicide of a patient is whether hospital authorities under the circumstances could have reasonably anticipated that the patient might harm himself." The court added that „whether these determinative factors are present depends on the detailed facts and circumstances of the particular case." The patient in *Stallman* was preliminarily diagnosed prior to her death as either manic-depressive or schizophrenic with paranoid ideas. In addition, the patient had a history of four previous suicide attempts as well as expressing suicidal ideation. In the court's view, suicide was foreseeable given the patient's history and specific risk factors. The risk factors for completed suicide in patients with schizophrenia which have been identified in at least three empirical studies are: young age, early in course of illness, frequent exacerbations and remissions, awareness of psychopathology, periods of clinical improvement after relapse, absence of florid psychosis, hopelessness, good premorbid history, lack of family support, history of suicide attempts, fear of further deterioration, recent

31 A. L. Berman and D. A. Jobes /1991/: *Adolescent suicide: Assessment and intervention*. Washington, DC: American Psychological Association.

32 D. Schultz /2000, August/: Defending the psychiatric malpractice suicide. *Health Care Law*, pp. 13 26.

33 R. I. Simon /1998/: Psychiatrists awake: suicide risk assessments are all about a good night's sleep, *Psychiatric Annals*, 28(9), pp. 479–485.

34 Stallman V., Robinson. /1953/:364 Mo. 275, 260 S.W.2d 743.

discharge and acute suicide ideation.[35] When these factors are present in a schizophrenic patient who commits suicide the courts may be more likely to determine that the suicide was foreseeable.

UNDERSTANDING DUTY AND BREACH OF DUTY

The elements of *duty* and *breach of duty* are the fundamental basis of negligence law since they establish the standard of care which, when not met, renders a defendant negligent. When considering the first element of duty, the courts primarily consider whether the defendant owed the plaintiff a duty. It is generally a particular relationship established between the two parties, which create the duty. As this pertains to our discussion, any health practitioner will owe a duty to his or her patient simply by taking on the role of health practitioner. In the case of *Stallman* referred to previously, where the decedent's husband sued for the death of his wife who hanged and strangled herself while an inpatient, the court noted: „the doctors in the case were specialists in care and treatment of the mentally ill and accepted the patient in the hospital operated by such doctors, and therefore owed the patient a specific duty." Simply put, a mental health practitioner will almost always owe a duty to his or her patient. What the specific duty actually requires becomes the crux of the matter.

Recall that negligence is defined by a failure to operate within a particular standard of care. Following this standard of care is the duty that the health practitioner owes his or her patient. When the practitioner fails to do so, it is the *breach of duty* that defines negligence. It is also the single element of negligence, which the health practitioner actually has control over after accepting the patient. The other elements can be debated and refuted by the parties' legal counsel after a case has been filed. This writing is not intended, however, to be a guide for lawyer's arguments in malpractice, cases but an attempt to guide practitioners in how to minimize liability.

It is our opinion that the practitioner's best line of defense is not in the courtroom, but rather to not be negligent in the first place. Specifically, to take precautions so as to not breach the duty by falling below the standard of care. The other elements are less within the defendant's control. The practitioner cannot prevent owing a duty to the patient since it flows from the doctor-patient relationship. The same is true when considering causation. Once a breach has occurred, followed by damage, there is either a causal link or there is not, and this is usually out of the defendant's control. Similarly, the practitioner has no control to either make something foreseeable or unforeseeable. [36] This is, again, for the courts to decide. Indeed, the key element the practitioner has control over is whether he or she breaches his or her duty. Therefore, a requirement for providing patients proper care and minimizing liability is to understand and examine what constitutes duty, i.e. practicing

35 N. Reynolds /2000/: *Suicidal risk factors with a schizophrenic population: Standard of care practice,* Unpublished doctoral dissertation, Pacific Graduate School of Psychology, California: Palo Alto.

36 However, as noted previously, the practitioner has a duty to conduct a comprehensive and reasonable assessment of risk (Jobes and Berman, 1993). Reasonably prudent care by clinicians involves implementing precautions or interventions based on the preceding assessment of risk.

within the standard of care. It is against this legal background that we discuss what usually constitutes breach of duty by the practitioner.

By looking back to the list of common allegations in malpractice cases following suicide we can extract specific elements, which are necessary to reasonable care by the practitioner. These are:

(1) Duty to properly predict a suicide and/or diagnose suicidal tendency.
(2) Duty to control, supervise or restrain.
(3) Duty to take proper tests and evaluations of the patient to establish suicide intent.
(4) Duty to medicate properly.
(5) Duty to observe the patient continuously (24 hours) or on a frequent enough basis (e.g., every fifteen minutes).
(6) Duty to take an adequate history.
(7) Duty to provide adequate supervision and remove dangerous objects, such as a patient's belt.
(8) Duty to place the patient in a secure room.

It is important to note that the above list is an illustrative, not exhaustive one of the specific duties owed to a suicidal patient. Nevertheless, most cases involving suicide will involve a breach of one or more of the above listed duties. What each duty requires (i.e., how much medication is „proper medication"; how much supervision is adequate) is unique to each circumstance and determined by the needs of the patient.

