Suicide: Unpredictable and Unavoidable—Proposed Guidelines Provide Rational Test for Physician's Liability

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I. INTRODUCTION

The physician who treats a suicidal patient faces real life-or-death
decisions. The primary decision depends on his professional evaluation of the likelihood that his patient will take his own life. If the physician concludes that suicide is imminent, medical ethics and the law require he take steps to protect his patient. Failing to take appropriate protective action, either "too little [or] too much restraint," exposes the physician to legal liability. The physician owes a duty to his patient, but defining parameters of this duty and methods to satisfy it are not clear. Neither the legal system nor current medical knowledge or practice establishes guidelines to aid the doctor.

The law fails to provide assistance because courts dealing with the problem have reached inconsistent results based on muddled analysis. Medical research provides exhaustive information about suicide, including some verified factors for determining whether a patient is suicidal, but fails to accurately predict whether a particular patient will take his own life. In fact, predictions of the likelihood a specific individual will commit suicide are wrong far more often than they are right. Using standard, generally-accepted predictors, physicians will misidentify twenty-five potential suicides for every one person who actually kills himself. Thus, the physician's dilemma: the difficulty of predicting the suicide of any one individual makes it almost impossible to decide how much intervention is necessary to achieve the twin goals of treating a patient's underlying illness and saving his life. Nevertheless, under the current system the physician is exposed to legal liability for failing to do just that.

The suicide of any individual is difficult to predict for a number of reasons. First, a person who has killed himself obviously cannot pro-

2. Masculine pronouns are used for readability only. No sexist implications are intended.
3. BENJAMIN M. SCHUTZ, LEGAL LIABILITY IN PSYCHOTHERAPY 75 (1982). "Both too little and too much restraint may be grounds for liability—the former for malpractice, the latter for abridgement of civil rights."
4. See infra text accompanying notes 49-61.
5. Keith Hawton, Assessment of Suicide Risk, 150 BRIT. J. PSYCHIATRY 145, 145 (1987). "While suicide risk factors may be useful in identifying high risk groups of individuals, such criteria are far less useful when it comes to predicting risk in the individual patient." Id.
vide information about factors which led to his suicide. Consequently, analysis of suicides often relies on some degree of speculation, and psychological autopsies are of limited value. Another obstacle to understanding, and thus predicting, suicide is the substantial probability of underreporting. Many people who kill themselves are not recorded as suicides due to religious, social or moral stigma. In addition, recognition of a suicide risk may prompt intervention, which may prevent, or at least postpone, suicide. Intervention, even when appropriate, further distorts the statistics and lessens their value as predictors. Prospective studies would be necessary to better predict who might actually commit suicide, but even these studies would have limitations. "Prospective studies of suicide require enormous samples from the general population and sizeable samples from the population who seem to be at high risk for suicide." Even though the suicide rate is consistently about twelve per 100,000 population, it remains "a rare and not very predictable event." These problems all contribute to the error rate of twenty-four out of twenty-five when attempting to predict who will commit suicide.

Explaining or understanding the high error rate, while informa-

8. One recent article proposes use of a psychological autopsy as useful "in laying the case to rest.... The focus should be less on "what did we do wrong?" and more on what can be learned from this and what can be done better." Neil S. Kaye & Stephen M. Soreff, The Psychiatrist's Role, Responses, and Responsibilities When a Patient Commits Suicide, 148 AM. J. PSYCHIATRY 739, 742 (1991).
9. George P. Smith II, All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination, 22 U.C. DAVIS L. REV. 275, 279 (1989)[hereinafter All's Well]. Under-reporting is generally a result of agreement between family members and physicians to disguise the less obvious suicides to avoid "any social stigma from attaching to the surviving relatives." Id.
11. Cf. Bruce Block & Mahmud Behfar, 148 AM. J. PSYCHIATRY 1092, 1092 (Letter 1991). ("[I]ts not possible that patients with suicidal ideation had a lower short-term suicide rate only because such ideation resulted in their receiving more treatment within the 1-year interval than patients without suicidal ideation?").
13. Robert M.A. Hirschfeld & Lucy Davidson, Risk Factors for Suicide, in 7 REVIEW OF PSYCHIATRY 307, 307 (Allen J. Frances & Robert E. Hales eds., 1988)(citing National Center for Health Statistics 1986). This means approximately 29,000 persons commit suicide every year. Although the total number is too small on which to base accurate predictions, suicide is the eighth leading cause of death in the United States. Id.
tive, does not make it any less troubling and, combined with the fundamental state and individual interests implicated, means otherwise valuable treatment plans may simply be unacceptable in certain situations. Because a physician cannot foresee if a particular patient will kill himself, even careful, conscientious physician's treatment decisions are fraught with uncertainty. Additionally, the spectre of legal liability for a patient's suicide may, consciously or unconsciously, influence a physician's decision, inappropriately clouding what should be solely a medical decision.

This Article briefly reviews current medical knowledge concerning suicide. It suggests that the physician must determine, aided by a proposed, defined list of risk factors, whether his patient is suicidal. If the patient is suicidal, the physician must expand his evaluation to determine if an underlying mental disease exists. If he discovers a disease, the physician must decide whether suicidal thoughts and impulses are the product of this underlying disorder. Where suicidal thoughts and impulses are the product of an underlying mental disease, the physician can—in fact, should—take reasonable steps to prevent the suicide.

This Article proposes a set of procedures all physicians should

15. "The painful reality is that one may be functioning as an ethical and competent therapist on a case and still face a lawsuit; that is, ethical and competent behavior is not an absolute bar to a legitimate suit." SCHUTZ, supra note 3, at x. Schutz says the issue of legal liability for psychotherapy provokes "intense anxiety and anger." Id. at ix. He suggests the reason for this discomfort is the perception held by many therapists of law as an unreasonable and capricious parent. As a result, many therapists simply avoid the issues. "They out-legalize the lawyers and avoid pushing at their own or their patients' frontiers.... Their adherence to the law does undermine clinical effectiveness ...." Id. at x.

He advocates "exactly the situation that we present our patients—that risk is inevitable in all worthwhile ventures.... We cannot, and should not, fail to undertake a project because of the risk, or be more concerned with safety than with healing." Id.

16. An additional, non-medical force which might operate contrary to the patient's best interest is the burgeoning need for, and thus influence of, third-party payers. Insurance companies frequently pay only for the least restrictive treatment. Thus, patients who might benefit from hospitalization are pushed into less effective treatment merely because it is cheaper. Cf., Hughes v. Blue Cross of N. Cal., 263 Cal. Rptr. 850 (Ct. App. 1989), cert. denied, 100 S. Ct. 2200 (1990); Tabor v. Doctors Memorial Hosp., 563 So. 2d 233, 238 (La. 1990)(physician improperly changed his decision to hospitalize patient when he learned admission was blocked by required $400.00 deposit).

17. Overlap exists between these two decisions. In other words, one factor which should alert the physician to a risk of suicide is the presence of certain underlying mental illnesses.

18. All physicians must be alert to potentially suicidal patients because three of four people who kill themselves saw a physician within months of their deaths. WILL THAT PATIENT COMMIT SUICIDE, PATIENT CARE, Oct. 1968, at 55. In fact, one psychiatrist estimated the average physician will see six suicidal patients a year, putting him in a "key position to prevent suicides." Id.
follow whenever suicide predictors are present and the physician decides the patient's suicidal thoughts and impulses are the product of an underlying mental illness. These procedures should also improve the quality of patient care. The physician must obtain the patient's informed consent for the least restrictive plan which would treat the underlying disease while minimizing the risk of suicide. If, however, after the physician explains the disease and proposed treatment plan, the patient refuses to submit, the doctor should intervene even without consent.

A different analysis is suggested if the patient's suicidal thoughts and impulses are a product of something other than an underlying mental disease. In this situation, the proposed analysis is similar to that used in the recent right to die cases. These decisions allow the competent and conscious patient control over his body and his life despite the wishes of physicians or the State to preserve and protect that body and life. Because only the person himself experiences his pain—physical or emotional—only he can decide whether life is worth continuing. By analogy, the Article concludes that an adult whose suicidal impulses do not stem from an underlying, high-risk mental disease has a right to kill himself. So long as the physician correctly concluded these thoughts and impulses are not the result of mental disorder, explained this to the patient, thoroughly explored with him reasons for and consequences of his proposed actions, and recorded these, the physician has satisfied his legal responsibility and no basis for liability exists.

19. One student author suggests that the distinction actually is "between patients who are generally able to make decisions but made a 'bad' decision this time and patients who lack decisionmaking ability." Martha Alys Matthews, Comment, Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment, 75 CAL. L. REV. 701, 752 (1987) [hereinafter Suicidal Competence]. If the patient's impaired mental condition is the reason for the decision, the court may consider the person incompetent. Because the State's interest is in preventing "incompetent" suicides, the State can intervene to prevent these. However, if the patient's reasons are based on value judgments concerning what degree of pain makes life not worth living, no valid basis for a finding of incompetence exists. Id. at 752-53.

20. See infra text accompanying notes 225-266.

21. "[R]emember that distress is subjective. Thus, although a nonparticipant may view a stress engendering situation as within the parameters of tolerable distress, this in no way may serve to mitigate the real anguish of the individual who, feeling life intolerable, ends it herself by suicide." All's Well, supra note 9, at 317.

22. Libertarians, for example, argue that "the individual, not the state, is considered the supreme judge of his own best interests. The individual is held to have a right to self-determination, free choice, and autonomy." H. Tristram Engelhardt, Jr. & Michele Malloy, Suicide and Assisting Suicide: A Critique of Legal Sanctions, 36 SW. L.J. 1003, 1010 (1982).
II. MEDICAL KNOWLEDGE

When evaluating a patient with suicidal tendencies, a physician engages in a complex decision-making process to assess the degree of risk of suicide. He begins, in the usual medical method, by establishing a diagnosis because some psychiatric illnesses increase the risk of suicide. These illnesses are depression, bipolar disorder, drug and alcohol abuse and dependence, panic disorder, schizoaffective disorder, schizophrenia, and borderline and antisocial personality disorders. Moreover, increased risk of suicide correlates with certain aspects of the patient's history: social isolation, hopelessness, formulation of a plan, access to lethal means, previous suicide attempt, concurrence of another illness, and family history of suicide. The physician must consider all these factors when formulating a treatment plan because each affects the probability of danger to the patient and the physician's major concern is the probability of suicide within a very short time span, the factors used focus on long term risk. This problem is further complicated by the fact that events might easily alter a patient's risk factors.

23. Hawton, supra note 5, at 145-46. Before discussing the factors, the author raises an interesting point. Although the physician's "major concern" is the probability of suicide within a very short time span, the factors used focus on long term risk. This problem is further complicated by the fact that events might easily alter a patient's risk factors.


26. An interesting phenomenon is the association between low levels of serotonin metabolites in cerebrospinal fluid and increased suicidality. However, the connection is neither sufficiently refined nor understood to be used as a test. Thus, at least presently, it remains of theoretical, rather than practical, significance. Michael Stanley & J. John Mann, Biological Factors Associated with Suicide, in 7 REVIEW OF PSYCHIATRY 334 (Allen J. Frances & Robert E. Hales eds., 1988).

27. The majority of people who kill themselves consulted a physician within months of their suicide. This fact "places the recognition of suicidal risk squarely on the doorstep of the physician." George E. Murphy, Recognition of Suicidal Risk: The Physician's Responsibility, 62 S. MED. J. 723, 723 (1969).

28. Two commentators raise an interesting correlation between decreased activity attendance and suicide in hospital patients. Byron Fry & Kim Smith, Activity Attendance, Hospital Expectations, and Suicide, 55 PSYCHIATRIC Q. 270 (1984). The suicidal outpatient tends to withdraw from his relationships and is erratic about going to school or work. Psychiatric inpatients manifest similar behavior by missing group meetings and failing to attend other activities. Id. at 270. The evidence illustrated that "seriously suicidal patients" attended activities less frequently the two to four weeks prior to their attempts. Further, the hospital staff's treatment philosophy impacted on the suicide rate. Hospitals which were "more 'permissive'" towards regressive acting up had the highest number of suicides and attempts. Id. at 274-75.

29. One author raises an interesting challenge to the validity of studies linking certain psychiatric illnesses with suicide. Hawton, supra note 5, at 145. He suggests that the findings may not be representative of all people who kill themselves because they only include deaths where suicide was the official cause of death. This is problematic for at least two reasons. First, the cause of death of a person with a known history of psychiatric illness is more likely to be labeled a suicide,
Because of the high incidence of suicide among those suffering from depression and bipolar disorder,\textsuperscript{30} symptoms of mood disorders\textsuperscript{31} should be carefully sought and explored. Compared with the general population, the illness of depression\textsuperscript{32} makes it six times\textsuperscript{33} more likely a person will kill himself. Even compared to people with other psychiatric illnesses, those suffering from depression are twice as likely to commit suicide.\textsuperscript{34}

Depressive disorder is generally treated with antidepressant medication combined with psychotherapy.\textsuperscript{35} Hospitalization is only imperative for patients who either fail to respond to this regimen or are in imminent danger of suicide. Outpatient treatment is preferable. However, if the physician chooses outpatient care, the treatment plan must include careful monitoring of the patient and medication because antidepressant medication is sufficiently toxic to be used to commit suicide by overdose.\textsuperscript{36}

leading to an overestimation of psychiatric illness among suicides. Second, people might have a tendency to try to explain suicide by overreporting psychiatric symptoms. \textit{Id.} at 146.

30. Robert W. Firestone & Richard H. Seiden, \textit{Suicide and the Continuum of Self-Destructive Behavior}, 38 J. AM. C. HEALTH 207, 208 (1990). One major study concluded that, of investigated suicides in the United States, 47\% of the people who committed suicide were clinically depressed at the time of suicide. \textit{Id.}

31. These symptoms include: depressed or irritable mood or loss of interest or pleasure, change in appetite or significant weight change, change in sleep habits with insomnia or hypersomnia, agitation or retardation in acting or thinking, loss of energy or increased fatigue, feelings of worthlessness or inappropriate guilt, indecisiveness or a diminished ability to think or concentrate. \textsc{American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders III-R} (3d ed. rev. 1987) [hereinafter DSM II-R].

32. Depression is correlated with a family history of such illness. \textit{See, e.g.}, Elliot J. Gershon, \textit{The Genetics of Affective Disorders}, in \textsc{2 Psychiatric Update} \textit{434, 435-39} (Lester Grinspoon ed., 1983).

33. Estimates vary widely. For example, some studies suggest that the annual rate of suicide among depressed patients is 3.5 to 4.5 times that of other psychiatric patients and 22 to 36 times greater than the rate of the general population. Jan Fawcett et al., \textit{Clinical Predictors of Suicide in Patients with Major Affective Disorders: A Controlled Prospective Study}, 144 AM. J. PSYCHIATRY 35, 35 (1987).

34. One recent, Swedish study challenges this statistic, concluding that inpatients under 70 with anxiety disorders may face the same risk of suicide as those suffering from depression. Christer Allgulander & Philip W. Lavori, \textit{Excess Mortality Among 3302 Patients With 'Pure' Anxiety Neurosis}, 48 ARCHIVES GEN. PSYCHIATRY 599, 599 (1991)[hereinafter 'Pure' Anxiety Neurosis.] Further, the patient is at equal risk of suicide if the depression stands by itself or represents the depressed phase of bipolar disorder. Suicide is infrequently associated with manic or hypomanic phases.

35. Psychotherapy might be supportive, dynamically oriented, or focused. Focused psychotherapy includes cognitive or interpersonal psychotherapies.

