Suicide Litigation and Risk Management: A Review of 32 Cases

Irwin N. Perr, MD, JD

Thirty-two cases of suicide or self-injury in which I served as a medicolegal consultant are reviewed. Suits involving suicide have increased to 18 to 25 percent of psychiatric practice litigation. The demography of suicide is discussed and contrasted with the population studied; this study stresses the problem of the young, unstable, and poorly predictable patient. Considerations in risk management include adequate and timely records, documentation for decisions (particularly involving privileges), clear hospital policies and procedures, and adherence to those policies. In this study, at least 10 percent of the cases did reflect defects in care by the psychiatrist or hospital staff.

Lawsuits against psychiatrists have increased rapidly. In 1975, an AMA study indicated that the claims rate against psychiatrists was 2.27 percent per year, the second lowest of physician groups.[1] A claim means that an action against a physician has been reported to an insurance company, and the percentage refers to the ratio of claims as related to numbers in that specialty in a one-year period. Slawson[2] reported that claims against psychiatrists have increased from 2 percent in 1978 to 4 percent in 1983 (the rate for non-psychiatrists is now about 25 percent). Psychiatric malpractice costs in five years have increased four-fold; in that series, negligence leading to suicide was invoked in 18 percent of threatened suits against psychiatrists.

Bellamy[3] reported earlier that 14 percent of claims against psychiatrists involved suicide. Slawson, in another article,[4] stated that claims in Southern California against psychiatrists for all causes from 1958 to 1967 were only 1.5 percent (1.5 per hundred psychiatrists per year), increasing by 1979 to 4 percent per year in California, with 25% involving suicide.[5]

I have previously discussed the law regarding suicide liability and how it should reasonably be applied.[6–9] Litman[10] noted that 1 percent of suicides occurred in hospitals, general and psychiatric; with one-third resulting in lawsuits, of which one-half were against psychiatric hospitals. He analyzed seven lawsuits as a suicidologist expert witness. I will report on 32 cases where I was a consultant to attorneys in litigation involving suicide (including cases of self-injury involving similar principles).

Dr. Perr is affiliated with the Department of Psychiatry, Rutgers Medical School, UMDNJ, Piscataway, NJ.

The Demography of Suicide

No discussion of the legal aspects of suicide would be meaningful without a review of the clinical aspects of suicide. The vast and contradictory literature necessitates a general, and perhaps simplistic, summary. This review is essential in considering the meaningfulness of clinical practices as potential liability must ultimately be based on prediction and control, not the mere occurrence of an adverse event.

Men commit suicide three to four times more frequently than women; women attempt suicide at least three to four times more frequently than men. Of those who have killed themselves, only 9 to 33 percent have previously attempted suicide;[11,12] thus, if all who have attempted suicide could be somehow prevented from doing so in the future, most suicides would still occur. Of those who have attempted suicide, less than 10 percent have died by suicide after an 18-year followup.[13] Another observation has been that 1 percent of suicide attempts die by suicide each year subsequently. Suicide attempts themselves are remarkably frequent; as many as one million people a year attempt suicide. In one general population, 7.8 percent reported having thoughts of life not worth living, 5 percent wished that they were dead, 2.3 percent had thoughts of attempting suicide, 1.5 percent had previously planned suicide, and 0.5 percent had made an attempt during the preceding year.[14] Schwab *et al.*[15] indicated that 15.9 percent of people had had suicidal thoughts (22.9 percent of those under 30) and that 2.7 percent had attempted suicide. These percentages translate into immense numbers.

Traditionally, the suicide rate has remained rather static—about 10 to 12 per 100,000 per year, with a slight increase in recent years, particularly in young people and in young male blacks. These numbers are misleading in that reported suicides are obviously fewer than actual suicides. Suicide by gun, hanging, or carbon monoxide is usually clear-cut. Suicide by drugs is frequently not checked. If an elderly white sickly male is found dead, autopsy review may not be done. The actual suicide rate may be as much as two and one-half times the reported rate. Single car accidents, falls, and cases involving alcohol raise unique questions. The low suicide rate in southern European countries has been partially attributed to the inadequacies of the reporting system and the cover-up of suicide as a shameful act. Protestant Sweden, Catholic Hungary, and non-Christian Japan have high suicide rates. The establishment of suicide prevention or crisis intervention centers has not lowered the frequency of suicide.