Duty to Take Proper Tests and Evaluations of the Patient to Establish Suicide Intent

Mental health practitioners are expected to reach the proper diagnosis and not misdiagnose patients. Misdiagnosis refers to a negligent failure to recognize the nature of the patient's condition and then to implement proper measures before harm occurs.[37] In *O'Sullivan v. Presbyterian Hospital in City of New York at Columbia Presbyterian Medical Center*[38] an expert witness testified that the psychiatrist failed to diagnose major depression, formulate a treatment plan, detect the severity and acuteness of the patient's problem, order a physical examination, consult the patient's treating physician about the patient's weight loss, assign the patient a therapist, or refer him for psychotropic medication. Given this evidence raising issues of deficient diagnosis and treatment, the court held that there was no basis to find that the psychiatrist conducted a competent evaluation. The link between diagnosing depression and liability for a patient suicide can be reasonably followed to also include sc-

37 W. L. Packman, T. O. Pennuto, B. Bongar and J. Orthwein, /2004/: Legal issues of professional negligence in suicide cases, *Behavioral Science and the Law*, 22 (5), pp. 697–713.

38 O'Sullivan V., /1995/: Presbyterian Hosp. in City of New York at Columbia Presbyterian, 217 A.D.2d 98, 634 N.Y.S.2d 101

hizophrenia. A failure to properly diagnose schizophrenia suffered by a patient who commits suicide can lead to similar liability as in *O'Sullivan*. This is particularly true when taking into consideration the increased risk schizophrenia poses for suicide.

Duty to Control, Supervise or Restrain

The duty to control, supervise or restrain covers many aspects of treatment. Hospitals have been found negligent in releasing a suicidal patient. In Bell v. New York City Health and Hospital Corporation[39], a physician recommended the release of a psychiatric patient despite the presence of the patient's potentially harmful delusions. The physician failed to investigate the previous psychiatric history of the patient, the patient's delusions, or an incident that occurred the evening before the patient's release, during which the patient had to be restrained. The court held that the decision to release provided sufficient basis to impose liability.

In some cases, psychiatrists and hospitals have been found negligent in failing to properly supervise a patient. In Fatuck v. Hillside Hospital[40], an action was brought to recover damages wherein it was claimed that the hospital was negligent in failing to prevent a patient from escaping the grounds a few hours before he committed suicide by jumping from the roof of a building. Evidence included a 14 year history of mental health problems and recently expressed suicidal threats. During the patient's nine day stay in the hospital, there were notations made in his record stating that he was not to be permitted to wander off. The patient was also placed on 15 minute checks for two days after admission; however, there was no notation that the checks were ever conducted. The court held that the evidence established negligence on the part of the hospital.

In *Bramlette v. Charter Medical Columbia*[41], a malpractice action was brought against a psychiatrist and hospital in connection with the suicide of a patient. The patient arrived at the hospital in a very distressed state. He was hoarse and very white and told the psychiatrist and staff that he had been screaming in the car during the entire thirty minute drive. He was extremely agitated and pulled at his clothing and hair. His daughter, upon bringing him to the hospital told his psychiatrist (one of the defendants in this case) and the hospital staff that her father was suicidal. Four days after being voluntarily admitted to defendant's hospital the patient committed suicide during a recreational outing off the hospital grounds. The outing was with a group of fellow patients and an occupational therapist of the hospital. On the return trip the patient told the therapist he was going to vomit and urged her to pull over and let him out. She pulled over, he jumped out, ran to a highway overpass, climbed on the ledge and jumped to his death.

An expert witness for the plaintiff enumerated the hospital's deviations from the reasonable standard of care by:

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39 Bell V., New York City Health and Hospitals Corporation, 90 A.D.2d 270, 456 N.Y.S.2d 787 /1982/.

40 Fatuck V. /1974/: Hillside Hospital, 45 A.D. 2nd 708, 356 N.Y.S.2d 105, New York

41 Bramlette V. /1990/: *Charter Medical Columbia*, 302 S.C. 68, 393 S.E.2d 914

1. failing to get a complete history from the family;
2. failing to order more intense supervision for the first seven to ten days after admission (before medication and therapy took effect);
3. failing to prohibit an outing off hospital grounds;
4. failing to diagnose the patient as a high risk of suicide based on his anxiety attacks. The court, in finding the hospital liable „recognized a cause of action in negligence for breach of a duty to prevent a known suicidal patient from committing suicide."

The above cases illustrate the specific duties owed to a suicidal patient.

What about instances where a person is simply *at a high risk* of suicide? For our purposes, the important question is whether having schizophrenia alone raises the standard of care. This is addressed in the following section.

THE STANDARD OF CARE FOR PATIENTS WITH SCHIZOPHRENIA

In the case of *Randolph v. Cervantes*[42] the patient had paranoid schizophrenia and was being treated as an outpatient at a mental health care facility. In this case, the patient/plaintiff did not attempt suicide, but injured herself by injecting insulin into her eyes resulting in loss of vision in one eye and impaired vision in the other. The court held that despite her schizophrenia there was no duty to protect her from herself when she was not confined in a mental health institution. Of note, the court in *Randolph* did not give special consideration to the patient's mental state. Had she injected herself with something more lethal than insulin and committed suicide it is unclear if the court would have followed the same reasoning. As an outpatient, the patient's schizophrenia alone was not enough to warrant a high duty to protect her from harming herself. It should be noted here, however, that the defendant was a state-associated mental health care facility. Thus, the court's analysis may not be followed in future cases involving non-governmental practitioners or inpatient situations.

