Suicide, Contributory Negligence, and the Idea of Individual Autonomy

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A set of cases involving individuals who intentionally injure themselves raises challenging and provocative questions about the legal relationship between mental illness and individual autonomy. In these cases, a malpractice suit is brought against a treater for negligence; the claim is that the treater has breached a duty of care to protect the patient against self-injury. The treater/defendant, in turn, attempts to raise the defense of contributory negligence, the law's way of taking into consideration a plaintiff's negligence as a court assesses liability for an untoward outcome.* While certain courts have allowed defendants to raise the patient's contributory negligence as a defense, others have not.

This article examines two cases that have come down on either side of this issue, highlighting the complicated questions that the courts' analyses raise concerning the relationship between a patient's exercise of individual autonomy and a treater's legal liability. The article puts forth two arguments. First, the article claims that determining the proper role of contributory negligence in a malpractice case requires assessing the patient/plaintiff's competence for contributory negligence. Second, the article argues that this assessment is a question of fact that should be placed before the fact-finder, usually a jury. The article concludes that, absent an assessment of competence for contributory negligence by the fact-finder, a court neither pays proper respect for the autonomy of individuals with mental illness nor allows an appropriate role for autonomy in public policy discussions.

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* In general terms, contributory negligence is a doctrine that says that if the person who claims to have been harmed—the patient, in this article—was himself negligent, recovery is barred. Comparative negligence, on the other hand, is a doctrine whereby plaintiff's damages are offset to the degree he has been negligent. (Both of these doctrines have variations that depend on the particular state's law.) This article uses the term "contributory negligence" throughout to refer to both contributory and comparative negligence. What is important for the purpose of the article is that each of these doctrines provides a way for a court to recognize and take into consideration the patient's negligence in assessing liability for an untoward treatment outcome.

Cowan v. Doering[1]

Marilyn Cowan was a troubled woman. In the early 1980s she accepted a job as a hospital nurse. Within a few weeks, she met and began a romantic relationship with Richard Doering, a physician on staff at the hospital. Both Ms. Cowan and Dr. Doering were married, and both were experiencing difficulties in their marital relationships. Shortly after beginning the relationship, Ms. Cowan, depressed over her failure to have a baby and the difficulties in her marriage, ingested 17 pentobarbital pills. She phoned Dr. Doering who, detecting a slur in her voice, called Ms. Cowan's husband and instructed him to take her to the hospital. The emergency room doctors pumped Ms. Cowan's stomach and she was

placed under the care of a psychiatrist, Dr. Alexandre Ackad. While in the hospital Ms. Cowan attempted to disconnect her intravenous tubes and remove her chest and wrist restraints. She was released from the hospital on the second day after admission, and she resumed her relationship with Dr. Doering. Ms. Cowan was referred to an outpatient psychiatrist, whom she saw on a twice weekly basis.

Approximately six weeks after her hospitalization, Ms. Cowan asked Dr. Doering to obtain pentobarbital to help her sleep because her outpatient psychiatrist, believing that Ms. Cowan had the potential to overdose, refused to treat her with drugs. Several times Dr. Doering refused the request. Finally, however, he relented and wrote the prescription. One evening several weeks later, when Ms. Cowan's husband was away, Dr. Doering came to Ms. Cowan's home. Ms. Cowan and Dr. Doering had intercourse, the first time in their relationship they had done so because of Dr. Doering's impotency. Ms. Cowan hoped that perhaps now Dr. Doering would leave his wife; her hopes were dashed, however, when she called him the following morning and during their conversation he made clear that he would not. After the phone conversation ended, Ms. Cowan took 10 pentobarbital that Dr. Doering had supplied. She locked the doors to her house and called Dr. Doering. Dr. Doering, hearing the slur in her voice, called the police. Ms. Cowan was again admitted to the hospital and again placed under Dr. Ackad's care.

Later on the day of Ms. Cowan's admission, Dr. Ackad had her moved into the intensive care unit, to a position visible from the nurses' station. Ms. Cowan was placed in chest and wrist restraints, which she attempted to remove, and was hooked up to a feeding tube, which she attempted to disconnect. The staff described Ms. Cowan as "somewhat disoriented and groggy, but also as alert and oriented to time and place." That evening Dr. Doering visited Ms. Cowan in the intensive care unit (ICU) for approximately 15 minutes. When he left, Dr. Doering closed the door to the ICU, contrary to ICU policy. In a short period of time Ms. Cowan's attending nurse, Kathleen Barlics, entered the room and discovered that Ms. Cowan was not in her bed. Carole Eltridge, the charge nurse, was notified, and the two realized that a window was open. Barlics and Eltridge heard a moaning outside. It was Ms. Cowan, who was lying on the ground some 12 feet below.

