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Legal and Ethical Issues in Suicide

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ABSTRACT

Suicide is one of the few fatal consequences of psychiatric illness and hence is a source of endless disquiet to mental health professional. Among the survivors of a suicide the reaction is often disbelief, shame, anger and shock even for the mental health professional. One of the shortcomings of suicide is that it unnecessarily answers a remediable challenge with a permanent irreversible negative solution. Even though attitudes in our societies have become more tolerant to suicide there are still undercurrents of ambivalence and social condemnation. This article reviews all the moral, legal and ethical dilemmas this problem poses for both the physician and in general.

KEYWORDS : Suicide, Legal aspects, Ethics

INTRODUCTION

Suicide is one of the few fatal consequences of psychiatric illness and hence is a source of endless disquiet to mental health professional (1). Among the survivors of a suicide the reaction is often disbelief, shame, anger and shock even for the mental health professional (2). One of the shortcomings of suicide is that it unnecessarily answers a remediable challenge with a permanent irreversible negative solution (3). Even though attitudes in our societies have become more tolerant to suicide there are still undercurrents of ambivalence and social condemnation. Judicial attitudes towards suicide have moved away from assessing guilt and enforcing punishment and towards protecting people who are suicidal and towards efforts to provide care and compensation for the surviving victims of suicide deaths (4).

PROPOSING A LEGAL DEFINITION OF SUICIDE

An operational definition of suicide must limit the term suicide to acts of committed suicide or efforts or attempts to cause death by suicide. This would allow for differentiation between sublethal acts and suicide as well the difference between self inflicting behaviour and suicide. The boundaries between self mutilation, sensation seeking and suicidal beaviour are rather cloudy and there is a lack of clarity whether a consciously expressed suicidal desire accompanying the behaviour is a must in order to classify a particular behaviour as suicidal (5). An individual that commits a non lethal, self inflicted and suicide like act is said to have committed parasuicide. There is a body of evidence that in general suicide completers make one lethal attempt while most suicide attempters make many low lethality attempts. Thus those that attempt suicide and those that complete suicide are two distinct though overlapping populations. Fine discriminations between suicide, attempted suicide, parasuicide, suicidal gestures, manipulative suicidal acts and so forth are needed from research and heuristic perspectives though from a legal perspective any time a patient uses or threatens to use even superficially suicidal or suicidal like behaviour to demonstrate any form of psychological pain it must be regarded as suicide (6).

An essential element of effective risk management and high quality clinical care in a professional psychiatric practice is the possession of the basic knowledge of the legal system and the understanding of the contemporary legal views on the standards of care. Until the 1990s the incidence of legal battles against mental health professionals in India was very low when compared to what courts regarded as other medical specialties. Furthermore whenever there was a legal battle more often it was the doctor that prevailed. In recent years there has been an increase in the number of malpractice actions against mental health professionals worldwide and decisions by courts in favour of patients is also increasing. Suicide is an uncommon cause of litigation in India though in the US it is the cause for the highest number of medical lawsuits and the highest cash settlements (7).

FAILURE TO PROPERLY DIAGNOSE

One of the legal theories brought into play in suicide cases is the failure to properly diagnose. Much of the case law on suicide abroad is based on the claims that allege liability for a misdiagnosis or lack of prediction of the risk of suicide. Many of the cases are directed against hospitals and institutions for clinical care and involve either inpatients or recently discharged patients (8). There have been instances that hospitals and physicians have been not held liable for a patients suicide more son if they have taken reasonable steps to assess and supervise the patient. On the other hand liability can be imposed where the hospital should have known or did know about the suicidal and escapist tendencies of the patient but were negligent in placing the patient in a high risk situation.

Hospitals have also been held negligent in releasing a suicidal patient. It may happen that a physician recommends the release of the psychiatric patient even though he has potentially harmful delusions. The physician did not investigate the pervious psychiatric history of patient nor did he investigate the patient's delusions or the incident of the previous evening when the patient had to be restrained.