Whites have higher rates than blacks, with white males, black males, white females, and black females showing a declining rate. The reported incidence is questionable because the rates are based on total population,

including children. Suicide increases with age, particularly in males. Recently there has been some increase in young adult male suicides, with the black male rate approaching the white rate. Suicide is related to many phenomena—such as economic catastrophe, illness, drug and alcohol use, loss of social supports, isolation, and personality traits.

Several studies previously reported indicated rate in mental hospitals of about 40 per 100,000, not a striking rate compared with the age groupings involved.[6] Physicians in general have a rate of about 70 per 100,000; thus, the suicide rate of physicians approaches that of the patients they care for.[16] Comparisons of suicide rates in general hospitals with those in mental hospitals have varied greatly.

A Veterans Administration study indicated an overall suicide rate of 150.9 per 100,000 and a neuropsychiatric rate of 370 per 100,000, significantly higher than that in the general hospital.[17] In the VA, 65 percent of the "neuropsychiatric" suicides occurred outside the hospital, with only 35 percent at the hospital. Most frequent means were hanging (52 percent) and jumping (21 percent). In that study, the general hospital rate was 41.7 per 100,000. The Farberow study[17] indicates significantly higher suicide rates, though it is not clear whether the rates were age, sex, and race corrected. For example, the age-adjusted suicide rate for white California men above 25 was 77 per 100,000 compared with a rate of 54 per 100,000 in the general population. Divorced physicians had a rate of 662 per 100,000 compared with all divorced white males with 82 per 100,000. Such remarkable variables do not lend themselves easily to clinical application.

Diagnostically, the various reports reflect a panorama of clinical categories.[6] One hospital system reported that schizophrenia was the diagnosis in one-half of the suicides, the same percentage as those in the hospital population. Alcoholism has varied greatly as a diagnostic category, to as high as 27 percent. Those with personality disorders make an inordinate number of suicide gestures and attempts, while the suicide rates themselves are low but not insignificant. Attempts may outnumber suicides by as much as 39:1.[18]

In estimating suicidality, one considers the appraisal of affect, suicidal ideation and preoccupation, the occurrence of an attempt or expression of concern with specific method, its lethality, and the circumstances of the event (cry for help and likelihood of rescue). Increasingly, hospitals use open units with short stays and liberal privileges. The key points in management are a judgment as to suicide potential at time of admission, the precautions or system used to minimize suicide, and changes in management in accord with patient status; these do not eliminate suicide but are thought to decrease frequency.

Many lawsuits involve claims against psychiatrists and hospital staff. The

psychiatrist is charged with failure to conform to appropriate medical practice or to utilize appropriate clinical judgment. The hospital staff is charged with not conforming to the medical orders, not following hospital policy, or not reporting significant events to the treating doctors.

Review of 32 Cases

I have reviewed 9 cases for the plaintiff attorney and 23 for the defense attorney, almost all in the last 10 years. I felt that there was negligence in 1 of 22 defense cases and in 2 of 8 plaintiff cases, for a total of 3 in 30 cases. Thus, based on my judgment, wrongful handling in 10 percent was apparent. In two cases, there was insufficient information. As will be discussed below, not all involved hospital suicide.

A lawsuit may have multiple defendants—the treating psychiatrist, staff doctors, nursing staff, administrative staff, and so forth. When there is one plaintiff and the case is reviewed for a plaintiff's attorney, the attorney wishes to know if there was wrongful conduct by any defendants. When one reviews a case for a defendant, one is concerned only with that defendant and not other named defendants. Thus, it is possible that in the cases reviewed for a specific defendant, other defendants may have been negligent.