Ms. Cowan sued Dr. Doering, Dr. Ackad, Kathleen Barlics, and Carole Eltridge† for malpractice. Ms. Cowan claimed that Dr. Ackad, Kathleen Barlics, and Carole Eltridge—by failing to provide adequate restraints and monitoring—had not prevented her jump from the ICU window and that Dr. Doering had been negligent in prescribing sleeping pills. At trial, the defendants attempted to raise the issue of contributory negligence. They argued that the defense was appropriate because Ms. Cowan should bear at least some responsibility for her injuries and that denying the opportunity to raise the defense would be tantamount to creating:

> . . . a rule in which a mentally disabled plaintiff is relieved from any responsibility for the consequences of his or her own conduct without any requirement that the plaintiff be incapable of exercising reasonable care.[2]

Before addressing the defendants' claim about contributory negligence, the court had first to examine whether the four elements of a successful claim in malpractice were present: that the defendants had breached a duty of care; and that this breach of duty was the proximate cause of Ms. Cowan's injury.‡ The Court saw the issue of foreseeability as central to its analysis.

The Court first explained that the scope of a defendant's duty is heavily dependent upon the foreseeable risks of the plaintiff's condition. The Court reasoned that if a risk is foreseeable, the defendant then has a duty to protect the plaintiff from that risk. In Ms. Cowan's case, the Court concluded, the "duty of care to prevent self-inflicted harm arises. . . because there was a foreseeable risk that plaintiff's condition, as it was known to defendants, included the danger that she would injure herself."[3] To support its conclusion, the Court looked to the testimony submitted at trial, which showed:

> . . . that defendants were aware of the plaintiff's propensity for self damaging acts; she had a history of such conduct; she had attempted suicide that same morning, and while hospitalized she had ripped off her intravenous tubes and tried to get out of the restraints. As doctors and nurses, the defendant's understood plaintiff's [borderline] personality disorder. Each respectively had a professional responsibility to treat her for this disorder and to treat her for the manifestations or symptoms of the disorder, namely, suicidal or other self-harmful acts.[4]

† A number of other individuals involved in Ms. Cowan's care were named as defendants as well.

‡ Thus, the four elements of a claim in malpractice are: (1) duty of care; (2) breach of that duty; (3) proximate (or "legal") causation; and (4) harm.

The Court concluded that because the defendants were on ample notice that Ms. Cowan might again attempt to injure herself—that such an attempt was foreseeable—the defendants owed Ms. Cowan a duty to prevent that injury.

The next question in the analysis was whether the defendants had breached their duty of care. Reviewing the jury's conclusions, the New Jersey Supreme Court ruled that the jury was entirely reasonable in finding that:

> . . . Dr. Ackad did not order sufficient monitoring or arrange for adequate restraints, and acted unreasonably in light of his knowledge of her mental condition and history of self-inflicted injury, and similarly, that nurses Barlics and Eltridge failed to observe Ms. Cowan sufficiently or to monitor her condition properly. With respect to Dr. Doering,. . . that he unreasonably created or enhanced the risk of self-inflicted injury when he prescribed nembutal in light of his actual knowledge of plaintiff's suicidal propensities and actual prior suicidal experiences.[5]

Having stated that the defendants owed Ms. Cowan a duty of care to prevent self-inflicted harm, and that the defendants had breached that duty, the court then took up the question of proximate causation—that is, the question of whether the defendants' breach of duty had caused Ms. Cowan's injury.

The Court again saw the issue of foreseeability as central. According to the law of torts, an intervening cause—sometimes referred to as a superseding cause and described as a remote or abnormal incident—breaks the chain of causation. An intervening cause may therefore be fatal to a malpractice claim, since it destroys the necessary element of proximate causation. In deciding whether a particular cause is an intervening cause (and so will ruin a malpractice claim) or a proximate cause (and so will preserve a malpractice claim), courts will often ask whether the event in question was foreseeable. A foreseeable event will likely be considered a proximate cause. For the purposes of establishing legal liability, then, the important question was whether Ms. Cowan's attempt to harm herself was foreseeable—if not, then it would be considered an intervening cause and so relieve the defendants of liability.[§]

To put the matter another way, for a malpractice claim to be successful, a breach of the duty of care must cause the plaintiff's injury. If, however, an unanticipated, unforeseeable event intervenes to cause the plaintiff injury, the defendants are relieved of malpractice liability—from the law's point of view their breach of duty is no longer considered to have caused the plaintiff's harm. The issue of causation therefore turned on whether the treaters, through their negligence, had caused Ms. Cowan's jump out the window, or whether Ms. Cowan's jump was an intervening cause that broke the chain of causation between the treater's negligence and the injuries she suffered. If the former, her malpractice claim could move forward; if the latter, the essential element of proximate cause would be missing and her claim would therefore fail.