Similarly, in *Dutcher v. United States*[43], the patient suffered from paranoid schizophrenia and voluntarily left the Veteran's Administration (VA) mental hospital before discharge and against medical advice. Following his leave he committed suicide by shooting himself. The issue was whether the VA hospital had a duty to notify family or police when the patient prematurely walked out. The court held that the VA hospital did not breach the standard of care because the patient, although known to have paranoid schizophrenia, and despite expressing some suicide ideation, had no suicide intent or plan and was not in imminent danger to himself or others before he shot himself. Subsequent to his admission, the patient repeatedly and consistently denied that he was suicidal or homicidal. The court held that the care and treatment rendered by the hospital met the standard of care for such patients. Thus, the patient's schizophrenia alone was not enough for the court in this

42 Randolph V. and Cervantes. /1996/:950 F. Supp. 771.

43 Dutcher V. /1990/: United States, 736 F. Supp. 1142.

case to raise the standard of care. The court's language does imply however, that if the patient could have been reasonably determined to be suicidal, the standard of care may have required calling the police and/or family when the patient prematurely left the hospital.

The case of *Stallman v. Robinson*[44] referred to previously, distinguish itself from the reasoning of the above cases. In *Stallman*, the patient had a preliminary diagnosis of manic-depressive disorder or schizophrenia with paranoia and the decedent's husband sued for the death of his wife who hanged and strangled herself while an inpatient. The court made no mention of her being suicidal, but referred only to her having „suicidal ideas." It is important to note the difference between having a suicidal intent (commonly what is referred to as being suicidal) and having suicidal ideation. The latter, aside from being a common characteristic among a wide range of disorders, is also common among the general population. It is estimated that up to one third of people in the general population of the United States have suicidal ideation at some point in their lives.[45] In contrast to the *Randolph and Dutcher* cases, the court in *Stallman* referred constantly to the patient's mental condition when determining the standard of care. They reasoned that the hospital owed the patient „a specific duty of exercising reasonable care to safeguard and protect her from injuring herself....and that their duty in this regard was proportionate to her needs; that is, such reasonable care and attention as her known mental condition required." Thus, the court determined the standard of care by what the patient's mental condition warranted, and not by her status as suicidal or non-suicidal. The holding of *Stallman* finding the hospital liable is even more striking given the high level of care exercised by the hospital to prevent suicide.[46] According to the court, the level of care was not high enough for the mental condition of the patient.

A review of the above cases provides mixed answers on the issue of the standard of care for patients with schizophrenia. In *Randolph*, schizophrenia itself was not enough to give rise to a duty to protect the patient from herself in an outpatient setting. In *Dutcher*, a diagnosis of schizophrenia, coupled with suicidal ideation was still insufficient to warrant a higher standard of care when suicidal intent was not present. However, in contrast to these cases, the court in *Stallman* focused on the mental condition of the patient to determine the standard of care. In this case the patient had previous attempts and suicidal ideation upon entering the hospital. Nevertheless, it was mainly her mental diagnosis of manic-depressive disorder or paranoid schizophrenia which alerted the court to a higher standard of care. Spe-

44 Stallman V., Robinson. /1953/:364 Mo. 275, 260 S.W.2d 743.

45 R. M. A Hirschfeld. and J. M. Russell /1997/: Assessment and treatment of suicidal patients, *New England Journal of Medicine,* 333, pp. 910–915.

46 During the patient's four-day stay at the hospital, she tore off strips of fabric from her nightgowns to successfully comit suicide by hanging and strangling herself. The court noted that the hospital had in place strict practices to protect and supervise the patient. Regular observations were made, unworn clothes were kept locked away, and patients were locked in safety belts when in bed. Nevertheless, the court determined that the hospital had a higher specific duty and that given the detailed circumstances they had breached their duty by failure to use ordinary care to watch the patient and prevent her self destruction by reason of her alleged nervous and mental derangement.

cifically, the court held that due to her „alleged nervous and mental derangement" the hospital had a duty to „prevent her self destruction." This ruling seems to imply that when a patient has schizophrenia, the hospital may be liable for any unprevented suicide.

It is clear that when involved with a patient with schizophrenia special attention should be given to the great risk the disease itself poses. Although in most cases it takes more than a diagnosis of a mental disorder to determine the standard of care, the ruling in at least one case (*Stallman)* indicates that the mental condition alone carries a great deal of weight. Thus, it is our recommendation to err on the side of caution for the protection of both the patient and clinician. The high rate of suicide among patients with schizophrenia should not be forgotten, and the standard of care should rise appropriately.

The practitioner may consider that raising the standard of care often involves a more restrictive environment, which while safe, may not correspond to the most healing environment. Still, the negative consequences of „over-caring" seem to pale in comparison to the worst-case scenario when the observation and care is insufficient. This worst-case scenario is particularly highlighted when as many as 40% of persons with schizophrenia are attempting suicide.[47] The judgment call of determining the standard of care belongs primarily to the practitioner. However, in the unfortunate cases where suicide is attempted or committed and a lawsuit is filed, the courts, through expert testimony, determine the standard of care. The challenge for mental health practitioners is how to safeguard themselves from liability while continuing to provide the best clinical care for the circumstances and save very vulnerable lives.

