

On Sound and Unsound Mind: The Role of Suicide in Tort and Insurance Litigation

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Suicide continues to be recognized as a crime by common law in a few states. In those jurisdictions, the beneficiary of a claim must prove that the individual who attempted or committed suicide was of unsound mind, to avoid having the patient's act declared illegal, which would bar recovery of the claim. In malpractice and insurance cases, expert testimony is required regarding the mental state of the individual who attempted or committed suicide. Psychiatric testimony varies widely, depending on the legal definition of "unsound mind" and the highly subjective interpretation of legal definitions. Some experts equate suicide with an unsound mind, whereas others apply M'Naghten criteria. Some psychiatrists who disagree with criminalizing suicide refuse to participate in these proceedings. In suicide malpractice cases, the appropriate function of the expert witness is to provide testimony about the standard of care. When experts attempt to testify about "sound or unsound" mind, they must be mindful of the imperfect fit between psychiatry and the law.

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Though rarely prosecuted, the criminalization of suicide may be an issue in civil litigation. Suicide was a crime in common law and remains a crime in several U.S. jurisdictions.^{1–6} In these jurisdictions, the beneficiary of a claim against a psychiatrist or psychologist alleging negligence in the patient's care leading to suicide must prove that the individual who attempted or committed suicide was of "unsound mind" (thus lacking the mental capacity to commit a crime). In general, "a party who consents to and participates in an immoral or illegal act cannot recover damages from other participants for the consequences of that act."⁷ The law does not permit a person to profit from the commission of a crime.^{8,9} For example, the law does not permit a person who murders another to inherit any part of the estate of

the murder victim. Although penal statutes proscribing suicide or suicide attempts have been repealed or remain unenforced in most states, in a handful of states, they or unchanged common law criminalizing suicide continue to play an important role in tort claims arising out of suicide.¹⁰

The intent to commit suicide may also be an issue in insurance litigation. The determination of an individual's mental capacity, or "soundness of mind," to form an intent to commit suicide may be of consequence in claims for recovery of death benefits under life insurance policies; disability policies; and homeowners policies containing intentional injury exclusion clauses that deny coverage for intentional violent acts; and in legal actions involving workers' compensation benefits, malpractice, and suicide committed as a consequence of injurious acts by third parties.¹¹

Case Example

A 36-year-old professor with a plan to commit suicide was admitted to a psychiatric hospi-

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tal for Major Depression, Severe, with psychotic features. The professor had been denied tenure because of a feud with his departmental chairman. He believed that the chairman was poisoning him.

The patient was not seen by the psychiatrist until 18 hours after admission. On admission, he was placed on standard 15-minute safety checks per telephone orders from the psychiatrist. Sleep and antidepressant medications were ordered. The patient remained agitated, constantly pacing. An antipsychotic medication was added to his treatment.

During the initial evaluation, the psychiatrist spent 30 minutes with the patient. The history of an earlier suicide attempt and hospitalization, when the patient was an undergraduate, was not obtained. The patient denied suicidal ideation, intent, or plan. He “contracted for safety.” The psychiatrist discontinued suicide precautions without contacting the patient’s wife, despite her leaving several telephone messages for the psychiatrist.

The patient planned to kill himself with a shotgun that he had at home. The psychiatric unit’s social worker called the patient’s wife and told her to secure any firearms that were in the home. The patient insisted on leaving the hospital. He explained that the belief that he was being poisoned by the department chairman was due to a lack of sleep and stated that he no longer held this belief, calling it “foolish and unfounded.” The psychiatrist tried to persuade the patient to remain in the hospital. After checking the involuntary civil commitment code, the psychiatrist determined that the patient did not meet substantive criteria of imminent danger to self or others for involuntary hospitalization. The patient left the hospital against medical advice.

Upon discharge, the patient went directly home, broke into the locked gun closet, loaded the shotgun, and committed suicide. The patient’s wife was not at home when the suicide occurred. She filed a malpractice claim against the psychiatrist and the hospital in a state where suicide is criminalized. The claim alleged negligent assessment, treatment, and management of the patient. In a separate legal action, the wife sued the insurance company that denied life insurance benefits under its intentional injury exclusion clause. The patient had purchased a \$1 million life insurance policy eight months prior to the suicide.