The number involving females (Table 1) was higher than one would expect based on suicide demography (though not unexpected considering the rate of female admissions to hospitals).

The age pattern of patients did not conform to conventional suicide demography (Table 2). People over 55, the group with the highest suicide risk, were not represented: 14 or 43.8 percent were in the 15 to 24 age group and only 6 or 10.9 percent were over 45.

Roughly two-thirds resulted from hanging, jumping, or falling (Table 3). Hanging is a persistent hospital problem because of the difficulties in

Table 1. Suicide-related Litigation (Analysis of 32 Cases)

	N	%	Average Age
Male	20	62.5	31.6
Female	12	37.5	32.3
Total	32	100.00	31.9
	Opinion as to negligence		
Negligence		3	
No negligence		27	
No opinion		2	
	Examined for defense		
Negligence		1	
No negligence		21	
No opinion		1	
	Examined for plaintiff		
Negligence		2	
No negligence		6	
No opinion		1	

Table 2. Suicide-related Litigation (Analysis of 32 Cases)

Age Grouping	Total	Male	Female
15–19	3	0	3
20–24	11	10	1
25–29	1	1	0
30–34	2	1	1
35–39	6	2	4
40–44	3	2	1
45–49	3	1	2
50–54	3	3	0
55 and over	0	0	0
	32	20	12

Table 3. Mode of Injury (26 Deaths, 6 Non-deaths)

	N	%	
Hanging	13	40.6	
Jump or fall	9	28.1	(2 non-deaths)
Jump in front of vehicle	3	9.4	
Exposure*	3	9.4	(2 non-deaths)
Wrist cutting or other	2	6.3	(2 non-deaths)
Overdose (outpatient)	1	3.1	
Shooting (outpatient)	1	3.1	
	32	100.0	

* One case, cause of death unknown.

prevention. This can temporarily be prevented by restraints, seclusion, and/or close observation. However, keeping patients nude or permanently restrained is not feasible.

Jumping may occur under a variety of circumstances; jumping from a psychiatric unit can be minimized when there are security windows or protective screens as a general preventive measure. No judgment of the individual patient has to be relied upon. With hospital or grounds privileges, hanging or jumping cannot be prevented. Three cases involved patients who eloped from the hospital and were found in the woods at a much later time. Only one died (the ultimate cause of death was unknown because of the deteriorated condition of the body). Two other cases resulted in loss of limbs due to gangrene; both cases were those of schizophrenics with no prior indication of suicidal intent.

One patient cut her antecubital fossa area with her broken eyeglasses. Eyeglasses are rarely successfully utilized in suicide so that different hospitals have different policies. I do not believe that allowing a patient to keep spectacles would usually constitute an act of negligence. Overdoses in hospitals are rare; the one case was an outpatient one. I am aware of cases where drug overdosage has occurred: control of medication is a difficult matter because hospitals are open to the public.

The location of the patient at the time of death is noted in Table 4. Generally, the few lawsuits involving outpatients reflect the reality that very

Table 4. Status of Patient

	N	%
General hospital psychiatric unit	10	31.3
State or local government mental hospital	7	21.9
Not hospitalized	5	15.6
General hospital (non-psychiatric)	4	12.5
Private psychiatric hospital	4	12.5
VA hospital	1	3.1
Prison	1	3.1

Table 5. Diagnosis* (Composite of DSM-II and DSM-III)

Psychotic			25
Psychotic depressive disorders		12	
Major depressive episode	7		
Bipolar illness	5		
Schizophrenia (including borderline and schizoaffective)†		12	
Organic brain syndrome with psychosis		1	
Neurotic			7
Depressive disorder—type unspecified		2	
Depressive-anxiety neurosis		4	
Hysterical personality		1	
Personality and substance abuse disorder			6
Drug use—multiple		3	
Alcohol disorder		1	
Antisocial personality		1	
Borderline personality		1	
Other			3
Postconcussion syndrome		1	
Mild mental retardation		1	
No diagnosis (probably depressive neurosis)		1	

* Number larger than 32 because of multiple diagnoses.
† 3 might be classified currently as borderline personality.

limited control exists outside an institutional setting.