FURTHER RISK MANAGEMENT STRATEGIES FOR MENTAL HEALTH PRACTITIONERS

Throughout this chapter we have expressed a generally high standard of care for suicidal patients with schizophrenia, and explained the reasoning behind the law. Even when providing the proper standard of care, practitioners should consider the following risk management guidelines to create an effective treatment plan and minimize liability:

1. Documentation

Perhaps the most important risk management technique is good record keeping.[48] Inadequate documentation can cripple a legal case, even if there was no actual negligence.[49] Thus, if a clinician fails to record an action in the records, the

47 M. Pompili, A. Ruberto, G. Kotzalidis, P. Girardi and R. Tartarelli, /2004/: Suicide and awareness of illness in schizophrenia: An overview, *Bulletin of the Menninger Clinic,* 68 (4), pp. 297–318.

48 W. L. Packman and E. A. Harris /1998/: *op. cit*., pp. 150–186.

49 L. VandeCreek and S. Knapp /1989/: *Tarasoff and beyond: Legal and clinical considerations in the treatment of life-endangering patients*, Sarasota FL: Professional Resource Exchange.

jury may assume the clinician failed to carry out the treatment completely[50]. In fact, clinicians „who make bad decisions but whose reasoning [is clearly articulated]" may come out more favorably than clinicians „who have made reasonable decisions but whose poor documentation leaves them vulnerable[51]." A thorough record should document interactions, consultations, and professional judgments.[52] The signed informed consent for treatment and documentation of confidentiality considerations should also be included.[53] It is also beneficial to document steps not taken along with reasoning. Gutheil[54] refers to this as „thinking out loud" for the record. Finally, tampering with records by inserting new material after-the-fact can destroy any chances of winning a case.[55]

2. Consultation

Clinicians should routinely consult colleagues who have expertise with suicidal patients.[56] It is advisable for clinicians to also seek consultation or supervision on cases that are outside of their competence area (or refer the patient out).[57] Both clinician and consultant should provide written notes for the record[58], as consultation can provide legal evidence for the reasonableness of selected diagnostic and treatment plans[59]. Clinicians should make appropriate referrals for medication evaluations if they are not physicians themselves, and should be knowledgeable about the effects of psychotropic medications.[60]

3. Know Legal and Ethical Responsibilities

Knowing one's legal and ethical responsibilities helps clinicians recognize risk before it becomes a liability.[61] It is important to be familiar with the laws, regulations, and ethical principles in one's jurisdiction.[62] Confidentiality and informed consent are two salient issues.

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50 W. L. Packman and E. A. Harris /1998/: *op. cit*., pp. 150–186.

51 T. G. Gutheil /1980/: Paranoia and progress notes: a guide to forensically informed psychiatric record-keeping, *Hospital and Community Psychiatry,* 31 (7), pp. 479–482.

52 S. Halleck /1980/: *Law in the practice of psychiatry*, New York: Plenum Press.

53 W. L. Packman and E. A. Harris /1998/: *op. cit*., pp. 150–186.

54 T. G. Gutheil /1980/: *op. cit*., pp. 479–482.

55 J. Monahan /1993/: Limiting therapist exposure to Tarasoff liability: Guidelines for risk containment, *American Psychologist,* 48, pp. 242–250.

56 W. L. Packman and E. A. Harris /1998/: *op. cit*., pp. 150–186.

57 B. Bongar /2002/: *The suicidal patient: Clinical and legal standards of care (2nd ed.),* Washington, DC: American Psychological Association.

58 B. Bongar /1991/: *The suicidal patient: Clinical and legal standards of care.* Washington, DC: American Psychological Association.

59 L. VandeCreek, S. Knapp and C. Herzog /1987/: Malpractice risks in the treatment of dangerous patients, *Psychotherapy: Theory, research and practice*, 24, pp. 145–153.

60 B. Bongar /1991/: *op. cit.*

61 W. L. Packman and E. A. Harris /1998/: *op. cit*., pp. 150–186.

62 *Ibidem.*

4. Obtain Risk Assessment Data

A thorough clinical assessment of elevated risk must be performed and recorded in a careful, professional manner.[63] Suicide potential should be evaluated several times during the treatment process, including such points as the time of admission, transfer to less restrictive areas, before home visits, and before discharge.[64]

Historical information should include details regarding past suicide attempts, prior incidents of self-harm, past suicidal ideation/impulses, as well as information about attempted and completed suicides in the patient's family.[65] Peruzzi and Bongar[66] stated the importance of also obtaining information about the medical seriousness or lethality of all prior patient attempts. In addition, the clinician should make reasonable efforts to obtain patients' previous treatment records.[67]

To promote a comprehensive evaluation, many theorists[68] advocate formulating clinical judgment based upon a combination of structured interviews, checklists, standard psychological instruments, and suicide risk scales and estimators. Assessing a patient's potential for suicide on the basis of one measure or score alone without considering previous behavior, psychiatric diagnosis, and other aspects of a clinical interaction is never an acceptable practice.[69] Serial and repeated assessment is another key aspect of proper patient care, for suicidal risk is certainly not a static trait, but a dynamic quality that varies over time.[70]

5. Determine Competence

Clinicians are limited as to their specific areas of professional competence.[71] One's competence varies greatly depending on education, training, and experience. Thus, clinicians must be aware of their own proficiencies and emotional tolerance levels in treating suicidal patients.[72] If a clinician decides not to treat suicidal patients, a list should be developed of colleagues to whom the clinician can refer these high-risk patients.[73]

63 *Ibidem.*

64 L. VandeCreek and S. Knapp /1983/: Malpractice risks with suicidal patients, *Psychotherapy: Theory, research and practice,* 20, pp. 274–280.