The Evaluation of Unsound Mind in Suicide

In *Wackwitz v. Roy*,¹ a case involving a malpractice claim arising out of a patient’s suicide, the Virginia Supreme Court concluded that in circumstances in which the performance of a crime might otherwise preclude the receipt of life insurance benefits, a person of unsound mind who lacks the mental capacity to commit a crime is not thereby prevented from recovery. Accordingly, in the case example, if Virginia law applies, the attorneys would focus on evidence that supports or refutes that the patient was of unsound mind at the time of the suicide. If it is determined that the patient was of sound mind when he committed suicide, it will be regarded as an illegal act for which recovery of a claim will be denied. If it is determined that the patient was of unsound mind when he committed suicide, it will not be regarded as an illegal act. The tort recovery will turn on the other elements of the *prima facie* case of negligence (i.e., did the defendant’s conduct constitute a breach in the standard of care that was the proximate cause of harm suffered?).

Although the consequences of finding that a patient who commits or attempts suicide was of unsound mind are clear in jurisdictions that criminalize suicide, the standard by which this is to be judged is not. Some courts equate unsound mind with “insanity.” The M’Naghten standard, promulgated in England in 1843, stated that an individual is not guilty by reason of insanity if he or she does not know the nature and quality of the act or does not know the act was wrong.¹² Other courts create their own standard, to be applied either independently or in combination with their test for insanity. For example, in one case, the judge defined an unsound mind as follows: “An unsound mind exists where there is an essential privation of the reasoning faculties, or where a person is incapable of understanding and acting with discretion in the ordinary affairs of life.”¹³ This definition was added to that state’s M’Naghten-type criteria for criminal responsibility, obfuscating the entire definition. In *Brown v. Harris et al.*,¹⁴ the federal appellate court defined a sound mind as sane and competent. Under Virginia law, the court stated that “insane” is defined as “idiot, lunatic, *non compos mentis*, or deranged.” The court clearly stated that under Virginia law, there is a presumption of sanity. In yet another definition of unsound mind, the Virginia Supreme

Court approved an “irresistible impulse” definition of unsound mind in a civil case.¹⁵ Inscrutable definitions of unsound mind invite expert opinions that may be highly colored by moral, religious, and personal biases.

Against the background of an unclear legal standard, psychiatric and psychological experts bring to the question a variety of different beliefs about the relationship between suicide and an unsound mind. At one end is the idea that anyone who commits suicide is mentally ill and therefore is of unsound mind. At the other end is the idea that only those persons attempting suicide who meet the determination of legal insanity are of unsound mind. A middle position is reflected in the view that a patient attempting suicide who was grossly psychotic (e.g., responding to command hallucinations to commit suicide) is of unsound mind. Under this middle position, an abusive husband who elaborately and carefully plans the murder of his wife and then commits suicide would be considered of sound mind. However, depression, even without psychotic features, can produce distortions of decision making, albeit more subtle than psychosis or delirium.¹⁶

In the case example, the expert who uses a narrowly defined M’Naghten-type standard would likely find that the professor was of sound mind. The professor knew he was committing suicide. He also knew it was wrong, not necessarily in a moral sense, but that by hiding his suicidal intent and plan, he indicated that he knew it was not an acceptable act when judged by societal norms. For the expert who applied an expansive definition, the professor’s delusional belief that his chairman was trying to poison him constituted psychosis, and therefore, represented evidence of an unsound mind.

Ethical experts testify honestly and strive for objectivity.^{17–19} Convolutional legal definitions can make such testimony a daunting task. Some experts refuse to undertake these cases, since definitions of unsound mind lack clarity and use language unfamiliar to clinicians (e.g., “essential privation of the reasoning faculties”). Competent experts are sensitive to nuances and shades of gray, especially regarding the standard of care in suicide cases. Moreover, psychiatrists and psychologists who are in disagreement with criminalizing suicide may turn down such cases, perhaps limiting access to well-qualified experts.