36. Jonathan M. Himmelhoch, \textit{Lest Treatment Abet Suicide}, 48 J. CLINICAL PSYCHIATRY 44, 45 (Supp. Dec. 1987). Dr. Himmelhoch also cautions physicians that "even more disconcerting is the occasion in which a properly selected medication abets
Drug and alcohol abuse and dependence are also associated with increased risk of suicide. One of the problems is intoxication itself organically impairs judgment and makes the impulsive development of a plan almost momentary, placing the patient at greater risk and the treating physician in a position of increased liability. Combining the two risk factors of drug and alcohol abuse and dependence and depression appears to substantially increase the likelihood of suicide. Nevertheless, because data show no significant advantage of inpatient over outpatient treatment of drug and alcohol abuse and dependence, hospitalization should be reserved for those who fail outpatient treatment, have concomitant diseases which require hospitalization, or are at definite risk for suicide.

Panic disorder is associated with suicide to approximately the same extent as is depressive disorder. Treatment of panic disorder is suicide through its very efficacy. Elevating a patient's mood from a regressed, cognitively-disorganized level to one that combines improved cognitive function with continuing despair provides the patient with both the cause and the capability for self-destruction. See, e.g., Yifrah Kaminer, Psychoactive Substance Abuse and Dependence as a Risk Factor in Adolescent-Attempted and -Completed Suicide, 1 AM. J. ADDICTIONS 21 (1992); Richard J. Frances et al., Suicide and Alcoholism, 13 AM. J. DRUG ALCOHOL ABUSE 327 (1987); Alex Roy & Mark Ku Linnola, Alcoholism and Suicide, 16 SUICIDE AND LIFE-THREATENING BEHAV. 244 (1986). Criteria for these diagnoses include recurrent use in hazardous situations, taking more alcohol or drugs over a longer period of time than intended, inability to cut down, persistent desire, symptoms of intoxication or withdrawal interfering with other responsibilities, tolerance, reduced occupational or recreational activities, spending much time and effort in obtaining the substance. The first two criteria constitute the syndrome of abuse; the syndrome of dependence is established by addition of the remaining criteria. DSM III-R, supra note 31, at 167-68, 173-75.

Aaron T. Beck & Robert A. Steer, Clinical Predictors of Eventual Suicides: A 5- to 10-year Prospective Study of Suicide Attempters, 17 J. AFFECTIVE DISORDERS 203, 208 (1989). Indeed, "a diagnosis of alcoholism at the time of the index admission increased at least five times the risk for eventual suicide." Id. at 207.

Treatment of these syndromes requires the patient to acknowledge the disease and abstain from use of the substance. Support of behaviorally-oriented, group-directed programs fosters continued abstinence.

Frances et al., supra note 37, at 328-30. In fact, 60 to 70 percent of alcoholics have another recognized psychiatric disorder. Id. at 331.

Richard J. Frances et al., Psychosocial Approaches to Treatment and Rehabilitation, in 8 REVIEW OF PSYCHIATRY 341, 343 (Allan Tasman et al. eds., 1989).

See generally Jan Fawcett, Targeting Treatment in Patients With Mixed Symptoms of Anxiety and Depression, 51 J. CLINICAL PSYCHIATRY 40 (Supp. Nov. 1990). According to Dr. Fawcett, "a high level of psychic anxiety was an accurate predictor of suicide within 1 year of assessment. A measure of severe emotional pain associated with overwhelming anxiety may thus be a useful indicator of high suicide risk in patients with major affective disorders." Id. Dr. Fawcett warns that the first consideration in treating major depression with anxiety is suicide prevention, and explains that certain drugs have proven effective in relieving anxiety. Id. at 42.

'Pure' Anxiety Neurosis, supra note 34, at 599. But see Aaron T. Beck et al., Panic
usually a combination of behavioral psychotherapy and antidepressant and/or specific anti-anxiety medications.  

Schizophrenic disorders also correlate with a greater risk of suicide than found in the general population. Schizoaffective disorders increase the risk of suicide to approximately that of bipolar disorder.

Personality disorders, especially borderline personality disorder or antisocial personality disorder, are also associated with increased risk of suicide. Suicide or suicide attempts during the course of these disorders are usually impulsive acts, based on acute changes in object relations. Disagreement about treatment programs exists, but most

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_Footnotes:

44. Jan Fawcett, _Predictors of Early Suicide: Identification and Appropriate Intervention_, 49 J. CLINICAL PSYCHIATRY 7, 8 (Supp. Oct. 1988). Symptoms of panic disorder include discrete periods of intense fear or discomfort with shortness of breath or smothering sensation; dizziness, faintness, or unsteady feelings; palpitations or tachycardia; trembling or shaking; sweating; choking; nausea or abdominal distress; depersonalization or derealization; numbness or tingling; flushed or chill; chest pain or discomfort; nor fear of dying, going crazy or doing something uncontrolled. _DSM III-R_, supra note 31, at 235-39.

45. Symptoms of schizophrenic disorders include delusions, hallucinations, incoherence, loosening of associations, flat or inappropriate affect, catatonic behavior, functional impairment in social relations, work, or self care. _DSM III-R_, supra note 31, at 187-89.

Schizophrenics are particularly vulnerable to suicide during the early manifestations of symptoms or during those times when they are without hope or social supports. Treatment for schizophrenic disorders generally combines supportive psychotherapy and environmental management with the use of neuroleptics.

46. Schizoaffective syndromes include those in which the symptoms of a major depressive disorder or manic disorder co-exist with those of schizophrenia. _Id_. at 208-10.

47. The symptoms necessary to make the diagnosis of borderline disorder include unstable and intense interpersonal relations, impulsiveness, affective instability, inability to control angry responses, persistent identity disturbances, feeling of emptiness or boredom, frantic efforts to avoid real or imagined abandonment. Symptoms of antisocial disorder include conduct disturbances, inconsistent work behavior, failure to conform to social norms, irritability and aggressiveness, failure to honor financial obligations, impulsivity, lack of regard for truth, recklessness concerning safety of self or others. _Id_. at 345-47.
commentators conclude that the principle focus of treatment should be some kind of outpatient psychotherapy.48

After making one of these diagnoses, other factors which increase an individual patient's risk of suicide must be explored. History of a past suicide attempt is statistically the most valuable of these other factors.49 Risk of suicide decreases as time since an attempt increases,50 but any person who has ever attempted suicide is a greater risk than one who has not.51 This is true even though studies show certain people attempt suicide several times.52 These people generally use methods likely not to be lethal, or choose circumstances where rescue is probable.53 Nevertheless, individuals in this group do some-

48. DSM III-R classifies psychiatric diseases on Axis 1; personality disorders are classified on Axis 2. Id. at 10. Medication is used only for those who have an additional psychiatric disease. Tokosz Byran Karasu, Borderline Personality Disorders, in APA TASK FORCE REPORT ON TREATMENTS OF PSYCHIATRIC DISORDERS 2749-59 (1989).

49. David A. Brent et al., The Assessment and Treatment of Patients at Risk for Suicide, in 7 REVIEW OF PSYCHIATRY 353, 357 (Allen J. Frances & Robert E. Hales eds., 1988).

50. "A recent suicide attempt requiring medical hospitalization may be considered prima facie evidence of suicidal risk . . . ." Richard J. Goldberg, The Assessment of Suicide Risk in the General Hospital, 9 GEN. HOSP. PSYCHIATRY 446, 446 (1987). Nevertheless, Dr. Goldberg recognizes that "the prediction of further suicidal behavior is a very uncertain science." Id.

51. Because of difficulty in obtaining psychological information on suicides, it is common to study those who have attempted suicide. However, because of the common belief that suicide attempters and those who complete suicide actually represent different kinds of behavior, some question is raised about the validity of the information. To resolve this dilemma, a group of attempters who ultimately did commit suicide was studied. Their depression and hopelessness were similar to those of attempters with the greatest intent to die. The study thus supported the conclusion that it is possible to extrapolate psychological characteristics of suicides from studies of attempters. Extrapolation, supra note 13, at 80.

52. One author suggests that attempters and those who succeed are actually "the same individuals at different points of a developmental continuum." Kenneth S. Adam, Early Family Influences on Suicidal Behavior, 487 ANNALS N.Y. ACAD. SCI. 63, 63 (1986). Dr. Adam claims that suicidal behavior is a "specific behavioral response with definable antecedents, an understandable course, and a range of more or less predictable outcomes." Id.

53. Robert A. Steer et al., Eventual Suicide in Interrupted and Uninterrupted Attempters: A Challenge to the Cry-for-Help Hypothesis, 18 SUICIDE AND LIFE-THREATENING BEHAV. 119, 125 (1988). This study showed differences in precautions taken by interrupted and uninterrupted attempters.

The interrupted attempters took fewer precautions against being discovered, chose less isolated places, and scheduled their attempts at times when discovery was more likely, whereas the uninterrupted attempters took more precautions against discovery, chose more isolated places, and scheduled their attempts at times when discovery was less likely. Id. at 125. These differences were considered important because interrupted attempters were three times more likely to eventually commit suicide. The authors concluded that further research is necessary to determine the reasons for this difference. Id. at 125-26. However, they speculate that one reason might be-
times kill themselves, perhaps by mistake. Consequently, even people who may seem at less risk because previous attempts did not appear serious, are at greater risk than the general population.

Hopelessness increases risk of suicide in every diagnostic category. In fact, hopelessness affect has been utilized as a test for suicidality. Because of the importance of hopelessness, one of the major objectives of any psychotherapy of these diseases is reinstilling hope.

A history of suicide in the family is also associated with greater risk that the person will kill himself. Another factor increasing the risk is access to means to commit suicide. Studies suggest decreasing access to lethal means is an effective deterrent, both in individual cases and general populations. Formulation of a definite plan, while not so extensively studied, is a sign of the seriousness of risk. Having both a plan and access to means cause interrupted attempters “felt more hopeless after the interruption because they believe that their problems were still unresolved, or other people may not have responded to the interrupted attempts as they had before.” Id. at 127.

54. David H. Rosen, The Serious Suicide Attempt: Five-Year Follow-up Study of 886 Patients, 235 JAMA 2105, 2109 (1976). This study confirmed significant differences between serious suicide attempters and those who seemed less serious. Id. However, the author warned that this does not mean the less serious attempters can be ignored. “Even though the suicide rate for the serious attempters is significantly higher than that for the nonserious attempters, the actual number of suicides is greater for the latter group (23 of 34, or 65% of the total number of suicides).” Id. at 2109.

55. One study concluded that the more closely a suicide attempter resembled a suicide “in personal and clinical characteristics as well as in the manner of carrying out his suicidal act, the higher his risk for a further and fatal suicide attempt.” D.J. Pallis et al., Estimating Suicide Risk Among Attempted Suicides II. Efficiency of Predictive Scales After the Attempt, 144 Brit. J. Psychiatry 139, 144 (1984).

56. In fact, the level of social integration among attempters is consistent with those who complete the act, and far less than the general population. “[S]uicide attempters are generally not only lonely in the context of family, friends and neighbors, but are also poorly situated with regard to work environment and are seldom engaged in community events.” U. Bille-Brahe & A.G. Wang, Attempted Suicide in Denmark. II. Social Integration, 20 Soc. Psychiatry 163, 170 (1985).


58. See generally J.A.T. Dyer & N. Kreitman, Hopelessness, Depression and Suicidal Intent in Parasuicide, 144 Brit. J. Psychiatry 127 (1984). This article concluded that hopelessness is also strongly correlated with suicide attempts.

59. Hawton, supra note 5, at 149. However, it is not clear whether this is due to “family predisposition to affective disorder and other conditions, to having a family model of suicidal behavior, or both.” Id.
to implement the plan\textsuperscript{60} are probably the two most important factors in evaluating the risk of suicide.\textsuperscript{61}

Emphasis on careful diagnosis, guidelines for treatment and specific risk factors should improve the quality of patient care. These medical data may also be used to create a decision tree to assess the seriousness and immediacy of risk of suicide in a particular patient. In addition to determining the appropriate treatment for the underlying illness, this information is critical for deciding the degree of intervention necessary to attempt to prevent suicide. More coercive intervention is justified as the likelihood of suicide increases.

In sum, following his initial determination that the patient is suicidal, the physician must decide if this patient suffers from depression, bipolar disorder, panic disorder, substance abuse or dependence, schizophrenia, schizoaffective disorder, or borderline or antisocial personality. If the patient has one or more of these disorders, the physician must consider the following factors which are likely to further increase the risk of suicide: hopelessness, existence of a plan, access to means, previous attempts, concurrence of another illness, and family history of suicide. Finally, although the physician should use this or a similar decision-making process, it is important to recognize that even when major congruences of these factors exist, the physician will predict suicide twenty-five times for every death that will occur.

### III. PHYSICIAN'S OPTIONS

Assuming a treating physician decides, using these or other predictors,\textsuperscript{62} that his patient is suicidal, suicidal thoughts and impulses

\textsuperscript{60} ROBERT G. MEYER ET AL., LAW FOR THE PSYCHOTHERAPIST 39 (1988).

\textsuperscript{61} Murphy, supra note 6, at 414.

\textsuperscript{62} See, e.g., William M. Patterson et al., Evaluation of Suicidal Patients: The SAD PERSONS Scale, 24 PSYCHOSOMATICs 345 (1983). An "easily learned scale" using 10 major risk factors had a positive influence on the accuracy of predictions by a control group of medical students. The acronym SAD PERSONS represents the predictors: 1) sex, 2) age, 3) depression, 4) previous attempt, 5) ethanol abuse, 6) rational thinking loss, 7) social supports lacking, 8) organized plan, 9) no spouse and 10) sickness. \textit{Id.} at 345. The psychiatrists who propose this scale recognize that other possible risk factors exist. However, they claim that these other factors—race, geographic region of residence, religion, occupation, drug abuse, defenselessness, season, and genetic disposition—"are inconsistent, less well documented, and of less practical importance to the average physician who is evaluating the potentially suicidal patient." \textit{Id.}

Advocates claim medical students can quickly and easily be taught this SAD PERSONS scale. Medical students who used the scale during an experiment predicted suicidality with a significantly greater degree of accuracy than the control group. In fact, they achieved approximately the same accuracy as experienced psychiatrists. However, while this scale might be useful for medical education, it apparently neither increases the accuracy of an experienced physician nor helps protect him from liability for a careful, considered, but incorrect, conclusion.
are the product of an underlying mental disease, and intervention is necessary to protect his patient, he still faces additional important decisions. Although he must presently make decisions on appropriate treatment in the absence of clear medical and legal guidelines, he would be liable if a jury decides other physicians would have predicted and prevented the suicide or attempted suicide. Liability is imposed if treatment falls below the standard of care for physicians in his specialty. Deceptively simple, this standard contains two almost-insurmountable, inherent difficulties: 1) predicting whether a particular patient will kill himself, and 2) determining appropriate steps for preventing suicide.

Presented with a suicidal patient, a physician's possible responses fall naturally along a continuum from simply continuing treatment for the underlying disorder to involuntary hospitalization. None of these options is perfect and, with the exception of merely continuing treatment, each option involves at least some degree of coercion and loss of personal autonomy. In addition, some require a breach of confidentiality and result in invasion of privacy. Other options impose varying degrees of restriction on a person's liberty.