65 D. R. Baerger /2001/: *op. cit*., pp. 359–366.

66 N. Peruzzi and B. Bongar /1999/: Assessing risk for completed suicide in patients with major depression: Psychologists' views of critical factors, *Professional Psychology: Research and Practice*, 30, pp. 576–580.

67 W. L. Packman and E. A. Harris /1998/: *op. cit*., pp. 150–186.

68 E. L. Bassuk /1982/: General principles of assessment, in: E. L. Bassuk S. C. Schoonover, and A. D. Gill, Eds., *Lifelines: Clinical perspectives on suicide,* New York: Plenum, pp. 17–46.

69 R. W. Maris, A. L. Berman, J. T. Maltsberger and R. I. Yufit (Eds) /1992/: *Assessment and prediction of suicide*, New York: Guilford.

70 R. I. Yufit and B. Bongar /1992/: Suicide, stress and coping with life cycle events. In R. W. Maris, A. L. Berman J. T. Maltsberger and R. I. Yufit Eds., *Assessment and prediction of suicide,* New York: Guilford, pp. 553–573.

71 B. Welch /1989/: A collaborative model proposed, *American Psychological Association Monitor,* 20 (10), pp. 28.

72 B. Bongar /2002/: *op. cit.*

73 W. L. Packman and E. A. Harris /1998/: *op. cit*., pp. 150–186.

Determining competence includes the knowledge of the appropriate standards of care when treating specialized clients. Reynolds[74] attempted to identify „standards of care" of practicing clinicians who work with suicidal schizophrenic patients. The goal of this survey was to establish this profile and then provide information to clinicians in the form of practice guidelines to upgrade the assessment and intervention behaviors of clinicians in the field.[75] Of the nearly 200 responding psychologists surveyed[76] regarding 36 potential risk factors, they rated the following attributes as critical or high: seriousness of past suicide attempt, history of attempted suicide, acute suicidal ideation, alcohol and/or other substance abuse, hopelessness, impulsivity, family history of suicide completion, command hallucinations, medication noncompliance, depressed mood, increased agitation, and lack of family support. In order to operate within the standard of care in assessing suicidal risk in schizophrenic patients, we suggest that clinicians conduct a thorough risk assessment that includes an inquiry into these critical risk factors.

6. Know the General Risk Factors of Suicidal Patients and Schizophrenic Patients

The risk factors associated with completed suicide may be qualitatively different than those for other diagnoses.[77] The literature has spoken to the importance of evaluating imminent suicide risk by tailoring assessment formulas to the principal psychiatric diagnosis implicated.[78] In general, clinicians must know what the literature and experts say about the management of suicidal patients in order to exercise good clinical judgment in such a situation.[79] In addition to the previous risk factors rated by psychologists[80], the general risk factors for suicide in schizophrenia are comprehensively described in other chapters of this text.

7. Involve the Family

In our view, it is advisable to inform the patient's support system of the patient's suicide potential and to increase their involvement in management and treatment.[81] Although the clinician must judge, however, if such interactions would be beneficial, or if the patient needs protection from them for the time being[82], the literature has repeatedly classified social isolation and lack of familial support as a high risk

74 N. Reynolds /2000/: *op. cit.*

75 N. Peruzzi and B. Bongar /1999/: pp. 576–580.

76 N. Reynolds /2000: *op. cit.*

77 D. C. Clark and J. Fawcett /1992/: An empirically based model of suicide risk assessment for patients with affective disorder. In D. Jacobs (Ed.), *Suicide and clinical practice,* Washington, DC: American Psychiatric: Press, pp. 55–74.

78 *Ibidem*. A. D. Pokorny /1983/: Prediction of suicide in psychiatric patients, *Archives of General Psychiatry,* 40, pp. 249–257.

79 W. L. Packman and E. A. Harris /1998/: *op. cit*., pp. 150–186.

80 N. Reynolds /2000: *op. cit.*

81 L. VandeCreek and S. Knapp /1989/: *op. cit.*

82 G. Jacobson /1999/: The inpatient management of suicidality, in: D. G. Jacobs (Ed.), *The Harvard medical school guide to suicide assessment and intervention*, San Francisco: Jossey-Bass, pp. 383–405.

factor for suicide in patients with schizophrenia. Further, the family is less likely to initiate litigation against the clinician when good relations have been achieved.[83]

CONCLUSION

Suicidal behavior is one of the few fatal consequences of psychiatric illness.[84] For persons with schizophrenia, suicide is the number one leading cause of premature death.[85] The loss of a patient to suicide is the most feared outcome among mental health practitioners, while the fear of litigation and liability after such suicide may be a close second. This chapter has emphasized the importance of understanding suicidality, schizophrenia and malpractice law. We have familiarized practitioners with the legal issues and essential elements of professional negligence in suicide cases and reviewed legal theories of liability and causes of action. We concluded with a discussion of risk management procedures that can substantially limit one's exposure to malpractice liability, and can also assist expert witnesses testifying in suicide cases evaluate whether a practitioner's practice is within the standard of care.