The Virginia insanity defense standard requires “total impairment” of cognitive or volitional capac-

ity.^{20,21} The law recognizes no gradations in responsibility between those who are of sound mind and those of unsound mind. It is a construction that does not comport with clinical knowledge, training, and experience, which suggest that a patient’s intentions, understanding, and reasoning exist on a spectrum of rationality that may be difficult to assess objectively. Furthermore, the expert is asked to reconstruct what was in the mind of a desperate individual who is now dead. The medical record is often inadequate to establish what the patient was thinking, especially when suicide appeared to be impulsive. The reliability of collateral sources of information from the family may be confounded by their emotional reactions to the suicide as well as their involvement in the litigation.

The role of the court in Virginia and other states that criminalize suicide, when the issue is raised, is to determine whether the suicide constituted a criminal act for which recovery should be denied. A reasonable approach to reach that determination is to apply the criminal responsibility standard that the jurisdiction would use to assess the person’s mental state, if it sought to prosecute the person who committed or attempted to commit suicide. Creating another definition of unsound mind is unnecessarily confusing. It is more reasonable, in assessing the civil consequences of a criminal act committed by a person with a mental disability, to follow the standard adopted by the state in its criminal insanity proceedings. If suicide is criminalized, criminal responsibility criteria should apply to the determination of unsound mind in criminalized suicide cases, as it would to other criminal offenses.

Psychiatry and Law: An Imperfect Fit

Psychiatrists must testify to the variations of narrow or expansive definitions of intent that courts apply in criminalized suicide cases or in insurance litigation after suicide. “Sound” or “unsound mind”, as well as “insanity,” are legal, not psychiatric terms. In addition, psychiatric theories of human behavior are deterministic, whereas the law envisions mankind as possessing free will. Thus, an imperfect fit exists between psychiatry and the law. The usefulness of psychiatric testimony to the court is measured by the forensic expert’s ability to bridge the gap between the two. In individual cases, it is in determining when the presumption regarding free will, as defined by the law, has been rebutted.

The question of intent also arises in insurance litigation, especially life insurance claims made by the beneficiaries of insureds who commit suicide. If suicide is suspected, the insurance company may invoke the policy's exclusionary clause, limiting or denying the responsibility to pay benefits. The intentional-injury exclusion clause is intended to prevent enrichment from immoral or illegal acts that are deliberately performed by a competent individual.²²

Companies issuing life insurance are permitted to determine the risks against which they are willing to insure, and most limit or exclude risks of self-destructive acts by the insured. Most courts have enforced suicide, sane or insane, exclusionary clauses that exclude coverage of suicide irrespective of the insured's mental state. For example, in 1985, in *Searle v. Allstate Life Insurance Company*,²³ the California Supreme Court upheld the "sane or insane" language but required the insurer to prove the existence of suicidal intent. The court reasoned that although many insane people have committed suicide, it is necessary to determine if the individual intended to end his or her life (i.e., whether the individual understood that the self-destructive act would end his or her physical existence). In a number of jurisdictions, the determination of intent is also influenced by the presumption against suicide (i.e., that the instinct for self-preservation makes suicide an improbability for a rational person).²⁴ Most jurisdictions, however, hold that the presumption *per se* is not evidence of intent. A minority of states give the presumption against suicide some evidentiary weight.¹¹

Intent is a slippery concept, despite Oliver Wendell Holmes' observation that "even a dog knows the difference between being tripped over and being kicked."²⁵ Courts that follow a narrow legal definition of intent rely on criminal insanity criteria. An increasing number of courts apply a more expansive definition of intent that rejects the criminal insanity standard to assess intent of persons who attempt or commit suicide. A separate categorization that is created by the term insanity is eliminated. Thus, the criminalization of intent is avoided.