Because of the importance of the affected interests—fundamental rights to privacy, autonomy and liberty—physicians and the legal system agree: the physician should choose the least restrictive alternative likely to prevent suicide. This means the appropriate treatment plan depends on the physician's prediction of degree and immediacy of the patient's risk of suicide. In other words, what is the probability

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63. Many people have attempted to isolate or define factors which increase the risk of suicide. For example, one report establishes a suicide-risk scale for hospitalized adults between the ages of 18 and 70. Jerome A. Motto et al., Development of a Clinical Instrument to Estimate Suicide Risk, 142 AM. J. PSYCHIATRY 680, 685-86 (1985). Nevertheless, the authors concede that they "never entertained the idea of an instrument that will predict suicide in individual cases." Id. at 684. Moreover, the proposed scale is not intended to replace clinical judgment. Where the two conflict, the clinician should follow his judgment. Id. at 685.


65. Predictions of suicidality may be even more difficult, and thus less accurate, than projections of dangerousness. This is particularly disturbing because physicians consistently, and almost uniformly, reject the notion that they can predict dangerousness. See, e.g., Bruce Ennis & Thomas R. Litwak, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 CAL. L. REV. 693, 711-16, 732-34 (1974).

that, without intervention, the patient will commit suicide within a short period of time?

How the physician answers this question, and which of the several treatment options he chooses, have obvious important consequences for the patient. When the decision is correct, the patient resolves his problems67 and avoids suicide. On the other hand, a bad choice may fail to prevent suicide or unnecessarily interfere with the patient's fundamental rights.

IV. STANDARD OF CARE FOR LIABILITY

The preferred treatment plan is the least restrictive because as treatment options become more intrusive, the patient's rights to liberty, privacy and autonomy are increasingly abridged.68 The most obvious individual interest is the life of the patient.69 The interest apparently belongs to the individual who wants to surrender it, and ordinarily a person may voluntarily relinquish a right. However, under certain circumstances the State, acting in its parens patriae role, may intervene to protect an individual.70 The State could protect the individual and alleviate concerns about unwarranted legal liability by protecting a physician from malpractice arising from his patient's suicide, so long as he made good faith treatment decisions following careful consideration of the proposed guidelines. This protection is only possible, however, if a general standard of care in treating suicidal pa-

67. In some cases, resolution of the patient's problems might not be possible. Under these circumstances, by teaching skills to the patient to cope with his problem, psychiatric treatment may eliminate the wish to commit suicide.
68. Cf. Jennifer E. Bennett Overton, Note, Unanswered Implications - The Clouded Rights of the Incompetent Patient Under Cruzan v. Director, Missouri Department of Health, 69 N.C. L. REV. 1293 (1991) [hereinafter Unanswered Implications]. "In constitutional terms, the right to die most often is linked with an individual's right to personal freedom, self-determination, and privacy." Id. at 1293-94.
69. Government has an interest in "preserving the sanctity of life in general under a guarantee of the 'right to life.'" A. Samuel Oddi, The Tort of Interference with the Right to Die: The Wrongful Living Cause of Action, 75 GEO. L.J. 625, 632 (1986) [hereinafter Wrongful Living]. The general response to this argument is the recognition that " 'individual freedom of choice and conduct' " are fundamental. Id. at 632-33 (quoting In re Osborne, 294 A.2d 372, 375 n.5 (D.C. 1972)). Moreover, as the patient's "physical condition deteriorates and as the intrusiveness of the refused treatment increases, the balance shifts toward recognition of the right to die." Id. at 633.
70. Indeed, several arguments are frequently raised to support intervention to prevent suicide. David F. Greenberg, Involuntary Psychiatric Commitments to Prevent Suicide, 49 N.Y.U. L. REV. 227, 229-36 (1974). Initial justification based on religion is less persuasive in a secular society which values freedom of religion. Current rationalizations for intervention emphasize "the prevention of harm to survivors, the prevention of harm to the suicide attempter and suicide as the product of mental illness." Id. at 230.
tients is established and physicians are aware of, and understand, the procedure.

Such a standard does not presently exist. It is virtually impossible to establish whether the reasonable physician could have prevented suicide because, using even the best indicators, physicians' predictions are correct in only one in twenty-five cases. This high error rate, and the potentially disastrous adverse consequences of an incorrect decision, place the physician in a difficult situation. Suits for a patient's suicide represent a high percentage of malpractice claims against psychiatrists, physicians most likely to be treating underlying mental disorders associated with suicide. This means the physician's choice of treatment plan could subject him to years of litigation, loss of his professional license, substantial attorneys' fees,

71. Some physicians recognize similar problems in attempts to apply the general malpractice standard in situations where "reliable, clinically validated paradigms" for prediction have not been established. Mark J. Mills et al., Protecting Third Parties: A Decade After Tarasoff, 144 AM. J. PSYCHIATRY 68, 72 (1987) (hereinafter Protecting Third Parties). Although they raise the issue in the context of difficulty in predicting dangerousness, similar difficulty in predicting suicide supports an analogous argument.

The authors suggest a "more flexible liability standard: the substantial departure rule." Id. at 72. The physician would only be liable if he "was acting in a cavalier or irresponsible fashion" but not if he "chose a course that many, although not all, reasonable practitioners in similar clinical circumstances would have chosen." Id. at 73. Because they conclude that issues surrounding predictions of violence "are much more public policy than psychiatry," the authors suggest that appropriate resolution of the issues should be sought through the judicial system whenever possible. Id. at 72.

72. See, e.g., James L. Rigelhaupt, Jr., Annotation, Liability of Doctor, Psychiatrist, or Psychologist for Failure to Take Steps to Prevent Patient's Suicide, 17 A.L.R.4th 1128 (1982).

Attempts to impose liability are probable if treatment fails and a patient commits, or even attempts, suicide. This might, at least partially, explain why physicians typically overpredict suicide.

73. Irwin N. Perr, Court Findings in Suicide Malpractice Suits Reveal Inconsistencies, THE PSYCHIATRIC TIMES, Nov. 1990, at 32, 32. "Suicide may instigate the second greatest number of lawsuits brought against psychiatrists." Id. Dr. Perr cautions that "[t]he idea that psychiatric or mental health intervention affects the suicide rate is, to my knowledge, unsubstantiated." Id. at 33. Further, after reviewing 32 lawsuits, he concluded that only 10 percent involved negligence. Moreover, none of the negligence was failure to predict behavior. "The attempt to impose responsibility seemed unreasonable in cases arguing that the caretaker should have anticipated suicide and prevented it. . . . One cannot prognosticate accurately in any individual case." Id. at 34.

74. Ironically, this is true both if the physician fails to take sufficient action to prevent suicide or if steps he chooses are subsequently declared too restrictive. Indeed, at least one court found that wrongful initiation of commitment proceedings could support a claim for malicious prosecution. Pellegrini v. Winter, 476 So. 2d 1363 (Fla. Dist. Ct. App. 1985). Absent some recourse for a person wrongfully detained for examination, involuntary commitment statutes would be vulnerable to a due process challenge. Id. at 1366.
and a large malpractice verdict. The physician who, after a good faith evaluation of risk of suicide, created and implemented what he believed was the best treatment plan for his patient, could be sued and lose. Such a result is particularly troubling when viewed in light of one recently reported eleven-year study of 1906 high risk patients. In the study, physicians, using commonly accepted predictors, failed to correctly anticipate even one suicide.75

Despite such overwhelming statistics, the legal system currently permits liability for failure to accurately predict suicide; a difficult, if not impossible, determination, verifiable only after it is too late.76 Contrast this with the proposed standard, which attempts to respond to the difficulty in prediction, requiring only that physicians respond to those objective, more easily identified and quantified factors they have been trained to recognize which increase the risk of suicide.

V. PROPOSED GUIDELINES

Confronted with the suicidal patient, the physician must review the continuum of options and consider the risk factors, asking himself:

1) will continuing to treat the underlying disease and problem, only discussing suicidal thoughts and feelings as they occur during therapy, be sufficient to protect the patient? If not,

2) will closely supervising the patient as an outpatient, possibly with daily contact, including agreement upon a treatment program involving the ongoing recognition of suicidal impulses be sufficient to avoid suicide? If not,

3) will alerting family or close friends who may be able to carefully monitor the patient effectively diminish the chance of suicide? If not,

4) will a partial hospitalization program protect the patient from his self-destructive thoughts and impulses? If not,

5) will the patient consent to hospitalization? If not,

6) is involuntary hospitalization the only way to prevent suicide?

The proposed guidelines would eliminate, or at least diminish, problems associated with treating suicidal patients. A physician would

75. See generally Rise B. Goldstein et al., The Prediction of Suicide; Sensitivity, Specificity, and Predictive Value of a Multivariate Model Applied to Suicide Among 1906 Patients With Affective Disorders, 48 ARCHIVES GEN. PSYCHIATRY 418 (1991). "The results appear to support the contention that, based on present knowledge, it is not possible to predict suicide, even among a high-risk group of inpatients." Id. at 418.

76. Alex D. Pokorny, Prediction of Suicide in Psychiatric Patients, 40 ARCHIVES GEN. PSYCHIATRY 249, 257 (1983). "The courts and public opinion seem to expect physicians to be able to pick out the particular persons who will later commit suicide. Although we may reconstruct causal chains and motives after the fact, we do not possess the tools to predict particular suicides before the fact." Id.
still be liable if he failed to recognize suicidality when other physicians in his specialty would have predicted it.77 Unlike the present system, however, the proposal provides the physician with clear guidelines to decide the critical question of how to treat his suicidal patient.

Another important component of the proposal is redefining negligence in treatment of suicidal patients. The physician would only be negligent if he failed to carefully consider the proposed guidelines and did not apply the risk factors in choosing an option.78 Thus, because liability requires negligence, the physician who follows the guidelines will not be liable even if his patient commits suicide.79

If a patient does kill himself,80 it might appear the physician chose the wrong option. Nevertheless, judges consistently, and correctly, refuse to impose liability for a mere error in professional judgment81 or

77. Nevertheless, liability will not be imposed “merely upon the disagreement of another physician with the manner in which treatment is provided.” Krapivka v. Maimonides Medical Ctr., 501 N.Y.S.2d 429, 431 (App. Div. 1986).

78. In fact, Congress recently endorsed the development of practice guidelines by various professional groups. Deborah W. Garnick et al., Can Practice Guidelines Reduce the Number and Costs of Malpractice Claims?, 266 JAMA 2856, 2858 (1991). The authors acknowledge that guidelines could be important in malpractice cases. However, this is only true if the guidelines are “assumed to be (1) developed for conditions or procedures that frequently lead to events for which negligence claims are filed; (2) widely accepted in the medical profession; (3) fully integrated into clinical practice; (4) straightforward and readily interpreted in a litigation setting.” Id. at 2858. As a result, the authors caution that the guidelines’ initial impact on the number of malpractice cases filed or settlement amounts received may be small. Id. at 2859.

79. Relevant, reliable practice parameters are currently generally admissible as evidence of the appropriate malpractice standard of care. However, courts retain the right to consider other evidence on the issue, and may even reach conclusions contrary to those parameters. Edward B. Hirshfeld, Should Practice Parameters Be the Standard of Care in Malpractice Litigation?, 266 JAMA 2886, 2886 (1991).

80. In fact, some physicians contend that it is impossible to prevent certain people from killing themselves, and that methods necessary to prevent such suicides might even be harmful. “[T]he only way to absolutely prevent suicide is to use four-way restraints on the patient ‘with half a dozen people watching every move.’” Breese v. State, 449 N.E.2d 1098, 1118 (Ind. Ct. App. 1983). Further, “such excessive restraint is detrimental to an already disturbed patient.” Id.

81. See, e.g., White v. United States, 244 F. Supp. 127 (E.D. Va. 1965), aff’d, 359 F.2d 989 (4th Cir. 1966)(per curiam).
a bad or undesirable result. This is because physicians must be permitted "a wide range of judgment and discretion. They cannot insure results and cannot be held liable under law for honest errors of judgment made while pursuing methods, courses, procedures and practices recognized as acceptable by their profession." 

This argument highlights one of the benefits of the proposed standard: it continues to permit the physician a "wide range of judgment and discretion," while specifically outlining "methods, courses, procedures and practices" which would be acceptable in the profession, thus, non-negligent. The physician who determines that his patient is suicidal, and that the suicidal thoughts and impulses are the product of an underlying mental disorder, is not negligent so long as he considers and chooses from the continuum of options, beginning with the least restrictive. He should use sound, medical judgment in choosing the appropriate treatment plan. In this way, he also assures quality patient care.

The physician should begin his evaluation with a determination of whether simply continuing treatment of the underlying illness will be sufficient to protect his patient. Assuming he decides the risk of suicide is too great, he should proceed along the continuum of options, 


84. A decision not based on a proper medical foundation, "one which is not the product of a careful examination, is not to be legally insulated as a professional medical judgment." Bell v. New York City Health & Hosps. Corp., 456 N.Y.S.2d 787, 794 (App. Div. 1982). In Bell, a former psychiatric patient sued for injuries sustained in his suicide attempt after his release from a hospital. Referring to the general refusal to impose liability in the absence of "something more" than an error of judgment, the court also conceded that "the line between medical judgment and deviation from good medical practice is not easy to draw." Id. (quoting Topel v. Long Island Jewish Medical Ctr., 431 N.E.2d 293, 295 (N.Y. 1981)). However, the defendant physician's decision to release the patient was made without a careful examination. He failed to inquire into prior psychiatric history. Further, the physician recommended release although the patient was experiencing potentially harmful delusions. He did not even investigate the nature of delusions suffered shortly before release. He determined that the patient had stabilized, despite a need to physically restrain him the day before his release. The evidence of this egregious negligence sustained the finding that the physician's decision to release the patient was not a professional judgment based on careful examination, and thus the erroneous judgment could be the basis for liability. Id. at 789-96. See also Hirschberg v. State, 398 N.Y.S.2d 470 (Ct. Cl. 1977)(egregious conduct of physician created liability for failure to make a professional judgment based on careful examination).
carefully weighing the risk of suicide against the potential infringement of the patient’s constitutional rights. For example, he should next consider whether the risk of suicide would be sufficiently alleviated by obtaining an agreement from the patient recognizing his suicidal impulses, and then by closely supervising him. While this option requires curtailment of the patient’s autonomy, the restraint is minimal and may be justified by the risk of suicide.

If the physician fears he cannot adequately supervise the patient, he may decide to alert family or close friends to the suicidal risk. It is true this option requires a breach of confidentiality which may be an essential part of the physician-patient relationship. However, under some circumstances a breach of physician-patient confidentiality has been approved and even required. Although courts have refused to


86. For example, the watershed case of Tarasoff v. Board of Regents of University of California, 559 P.2d 553 (Cal. 1974), aff’d in part, rev’d in part, 551 P.2d 334 (Cal. 1976), imposed on therapists a duty to warn identifiable third-party victims of their patients. However, courts consistently refuse to extend this duty to suicidal patients. Bellah v. Greenson, 146 Cal. Rptr. 535 (Ct. App. 1978), is illustrative. Plaintiffs’ daughter had been defendant’s patient for an unspecified time before her suicide. Her parents stated a cause of action against her physician by alleging (1) the existence of psychiatrist-patient relationship, (2) defendant’s knowledge that patient was likely to kill herself because defendant’s written notes indicated plaintiffs’ daughter was suicidal, and (3) defendant’s failure to take appropriate preventive steps. Id. at 538. The court held that what constitutes appropriate treatment is a “purely factual question.” Id. The facts did not support imposing liability on defendant for failing to warn plaintiffs that their daughter was suicidal. The Bellah court said that Tarasoff actually protects against disclosure unless the strong interest in confidentiality is outweighed by some stronger public interest, such as protecting third parties from violence. Because of the “virtual necessity” of confidentiality, and because imposition of the duty to warn of “vague or even specific manifestations of suicidal tendencies . . . could well inhibit psychiatric treatment,” the court limited the Tarasoff duty to warn to situations involving danger to a third person. Id. at 539-40.