The New Jersey Supreme Court explained that this very question had been placed before the jury at trial:

> . . . the evidence submitted concerning her [plaintiff's] conduct was considered by the jury as it related to the defendant's [sic] ultimate responsibility, through the concept of proximate cause. The trial court instructed the jury that the defendants' negligence or malpractice would not give rise to liability for plaintiff's injuries if the jury found that plaintiff's leap from the window constituted an intervening cause that broke the chain of causation linking defendants' conduct to plaintiff's injury, as it might if her act were volitional and not attributable to her disorder or condition. . . .[6]

The jury concluded that Ms. Cowan's jump from the window was not an intervening cause, and so did not break the chain of causation between the defendants' negligence and her injuries. The New Jersey Supreme Court agreed with this reasoning on the basis that the jump was foreseeable, "Because it was clearly foreseeable that defendants' conduct created a risk that plaintiff would engage in self-damaging acts, the jury's rejection of the intervening causation was fully supported by the evidence."[7] The Court had concluded that the defendants' failure to provide adequate monitoring and restraint was the proximate cause of Ms. Cowan's injuries. All of the elements of a successful claim in malpractice were present and in place: duty, breach of duty, proximate causation, and damages.

§ As an example of the difference between a proximate and an intervening cause, consider a 30-year-old man whose leg is severely lacerated. If the emergency room physician fails to clean the wound properly before it is stitched and bandaged, and the leg then becomes infected, the physician's negligence will be seen as the *proximate* cause of the infection. The physician will be liable for the additional harm or injury brought on by the infection, because it was foreseeable that an infection would result from an improper cleaning. If, however, the man returns home from the emergency room, removes the bandage, and goes swimming in polluted water, the situation is much different. The man's actions, which the physician would not have foreseen, would likely be considered an intervening, or superseding, cause and would relieve the physician from liability. The question before the Court, then, was whether Marilyn Cowan's suicide attempt was more like the physician who does not properly clean the wound or more like the man who goes home and swims in polluted water.

The question of whether Ms. Cowan had negligently contributed to her own injury, however, remained. The question was important, because an affirmative answer would mean that Ms. Cowan, too, bore some responsibility for what had happened. The Court's analysis of this specific question was brief, and it was based primarily on public policy grounds:

> We are satisfied in this case that no legitimate concerns of public policy are disserved by the removal of the issue of contributory negligence with respect to a mentally disturbed but not totally incompetent plaintiff in the context of this case. The plaintiff's inability adequately to control her self-damaging behavior—which indeed was symptomatic of her mental disturbance—was known to the defendants, and the defendants were under a duty to prevent plaintiff's self-damaging acts. Thus, because defendants' duty of care was co-extensive with the plaintiff's ability to avoid self-damaging acts, the withdrawal of contributory or comparative negligence supports the policy that undergirds our "fault-based" system of tort law, particularly the discouragement of unreasonable conduct. . . . Because the improper application of contributory negligence can prevent any recovery from tortious injury and enable a tortfeasor to escape liability, it can directly lessen responsibility for wrongful conduct and defeat the goals of tort law.[8]

The New Jersey Supreme Court concluded that:

> Because [the defendants'] duty of care included the prevention of the kind of self-damaging acts that caused the plaintiff's injuries, the plaintiff's actions and capacity were subsumed within the defendant's scope of duty. Thus, the trial court correctly ruled that the defense of contributory negligence was not available.[9]

Put simply, the Court saw the plaintiff's injury as the very harm the defendants had a duty to prevent. The defense of contributory negligence, reasoned the Court, might therefore allow the defendants to escape responsibility for failing to fulfill their duty. As a matter of public policy, such an outcome would be unacceptable—would "defeat the goals of tort law"—by potentially removing the penalty for negligence, thereby attenuating a powerful incentive to provide treatment that meets the standard of care. That Ms. Cowan may have been negligent, or that she failed to exercise adequate self-care, was simply not relevant to the Court's public policy analysis. Ms. Cowan's malpractice lawsuit could move forward, unfettered by the defendants' objection that she bore some responsibility for her injuries. The defense of contributory negligence would not be allowed.