The psychiatric or psychological assessment of a deceased's intent requires evaluating the mental capacity to conceive, plan, and execute a suicide.¹¹ These capacities roughly parallel the legal criteria of motive, intent, and act in judicial determinations of sound and unsound mind. Although mental functioning is usually integrated, predominant dysfunction

may be identified in one or more psychological capacities. A manic patient who believes that he can fly and leaps from a 10-story building does not have the mental capacity to conceive (motive), to plan (intent), and to commit suicide (act). In contrast, a terminally ill patient who commits suicide with the assistance of a physician presumably conceived, planned, and executed a suicide with adequate mental capacity. Suicides, however, are distributed along a continuum between these extremes, often presenting experts with difficult forensic challenges.

The intent to die distinguishes a suicide from an accidental death. Motive, however, is what impels the intent to commit suicide. In the case example, the patient is able to plan and execute his suicide; however, the motive arises from a mind distorted by psychosis. A suicidal patient may know that he or she is ending life and know it is wrong but may be affectively incompetent.²⁶ For example, severe depression may cause a patient to feel utterly hopeless, that life is meaningless, and that treatment is futile. Thus, mood states may overcome or distort reasoning, rendering the patient affectively incompetent, although judging the patient's competence can be complex.¹⁴ Purely impulsive suicides without prior thought are typical of medically ill, delirious patients who commit suicide and sometimes occur in intoxicated or psychotic patients.²⁷ In some cases, there actually was no intent to kill oneself (e.g., the delirious or psychotic patient who jumps through a window trying to escape from a frightful visual hallucination).

A narrowly constructed definition of intent, borrowing heavily from the M'Naghten criminal insanity standard, would probably result in the application of the intentional injury exclusion clause. A more expansive definition would not separate the patient's state of mind from the act of suicide. In *Arkwright-Boston Manufacturers Mutual Insurance Company v. Dunkel*, the court stated:

The sole issue that controls the main appeal is whether an allegedly insane individual possesses the requisite capacity to act "intentionally," within the framework of "an injury exclusion clause" found in an insurance policy. . . . [W]e believe the better rule to be that an insane individual cannot be deemed to have acted "intentionally."²⁸

The court repudiated the narrow view that an "insane" individual can act "intentionally," even though he or she does not possess the mental capacity to comprehend the consequences of an act.

The narrow definition of intent follows a criminal model of insanity, usually some version of M’Naghten or the American Law Institute (ALI) definition of intent.²⁹ Both tests of insanity rely on cognition—that is, knowing what one is doing and knowing it is wrong. The ALI test, also known as the substantial capacity test, has a volitional prong in addition to a cognitive prong. The assessment of volition is highly uncertain.³⁰ Was the impulse irresistible or was it not resisted? No science of volition exists.³¹

Both tests exclude psychological motivation in the determination of intent. The forensic expert must try to apply psychological findings to vague legal definitions of criminal responsibility. Psychiatrists and psychologists would prefer to inform the court about mental capacity, unencumbered by legal constructions that do not make clinical sense, such as “unsound mind.” But, such nuanced clinical judgments are not relevant to the specific legal issues as the substantive legal standards are now framed. Specifically, they do not inform the legal standard that arises out of the contractual arrangement between the parties or social policies these standards seek to enforce.

The trend toward an expansive view of a person’s mental capacity and intent parallels a similar development in a few states that have statutorily abolished the insanity defense (Ref. 32, p 263). At the same time, evidence of insanity is admissible to negate *mens rea*. In *George v. Stone*,³³ the court held that the insured’s act of shooting his mother-in-law and a doctor and committing suicide raised an issue of fact concerning the insured’s mental state that precluded a finding of sanity. A concurring opinion set forth the expansive position that the mental capacity of the individual committing a violent act is determinative:

However, to let the question of mental capacity turn on the issue of “insanity” is too restrictive and much too susceptible to conflicting meanings. “Insanity” has different standards of measurement depending upon the circumstances of its application. In the area of criminal responsibility it means one thing; medically defined it may take on a much broader meaning [Ref. 33, p 28].