This limitation is troubling for at least two reasons. First, the problems associated with disclosure are the same whether the patient is a danger to others or is only a danger to himself. Confidentiality is a “virtual necessity” and disclosure “could well inhibit psychiatric treatment” in either case. The only real difference is the interest to be balanced: the life or well-being of a third person compared with the suicidal person’s own life. Making this the critical distinction is disconcerting because it suggests that the system appears to value one life more than another. The second objection to this distinction is based on its contrast with most civil commitment statutes. Generally, involuntary commitment may be sought where the individual is a danger to himself or others. See, e.g., FLA. STAT. ch. 394.462 (1991). These statutes appropriately seek to treat and protect if the patient is dangerous, and are not concerned with whether the victim is a third person or the patient himself.

Naturally, some differences exist and warning the potential “victim” would be foolish when the patient is contemplating suicide. He knows he is thinking about
extend the duty to breach confidentiality to the case of the suicidal patient. The option to do so without liability should be available to the treating physician. While such a breach does infringe upon an individual's privacy, and might have adverse consequences, it may be warranted by the risk of suicide. Further, limited disclosure to family or close friends is preferable to, and might eliminate the need for, more intrusive treatment options.

In some situations, however, the physician will decide that warning family or friends would be inadequate to protect his patient. He might decide his patient requires hospitalization. Partial hospitalization should be considered first because it is less restrictive to the patient's liberty than 24-hour inpatient care.

In those cases where partial hospitalization will not be sufficient to prevent suicide, the physician should attempt to convince his patient to voluntarily enter a hospital. Voluntary hospitalization is preferable, but, under certain circumstances, only the most restrictive treatment—involuntary hospitalization—may protect the patient. The suicide and thus poses a danger to himself. Even so, it makes sense to provide physicians with the option of informing family or friends. This breach of confidentiality, which clearly implicates a patient's privacy interest and might inhibit treatment, could be justified to save his life. Physicians should carefully restrict the number of people they inform to only those necessary to protect the patient.

87. See supra note 86.
88. The law generally imposes an obligation on a physician to warn those who might protect third parties from his potentially dangerous patients but rejects such a duty if his patient is suicidal. See supra note 86. This split is ironic because research establishes that the mentally ill are no more likely to be violent than members of the general public, Protecting Third Parties, supra note 71, at 73, while the vast majority of suicides are people suffering from mental disorders. See infra note 202.
89. But see Lawson R. Wulsin et al., Unexpected Clinical Features of the Tarasoff Decision: The Therapeutic Alliance and the "Duty to Warn," 140 AM. J. PSYCHIATRY 601 (1983), in which the authors conclude that warning a third party actually furthered the therapeutic alliance in some cases.
90. An accurate assessment of whether or not the patient can be helped on an outpatient basis is of crucial importance. This involves a suicide/homicide assessment; because of the acute and intense disorganization of the patient’s ego functioning, this can be of real life-and-death importance. This issue must not be minimized by the therapist! All persons assessed to be a serious threat to themselves or others must be referred immediately to a psychiatrist for evaluation and possible hospitalization. This same precaution is necessary if the patient is exhibiting psychotic behavior according to the DSM-III-R (American Psychiatric Association 1987) definition of the term. Such referral is necessary to protect the patient when he is unable to protect himself, and to protect the nonphysician therapist from legal liability in a very dangerous situation. Because of the disruptive effect it has on many people's lives, hospitalization should be considered very carefully and used only when other methods of helping the patient are considered ineffective or dangerous.

patient who has formulated a fully lethal plan and who possesses or can readily access the means to carry it out should be admitted "forthwith" to a secure psychiatric facility.91

VI. PHYSICIAN'S DUTY TO COMMIT

The most restrictive alternative— involuntary hospitalization92—generally has the best chance of preventing suicide. Nevertheless, imposing a general duty to commit suicidal patients is inappropriate for several reasons. Such intrusive intervention is neither warranted nor acceptable in many cases because of its enormous intrusion on an individual's privacy, liberty and autonomy. Indeed, some experts suggest involuntary hospitalization might actually harm certain patients. They believe freedom to move around93 and personal responsibility improve chances of recovery.94 Further, they assert "no amount of security or physical restraint short of rendering the patient unconscious can effectively prevent suicide."95 Liability could not be imposed on the physician

each time the prediction of future course of mental disease was wrong, [or] few releases would ever be made and the hope of recovery of a vast number of patients would be impeded and frustrated. This is one of the medical and public risks which must be taken on balance even though it may sometimes result in injury to the patient or others.96 Only if the physician is convinced his patient is in serious and imminent danger of suicide can such interference be justified.

Judges appear to recognize these problems and refuse to impose a legal duty to commit.97 For example, a Florida court recently rejected the notion that a physician has a duty to commit or assume custodial

91. Murphy, supra note 6, at 414.
92. Ironically, many suggest a psychiatrist should not be liable unless the patient was under hospital care at the time of suicide or the attempt. Victor E. Schwartz, Civil Liability for Causing Suicide: A Synthesis of Law and Psychiatry, 24 VAND. L. REV. 217, 245-46 (1971). This argument is based on control. Only when the patient is in a hospital can the physician exercise the type of control and supervision necessary to prevent suicide.
94. A trend is discernible which permits physicians and hospitals to risk allowing a potentially suicidal patient increased freedom. The greater risk is justified because of the potentially therapeutic effects of the freedom. Schwartz, supra note 92, at 249-50.
97. But see All's Well, supra note 9, at 316. "[F]or persons believed to be suicidal, civil commitment procedures still enjoy support. . . . Most commitment statutes exercise a form of benevolent coercion designed as such to prevent self-injury by suicide." Id. Statutes frequently specify that the defendant must be dangerous to himself "if not committed," and be adjudged mentally ill. Id.
care over his patient. In *Paddock v. Chacko*, the court acknowledged "some precedent in Florida law for liability predicated upon the negligent failure to safeguard and protect a psychiatric patient with suicidal tendencies." However, the court distinguished those cases because the patient in each was hospitalized at the time of the suicide or attempt. This was different from *Paddock*, where the alleged negligence was failure to commit a suicidal patient.

Mrs. Paddock's experts testified that Chacko deviated from the acceptable standard of care by allowing plaintiff to remain with her parents rather than hospitalizing her. The appellate court affirmed the

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99. *Id.* at 415.
100. Plaintiff also claimed that the physician was negligent because he failed to prescribe the proper amount of medication to prevent the suicide attempt. The court had little difficulty rejecting this argument, simply stating that expert testimony did not establish "plaintiff more likely than not would have overcome her suicidal tendencies with a different prescription." *Id.* at 417. Therefore, failure to prescribe proper medication was not shown to be the proximate cause of the injury. *Id.* at 418.
101. The facts in *Paddock* are important. Several days after an initial session with Dr. Chacko, Linda Paddock attempted to kill herself. She had consulted the psychiatrist while visiting her parents following a previous suicide attempt and brief hospitalization in North Carolina. Dr. Chacko diagnosed her as having a severe nervous breakdown from which she had substantially recovered. He recommended further psychiatric care either with a psychiatrist in North Carolina, if she followed through with her intent to return home, or with him if she remained in the area. After she called her husband, who said he would not or could not come from North Carolina to get her, she became fearful and anxious. She telephoned Dr. Chacko, and was able to speak with him immediately. She explained her feelings, admitting she had not been completely truthful during the consultation. Dr. Chacko suggested hospitalization. Mrs. Paddock agreed but asked Dr. Chacko to speak with her parents first. Her mother talked with the doctor but said the father made these decisions and he was not available.

Dr. Chacko reserved a bed in a psychiatric hospital for plaintiff. However, when her father spoke with the doctor later that day, plaintiff's father refused to consent to hospitalization. Although she was 35 when the incident occurred, plaintiff testified that her father was a strong authority figure and she did whatever he said. *Id.* at 412-13. Plaintiff's father testified that, at the time, he did not believe his daughter required hospitalization. Indeed, plaintiff's own statement, which was written some two months after the incident and was read to the jury, was that her father told her—after speaking with Dr. Chacko—that "they could handle the situation by themselves and he did not think it necessary for her to go to the hospital." *Id.* at 413 n.2.

As a result, Dr. Chacko agreed to postpone the hospitalization decision and increased plaintiff's medicine. He was going out of town for the weekend but said that he could be reached through his answering service if needed. Plaintiff appeared to be well on Saturday. On Sunday morning, however, she told her father that she was upset, and had had hallucinations during the night. Nevertheless, neither she nor her father attempted to contact Dr. Chacko. After her father left to play golf, Mrs. Paddock went into the woods, made minor cuts on her wrists and then set her blouse on fire.

102. The jury awarded $2,150,000 in damages for the failure to prevent the suicide
trial judge’s conclusion that:

the law did not impose a legal duty on a psychiatrist to involuntarily take a patient into his custody; that he was not legally obligated (nor empowered) to take control of her life away from her against her will to protect her from her self-destructive tendencies. We agree that no such duty exists.103

Seeking alternative theories to establish liability, plaintiff turned to the state mental health statutes, claiming that the statutes call for hospitalization of a patient where otherwise “[t]here is a substantial likelihood . . . he will cause serious bodily harm to himself.”104 The court also rejected this theory, stating that the statute is permissive and fails to support an imposition of an affirmative obligation to hospitalize.

The court did not stop there. It recognized still another problem with imposing an affirmative duty to commit: a person who improperly commences a civil, involuntary commitment proceeding may be liable for malicious prosecution. Therefore, imposing liability for failure to involuntarily hospitalize plaintiff, where defendant’s advice to hospitalize was rejected and plaintiff remained in the care of her parents, “would create an intolerable burden on psychiatrists and the practice of psychiatry.”105

The court said it found no case imposing liability for failure to commit,106 but a Wisconsin Supreme Court case, decided later the same year, casts doubt on that statement’s continuing validity. In Schuster v. Altenberg,107 the Wisconsin Supreme Court concluded plaintiff could state a cognizable cause of action for failure to seek commitment. To recover, however, plaintiff would have to establish that the patient met the statutory criteria for involuntary commitment.108

A duty to commit appears consistent with the spirit of mental health acts which provide that danger to self justifies involuntary commitment. However, imposing such a responsibility on physicians is contrary to the well-established rejection of such an affirmative duty found in Paddock and other similar cases. Schuster is distinguishable from suicide cases because the record contained no evidence the patient took her own life.109 Nevertheless, the relevant dicta110 is

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103. Id. at 411. It is, of course, impossible to determine just how important it was to the judge that the physician had recommended hospitalization.
104. Id. at 414-15 n.5 (quoting FLA. STAT. ch. 394.463 (1985)).
105. Id. at 415.
106. Id. at 417. In a footnote, the court effectively distinguished the two cases which plaintiff claimed supported her claim. Id. at 417 n.9.
108. Because the questions were factual, a jury was the proper decision-maker. Id. at 162.
109. Indeed, the concurring justice seized upon the absence of allegations and facts establishing suicide to reach the conclusion that the fatal car accident was just
contrary to decisions in other jurisdictions, and troubling in its potentially far-reaching consequences.

Dr. Altenberg was Edith Schuster's psychiatrist. His alleged negligence was failing to seek commitment and to alert the family or patient about her condition or possible dangerous implications. According to the patient's husband, the physician's alleged negligence led to Ms. Schuster's death in an automobile accident. Their daughter, who was a passenger in the car, was paralyzed. Decided on a motion for judgment on the pleadings, the case provides no facts about the accident other than that decedent was driving. Nevertheless, the court used the case to suggest that a physician has a duty to institute commitment proceedings not only if his patient is a threat to the public but also if the patient is a threat to himself. This is because, according to the court, to the extent expert testimony establishes commitment was the only proper treatment, the suit is simply one for malpractice.

In addition to its obvious and direct conflict with the law in other jurisdictions, Schuster is problematic because of its selective acceptance or rejection of psychiatric research, seemingly based on whether it is consistent with the court's conclusions. For example, the court raises an interesting point, but then apparently either fails to understand it, or simply chooses to ignore it. The court acknowledges that "dangerousness" is a basis for involuntary commitment, but concedes that holding a psychiatrist liable using "this standard is so plagued with uncertainty as to be without value [and] would raise 'serious questions . . . as to the entire present basis for commitment procedures.'" Nevertheless, the court rejected the argument that this inherent difficulty in predicting human behavior made imposition of a

that—an accident. Certainly, he opined, a physician should not be liable for the negligent acts of his patient. Id. at 178 (Steinmetz, J., concurring).

110. The court conceded that Wisconsin law is contrary to most jurisdictions on another important issue. Id. at 164. The Schuster court acknowledged that, in most jurisdictions, unless there is a "readily identifiable victim," a psychiatrist has no duty to warn third parties that his patient may be dangerous. This analysis is based on the majority opinion in Palsgraf v. Long Island Railroad Co., 162 N.E. 99 (N.Y. 1928), which held that such a duty was founded upon the foreseeability of harm to the person in fact injured. However, Wisconsin adopted the minority position in Palsgraf, finding negligence where the defendant's act may foreseeably harm someone. Consequently, a negligent defendant in Wisconsin is liable for unforeseeable consequences and is also liable to unforeseeable plaintiffs. Schuster v. Altenberg, 424 N.W.2d 159, 164 (Wis. 1988)(citing A.E. Investment v. Link Builders, Inc., 214 N.W.2d 764 (Wis. 1974)).


112. Id.

113. Id. at 170.

114. Id.

115. Id. at 169 (quoting McIntosh v. Milano, 403 A.2d 500, 514 (N.J. 1979)).
duty to commit inappropriate.\textsuperscript{116} Without referring to the daunting number of psychiatrists who vehemently deny the ability to predict dangerousness, and studies which consistently illustrate the inaccuracy of such predictions, the court says "'assessing dangerousness is not . . . beyond the competence of individual therapists.'"\textsuperscript{117} By its simple assertion,\textsuperscript{118} the court discounts problems associated with predicting dangerousness.\textsuperscript{119} The court is correct that one survey of psychotherapists suggests "practitioners are quite confident of their ability to assess dangerousness,"\textsuperscript{120} but a plethora of contradictory data is simply disregarded. While the court's discussion focused on dangerousness to others, predicting dangerousness to self is at least as difficult.\textsuperscript{121}

\textsuperscript{116} It is interesting to note that a Florida appellate court recently adopted this analysis to reject imposing a Tarasoff duty to warn on psychiatrists whose patients may be dangerous to themselves or others. In Boynton v. Burglass, 590 So. 2d 446 (Fla. Dist. Ct. App. 1991)(en banc), defendant's patient shot and killed the victim. Although decedent's family was unable to obtain defendant's records, and thus could not allege specific threats made by his patient to defendant, the complaint stated that the doctor knew or should have known of such threats to harm the victim. The majority refused to impose a duty to warn on psychiatrists because it "would require the psychiatrist to foresee a harm which may or may not be foreseeable, depending on the clarity of his crystal ball. Because of the inherent difficulties psychiatrists face in predicting a patient's dangerousness, psychiatrists cannot be charged with accurately making those predictions and with sharing those predictions with others." Id. at 450. Imposing a duty to warn and protect would be "fundamentally unfair" because "such predictions are fraught with uncertainty." Id. at 451.