Classification or diagnosis does not particularly aid in management or prevention (Table 5). One major problem is that of chronic but low-grade suicide potentiality, particularly in schizoaffective disorder or borderline personality (some listed in the schizophrenia group would now be classified as borderline under DSM-III). Short-term hospitalization (or even long-term hospitalization) and various biologic treatment modalities remain controversial as suicide preventers.

The need for adequate and detailed records has been repeated so often that it has become trite; nonetheless, this review emphasizes the importance of recording. One who proclaims conformity to good practices can verify that practice by documentation; if the documentation is lacking, then that party is crippled in demonstrating what was done and why.

Three examples will suffice. A depressed patient was given grounds privileges after one week in the hospital. The hospital records were mediocre. The psychiatrist who saw the patient every day during the week wrote a

note on a Monday and then on a Friday. After being given grounds privileges on Friday, the patient disappeared and the remnants of her body were later found. The psychiatrist had written a thorough note prior to the change of patient status describing the clinical picture and justifying the increase of privileges; there was no indication of imminent suicide. At trial, the physician was found to be innocent of negligence (the hospital, apparently fearful of a court hearing, settled for a modest amount, although the case was defensible).

A psychiatrist saw a patient twice in a hospital emergency room where the patient was kept overnight for observation. Two days later, after release from the hospital emergency room, he shot his wife, severely injuring her, and killed himself. The notes were quite sparse, without history, mental status, or tentative diagnosis. Ultimately the case was settled for a large sum of money even though the facts, as presented in the psychiatrist's deposition, if true, could have provided a reasonable defense. Unfortunately for him, the records did not confirm the material in the deposition long after the event. Clearly, contemporaneous notes enhance the writer's credibility.

A resident psychiatrist at a university hospital evaluated a patient in the hospital emergency room. He carefully noted the history, lack of previous hospitalization, mental illness, or suicide attempt, and absence of suicidal ideation, albeit the patient manifested depressive symptoms. He gave a prescription for one day's worth of medication and referred her to a psychiatric clinic, recording the prescription and the phone number given her. In fact, she did have a previous psychiatric hospitalization history and previous suicide attempts (many years before). She did not inform the resident or other psychiatrists that she had seen at the same hospital of her previous history. Diagnoses of hysterical personality, depressive neurosis, and conversion symptoms were previously noted in the hospital chart. Two weeks later, she attempted suicide and the resident and hospital were sued on the grounds that she should have been hospitalized two weeks earlier. The excellence of the records was apparent, and the recommendations were logical and reasonable in view of the data available. The case was dropped.

Two cases involved hospitals in which the patient obtained hospital keys. In one, the patient hung himself in a locked basement room (the patient was noted to be deteriorating and grossly psychotic with suicidal concerns). Rapid tranquilization (every half hour with haloperidol) was ordered, but the patient was not even restricted to the ward. This case was settled.

Another patient used a key to open a screened window to go out on the roof from which he fell or jumped. A third, clearly suicidal, frankly schizophrenic patient was placed in a seclusion room with a locked screened window. She jumped to her death from the window; the screen was found open with no signs of mechanical manipulation. Apparently, somebody

had left it unlocked. These cases stress the import of conformity to hospital practice.

A wide variety of people make notes in a chart. Aides, social workers, and others gratuitously offer diagnoses or describe patients as "suicidal." If these comments are not in keeping with appropriate standards, such practices should be reviewed with such hospital staff. If significant notes relevant to suicidality are placed in the chart by others, the physician should be alert to the need for clarification. When a change in status from one type of patient privilege status to another is made or if suicidal precautions are to be lessened, a note dealing with clinical improvement and the need for the change should be made.