REFERENCES

Baerger D. R. /2001/: Risk management with the suicidal patient: Lessons from case law, *Professional Psychology: Research and Practice,* 32(4)

Bassuk E. L. /1982/: General principles of assessment, in: E. L. Bassuk S. C. Schoonover, and A. D. Gill, Eds., *Lifelines: Clinical perspectives on suicide,* New York: Plenum

Bell V., New York City Health and Hospitals Corporation, 90 A.D.2d 270, 456 N.Y.S.2d 787 /1982/

Berman A. L. and Jobes D. A. /1991/: *Adolescent suicide: Assessment and intervention*. Washington, DC: American Psychological Association

Black H. C. /1996/: *Black's law dictionary,* St. Paul, MN: West

Bongar B. /2002/: *The suicidal patient: Clinical and legal standards of care (2nd ed.),* Washington, DC: American Psychological Association

Bongar B. /1991/: *The suicidal patient: Clinical and legal standards of care.* Washington, DC: American Psychological Association

Bongar B., Maris R. W. Berman A. L. and Litman R. E. /1998/: *Outpatient standards of care and the suicidal patient,* in: B. Bongar, A. L. Berman, R. W. Maris and M. M. Silverman., E. A. Harris and W. L. Packman (Eds.): *Risk management with suicidal patients*, New York, New York: Guilford

Bramlette V. /1990/: *Charter Medical Columbia*, 302 S.C. 68, 393 S.E.2d 914

Caldwell C. B. and Gottesman II. /1990/: Schizophrenics kill themselves too: A review of risk factors for suicide, *Schizophrenia Bulletin,* 16 (4)

Clark D. C. and Fawcett J. /1992/: An empirically based model of suicide risk assessment for patients with affective disorder. In D. Jacobs (Ed.), *Suicide and clinical practice,* Washin-

83 B. Bongar /2002/: *op. cit.*

84 *Ibidem.*

85 C. B. Caldwell and II. Gottesman /1990/: Schizophrenics kill themselves too: A review of risk factors for suicide, *Schizophrenia Bulletin,* 16 (4), pp. 571–589.

gton, DC: American Psychiatric: Press Dutcher V. /1990/: United States, 736 F. Supp. 1142 (1990)

Fatuck V. /1974/: Hillside Hospital, 45 A.D. 2nd 708, 356 N.Y.S.2d 105, New York

Greaney S. /1995/: *Psychologists behaviors and attitudes when working with the non hospitalized suicidal patient*, Unpublished doctoral dissertation, Pacific Graduate School of Psychology, Palo Alto, California

Gutheil T. G. /1980/: Paranoia and progress notes: a guide to forensically informed psychiatric record-keeping, *Hospital and Community Psychiatry,* 31 (7)

Gutheil T. G. /1984/: Malpractice liability in suicide. *Legal Aspects of Psychiatric Practice*, 1

Halleck S. /1980/: *Law in the practice of psychiatry*, New York: Plenum Press

Hersen M. and Turner S. M. /2003/: *Adult Psychopathology and Diagnosis (4th ed.)*, Hoboken NJ: John Wiley and Sons

Hirschfeld R. M. A. and Russell J. M. /1997/: Assessment and treatment of suicidal patients, *New England Journal of Medicine,* 333

Jacobson G. /1999/: The inpatient management of suicidality. In Jacobs D. G. (Ed.), *The Harvard medical school guide to suicide assessment and intervention*, San Francisco: Jossey-Bass

Jobes D. A. and Berman A. L. /1993/: Suicide and malpractice liability: Assessing and revising policies, procedures, and practice in outpatient settings, *Professional psychology: Research and practice,* 24

Lish J. D., Zimmerman M., Farber N. D., Lush D. T., Kuzma M. A. and Plescia G. /1996/: Suicide screening in a primary care setting at a veterans affairs medical center, *Psychosomatics,* 37(5)

Maris R. W., Berman A. L., Maltsberger J. T. and Yufit R. I. Eds /1992/: *Assessment and prediction of suicide*, New York: Guilford

Maris R. W., Berman A. L. & Silverman MM. /2000/: *Comprehensive textbook of suicidology*, New York: The Guildford Press

Monahan J. /1993/: Limiting therapist exposure to Tarasoff liability: Guidelines for risk containment, *American Psychologist,* 48

Morselli E. /1881/: *Suicide: an essay on comparative moral statistic*, C. Kegan Paul & C., London

O'Sullivan V., /1995/: Presbyterian Hosp. in City of New York at Columbia Presbyterian, 217 A.D.2d 98, 634 N.Y.S.2d 101