FAILURE TO TAKE ADEQUATE PROTECTIVE MEASURES

The psychiatrist must take adequate precaution against patient suicide consistent with the accepted practices and on the basis of his or her knowledge and assessment of the patient. Psychiatrists are liable when a treatment plan overlooks or neglects the patient's suicidal tendencies. It is also noted that courts do not usually find the psychotherapist or psychiatrist liable when a patient's suicide attempt is not foreseeable (9). No liability has been found in many cases when a cooperative or apparently contented patient suddenly attempts suicide as or when an aggressive patient fails to reveal any suicidal intent and commits suicide. The failure to take adequate precautions is also liable when a psychiatrist was found liable when a patient committed suicide after being transferred from a suicide watch status to a lower level of precaution without adequate medical notes to explain the rationale of such a critical management decision.

Courts are often less stringent on out patient suicides especially when they are less foreseeable and there is always an increased difficulty in controlling the patient's behaviour. In both out patient and inpatient cases it is necessary that clinicians must use reasonable care in the development and the implementation of treatment plans.

A psychiatrist and a mental health foundation was sued because their patients had taken a lethal dose of sleeping pills that had been prescribed to him. The court found that there was no foreseeable suicidal intent and hence the psychiatrist and the foundation were found not guilty but this case warns us on the judicious use of medications in patients that exhibit suicidal tendencies. A case discussed that a psychiatrist's duty to his outpatients is less than his or her responsibilities to his inpatients.

The parents of a patient who died due to an overdose of sleeping pills brought a malpractice litigation against the treating psychiatrist who was treating the patient on an out patient basis. The psychiatrist had recognized the fact that the patient was disposed to suicide and he recorded his conclusions on his written notes. The parents stated that the

psychiatrist had not taken adequate measures to protect the patient. He even had failed to warn the relatives about the seriousness of the patient's condition and his suicidality. The court in this case refused a mandate on the duty to warn although the out patient was a dangerous to self and as the patient was not always under the control of the psychiatrist to take adequate protective measures. The court held the view that the nature of precautionary measures taken by the psychiatrist present a factual question to be resolved at the trial on the merits and both sides were given a chance to produce expert medical testimony on the subject. The case would also require the testimony of expert witnesses analyzing the psychiatrist's performance after the fact to determine if negligence had in fact occurred.

The imposition of the duty of a psychiatrist to disclose to others vague or even specific manifestations of suicidal tendencies on the part of the patient who is coming as an out patient may inhibit psychiatric treatment at times. The patient therapist dynamics in an office settings are often very subtle and complex. It is important to consider that when an out patient presents with risk duty to warn the relatives is the most important consideration that a psychiatrist must use seriously. This allows a limited breach of confidentiality to guard the patient and help with the treatment when the patient has an imminent danger to himself and when the patient is unable to follow the recommendations for out patient treatment or hospitalization. Of course hospitalization in these cases shall involve the family members and significant others.

EARLY PATIENT DISCHARGE

A psychiatrist may be found liable for the early release of a patient if the release is negligent and not a valid exercize in professional judgement. A court may impose liability when a psychiatry does not inquire into the nature of a patient's symptoms though observations about the same have been stated by relatives, when a psychiatrist fails to inquire about significant past history and past eventful discharges, if there is failure on the part of the psychiatrist to communicate with the nursing staff and the relatives when they are pressing for a discharge. If a psychiatrist makes a reasonable assessment of the danger and believes that the risk no longer exists then he or she is not held liable for the post discharge death of the patient.

FAILURE TO COMMIT

In making a decision to commit or not to commit to a patient the legal issue one of whether the clinician took the complete history into account, made a thorough examination of the patient and then exercised sound judgement in his or her decision to commit or not to commit to the patient. The greater the suicidal intent the bigger shall be the psychiatrist's liability for the failure to take the elevated risk into account in the treatment plan. A patient had been hospitalized for 9 days and was determined by the psychiatrist to be well enough to be transferred to less secure part of the hospital. The patient then jumped from the window. The only argument was that the psychiatrist was negligent and erred in judgment. This case brought out the fact that physicians cannot be held responsible for errors in judgment when pursuing methods and practices within the standards of care.