If hospital policies dictate 15- or 30-minute observation, then a written record of such observation will lessen the likelihood of an accusation that this was not done. If the hospital rule stipulates constant supervision in accord with a specified type of physician's order, then it should be so recorded.

A woman with a diagnosis of psychotic depression made two suicidal attempts in the 14 days before admission, the last a slashing of wrists following command hallucinations. Despite hopelessness and depression, she was given off-grounds privileges. On the morning of her hanging, she described herself as hollow, empty, afraid of hurting herself, crying uncontrollably, and felt herself racing. A nurse notified the attending psychiatrist because the patient stayed in bed and would not eat. The nurse noted in the chart that the patient was to be closely observed. A few hours later she hung herself with a bed sheet looped over a sprinkler pipe.

A nurse had stayed with the patient that morning. The doctor indicated that he ordered "close personal supervision" and wanted someone to stay with the patient. No note of the doctor's reported orders was made on the order sheet. Another nurse indicated that she later checked the patient every 15 minutes, but no record of the order or observations was made.

There was no clear hospital policy regarding suicidal patients and no written guidelines for management. The only reference to management in the hospital policy manual was the statement: "Patients who are overactive or show suicidal tendencies require stricter supervision than do others."

My report stated that while hospital staff are required to follow physicians' orders, in accord with hospital policy, they are generally not required to exercise a degree of care which has not been ordered or brought to their attention. They are required to bring to the attention of the attending physician significant changes in a patient's clinical status. This was done in this case, despite the ambiguities in the manner and timing.

Generally, a newly constructed hospital should not be built in such a manner that a likelihood of catastrophe is ignored. Thus, hospitals generally

have either locked units, secure windows, and a minimizing of exposure to situations where destructive acts may occur. Seclusion rooms where individuals are left alone should not have elements such as exposed pipes. If a hospital, due to old construction, has such structures, then suicide policies should take such risks into account.

The hospital and its staff failed to meet a reasonable standard of care by not having a system for the handling of suicidal patients. One purpose of policies is to provide guidance and to avoid ambiguity and confusion.

Both the psychiatrist and the nurse indicated that a risk was recognized and orders given. They differed somewhat on what orders were given. In either case, orders referable to direct patient care were not noted in the doctors' orders where they should have been placed.

A hospital may provide a number of means for handling such patients: (1) use of a safe, secure room; (2) constant personal observation (also called one-on-one), where a staff person is always immediately in attendance; (3) periodic observation (at 15- to 30-minute intervals); (4) general close observation where staff looks in on a patient in a nonformalized fashion; (5) use of a room close to the nursing station; and so forth. The only note dealing with observation was one by the nurse in the staff note section that the patient was to be closely observed. The hanging was related to a period of time when the patient was left alone.

The physician did not specifically rescind off-grounds privileges; however, as the hanging occurred on the unit, this possible lapse was not related to what eventuated.

The lack of a policy and failure of communication were obvious. Despite the ambiguity and factual discrepancy, the problem was reported to the attending psychiatrist who made specific recommendations noted by a nurse. The physician's recommendations were not followed or were not documented in terms of what the hospital staff did.

Discussion

In the cases reviewed, to my knowledge, not one case went to trial with a verdict for the plaintiff, none at which I testified (I have not been informed as to all; a few are still pending). Several were settled. The largest settlement, more than $500,000, involved both a suicide and severe injury to another party. While I felt that there was no negligence, the almost complete lack of records left a legitimate issue as to the facts and so the settlement against the hospital and psychiatrist was made. Two cases of injury to the patient from exposure (based on dangerousness to self) resulted in a settlement of about $300,000 in one and a verdict in the same range in the other (the latter was overturned on appeal and at last report was still pending). Several were settled in the $30,000 to $50,000 range. In these cases, the defense

attorneys felt generally that their cause was justified but that the cost of trial and the risk of an adverse verdict justified a settlement. These were modest settlements in view of the potential damages; on the other hand, the decedents often had a history of poor function, previous mental illness, and limited economic potential. Others where there was clear-cut negligence were settled in the same range, again reflecting the professional disagreement, the desire of the parties to settle, compromise, and so forth.