Packman W. L. and Harris E. A. /1998/: Legal issues and risk management in suicidal patients, In B. Bongar A. L., Berman R. W., Maris M. M., Silverman E. A., Harris and W. L. Packman (Eds.), *Risk management with suicidal patients*, New York: Guilford

Packman W. L., Pennuto T. O., Bongar B. and Orthwein, J. /2004/: Legal issues of professional negligence in suicide cases, *Behavioral Science and the Law*, 22 (5)

Peruzzi N. and Bongar B. /1999/: Assessing risk for completed suicide in patients with major depression: Psychologists' views of critical factors, *Professional Psychology: Research and Practice*, 30

Pokorny A. D. /1983/: Prediction of suicide in psychiatric patients, *Archives of General Psychiatry,* 40

Pompili M., Ruberto A., Kotzalidis G., Girardi P. and Tartarelli, R. /2004/: Suicide and awareness of illness in schizophrenia: An overview, *Bulletin of the Menninger Clinic,* 68 (4)

Pompili M., Lester D., Leenaars A., Tatarelli R., & Girardi P. /2008/: Psychache and suicide: a preliminary investigation, *Suicide and Life-Threatening Behavior* 38

Prosser W. L. /1971/: *Handbook of the law of torts* (4th ed.), St. Paul, MN: West

Randolph V. and Cervantes. /1996/:950 F.Supp. 771

Reynolds N. /2000/: *Suicidal risk factors with a schizophrenic population: Standard of care practice,* Unpublished doctoral dissertation, Pacific Graduate School of Psychology, California: Palo Alto

Robertson J. D. /1988/: *Psychiatric malpractice: Liability of mental health professionals.* New York: Wiley

Schultz D. /2000, August/: Defending the psychiatric malpractice suicide. *Health Care Law*

Shneidman E. /1951/: *Thematic test analysis*, New York: Grune and Stratton

Shneidman E. S., & Farberow N. L. /1956/: Clues to suicide, *Public Health Reports* 71

Shneidman E. S. & Farberow N. L. /1957/: Some comparisons between genuine and simulated suicide notes in terms of Mowrer's concepts of discomfort and relief, *Journal of General Psychology,* 56

Shneidman E. S., & Farberow N. L. /1957/: *Clues to suicide*, New York: McGraw-Hill

Shneidman E. S. /1964/: Grand old man in suicidology, a review of Louis Dublin's Suicide: a sociological study, *Contemporary Psychology,* 9

Shneidman E. S. /1971/: „Suicide" and „Suicidology": a brief etymological note. *Suicide & Life-Threatening Behavior* 1

Shneidman E. S. /1985/: *Definition of suicide*, Aronson: Northvale

Shneidman E. S. /1993a/: *Suicide as psychache: a clinical approach to self-destructive behaviour*, Jason Aronson: Northvale

Shneidman E. S. /1993b/: Suicide as psychache, *The Journal of Nervous and Mental Disease* 181

Shneidman E. S. /1993c/: Some controversies in suicidology: toward a mentalistic discipline, *Suicide & Life-Threatening Behavior* 23

Shneidman E. S. /1996/: *The suicidal mind*, New York: Oxford University Press

Shneidman E. S. /1999/: The Psychological Pain Assessment Scale, *Suicide & Life-Threatening Behavior* 29

Shneidman E. S. /2004/: *Autopsy of a suicidal mind*. (Tr. It: Autopsia di una mente suicida, Fioriti Editore, 2006), New York: Oxford University Press

Shneidman E. S. /2005/: Anodyne Psychotherapy: A Psychological View of Suicide, *Clinical Neuropsychiatry* 2

Simon R. I. /1992/: *Concise guide to psychiatry and the law for clinicians,* Washington, DC: American Psychiatric Press

Simon R. I. /1998/: Psychiatrists awake: suicide risk assessments are all about a good night's sleep, *Psychiatric Annals*, 28(9)

Simpson S. and Stacy M. /2004/: Avoiding the malpractice snare: Documenting suicide risk assessment, *Journal of Psychiatric Practice,* 10 (3)

Stallman V., Robinson. /1953/:364 Mo. 275, 260 S.W.2d 743

Tatarelli R. /1992/: *Suicidio. Psicopatologia e prevenzione*, Il Pensiero Scientifico Editore, Roma

VandeCreek L. and Knapp S. /1983/: Malpractice risks with suicidal patients, *Psychotherapy: Theory, research and practice,* 20

VandeCreek L. and Knapp S. /1989/: *Tarasoff and beyond: Legal and clinical considerations in the treatment of life-endangering patients*, Sarasota FL: Professional Resource Exchange

VandeCreek L., Knapp S. and Herzog C. /1987/: Malpractice risks in the treatment of dangerous patients, *Psychotherapy: Theory, research and practice*, 24

Welch B. /1989/: A collaborative model proposed, *American Psychological Association Monitor,* 20 (10)

Yufit R. I. and Bongar B. /1992/: Suicide, stress and coping with life cycle events. In R. W. Maris, A. L. Berman J. T. Maltsberger and R. I. Yufit Eds., *Assessment and prediction of suicide,* New York: Guilford

Appendix:
RISK FACTORS FOR SUICIDE
(U.S. Dept. of Health and Human Services, 2001)