LIABILITY OF THE HOSPITALS

Psychiatrists must be aware that malpractice actions of inpatient suicides can be directed against the psychiatrist, the hospital or both. An important point here is that malpractice action can be brought against psychiatrists within the hospital setting if they have staff or hospital privileges. The duty of the hospital can be best defined as using the generally accepted standard of care in the treatment of the patient. If the hospital also notices that a patient is suicidal then it is the duty of the hospital to safeguard the patient from self inflicted injury or death. The issue of foreseeability is crucial. The hospital staff must always perform proper evaluations and observation though the patient may be under private care of a psychiatrist. Hospitals have never been held liable when the surveillance was found adequate or proper procedures were followed. The law and psychiatry has today however come to a conclusion that an overly restrictive environment in suicidal cases can be as destructive as an overly permissive one. The psychiatrists must always balance the benefits of treatment against the risk of freedom.

The issue of calculated risk has been rejected. The court states that prediction of the future course of mental illness is a professional judgment of high responsibility and in some instances this involves a measure of calculated risk. Liability cannot be based on the disagreement of another physician with the manner in which treatment is provided. It is remarked that hospitalization has its drawbacks though for relatives it is a panacea. There are benefits but there are risks like regression, fostering dependency, loss of time from work and severe stigma (9). Psychiatrists must demonstrate their best professional judgment in assessing the therapeutic risks for freedom. They must assess decisions regarding suicidal patients, involving discharge, transfer, decision to commit and other actions.

ABANDONEMENT

Once a professional relationship has been established the psychiatrist is required to provide treatment till the relationship is properly terminated. Abandonment may be overt or implied i.e. failure to be available or to monitor the patient adequately. If a therapist errs in judgment that treatment is no longer needed he or she may be liable for negligence under malpractice. Usually expert witnesses are needed to decide this fact. If the therapists willfully terminate or withhold treatment knowing that further care is needed or the referral is indicated then they may be liable for intentional abandonment. Patients must be provided a way of contacting the doctor especially between visits, when on vacation, on leave and so forth. This is all the more needed for hospitalized patients.

There are generally three types of lawsuits over suicide that arise – (10)

- Psychotherapists and Psychiatrists that are sued when an inpatient commits suicide with survivors claiming that the facility failed to provide adequate care and supervision.
- A recently released patient committing suicide, and
- An outpatient commits suicide.

There is a tremendous legal burden when it comes to suicide because simply stating, we are holding the clinician responsible for someone else's behavior (11). The threat of litigation compounds the burden that a patient's death carries for the clinician. The threat of suicide is always a possibility in psychiatry. The assessment and diminution of suicide potential among psychiatric patients is a task of highest priority for mental health professionals (12). Researchers have stated that almost all suicides are avoidable if the patient was properly diagnosed, monitored and treated in an appropriate and timely manner. Suicide as discussed is not always preventable and defies predictability although these facts offer little solace in a courtroom (13). The pivotal element in most cases of malpractice are the twin issues of the ability to foresee and causation. Courts often struggle with these two issues in cases of suicide focusing on whether the clinician should have predicted suicide or in the presence of sufficient evidence of an identifiable risk, did the psychiatrist do enough to protect the patient (14). Usually the quality of the clinician's practice has little to do with malpractice litigation. It is bad outcome combined with bad feelings that leads to lawsuits. The issue of what is meant by adequate training in handling suicide is a thorny issue due to the unpredictable nature of suicide itself. One needs to be wary of reduction when it comes to suicide. Suicide is a symptom and not a diagnosis and though the state of being suicidal can be analyzed the act of suicide cannot. This thought reverberates throughout suicide literature (15). We cannot be afraid of litigation so as to deny our patients their right to learn to live. Clinical decisions are to be made on a case by case basis and must represent the most through the knowledge available. The manageable standards of care will thus be set by us as mental health professionals and presumable then courts shall follow in our reasonableness.