\textsuperscript{118} The dissent in Boynton also almost blithely dismisses this concern as "without foundation." Id. at 453 (Schwartz, C.J., dissenting). Judge Schwartz contends that the majority's "self-created fear" should be laid to rest because liability will be "imposed only when, on the basis of professional standards, the psychiatrist actually knows or should know that the threat is a viable one." Id. Unfortunately, Judge Schwartz seems to have missed the point. Professional standards are of little or no assistance in actually determining whether a particular patient's threat is viable.


\textsuperscript{120} Schuster v. Altenberg, 424 N.W.2d 159, 169 (Wis. 1988).

\textsuperscript{121} See supra text accompanying notes 7-13. The additional public policy argument based on the importance of confidentiality in the patient-therapist relationship is raised. Nevertheless, the court correctly decided the law and the physician's ethical code recognize that the protection of the public or the patient may outweigh the patient's interest in confidentiality. Schuster v. Altenberg, 424 N.W.2d 159, 170 (Wis. 1988).
Finally, the Schuster court exhibits troubling naivete, or stunning dishonesty, when it states "mere initiation of detention or commitment proceedings does not threaten the patient's constitutionally protected liberty."\textsuperscript{122} Certainly, as the court said, "a constitutionally proper procedure" must be followed. But can the court seriously believe liberty, as well as other fundamental rights it fails to even mention, are not threatened by the "mere initiation" of the action?

Imposing a duty to involuntarily commit is troubling for an additional reason. Some experts suggest certain patients cannot be deterred from killing themselves and the extreme steps necessary to attempt to prevent suicide may actually injure patients. In Bates v. Denney,\textsuperscript{123} for example, one psychiatrist defendant testified that he believed involuntary commitment could be "counterproductive."\textsuperscript{124}

After reviewing the extensive expert testimony presented by both sides concerning the issue of whether failure to involuntarily commit is actionable negligence, the court refused to disturb the jury verdict for defendants.\textsuperscript{125}

In other words, despite the emergency room patient's history of mental illness and recent hospitalizations for two previous suicide attempts, the court concluded that no clear, affirmative duty to commit existed.\textsuperscript{126} Expert testimony persuaded the court that involuntary commitment might have made the decedent "less treatable."\textsuperscript{127} The court held that the defendant was not negligent in releasing the patient because: 1) the decedent had been resistant during previous hospitalization, and probably would have been the same this time, 2) the decedent could not "be hospitalized forever," and 3) even hospitalization is "no guarantee" suicide will be avoided.\textsuperscript{128}

The Fourth Circuit also recently grappled with the parameters of the physician's duty to prevent his patient's suicide.\textsuperscript{129} State statutes prevented a physician from seeking involuntary commitment if the patient agreed to voluntary hospitalization. As a result, the case might have limited value but for the court's refusal to hide behind these statutes. Rather, it concluded that the limits of the physician's duty are

\textsuperscript{122} Id. at 175.
\textsuperscript{124} Id. at 301.
\textsuperscript{125} Jurors "obviously resolved the conflicting testimony in favor of defendants.... [Such findings were not] manifest error." Id. at 303.
\textsuperscript{126} Before the patient left the hospital, defendant did make an appointment for the following morning, but the patient committed suicide before the appointment. Id. at 299.
\textsuperscript{127} Id. at 303.
\textsuperscript{128} Id. Actually, however, the primary reason defendant escaped liability may have been the fact that decedent denied suicidal ideation. Defendant concluded he was "not acutely suicidal... [and] potentially suicidal patients who are not acutely suicidal are often treated outside the hospital." Id.
\textsuperscript{129} Farwell v. Un, 902 F.2d 282 (4th Cir. 1990).
"not wholly defined" by the constraints of the involuntary commitment statutes.

On the other hand, the court did reject the assertion by decedent's relatives that "physicians have an unbounded duty to take whatever other action is humanly possible to ensure that the patient will actually follow through on a competently expressed willingness and intention to commit voluntarily." The court correctly surmised such a duty might require a physician either to obtain "physical custody of the patient or, at the very least, maintain such continuous and close physical surveillance that effective physical intervention could occur at any time." The importance of a patient's privacy and dignitary rights outweigh the physician's professional judgments about the "best interest" of his patient.

VII. PROBLEMS WITH THE CURRENT SYSTEM

The current malpractice system, which provides little guidance or comfort to the physician, also fails to meet the needs of potential plaintiffs in suicide cases. Several problems with the system combine to make the outcome in most of these cases neither predictable nor even equitable.

A. Proximate Cause

Plaintiffs who meet the first malpractice hurdle by establishing the physician was negligent face yet another major obstacle: the difficult task of proving the defendant's negligence was the proximate cause of

130. Id. at 289.
131. Id.
132. Id.
133. One recent study matched the medical records of a random sample of 31,429 patients with statewide data on medical malpractice claims. A. Russell Localio et al., Relation Between Malpractice Claims and Adverse Events Due to Negligence, 325 NEW ENG. J. MED. 245 (1991). The conclusions were troubling. First, the results establish that civil litigation "only infrequently compensates injured patients." Id. at 250. Even more distressing, however, is the conclusion that the system "rarely identifies and holds health care providers accountable for substandard medical care." Id. The authors concede that the current malpractice system fails to achieve its two primary objectives, but "unless credible systems and procedures, supported by the public, are instituted to guarantee professional accountability" no changes will be made. Id.
134. See generally Barry Furrow, Defective Mental Treatment: A Proposal for the Application of Strict Liability to Psychiatric Services, 58 B.U. L. REV. 391 (1978)(suggesting that strict liability should apply as the standard of liability for defective mental treatment). "Due to its doctrinal and practical limitations, negligence doctrine has unquestionably failed to offer the psychiatric patient a viable means of recovery. Nor has self-regulation by the profession provided adequate control over the quality of psychiatric care." Id. at 434.
the suicide. The physician's negligence is only the proximate cause where the ultimate injury is foreseeable as a "natural and probable consequence of an act or omission." The "controlling factor . . . is whether the defendants reasonably should have anticipated the danger that the deceased would attempt to harm himself." Courts generally agree that "[m]aking a physician's duty to guard against a suicide conditional on its foreseeability is a prudent rule," but application of this "prudent rule" is difficult. Whether any particular patient will commit suicide simply cannot be accurately predicted.

An additional problem plaintiffs encounter when attempting to establish physician's negligence as the proximate cause of the suicide is distance in time between the negligent act and the suicide. As with other issues in this quagmire of proximate cause, this is a fact question. This means outcomes are unpredictable and a plaintiff's lawyer will not be able to confidently advise his client on what legal action, if any, is appropriate. Just a few examples should suffice.

The Fourth Circuit decided that, as a matter of law, the physician's care prior to a suicide attempt could not be the legal cause of his patient's suicide nine days later. The court noted that the physician's care might have been "a cause-in-fact of the suicide . . . as undoubtedly were many other factual causes." Nevertheless, it was not "sufficiently 'substantial' to warrant imposing liability upon the actor." The court recognized that many factors contribute to suicide. Even when only nine days had passed since the negligence, these other factors had the opportunity to contribute to the suicide, thus preventing a finding of proximate cause.

In another case, a Tennessee court refused to find that the physician's care prior to a suicide attempt could not be the legal cause of his patient's suicide nine days later. The court noted that the physician's care might have been "a cause-in-fact of the suicide . . . as undoubtedly were many other factual causes." Nevertheless, it was not "sufficiently 'substantial' to warrant imposing liability upon the actor." The court recognized that many factors contribute to suicide. Even when only nine days had passed since the negligence, these other factors had the opportunity to contribute to the suicide, thus preventing a finding of proximate cause.

In another case, a Tennessee court refused to find that the physi-

135. Nieves v. City of New York, 458 N.Y.S.2d 548 (App. Div. 1983). The court unanimously reversed a $194,000 verdict for a suicide which occurred one month after decedent's discharge from a hospital where he had been treated for a self-inflicted stab wound. During his five-day hospital stay, he was seen twice by a psychiatrist. The psychiatrist rejected decedent's claim that his injury was accidental but released him because he was "alert, rational and cooperative." Id. at 548. Plaintiff's expert testified that the suicide "'could have been' a result of the decedent's discharge, and that it was 'possible' that had he received treatment he would not have taken his own life." Id. at 548-49. Nevertheless, the court found, even assuming negligence in discharging the decedent without treatment, plaintiff failed to prove the negligence was the proximate cause of the suicide. Id. at 548.

141. Id.
142. Id.
cian's alleged negligence in failing to commit decedent was the proximate cause of his suicide seventeen days later. Because there was sufficient evidence in the record to establish that the defendant did not meet the requisite standard of care, the court assumed the treatment was negligent. Nevertheless, due to the absence of evidence that decedent was "in such a state of anxiety or depression that he did not know what he was doing" and the "overwhelming evidence . . . [that during this time he] functioned normally and lived an unremarkable life," the physician's negligence was not the proximate cause of the suicide.

Contrast the cases above with Naidu v. Laird, where the court upheld a finding that the physician's negligence in releasing his patient five and one-half months prior to the injury was the proximate cause of that injury. The court rejected the argument "that remoteness in time or space indicates the likelihood that intervening causes have prevented defendant's acts from being proximate causes of the harm." Acknowledging that lapse of time may be a factor to consider, the Delaware Supreme Court concluded "it is not controlling in the absence of any evidence that Putney's [the former patient] conduct was influenced by some unrelated and independent factor which broke the chain of causation." However, attributing much importance to this decision may be a mistake. Because dangerousness is overdetermined, presumably a skillful advocate could have discovered many factors which impacted on the suicidal person in five and one-half months and could have "broke[n] the chain of causation." Indeed, the court almost seems to make this argument by its pointed reference to "the absence of any evidence." Arguably, therefore, Naidu is merely an example of bad lawyering.

Despite aberrant cases such as Naidu, and because of the difficulty frequently encountered in establishing that the physician's negligence was the proximate cause of injury, the causation requirement has been relaxed in some malpractice cases where the physician's failure to exercise reasonable care increased the risk of harm. A plaintiff need not prove "a patient would have survived if proper treatment had been given, but only that there would have been a chance of sur-

144. Id. at 77.
145. Id. at 79.
147. Although the injury in Naidu was to a third person, the court's reasoning on the issue of timing is applicable to suicide.
149. Id.
150. Id.
vival.' The concurring judge in *Gaido v. Weiser* unsuccessfully proposed expanding this "lost chance of survival" theory to a malpractice case involving suicide. Plaintiff had argued her husband died because his mental illness impaired his judgment. She further stated that the defendant physician had a duty to treat the decedent's condition—that he was suicidal. This condition involved a grave risk of harm but proper treatment might have reduced or eliminated the risk. Failure to properly treat decedent might have increased the risk of suicide, which could have been "a substantial factor in the chain of causation" in the suicide.

B. Suicide as an Intentional Act

Another problem plaintiffs encounter when attempting to impose liability on physicians for their patients' suicides is that generally an intentional act absolves a previously negligent actor from liability for his negligence. This means that his patient's intentional act of suicide presumably should shield even the negligent physician from malpractice liability. But, where an intentional act—such as suicide—is a predictable result of a person's negligence, that act is not a supervening cause which breaks the chain of causation and protects the physician from liability for his negligence. This conclusion led one psychiatrist to object that "bizarre trends" make it necessary to pay "some attention ... to a problem in which one person or group is charged with liability for the poorly predictable acts of another."

In fact, the general rule that an intentional or voluntary act protects a person from liability for his negligence is not absolute. Judges use different language and legal theories to avoid the general rule in suicide cases, but rely on one of two basic exceptions: 1) the patient did not understand what he was doing, or 2) because of the nature of the doctor-patient relationship and the illness for which treatment is sought, the duty of the physician to use reasonable care to protect his patient encompasses the patient's duty to care for himself.


154. Gaido v. Weiser, 558 A.2d 845 (1989). Based on the failure to find "plain error," the majority opinion simply affirmed the judgment for the defendant on procedural grounds without even reviewing the substantive issues. *Id.* at 845.

155. *Id.* at 847 (Handler, J., concurring). Although convinced that the evidence was adequate to support a jury instruction concerning "whether plaintiff proved, within a reasonable degree of medical probability, that defendant's failure to render proper treatment increased plaintiff's [sic] risk of suicide," the judge concurred in the judgment for defendant. *Id.* The failure to give this instruction was not "sufficient to satisfy the strict standard of the plain error rule." *Id.* at 848.


158. Usually the physician-patient relationship is sufficient to establish this duty, but
The first exception seems obvious. If the patient did not understand what he was doing when he killed himself, suicide is neither a voluntary nor intentional act. Therefore, the general rule that an intentional act intervenes to protect the negligent physician simply does not apply. Further, combining the prediction that the patient was suicidal with the fact that he did not know what he was doing makes suicide a foreseeable consequence of, and thus proximately caused by, the physician's negligence. "[A]n act of suicide breaks the chain of causation unless the decedent's reason and memory were so far obscured that he did not know and understand what he was doing and was not therefore a responsible human agency." 1

While several cases discuss this exception, courts seem reluctant to allow a decision to turn on the conclusion that the patient did not know what he was doing. In Weathers v. Pilkinton, for example, the spouse's wrongful death claim was rejected because the court

not always. For example, one therapist's "minimum personal contacts... especially in view of the outpatient character of [the therapist-patient] relationship" did not establish the special relationship necessary to impose liability for the patient's subsequent suicide. King v. Smith, 539 So. 2d 262, 264 (Ala. 1989). Following a significant behavioral change, decedent became violent and abusive, threatening to kill himself and his family. He was involuntarily committed to a psychiatric hospital, where Dr. Smith conducted the initial evaluation. The patient was diagnosed as suffering from alcohol abuse and mild mental impairment. Following further evaluation by other doctors at the hospital, decedent attended six voluntary outpatient sessions. Although defendant supervised the program, a trained counselor actually conducted the sessions.

After another violent episode and suicide attempt, decedent was again hospitalized. This time he was evaluated by other staff doctors, who found him to be suffering from alcohol and substance abuse as well as a mixed personality disorder.

Following his release, decedent attended six more outpatient counseling sessions. Approximately three months later, he killed his two daughters and himself. The court said that the murders and suicide are "tragic in the extreme," but that Dr. Smith was not liable "because the facts fail to show a special relationship or circumstance that would make the therapist liable." Id. at 264.

A doctor who evaluated decedent during both hospitalizations recommended he be released. He concluded that decedent "was a dangerous man with an anti-social personality, but that he was not suffering from a mental illness." Id. at 264. This physician's conclusion supports the notion that a doctor's only role is to treat underlying illness. Absent such an illness, the patient must be released. The King court never had to decide this particular issue, however, as plaintiff inexplicably failed to file a timely appeal against all defendants except Dr. Smith.

159. Weathers v. Pilkinton, 754 S.W.2d 75, 78 (Tenn. Ct. App. 1988)(citing Lancaster v. Montesi, 390 S.W.2d 217, 222 (Tenn. 1965)). The court reviewed the law of several other jurisdictions before reaching its conclusion.


161. The court acknowledged plaintiff was required to establish defendant's negligence as the proximate cause of the suicide. It also recognized foreseeability is the basis of probable cause, and conceded mentally ill people are more likely than
found decedent knew what he was doing when he killed himself. De-
cedent would not have had a cause of action against the physician for
his own voluntary act. As a result, his spouse had no claim. Although the court conceded that the jury could have found the doctor
was negligent, the alleged negligence was not the proximate cause
of the decedent's death. Rather, the suicide "[was], as a matter of
law, an intervening independent cause."