BIOPSYCHOSOCIAL RISK FACTORS

Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders

Alcohol and other substance use disorders

Hopelessness

Impulsive and/or aggressive tendencies

History of trauma or abuse

Some major physical illnesses

Previous suicide attempt

Family history of suicide

ENVIRONMENTAL RISK FACTORS

Job or financial loss

Relational or social loss

Easy access to lethal means

Local clusters of suicide that have a contagious influence

SOCIOCULTURAL RISK FACTORS

Lack of social support and sense of isolation

Stigma associated with help-seeking behavior

Barriers to accessing health care, especially mental health and substance abuse treatment

Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)

Exposure to, including through the media, and influence of others who have died by suicide

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SAMOUBISTVO I NJEGOVI PRAVNI ASPEKTI UZ POSEBAN OSVRT NA PACIJENTE OBOLELE OD SHIZOFRENIJE

REZIME

Samoubistvo predstavlja jedan od najznačajnih zdravstvenih problema pri čemu se procenjuje da se u svetu na svakih 40 sekundi izvrši jedno samoubistvo a da na svako uspelo samoubistvo dolazi oko 25 pokušaja samoubistava. Mlađa lica čine najugroženiju kategoriju kako u razvijenim tako i u zemljama u razvoju. Samoubistvo je kompleksan fenomen uzrokovan mnogobrojnim faktorima. Neka istraživanja su pokazala da postoji povezanost između samoubistva i određenih bioloških abnormalnosti a takođe se ističe da doprinos mogu imati i neki psihijatrijski poremećaji i psihosocijalne krize. Rizični faktori mogu biti i agresivnost, pol, religija, genetski faktori, iskustva u detinjstvu pri čemu postoji njihova međusobna povezanost. Tako su npr. muškarci agresivniji i skloniji konzumiranju alkohola što bi moglo biti jedno od objašnjenja za višu stopu samoubistva kod ovog pola. Za razumevanje samoubistva mora se uzeti u obzir da ono nije prvenstveno korak ka smrti već pre svega korak usmeren na uklanjanje neprihvatljivih i emocija koje se ne mogu tolerisati. Samoubistvo je rezultat unutrašnjeg dijaloga. Kako bi se uklonio bol, analiziraju se moguće solucije pri čemu se tek posle nekoliko puta pojavljivanja ideje o samoubistvu ona konačno usvaja. Samoubistvo nastaje kada u individui dodje do sjedinjavanja nemira i letaliteta. Nemir je motivacija a letalitet okidač samoubistva. Zato je jedno od ključnih pitanja kod potencijalnih samoubica „Kako ti mogu pomoći?" Neke od emocija koje predstavljaju potencijalni rizik za samoubistvo su: osećanje bespomoćnosti, želja za osvetom, bes, nekontrolisani gnev, osećanje bezizlaznosti, anksioznost itd. Samoubistvo se može sprečiti. Većina suicidalnih pojedinaca želi da živi ali ne uspeva da vidi alternative za svoje probleme.

Samoubistvo ima i pravnih posledica. One se pre svega odnose na pitanja prava osiguranja i nesavesnog postupanja zdravstvenih radnika u bolnicama koji nisu preduzeli potrebne mere radi sprečavanja samoubistva. U drugom slučaju radi se o građanskopravnoj odgovornosti koja postoji ako su ispunjeni određeni uslovi koje dokazuje tužilac: dužnost, kršenje dužnosti, šteta, uzročna veza. Šteta će postojati ako je samoubistvo izvršeno ili ako su nastupile štetne posledice usled pokušaja samoubistva u vidu psihičkih patnji. Drugačije je u pogledu utvrđivanje uzročne veze jer je neophodno utvrditi da li bi posledica izostala da je zdravstveni radnik preduzeo adekvatnu radnju i da li njegovo činjenje odnosno propuštanje predstavljalo

odlučujući, neposredan uzrok posledice. Dužnost se zasniva na odnosu zdravstveni radnik – pacijent. Ona je sastavljena iz više komponenata među kojima su npr. dužnost sprovođenja testova i evaluacije pacijenta kako bi se utvrdila eventualna suicidalna namera, dužnost kontrole i nadgledanja, dužnost analiziranja ranijeg ponašanja pacijenta, dužnost smeštanja pacijenta u sigurnu i obezbeđenu prostoriju kako bi se sprečilo samoubistvo itd. U pogledu dužnosti zdravstvenih radnika, kao posebno se otvara pitanje dužnosti koja bi trebalo da postoji kod određenih kategorija lica kod kojih opasnost od samoubistva postoji zbog nekog psihičkog oboljenja kao što je npr. slučaj sa shizofrenijom.

U cilju minimalizovanja odgovornosti, zdravstveni radnici bi trebalo da se pridržavaju sledećih uputstava: vođenje dokumentacije, razmenjivanje iskustava sa kolegama, upoznavanje sa pravnim pravilima koja regulišu pitanje odgovornosti, prikupljanje podataka o pacijentu a posebno o prošlim događajima i pokušanim samoubistvima, kompetentnost postupanja u specifičnim situacijama, uključivanje porodice pacijenta u tretman.

Ključne reči: samoubistvo, uzroci, nesavesno lečenje, shizofrenija, nepažnja, šteta, uzročna veza, dužnost, kršenje dužnosti.