THE ETHICS OF SUICIDE

Suicide has always been an act having ethical significance one for which moral blame or praise was a proper response. During the Stoic Era of Greece and Rome, suicide was praised as a morally responsible act of a wise man. During the medieval Christian era, it was blamed as the most reprehensible of sins. With the influence of Esquirol and Durkheim at the close of the 19th century the older ethical view of suicide was replaced by a newer scientific one. Contemporary thinkers are suggesting that ethical considerations do apply in some cases of suicide. The ethical theory divides into two major camps – the utilitarians, both classical and contemporary and the Kantians with their deontological descendants, the modern Kantians and the libertarians.

Utilitarians are consequentialists who assess the moral status of an act by inspecting the outcomes it would have. To decide if a certain thing was good we would consider what result it would have if we did it. If it

would provide happiness for the self and those affected by the action in a greater manner than any alternative action open to us then it is the right thing to do. It is wrong to commit suicide as per the utilitarian view if it destroys the life that is of benefit to oneself, and shall cause others anguish, sorrow with emotional, social and financial disbenefits due to deprivation and loss.

The other group considers that considerations other than consequences are also relevant in fact is central in any moral choice. One ought to honour contracts and promises not just because the outcomes are good but because contracts ought to be honoured and promises ought to be kept. In Kantian theory, underlying and justifying this set of moral rules is the general principle requiring respect for other persons and the respect for the human being as a rational being to generate moral law. Ethical abuses are actions that fail to respect the moral worth of people who are the victims.

On one hand we deplore suicide pointing to all its horrible consequences, and the way suicide violates the most fundamental moral rule – do not kill. The phenomenon of suicide may serve as a test par excellence for both types of moral theory.

Philosophers distinguish between two very diverse issues – whether it is wrong to commit suicide and whether it is desirable, advisable and rational to do so. The former is to be seen from the point of view of society in general for forbidding it. This is a more contractarian view. There are many definite obligation that shall be violated when committing suicide and one has obligations to the community strong enough to make suicide immoral. One can hardly claim that suicide is necessarily imprudent or inadvisable. We should generally be disposed to prevent suicides when we can. Naverson argues whether we own ourselves and hence have the right to do what we want with our bodies. He says that we do own ourselves, being free to choose to live, or die on the basis of the hedonistic judgment on balance that we make predicting the future courses of our lives. If a person judges that on balance his life shall not go well and will mean less pleasure, more pain than he can endure then we must be prepared to help him change his balance before we have the right to interfere. His life is his own to do with as he will (16).

A Kantian moral theory provides an objection to suicide even when it does not affect persons other than the agent himself. There are four kinds of cases – the impulsive suicide, the apathetic suicide, the suicide who abases himself and the suicide as a result of hedonistic calculation. The attitudes expressed by such suicides are described as those of a consumer who looks ahead to count up the pleasures and pains he can expect from the purchase of an additional life or the obituarist that looks back at life to assess all that has been achieved till date. In discussing the modified Kantian ideals it permits some types of suicide like in those that are facing the onset of permanent vegetative states, of patients in irremediable pain and of people that act with strong moral conviction but it does not commend suicides that are out of line of this ideal. Many of the suicides we confront do fall short of this ideal (17).

Both utilitarianism and modern Kantism fail to provide the modern condemnation that they should. They fail as they do not specify what an individual must do with his life and hence they cannot state why a person ought not to end his life. There are a number of cases where suicide is commendable including the soldier that kills himself to protect the secret military information that torturers would otherwise extract from him and the persons in the final stages of a terminal illness. If someone acts in the morally correct way and if he does the right thing by remaining alive then not only does his life have more intrinsic value it will have more good in it and thereby more pleasure in it as well (18).

Moral theory becomes the basis of public policy with regard to suicide prevention. The liberty of an individual is of paramount importance because what gives meaning to life is the freedom to choose one's own life plan and to live as one sees fit. Under this view no one is entitled to be prevented from suicide. If a person attempts suicide then no one else or no group is entitled to save him. If they do so it is a matter of generosity and above and beyond the call of duty. No one can complain that inadequate rescue efforts or no rescue efforts at all were made on the suiciding individual's behalf (19).

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