The Supreme Court of Louisiana also flirted with the first excep-
tion in a wrongful death action based on a drug overdose. The defend-
ant physician prescribed dangerous substances in excessive amounts to
an uneducated teenaged patient who was a known drug addict in
Argus v. Scheppregrell. The physician knew his patient was "seri-
ously addicted" and in danger of adverse physical reactions. He also
was aware that accidental or voluntary overdoses could be fatal. Nev-
evertheless, he prescribed drugs in increasing amounts even after a
promise to the patient's mother that he would stop prescribing for her
dughter. Expert medical testimony established that one of the
prescribed drugs might alter consciousness so the patient would be un-
able to judge how much medication she had already taken. Therefore,
it was impossible to prove whether the death was an accident or a sui-
cide. Proof of suicide was essential to the defendant's case because the
lower courts had concluded the doctor should not be liable despite his
obvious "misconduct," if decedent knowingly took an overdose. The
supreme court agreed, implicitly approving liability if side effects
of the drug interfered with decedent's ability to know what she was
doing. Because the record contained conflicting evidence on whether
the overdose was deliberate, and an accidental overdose was equally
likely, the defendant failed to prove that decedent committed sui-
cide. Therefore, the defendant was not insulated from liability for

members of the general population to commit suicide as a result of negligent in-
162. Id.
163. At least one court would relieve the physician of liability " 'even though the
choice is determined by a disordered mind.' " Id. (quoting Daniels v. New York
N.H. & H.R. Co., 67 N.E. 424, 426 (1903)). This conclusion goes beyond the propo-
sal suggested in this article. Recognizing the difficulty in deciding whether dece-
dent understood what he was doing, this article suggests that suicide acts as an
intervening circumstance only if suicidal thoughts and impulses were not a pro-
duct of an underlying disease.
164. Id.
166. Id. at 576.
167. Defendant conceded misconduct and admitted he had no defense. As a matter of
fact, the defendant spent time in prison for similar misconduct in prescribing
drugs. Further, the appellate court said the doctor's explanation was " 'not just
incredible,' " but was " 'ridiculous.' " Id. at 576 n.5.
168. Id. at 576 n.6.
169. Id.
his negligence.

Nevertheless, the Louisiana court actually decided the case based on a variation of the second exception, focusing on the nature of the doctor-patient relationship and the decedent’s specific illness. The court found the physician liable for several reasons: disparity of positions between doctor and patient, risk of harm from breach of the physician’s duty, and the fact that the duty arose “to protect the victim against the risk of his own negligence.” This meant that the physician “could only fulfill his duty to his patient by not giving her further prescriptions for drugs.”

The New Jersey Supreme Court used the second exception to impose liability on a physician for his patient’s suicide attempt in Cowan v. Doering. Plaintiff was hospitalized following a second, unsuccessful suicide attempt. Shortly after her admission, plaintiff jumped from her window, sustaining serious, permanent injury. The court concluded that a person is excused from exercising reasonable self-care when that duty is encompassed in the duty owed to plaintiff by the defendant. The defendants were aware of the plaintiff’s “propensity for self-damaging acts” and her history of suicide attempts and, because of their medical training, should have understood her personality disorder. Therefore, they had a “professional responsibility to treat her for this disorder and to treat her for the manifestations of the disorder, namely, suicidal or other self-harmful acts.”

This case is particularly important because the court correctly recognized that the physician’s primary role is to treat disease. In addition, the judges were aware suicidal thoughts and impulses are “manifestations or symptoms of the disorder” the physician must address. If the reasonable physician would have recognized the risk, based on the patient’s condition, and prevented the suicide, the defendant would be liable for failing to do so. Although a psychiatrist is not “an insurer... bound to prevent suicide,” he is not protected from liability for his own negligence. Further, the physician is not automatically absolved from liability merely because suicide, or attempts, are intentional.

Interestingly, both exceptions are used by the Weathers dissent,
although again in slightly different technical forms.\textsuperscript{179} Citing New York\textsuperscript{180} and New Jersey\textsuperscript{181} cases, Judge Tatum argued the history of previous suicide attempts provided "circumstantial evidence sufficient to make a jury question whether the suicide was committed by 'intelligent power of choice' or by compulsion due to mental illness."\textsuperscript{182} The judge analogized this to the test for insanity in criminal cases. Even if a criminal defendant knows his conduct is wrong, he presents a valid insanity defense if he lacks the capacity to "'conform his conduct to the requirements of law.'"\textsuperscript{183} Unfortunately, the dissent's argument is less persuasive than it might seem at first blush because this volitional prong of the insanity defense generally has been rejected.\textsuperscript{184} Nevertheless, this argument, although flawed, has not totally missed the point. Indeed, under most circumstances—whether criminal or civil—the mentally ill person, rather than his physician, is, and should be, responsible for his acts.\textsuperscript{185}

\footnotesize

\textsuperscript{179} Another theory raised to attempt to impose liability on the treating physician is res ipsa loquitur. However, res ipsa is inappropriate because it requires that, although no direct evidence of negligence exists, the injury generally would not occur without negligence. Where res ipsa is appropriate it is used to shift the burden to defendant to rebut the inference of negligence res ipsa creates. Ray v. Ameri-Care Hosp., 400 So. 2d 1127, 1133 (La. Ct. App. 1981). However, the evidence in Ray justified the jury's conclusion that neither defendant physician nor hospital was negligent when decedent drowned in a hospital bathtub, apparently attempting to prove he could breathe under water.

The Ray court recognized the problem common to these cases. According to expert testimony, there was no reasonable way to foresee the suicide or to alter the treatment plan. Even though plaintiff argued defendants' negligence was the most plausible proximate cause of the suicide, the court said decedent's "death was unforeseeable and unpredictable." \textit{Id.} at 1135.

Defendant psychiatrist who admitted decedent to the hospital diagnosed him as a delusional and paranoid schizophrenic. In his testimony, the physician explained problems associated with treating delusional patients. "[T]here is no way we can take precautions for every possible delusion that a person might have because then we would probably have to keep the person asleep or something . . . . The delusions do not remain static of the same type, but they vary . . . ." \textit{Id.}


\textsuperscript{183} \textit{Id.} (quoting Graham v. State, 547 S.W.2d 531 (Tenn. 1977)).

\textsuperscript{184} See, e.g., United States v. Lyons, 731 F.2d 243 (5th Cir. 1984)(en banc), cert. denied, 105 S. Ct. 323 (1984). "[W]e conclude that the volitional prong of the insanity defense—a lack of capacity to conform one's conduct to the requirements of the law—does not comport with current medical and scientific knowledge, which has retreated from its earlier, sanguine expectations." \textit{Id.} at 248.


The dissenting judge is more convincing when, agreeing with Cowan, he argues that a suicidal patient should not be judged by the same standards as those applied to an adult not suffering from mental illness. However, rather than continuing to focus on the issue of decedent's awareness, the dissent switched to the second exception to support his conclusion.

Where it is reasonably foreseeable that a patient by reason of his mental or emotional illness may attempt to injure himself, those in charge of his care owe a duty to safeguard him from his self-damaging potential. This duty contemplates the reasonably foreseeable occurrence of self-inflicted injury regardless of whether it is the product of the patient's volitional or negligent act. 186

Using this analysis, whether decedent's suicide was intentional is no longer important. Instead, the critical issue is that the suicide was "specifically the ailment which the defendant was entrusted to treat." 187 Although this analysis has merit, the dissenting judge is technically incorrect here too. Suicide is not "the ailment," but a complication of the underlying mental disorder the physician is treating. Suicidal thoughts and impulses may be manifestations of an underlying disorder or simply a product of despair associated with some illness. This means that the physician should be liable only if he negligently treats the underlying disorder, or if he fails to appropriately respond to any symptom of that disease, including suicidal thoughts and impulses. The physician's primary obligation is to attempt to "cure" his patient's illness. As with other diseases, 188 once the illness is eliminated, its manifestations, such as suicidal thoughts and impulses, also may disappear. 189

are capable of forming an intent and who actually do intend an act that causes damage will be held liable for that damage." Id. at 146 (quoting McGuire v. Almy, 8 N.E.2d 760, 763 (Mass. 1937)). It follows that a mentally ill person can be comparatively negligent in some circumstances. This was a case of first impression for the Massachusetts Supreme Court.

We join a number of courts in holding there can be no comparative negligence where the defendant's duty of care includes preventing the self-abusive or self-destructive acts that caused the plaintiff's injury. Clearly, the duty of care that the defendants owed to an institutionalized patient such as Karen McNamara included taking reasonable steps to prevent her suicide when it was a known or foreseeable risk. To allow the defense of comparative negligence in these circumstances would render meaningless the duty of the hospital to act reasonably in protecting the patient against self-harm.

Id. at 146-47 (citations omitted).


187. Id. at 81.

188. For example, the pain of a strep throat vanishes if penicillin destroys the streptococci which caused it.

189. Nevertheless, it has been asserted that suicide does not "seem to be simply a symptom of an underlying diagnostic condition that goes away if the condition responds to treatment. . . . [A]ssigning to a patient a diagnosis that has a high risk
Certainly, a real risk of suicide cannot be ignored. However, because behavior is so unpredictable, especially in cases of suicide, attempts to impose liability for anything other than failure to do that for which physicians are trained—treating the underlying disease under medical guidelines and identifying potential suicide risks—is inappropriate.

C. Contributory Negligence as an Affirmative Defense

The Cowan court, in dicta, explained that, had the issue been before it, it would have rejected the defendants’ affirmative defense of contributory negligence because its application to a disturbed plaintiff requires consideration of his capacity. This flexible standard, which recognizes that a particular plaintiff may not be capable of adhering to a reasonable person’s standard of self-care, only holds the patient responsible for any conduct which, based on his capacity, is unreasonable. However, despite its refusal to allow contributory negligence as a defense, the Cowan court considered plaintiff’s conduct in deciding proximate cause, thereby actually returning to the general rule. If a particular result is a foreseeable consequence of the defendant’s negligence, even the plaintiff’s voluntary acts are not an intervening cause which break the chain of causation. Where the plaintiff was mentally disturbed, and her suicidal thoughts and impulses were symptomatic of her condition, the defendants’ duty was to prevent her from harming herself. Because this duty of care included preventing the kinds of acts that caused the plaintiff’s injuries, the plaintiff’s actions and capacity were subsumed within the defendants’ duty. Permitting contributory negligence would “‘render meaningless the duty of the hospital to protect the patient against self-inflicted harm.’”

A similar argument was recently raised in Bramlette v. Charter-Medical Columbia. The decedent committed suicide following the defendant physician’s alleged negligence. The defendant argued

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190. See, e.g., Ake v. Oklahoma, 470 U.S. 68, 81 (1985)(“Psychiatry is not, however, an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnoses to be attached to given behavior and symptoms, on cure and treatment, and on the likelihood of future dangerousness.”)


194. Expert testimony indicated that the physician defendant had deviated from acceptable medical practice in several ways:

- failing to get a complete history from the family;
- failing to order more intense supervision for the first seven to ten days after admission; failing
that the decedent "was contributorily negligent or assumed the risk as a matter of law because he was not insane and therefore acted knowingly when he killed himself." The Bramlette court neatly side-stepped the issue of decedent's sanity by focusing on the duty owed by a treating physician "to prevent a known suicidal patient from committing suicide." Agreeing with the Cowan majority, the court concluded that "the very act which the defendant has a duty to prevent cannot constitute contributory negligence or assumption of the risk as a matter of law."

Nevertheless, some courts argue "a mentally disturbed" person might be capable of contributory negligence. For example, in Biundo v. Christ Community Hospital a physician operated on a patient whose body was discovered under his hospital window four days after the procedure. The plaintiff, decedent's widow, claimed that the decedent either jumped or fell because of the pain from the surgery, and that the defendant was negligent in not recognizing the risk of suicide. However, based on unchallenged expert medical testimony that the defendant used reasonable skill for a neurosurgeon, the court upheld a directed verdict for the defendant. The plaintiff's objection to the jury instructions regarding contributory negligence was rejected. "Whether or not a mentally disturbed person is capable of contributory negligence is a question of fact for the jury where, as here, decedent was never found mentally ill or incapacitated." Thus the court implied that, under some circumstances, a disturbed individual may be found contributorily negligent.

VIII. TREATING THE PATIENT

Despite the potentially high cost of protection to the suicidal patient—a price exacted not only in money and risk to life but also in loss of personal autonomy, liberty and privacy—intervention to prevent suicide is permissible because most judges and legislators agree preserving life satisfies the requisite compelling state interest. The underlying hypothesis is a person who commits suicide acts contrary to prohibit an outing off hospital grounds; failing to diagnose Bramlette as a high risk for suicide based on his anxiety attacks and his unrealistic improvement immediately upon admission to the hospital. Id. at 916. Additional testimony established that a patient is at greater risk of suicide in the few days following admission to the hospital. As a result, "extreme vigilance is required during the initial seven to ten day period to allow the medication and therapy to begin to take effect." Id.

195. Id. at 917.
196. See supra note 184.
198. Id.
200. Id. at 1297.
to his interests and needs someone to protect him from himself. At least implicit in this hypothesis is the belief that by attempting, threatening or, perhaps, even contemplating suicide, the suicidal person exhibits an inability to make such an irrevocable decision. This hypothesis as an absolute is untenable because some suicides occur without a demonstrable mental disorder. The argument is only persuasive when the suicidal thoughts and impulses are the product of an underlying mental illness and, thus, the patient’s idea to end his life is not something he decided but rather a result of a psychiatric disorder. Even so, this second argument is troubling, as it seems to support a form of quasi-incompetency. In other words, without a finding—with all its concomitant substantive and procedural rights—of incompetency, the physician decides his patient is not capable of making decisions for himself. As the result of this conclusion, the physician makes important choices, with potentially serious adverse consequences, for his patient. When made without the patient’s consent, these choices are particularly problematic. Indeed, a physician ordinarily obtains informed consent to any treatment he proposes. Consequently, an argument could be made that the physician’s responsibility should end with diagnosis, including recognition of suicidal thoughts and impulses; explanation of the disease, including risk of

201. Despite compelling and persuasive theoretical arguments, legitimate questions about intervention may be raised because present knowledge indicates patients will be subjected to unnecessary restrictions of freedom and invasions of privacy to preserve a single life. In a free society, this may simply be an unacceptable ratio and an unjustifiable use of resources in a system which already rations health care.

202. See infra text accompanying note 216. Estimates do vary. For example, one psychiatrist argued 85 to 90 percent of suicides were the result of serious mental illness. However, another doctor claims that no sane person would kill himself. Schwartz, supra note 92, at 232.

203. Some psychiatrists argue that suicidal people are actually ambivalent about their wish to die. Further, these physicians believe the will to live is stronger than the desire to die in the majority of suicidal persons. Norman L. Farberow et al., Evaluation and Management of Suicidal Persons, in The Psychology of Suicide 273, 274 (1970). Such a belief may be used to justify intervention.

204. See infra note 216.

205. Contrast this with the fact that an increasingly intense debate over the past twenty years has resulted in greatly enhanced procedural rights prior to involuntary commitment. Substantive criteria have also been established, in addition to the requirement that treatment be the least restrictive alternative. All’s Well, supra, note 9, at 318.