In the beginning of this article, the demography of suicide was discussed. This was done to point out the differences between expectations based on clinical knowledge and epidemiologic data and what actually occurred. For those who focus on predictability, neither age, sex, nor diagnosis was particularly helpful in prediction. The problem of the young borderline patient is a particularly difficult one. The number of young suicides (43.8 percent in the 15 to 24 age group) is quite striking. Psychiatrists would be well advised to include a specific judgment as to suicidality in their hospital workups and progress notes on such patients.

Similarly, attention to minimizing access to jumping and hanging should be considered, even though complete control of the latter possibility is especially problematic.

The lack of adequate records was clearly responsible for one large settlement. Similarly, the lack of a hospital policy in dealing with suicidal patients was probably a major factor in another moderate settlement. In several cases, the issue of the records was a major one, both at trial or in settlement, even though the defense managed to win at the trial or obtained a modest settlement.

Plaintiffs received monetary awards through settlement in at least six cases and, based on this sampling, suicide litigation represents a significant liability risk in the practice of psychiatry.

Conclusion

Thirty-two cases of litigation involving suicidal issues have been presented. The increasing rate of such lawsuits requires unceasing review of the suicide problem and recognition of the difficulties in care and prevention, both to minimize the risk in the care of such patients and to establish reasonable criteria that can be applied to claims of negligent care. Limitations in prediction and control must be acknowledged and legal rules of negligence must be applied in a reasonable and fair manner so that care, rather than fear, can be maintained as the dominant therapeutic principle.

References

1. Malpractice in Focus. Chicago, American Medical Association, 1975, p. 13
2. Slawson PF: Psychiatr News 18(21):3, 1983
3. Bellamy WA: Psychiatric malpractice, in American Handbook of Psychiatry. Edited by Friedman

D and Dyrud JE. 2 ed., vol. 5, chap. 45. New York, Basic Books, 1975, pp. 899–923
4. Slawson PF: Psychiatric malpractice: A California state-wide survey. Bull Am Acad Psychiatry Law 6:58–63, 1978
5. Slawson PF: Psychiatric malpractice: the California experience. Am J Psychiatry 136:650–654, 1979
6. Perr IN: Liability of hospital and psychiatrist in suicide. Am J Psychiatry 122:631–638, 1965
7. Perr IN: Suicide and civil litigation. J Forensic Sci 19:261–266, 1974
8. Perr IN: Legal aspects of suicide. Leg Aspects Med Pract 6:49–55, 1978
9. Perr IN: Legal aspects of suicide, in Suicide: Theory and Clinical Aspects. Edited by Hankoff LD and Einsidler B. Littleton, MA, PSG Publishing Co., 1979, pp. 91–101
10. Litman RE: Hospital suicides: Lawsuits and standards. Suicide Life Threatening Behav 12:212–220, 1982
11. Coe JI: Suicides: A statistical and pathological report. Minn Med 46:22–30, 1963
12. Dorpat TL, Ripley HS: A study of suicide in the Seattle area. Compr Psychiatry 1:349–359, 1960
13. Stengel E: Recent research into suicide and attempted suicide. Am J Psychiatry 118:725–727, 1962
14. Paykel ES, Meyers JK, Lindenthal JJ: Thoughts of suicide: A general population survey. Fifth World Congress of Psychiatry (Abstracts), La Prensa Medica Mexicana, 1971, p. 461
15. Schwab JJ, Warheit GJ, Holzer CE: Suicidal ideation and behavior in a general population. Dis Nerv Syst 33:745–748, 1972
16. Rose KD, Rosow I: Physicians who kill themselves. Arch Gen Psychiatry 29:800–805, 1973
17. Farberow NL: Suicide prevention in the hospital. Hosp Community Psychiatry 32:99–104, 1981
18. O'Brien P: Increase in suicide attempts by drug ingestion. Arch Gen Psychiatry 34:1165–1169, 1977