In *Hobart v. Shin*, the Illinois Supreme Court held that contributory negligence may be raised as a defense in a wrongful-death suit brought against a physician whose patient commits suicide while under mental health treatment. The court upheld the trial court’s instruction to the jury that measured the deceased’s conduct by “the care a reasonably careful

person would use under circumstances similar to those shown by the evidence.”³⁴ This standard allows experts to provide, by a preponderance of the evidence, testimony about the individual’s mental capacity, life circumstances, and psychological factors.

Standard of Care Versus Criminalization

Until recent times, suicide was prohibited by most of the world’s religions. Individuals who attempted suicide were imprisoned or excommunicated. The body of the individual who committed suicide was sometimes desecrated and the funeral liturgy and burial rites denied. In some religions, suicide continues to be anathema. Stigmatization of the mentally ill combined with the religious condemnation and moral disapproval of suicide by society led to its criminalization in the common law. Scientific understanding combined with a growing sensitivity to the plight of the mentally ill has contributed to the decriminalization of suicide.

In the case example, the plaintiff’s expert is prepared to testify that the psychiatrist and the hospital violated the standard of care. To prevail, however, the plaintiff must also prove that the patient was of unsound mind. Depending on the judge’s definition of unsound mind, the patient may be found of sound mind and the case dismissed. Thus, criminalizing suicide places a heavy burden on the plaintiff, be it in malpractice cases or in insurance litigation. Criminalizing suicide perpetuates the stigmatization of the mentally ill and those who commit suicide.

Studies have shown that more than 90 percent of suicide victims were mentally ill before their deaths.^{16,35} Nonetheless, unless a suicide is impulsive, the result of confusion or severe intoxication, or the result of a miscalculation, a patient’s suicide is usually a conscious choice to end intolerable mental pain or circumstances. “Rational” suicides may occur when an individual can no longer endure suffering from a terminal illness.²⁴ Whether the standard of care was violated when a patient attempted or committed suicide should be the question.³⁶ The doors to the courtroom should not be barred by legal abstractions that do not make clinical sense.

Conclusion

However tempting it may be psychiatrically to classify all attempts to commit suicide as the irrational product of mentally disordered behavior, the law

asks the assistance of forensic mental health experts in distinguishing those suicides that result from a sound mind from those that result from an unsound mind. Unless or until the criminal law is reformed to decriminalize suicide and insurance law is reformed to limit exclusion of coverage for self-destructive acts, the legal construct of “sound” and “unsound mind” applied to suicide cases softens the impact of harsh legal rules that would otherwise deny recovery of claims of malpractice resulting in a suicide or claims after the death of an insured. We are sensitive to the beneficent role that this sound and unsound mind dichotomy may play, but suggest there is a better way for the law to address this matter directly, both from the standpoint of the expert’s input and the fact finder’s decision-making.

The central question for the fact finder in each case in which suicide is raised to deny recovery in tort or contract is the responsibility that the person who committed or attempted suicide should bear for his or her circumstances. In malpractice and other tort actions, the concept of comparative fault or responsibility is a much more accurate and practicable way to resolve this question than to attempt to fit it into an all-or-nothing insanity defense standard that seems ill suited to address the multifactorial considerations that may result in a decision to take one’s life. From the perspective of expert input, this standard focuses on matters within the expert’s expertise, the professional standard of care, and what is required for a patient under the circumstances. From the perspective of fact finders, rather than directing their attention to a binary criminal responsibility choice in a civil action, it directs them to a spectrum of civil responsibility to account for each actor’s role in the events that led to the patient’s death.

The proper function of expert witnesses in suicide cases before the courts is to provide credible testimony about the standard of care. When psychiatrists and psychologists testify about soundness of mind, they must be mindful that the imperfect fit between psychiatry and the law is never more evident.

Insurance companies are permitted to decide which risks they want to insure, and are permitted to exclude the risk of suicide. Thus, whether the insured died in an accident or of natural causes rather than suicide will remain an issue in insurance litigation, even if suicide is decriminalized. Nonetheless, from the perspective of expert input as well as the fact

finder’s decision-making, assessing responsibility for choices made by the insured is aided by a standard that addresses intentionality directly, rather than interjecting the question of whether the insured committed a crime.

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