206. To a greater or lesser extent, depending on the option chosen, he then acts for the patient, overriding the patient’s stated desires. Such a decision must be distressing to the physician, but further consideration of this unilateral declaration of at least partial incompetency is beyond the scope of this paper.
suicide; and treatment of the underlying disorder. However, this is not the standard, and the doctrine of informed consent fails to insulate physicians from an obligation to attempt to prevent suicide.207

A. Informed Consent

Physicians seek informed consent prior to initiating medical treatment. They explain the disease and proposed treatment plan, including potential risks, to enable the competent patient to make informed decisions about suggested procedures. A necessary corollary to the competent person's right to consent to treatment is his right to refuse treatment. If the patient persists in refusing treatment after the physician carefully explains the probable course of the disease and consequences of failure to submit to the proposed treatment, he has given informed consent to withhold treatment. Most courts, legislators and commentators agree that the patient's right to refuse treatment should be honored.

Similar analysis may be appropriate when the patient is suicidal and the proposed medical treatment is psychiatric.208 The physician will attempt to persuade his suicidal patient to submit to the proposed treatment plan, but may be unsuccessful. In those rare cases in which suicidal thoughts and impulses are not the result of underlying psychiatric illness, the patient should be permitted to reject psychiatric treatment and choose suicide.209 The physician should explore with the patient his reasons for suicidal tendencies and explain the probable consequences of acting on them. However, if the patient continues to refuse treatment following these disclosures and explorations, his right to self-determination should be respected. This means, of

207. Indeed, because “[suicide is a societal ailment of tremendous proportion],” Kate E. Bloch, Note, The Role of Law in Suicide Prevention: Beyond Civil Commitment—A Bystander Duty to Report Suicide Threats, 39 STAN. L. REV. 929, 930 (1987), it has even been suggested that a legal duty to report threats be imposed upon any person who hears of such a threat. Id. at 945.


209. The authors of a recent study of psychiatric patients who refused treatment raise an interesting question. See, Stephen K. Hoge et al., A Prospective Multicenter Study of Patients' Refusal of Antipsychotropic Medication, 47 ARCHIVES GEN. PSYCHIATRY 949, 949 (1990). They refer to the continuing debate over the proper scope of the right to refuse treatment, and standards and procedures to determine when refusal may be ignored. "Mental health professionals, in general, favor approaches that emphasize appropriate treatment, whereas many legal advocates favor models that focus on patients' rights to determine their own care." Id. The authors attribute this lack of consensus not only to "differences in perspective, but also the lack of reliable information about the overall effects of the right to refuse treatment." Id. Predicting suicide suffers from similar problems.
course, the physician would not be liable if the patient does commit suicide.

The situation is more difficult if suicidal thoughts and impulses are results of mental disorder. As with any patient, the physician should explain the disorder and the proposed treatment plan, including the likelihood of success and the high probability that when the disease is treated suicidal thoughts will disappear.

The patient might refuse treatment for many reasons, including an unwillingness to endure further suffering. At this point the physician is faced with a serious dilemma: accede to the patient's self-destructive desire or overrule him through coercive intervention. Although such intervention may violate a person's rights to privacy, liberty and autonomy, two important distinctions justify treating some mentally ill patients differently from those suffering from physical illnesses. First, people suffering from physical illness who are permitted to choose to die have no possibility of recovery. Second, mental disorders underlying suicidal impulses may directly affect cognitive abilities.

Cases allowing a physically ill patient the right to die focus on his

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210. Many mentally ill patients are no less likely to comprehend what their physician tells them than are people who are physically ill. They have the same fundamental rights of privacy, autonomy and liberty, and even people who have been involuntarily committed may have the right to refuse treatment. Limitations on the right to refuse treatment exist only if 1) the mentally ill person has been adjudicated incompetent, or 2) there is an emergency where the mentally ill person "poses an immediate threat of physical harm to himself or others." *In re Orr*, 531 N.E.2d 64, 73 (Ill. App. Ct. 1988). Even if he is dangerous, drugs should be forcibly administered only after considering alternative treatments. *Id.*

For example, when three inpatients refused psychotropic medication, the New York Court of Appeals rejected the notion that either mental illness or involuntary commitment "without more, constitutes a sufficient basis to conclude that they lack the mental capacity to comprehend the consequences of their decision." *Rivers v. Katz*, 495 N.E.2d 337, 342 (N.Y. 1986). Involuntarily committed patients were seeking recognition of their right to refuse antipsychotic drugs. Referring to "considerable authority within the psychiatric community," the court acknowledged that "the presence of mental illness does not ipso facto warrant a finding of incompetency." *Id.* Nevertheless, the court also denied that the patient's rights were absolute and concluded when a compelling state interest exists, courts may intervene. *Id.* This is only permissible, however, when the patient is proven, by clear and convincing evidence, to be unable to make a competent decision for himself. See, e.g., *In re Charles C.*, 562 N.Y.S.2d 208 (App. Div. 1990) (rejecting the idea that the clear and convincing standard of incompetency had been met even though the patient's testimony was "somewhat rambling and incoherent.")

Arguably, however, the right to refuse psychotropic medication can not be stretched to grant a suicidal patient a right to end his life. This is because, even in these cases, courts generally find a compelling state interest, and permit intervention, denying the right to refuse treatment where the patient is a danger to himself or others. *Rivers v. Katz*, 495 N.E.2d 337, 343 (N.Y. 1986).

211. See infra text accompanying notes 225-28.
quality of life now and in the future. Although the legal system no longer requires the physically ill person to be terminal or even in great pain, he must have a serious illness or disability and no chance for improvement. Courts recognize the right to die because denial would only prolong suffering without hope of recovery. Physically ill or disabled patients who choose to die will not recover from their underlying disorder.

The mentally ill, suicidal person's present quality of life is also bad. In addition, if he is not permitted to die, he will be forced to endure further suffering during his treatment. However, the similarity ends there. The mentally ill patient generally recovers, and is no longer suicidal. Psychiatric treatments have improved so that four of five people suffering from these underlying diseases improve, and the concomitant suicidal wishes usually disappear with those improvements. Further, even though the suicidal patient is apparently competent, illnesses which increase the risk of suicide may also affect cognitive abilities. Certainly physical pain and illness may influence a patient's decisions, but the direct and immediate effect on cognition frequently present in the mentally ill person has not been established in the physically ill.

These differences may justify intervention, even without the patient's consent. Nevertheless, difficulty in predicting 1) which suicidal person will take his own life, 2) which intervention is indicated, and 3) which mentally ill person will get better with the proposed in-

214. Recently the Supreme Court further complicated the issue. In Zinermon v. Burch, 110 S. Ct. 975 (1990), the Court questioned the competence of a mentally ill person "to make a knowing and willful decision" to consent to hospitalization. Id. at 987. However, while some mentally ill people are incapable of informed consent, others retain "a significant capacity for normal and rational thought and action." Bruce J. Winick, Voluntary Hospitalization after Zinermon v. Burch, 21 PSYCHIATRIC ANNALS 584, 587 (1991). Indeed, the Court's apparent distinction in accepting decisions of physically ill but not mentally ill patients represents "a largely mistaken view of the impact of mental illness on decision-making capacity." Id. at 586. Pain and stress of any illness sufficient to require hospitalization, in addition to difficulty in understanding medical information, may easily impair the ability of the physically ill patient to give informed consent. Id. at 587. Professor Winick's argument is particularly interesting and relevant to the transparently artificial distinction courts repeatedly raise in the right to die cases. See infra text accompanying notes 228-45.
215. Cf. Phil Brown, Psychiatric Treatment Refusal, Patient Competence, and Informed Consent, 8 INT'L J. L. & PSYCHIATRY 83, 89 (1985). "Informed consent involves three components—the informed nature of consent, the voluntariness of the consent, and the patient's competency. In fact it is often difficult to distinguish them, especially informed nature and competency, since the person's mental competence so strongly determines his cognitive abilities." Id. at 89 (citation omitted).
tervention means that the physician should be able to discharge his legal duty by recognizing the risk of suicide, considering the proposed options, informing his patient and documenting he has done so.

B. The Right to Die Includes Suicide

When the decision to commit suicide is not a product of an underlying disorder,\textsuperscript{216} a "rational suicide,"\textsuperscript{217} the analysis is different\textsuperscript{218} and intervention is difficult to justify.\textsuperscript{219} Advocates of the notion that some suicides are rational propose permitting, and possibly even assisting,\textsuperscript{220} suicide.\textsuperscript{221} However, this "rational suicide" theory is problematic for several reasons. Although adoption of the theory would presumably protect the physician who fails to intervene from liability, the label is simply too vague to be meaningful or helpful in deciding which option to chose. Neither the legal system nor the medical estab-

\textsuperscript{216} The majority of suicides do have an underlying mental disorder. However, not all do. For example, one recent Finnish study concluded that 94% of adolescent suicides suffer from a mental disorder. This means, of course, that 6% do not. Marttunen et al., supra note 24, at 835.

\textsuperscript{217} It is considered a rational suicide if a terminally ill person decides to kill himself. James Podgers, 'Rational Suicide' Raises Patient Rights Issues, 66 LAWSCOPE 1499 (1980).

\textsuperscript{218} For an interesting article explaining libertarian support for the right to suicide see generally Rolf Sartorius, Coercive Suicide Prevention: A Libertarian Perspective, 13 SUICIDE AND LIFE-THREATENING BEHAVIOR 293 (1983).

\textsuperscript{219} Indeed, some suggest intervention is inappropriate unless the suicidal person voluntarily seeks help. Thomas Szasz, for example, claims suicide may be an exercise of free will. Thomas S. Szasz, The Ethics of Suicide, in BETWEEN SURVIVAL AND SUICIDE 163, 175 (Benjamin B. Wolman & Herbert H. Krauss eds., 1976). One author, a physician and J.D. candidate, raised an interesting point in support of physician intervention to prevent suicide. See generally Michael R. Flick, The Due Process of Dying, 79 CAL. L. REV. 1121 (1991). Dr. Flick suggested that suicide attempts are generally "for reasons other than a settled desire to die." Id. at 1125. Rejecting the idea that people attempt suicide because they want to die, he claimed "[s]elf-destruction can be a reaching out not to death but to others, a plea for their attention, love, and concern." Id. at 1128-29. Therefore, the physician's job is to offer patients the option to reappraise and live their lives. "The ground for interference is not so much the sanctity of life as it is the finality of death. A person can only be condemned to live for a finite time—but death is forever." Id.

The author builds on this argument, explaining that once a patient is permitted to choose to die, no way exists to determine if that was the correct decision. Further, if it was a bad decision, once the patient is dead, no way to correct it exists. Id. at 1128.

\textsuperscript{220} It is interesting to note that voters in Washington state recently rejected legislation to permit physician-assisted suicide. Philip J. Boyle, Vote Shows that Euthanasia Debate Will Go On, L.A. TIMES, Nov. 9, 1991, at F17. Nevertheless, the close vote is seen as an indication that the debate is not over. The American Bar Association has also refused to endorse physician-assisted suicide. ABA Adopts Lawyer Discipline Model But Resists Call for Greater Openness, 60 U.S.L.W. 2491 (Feb. 11, 1992). However, this issue is beyond the scope of this paper.

\textsuperscript{221} See generally All's Well, supra note 9.
lishment presently provide for different treatment depending on whether the suicide is rational. Further, requiring the doctor to evaluate whether a decision to commit suicide is rational inevitably introduces inappropriate moral and ethical judgments into what should be solely a medical decision. Using rationality as the test would force physicians to decide questions for which they have no particular expertise. In addition, if the physician's duty to his patient was dependent on whether the suicide was rational, he would presumably be subject to liability for conclusions, reached without explicit legal or medical guidance, with which a jury later disagreed.

Instead of this uncertain and inappropriate evaluation, the law should expect the physician to make only the more objective, medical decisions for which he has been trained. Legal or ethical evaluations should be left either to courts or agencies better suited to make them, or to the individual himself. The physician's duty to his patient should be satisfied if he, with due care, reaches the conclusion that suicidal thoughts and impulses are not the result of an underlying mental disorder and so informs his patient. This apparently radical conclusion is actually consistent with—indeed seems almost mandated by—an honest evaluation of recent cases and statutes acknowledging fundamental individual rights to autonomy and to choose to die.

C. The Right to Die

The early, so-called right to die cases recognized only a right to

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222. In an interesting article, a physician and a lawyer argue it is not clear exactly how to determine another person's best interests. H. Tristam Engelhardt, Jr. & Michele Malloy, Suicide and Assisting Suicide: A Critique of Legal Sanctions, 36 S.W.L.J. 1003, 1006 (1982). Such a judgment requires establishing priorities of benefits and detriments. “This ordering, however, presupposes a particular moral or evaluational sense, and is therefore irradically [sic] subjective.” Id. at 1007. The article supports the libertarian view that “the individual, not the state, is considered the supreme judge of his own best interests. The individual is held to have a right to self-determination, free choice, and autonomy.” Id. at 1010.

223. A persuasive argument can be made that a person suffering from an underlying mental disorder ought to be permitted to end his life. [I]t is not so obvious that to prevent someone who is mentally ill from committing suicide is necessarily to bestow a blessing. The woman who, despite medical evidence to the contrary, is convinced she has cancer may be mistaken, but, if her delusion persists, she may nevertheless find death preferable to a protracted life of fear and anxiety. Though her beliefs may be in error, her emotions may be just as acute and distressing as if they had been well-founded in physiological reality. Greenberg, supra note 70, at 236. Ironically, the author does not suggest that a physician should not intervene in such a case.

224. Statutory prohibitions are not uniform. Several courts and legislators find a constitutional right to terminate any treatment, but others prohibit the withdrawal of food and water. See Wendy Ann Kronmiller, Comment, A Necessary Compromise: The Right to Forego Artificial Nutrition and Hydration Under Maryland's Life-Sustaining Procedures Act, 47 Md. L. Rev. 1188, 1190-91 (1988).
refuse medical treatment. Courts concluded that a competent person had a right, generally arising from his constitutional right to privacy, to refuse even life-saving medical treatment. These patients, who were suffering great physical pain, were permitted to choose to “die with dignity” by rejecting intrusive medical procedures. Courts distinguished these situations from suicide because, absent the extraordinary medical care, terminal patients would die from their underlying medical illness whereas the suicidal patient’s own self-destructive acts, rather than an underlying illness, were the cause of death. Although factually correct, the distinction was difficult to

225. Many courts face the problem of the conflict between the rights of the incompetent patient and the appropriate limits of substituted judgment. The most notable, and the only case to reach the Supreme Court, is Cruzan v. Director, Missouri Department of Health, 110 S. Ct. 2841 (1990). See infra text accompanying notes 253-66. These questions are beyond the scope of this article.


227. A recent Nevada case concluded that the individual’s right to refuse extraordinary medical treatment outweighs claimed State interests. McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990). Petitioner, a 31-year-old quadriplegic, requested that the court permit him to be removed from his respirator because his father, who was his caretaker, was dying. He also asked for medication to minimize the pain, and that the person assisting in his death be protected from liability. Id. at 620.

The court began its analysis with a balancing test. On one side was the petitioner’s individual interest in autonomy or freedom to determine his own medical treatment. On the other side were several “significant” State interests. These include preserving life, preventing suicide, protecting innocent third parties, preserving the integrity of the medical profession and encouraging charitable and humane care of sick people. Id. at 621-28. Acknowledging the importance to each person of “the possession and control of his own person, free from all restraint or interference of others,” the Nevada court explained that the right is not absolute but must be balanced against the State’s interests. Id. at 621 (quoting Cruzan v. Director, Mo. Dep’t of Health, 110 S. Ct. 2841, 2846 (1990)(quoting Union Pacific R. v. Botsford, 141 U.S. 250 (1891))). Still, the court also recognized a fundamental privacy right to withhold or withdraw from medical treatment which prolongs life, and that a person’s liberty interest is implicated in right to die cases. At some point, a patient’s “quality of life may be so dismal” that his rights must prevail. Emphasizing that the case involved a competent adult, the court said “[i]n instances where the prospects for a life of quality are smothered by physical pain and suffering, only the sufferer can determine the value of continuing mortality.” Id. at 624.

See also All’s Well, supra note 9, at 317 (“Preventing suicides means someone else is making a decision that a potential suicide attempter is better off suffering alive than dead.”)


229. A New Jersey case explored the State interests in preserving life, preventing suicides, safeguarding the medical profession’s integrity and protecting innocent third parties. However, the court in In re Farrell, 529 A.2d 404 (N.J. 1987), concluded that the right of the patient to refuse medical treatment outweighed these
justify. In truth, the direct cause of the patient's death was his choice to refuse medical treatment. Nevertheless, courts viewed this choice as merely hastening death rather than causing it.

Even if the distinction had merit in the past, it is simply not credible in light of the law's evolution. Courts and legislators in several states have expanded a patient's constitutionally-based privacy right to refuse medical treatment to include the right to reject artificial nutrition and hydration. Such a decision means the patient will not die from his underlying physical ailment, but rather from starvation. The right has been further broadened to include a patient who is neither in great physical pain nor terminal, but is suffering from a condition which is not going to improve.

Having ventured this far down the path of self-determination, however, courts refuse to take the final step and recognize that these cases are similar to a competent adult's choice to commit suicide. Courts stubbornly cling to some imagined distinction. In fact, courts frequently assert the difference as if simply stating it proves it exists. Judges disingenuously claim that the patient who refuses artificial nutrition and hydration, unlike the suicidal patient, is not choosing to die, but rather wants to live without that particular procedure. Ironically, Bouvia v. Superior Court of California which tried to perpetuate this distinction, actually exposed the flaw in the arguments attempting to limit the right to die.

Elizabeth Bouvia, a 28-year-old quadriplegic, "totally dependent"

State interests. Id. at 416. Still, as in other right to die cases, the Farrell court specifically distinguished suicide from refusing medical treatment, finding support in the action versus inaction distinction. The court approved the refusal of medical treatment because if the patient dies, it is "the result, primarily of the underlying disease, and not the result of self-inflicted injury." Id. at 411 (quoting In re Conroy, 486 A.2d 1209, 1224 (N.J. 1985)). Although this may be true, focus on such a technical distinction seems absurd.

230. See, e.g., In re Conroy, 486 A.2d 1209, 1222-23 (N.J. 1985).

231. In fact, one commentator, writing prior to the recent refusal of hydration and food cases, used starvation as an example of an impermissible method of suicide. Richard Sherlock, For Everything There is a Season: The Right to Die in the United States, 1982 B.Y.U. L. REV. 545, 557-58. He contrasted this with the approved right to refuse medical treatment. Following this analysis, Professor Sherlock concluded that "it is impossible to establish any systematic, coherent legal differentiation between suicide and the refusal of clearly life-saving medical therapy. In all legally relevant particulars the individual who refuses to take nourishment is no different than the person who refuses treatment." Id. at 558.


for all her needs, was permitted to refuse involuntary feeding through a nasogastric tube even in the absence of a terminal illness or great physical pain. She was an intelligent, mentally competent woman who had several times expressed the desire to die. The court recognized that fundamental state and federal rights of privacy include the right to reject medical treatment even if such refusal causes a life threatening condition.

Bouvia could have lived another fifteen or twenty years, but the appellate court disagreed with the trial judge's decision that preserving her life outweighed her right to decide. Such a conclusion "mistakenly attached undue importance to the amount of time possibly available to petitioner, and failed to give equal weight and consideration for the quality of that life; an equal, if not more significant, consideration." In other words, permitting a patient to reject medical treatment generally hastens death, which is justified because the patient's quality of life is so diminished. This "moral and philosophical decision" belongs to the individual, whether the patient's life expectancy is "15 to 20 years, 15 to 20 months, or 15 to 20 days, if such life has been physically destroyed and its quality, dignity and purpose [are] gone." The court seems to imply that there is even more reason to permit the patient to choose to die when he is not terminal. "It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or more accurately, endure, for '15 to 20 years.' We cannot conceive it to be the policy of this State to inflict such an ordeal upon anyone."

Unfortunately, however, the court stubbornly refuses to acknowledge the similarity between Elizabeth Bouvia's permissible decision to refuse forced feeding and an unacceptable decision to commit suicide. Instead, the judges conclude she "merely resigned herself to ac-

235. Id. at 300.
236. Id. at 301.
237. Id. at 303. See also McKay v. Bergstedt, 801 P.2d 617, 617 (Nev. 1990).
239. Id.
240. Id. at 305.
241. Id.
242. Of course, the finality of death, and the inability to rectify the mistake if it is the wrong choice, is a problem in the case of the physically impaired as well.

Ironically, after having been granted the right to refuse artificial nutrition and hydration, Elizabeth Bouvia changed her mind. Two years later she explained she still believed individuals should have the right to decide whether to continue suffering. "The irony, of course, is that as the result of her court victory the threat to her ability to voice that conviction was that the decision would be executed." Flick, supra note 219, at 1128. Dr. Flick argued "Elizabeth Bouvia did not want to be put out of her suffering—she just did not want to be abandoned to it."

cept an earlier death, if necessary, rather than live by feedings forced upon her by means of a nasogastric tube. Her decision to allow nature to take its course is not equivalent to an election to commit suicide . . . ."244 Nevertheless, apparently recognizing the shaky ground on which its argument stands, the court refused to define suicide, or even consider the patient's "motive" in exercising her right to refuse treatment. "If a right exists, it matters not what 'motivates' its exercise."245

Thus, *Bouvia* protects the right of the patient to refuse food and water as long as he denies the desire to commit suicide and does not need a third person to engage in "affirmative, assertive, proximate, direct conduct such as furnishing a gun, poison, [a] knife."246 The question is, of course, whether permitting a patient to refuse food and water, and thus to starve, is so different from these affirmative acts as to justify different treatment. The *Bouvia* court's conclusion that they are is simply unconvincing.

Concurring Judge Compton is far more honest, even implicitly chastising the majority for its need to "dance" around the issue. He points out that Elizabeth Bouvia wanted to die, and under the circumstances, cannot be blamed "if she wants to fold her cards and say 'I am out.'"247 He objects that the state's prohibition on assisting suicide compels her to deny her wish to end her life.248 "If there is ever a time when we ought to be able to get the 'government off our backs' it is when we face death—either by choice or otherwise."249

In fact, *Bouvia* and other right to die cases actually support the right of the competent, but mentally troubled, individual to choose to end his life. As even the *Bouvia* court acknowledges, exploring the patient's motive is not appropriate. If the cause of death is directly attributable to an individual's choice, the vehicle the patient uses to achieve his goal makes little, if any, difference.250 However, despite a strong hint that suicide might be acceptable as "probably the ultimate

244. *Id.* at 306.
245. *Id.*
246. *Id.*
247. *Id.* at 307 (Compton, J., concurring).
248. *Id.*
249. *Id.* at 308 (Compton, J., concurring).
250. For a similar argument, see generally *Suicidal Competence*, supra note 19. However, that author concludes that in cases where the patient's decision "strongly resembles suicide, the policy reasons for preventing suicide should be weighed into the balance between the patient's and the State's interests." *Id.* at 743. Although most of these policy arguments have been challenged, she said, the potential for saving lives and helping those who are, by their suicidal acts, asking for help, outweighs any potential affront to autonomy of the patient. "Before setting a person free to die, society should try to set her free to live by seeking to relieve her despair and hopelessness. Legal provisions for temporary restraint and counseling are an acceptable compromise between the values of autonomy and self-
exercise of one’s right to privacy,” courts continue to distinguish a patient’s “decision to allow nature to take its course . . . [from] an election to commit suicide.”

The Supreme Court has never decided whether a right to suicide exists. The Court did recently conclude “a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment” in Cruzan v. Director, Missouri Department of Health. The conclusion was merely dicta, but the case is interesting for its analysis and recognition of problems created by earlier judicial attempts to establish appropriate boundaries in the changing environment of right to die cases.

Even though “squarely presented” with the issue of whether the United States Constitution provides a right to die, the Cruzan Court neatly avoided establishing limits, if any, on a patient’s decision to end his life. The Court’s refusal to allow life-sustaining treatment withdrawn was not because Nancy Cruzan did not have the right to make this irrevocable decision, nor because her interest was outweighed by a compelling State interest. In fact, the Court suggested exactly the opposite when it said “[t]he choice between life and death is a deeply personal decision.”

The problem was petitioners failed to prove Nancy Cruzan, who had been in a persistent vegetative state for six years and thus could not be consulted, if aware of her condition, would have made that choice.

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252. Id.
254. Id.
255. Nancy Cruzan had been in a persistent vegetative state since a car accident six years earlier. Her parents sought to terminate artificial hydration and nutrition when it became clear she had no chance for recovery. The Court recognized “the right of every individual to the possession and control of his own person, free from all restraint or interference. . . .” Id. at 2846 (quoting Union Pacific R. v. Botsford, 141 U.S. 250, 251 (1891)). Further, the Court found that the right to self-determination generally outweighs countervailing State interests and permits people to refuse even life-saving medical treatment. Most cases which reach a contrary result focus on “the patient’s competency to make a rational and considered choice.” Id. at 2848 (quoting In re Conroy, 486 A.2d 1209, 1225 (N.J. 1985)). However, the Court unequivocally stated that these rights are not absolute. Whether rights are violated depends on balancing the patient’s liberty interest against relevant State interests.
256. Id. at 2852.
257. Id. at 2852-53.
258. Id. at 2854-55. The Court also decided that the refusal to accept the substituted
More important for purposes of its analogy to suicide, the Court rejected a recurring but inappropriate distinction: "the distinction between actively hastening death by terminating treatment and passively allowing a person to die of a disease." However, the Court refused to take the final, logical step and acknowledge that a competent individual has the right to choose to die—regardless of his reason. Instead, the Supreme Court joined others in distinguishing between right to die cases and suicides.

In his interesting, but ultimately disappointing, concurring opinion, Justice Scalia employed an analysis which toyed with candidly recognizing the absurdity of the distinction but he, like the majority, stopped short of the logical conclusion. He argued convincingly against the distinction between action and inaction and found it an "unreasonable" place to draw the line. "It would not make much sense to say that one may not kill oneself by walking into the sea, but may sit on the beach until submerged by the incoming tide," Justice Scalia correctly opined. Such a distinction does "not make much sense." In fact, although he refuses to acknowledge it, both are suicides.

Indeed, Justice Scalia appears to agree that "[s]tarving oneself to death is no different from putting a gun to one's temple as far as the common-law definition of suicide is concerned; the cause of death in both cases is the suicide's conscious decision to 'pu[t] an end to his own existence.'" But then Justice Scalia inexplicably retreats. Because states have the power to prohibit suicide, "[i]t is not even reasonable, much less required by the Constitution," that the State be prevented from intervening. Justice Scalia apparently can reach this conclusion because he, unlike his colleagues who dissented, rejects the idea of a constitutional guarantee of a right to die.

judgment of close family members did not violate due process. Id. at 2855-56. Following the Supreme Court decision, petitioners located additional witnesses who testified that Nancy Cruzan, prior to the accident, had expressed a desire to refuse treatment if she were in such a condition. The Court concluded that petitioner satisfied the clear and convincing standard and, thus, permitted the withdrawal of artificial hydration and nutrition. Nancy Cruzan died a short time later. Life-Support Removed, Coma Patient Cruzan Dies, L.A. TIMES, Dec. 26, 1990, at p.1.

260. Id. at 2861 (Scalia, J., concurring).
261. Id. (quoting 4 WILLIAM BLACKSTONE, COMMENTARIES *189). Justice Scalia also concedes that, in balancing the interests of the patient and State, "there is nothing distinctive about accepting death through the refusal of 'medical treatment,' as opposed to accepting it through the refusal of food, or through the failure to shut off the engine and get out of the car after parking in one's garage after work." Id. at 2862 (Scalia, J., concurring).
262. Id.
263. For an interesting, exhaustive article rejecting the notion of a constitutional right
By contrast, Justice Stevens presents a convincing argument that each individual possesses a constitutional right to choose to die. "Choices about death touch the core of liberty." Further, the need to analyze and understand mortality is "so rooted in the traditions and conscience of our people as to be ranked as fundamental." Justice Stevens explains that, by interfering with the individual's choice, the Court permits an "unreasonable intrusion upon traditionally private matters encompassed within the liberty protected by the Due Process Clause."

Emotional suffering is not less painful than physical pain; consequently, no justification to treat them differently exists. Mental pain may so adversely affect a person's quality of life that he wants to die. However, the mentally ill person generally does not have an underlying physical illness which, if allowed "to take its course," would cause his death. Therefore, if mental anguish is the source of the patient's choice to end his life, "affirmative, assertive" acts are necessary to achieve the goal. Judicial or physician intervention would only be appropriate if the decision is not actually a "choice" but rather the result of an underlying mental disorder. In other words, judges and physicians should not attempt to prevent self-destruction—whether the immediate cause of death is refusal of medical treatment or some


265. Id. (quoting Snyder v. Massachusetts, 291 U.S. 97, 105 (1934)).

266. Id. at 2882.

267. It is troubling that the Dutch government recently utilized this same inappropriate distinction. Laws in the Netherlands continue to prohibit assisting suicide, but it has been more than 20 years since a doctor has been prosecuted. Marlise Simons, Dutch Survey Casts New Light on Patients Who Choose to Die, N.Y. TIMES, Sept. 11, 1991, at B7. Medical experts attribute this tolerance to public approval of the practice, and establishment of criteria for assisting suicide. Physicians require repeated requests by a fully conscious patient and an independent consultation with another physician. Further, physicians will only assist suicide if the patient is terminally ill with no hope of improvement, and the victim of physical or great mental suffering. Nevertheless, the Dutch Ministry of Health recently issued a letter warning all doctors that mental suffering does not justify assisting suicide. Specialists suggest the main purpose of this notice was to protect psychiatric patients who might not be capable of informed consent. Id.


269. One author raises an interesting argument. Wrongful Living, supra note 69. Recognition of a right to die creates "a correlative duty to act in such a manner as not to infringe upon that right." Id. at 636. Professor Oddi suggests that physicians who treat competent patients who have refused medical treatment have breached this duty. Whether interference with his patient's right to die was intentional or negligent, the physician's conduct was tortious. Based on this analysis, he proposed creation of a "wrongful living" cause of action, where damages would be awarded for prolonging life. Id. at 637-39.
affirmative, assertive act—when there is no mental disease. In the absence of an illness, the patient should be permitted to kill himself and the doctor should not be subject to liability.

IX. CONCLUSION

The physician who treats a suicidal patient faces difficult, urgent decisions. The legal system imposes malpractice liability if the physician fails to predict suicide when other physicians in his specialty would have done so. However, current medical research provides risk factors which do not adequately predict which patient will commit suicide.

This article suggests the physician be protected from malpractice liability if he follows the proposed guidelines. Initially, the physician must determine whether the suicidal patient suffers from an underlying mental disorder. If he does, the physician must carefully review the continuum of options, applying the risk factors, and employ the least restrictive alternative he believes will prevent suicide. If he does so, the patient has received proper care and the physician should be shielded from malpractice liability, even if his patient commits suicide.

If the patient does not have an underlying mental disorder, or at least suicidal thoughts and impulses are not a product of such mental disorder, the physician has no legal responsibility in relation to the suicide.