Hobart v. Shin[10]

In the fall of 1988, Kathryn Hobart was a 27-year-old student at the University of Illinois. Ms. Hobart reported to her primary care physician at the university, Dr. Shin, a number of symptoms, including loss of appetite, changing moods, irritability, dizziness, nausea, difficulty breathing, and fatigue. Dr. Shin diagnosed her with generalized anxiety disorder. Over the next three months Ms. Hobart's condition seemed stable; she saw Dr. Shin three times and either reported that she was feeling better or came in for a physical problem and did not mention her mental condition.

In late November, Ms. Hobart's mother called Dr. Shin to report that Ms. Hobart could not sleep and was panicked and that the family physician had recommended Kathryn be seen by a psychiatrist. The psychiatrist reported to Dr. Shin that Ms. Hobart had a history of panic attacks and depression, although she did not appear to be suicidal. When Dr. Shin subsequently saw Ms. Hobart, she had no appetite, could not stand, had trouble sleeping, and was feeling hopeless. Aware that Ms. Hobart had attempted suicide approximately seven years earlier on two occasions, Dr. Shin recommended a hospitalization. Ms. Hobart refused, but she did agree to see a psychologist, who managed to convince her to enter the hospital, where she stayed from November 23 until December 12. While hospitalized Ms. Hobart was diagnosed with recurrent major depression and prescribed doxepin.

Following her discharge from the hospital, Ms. Hobart saw Dr. Shin on a single occasion, on December 21. He noted that Ms. Hobart "was smiling and upbeat, had no thoughts of hopelessness or suicide, and talked of her plans to become a teacher." In response to Ms. Hobart's concerns that she might run out of her prescribed doxepin and that it would be expensive to fill small prescriptions on a frequent basis, Dr. Shin wrote Ms. Hobart a one-month prescription for 90 50-milligram pills. Dr. Shin's prescription included one refill, something about which he failed to notify Ms. Hobart's outpatient psychiatrist. Ms. Hobart saw her outpatient psychiatrist several times in December of 1998; on each of these visits she did not display any signs of depression, nor did she indicate any active or passive suicidal ideation.

In early January, Ms. Hobart became severely depressed after her backpack, which contained her school notes, was stolen. Ms. Hobart's mother encouraged her to contact her doctors, but Ms. Hobart refused, stating that she did not want to go back into

the hospital. Two days later, Ms. Hobart's body was found in a hotel room. She had registered under a fictitious name and then ingested over 10 times the lethal dose of doxepin.

The administrator of Ms. Hobart's estate brought a malpractice suit against Dr. Shin. The trial court allowed Dr. Shin to raise the issue of contributory negligence, thus permitting the jury to consider whether Ms. Hobart's own negligence had contributed to her death. The appellate court, however, ruled that the defense of contributory negligence was "inappropriate in a suit brought against a physician whose patient commits suicide while under mental health treatment."[11] The Supreme Court of Illinois then disagreed with the appellate court and ruled that the defense of contributory negligence was properly placed before the jury.

The Illinois Supreme Court began its analysis by stating that Illinois had a statute that provided for contributory negligence as a defense. This statute, explained the Court, was based on the principle that "people generally have a duty to exercise ordinary care for their own safety."[12] The Court went on to say that this principle could apply even to patients "who commit suicide while under treatment for suicidal tendencies."[13] The important question, in the eyes of the Illinois Supreme Court, was how much self-care a particular individual was able to exercise.

According to the Court, the degree of a plaintiff's contributing negligence is a question of fact for the jury to decide, unless the patient is obviously incompetent and so not capable of exercising reasonable care on his or her own behalf. The Court quoted with approval the language of a California court that had reasoned in a similar case:

> "[T]he issue of contributory negligence of a mentally disturbed person is a question of fact; unless, of course, the evidence discloses that the person whose actions are being judged is completely devoid of reason. If he is so mentally ill that he is incapable of being contributorily negligent, he would be entitled to have the jury so instructed. . . . " But only in those cases in which the evidence would admit to no other rational conclusion would plaintiff be entitled to have the issue determined as a matter of law [citation to *De Martini v. Alexander Sanitarium, Inc.*[14]].[15]

The Illinois Supreme Court defined a narrow role for the court—a court should preclude the jury from examining the patient's contributing negligence only when the patient was so "completely devoid of reason" that he or she was not capable of contributorily negligent action. If there is any reasonable doubt about the patient's capacity in this regard, the question should be put to the jury.

The Court then reasoned that allowing the defense of contributory negligence—except in cases where the patient is obviously incompetent—made good sense from a public policy point of view:

> To rule otherwise would be to make the doctor the absolute insurer of any patient exhibiting suicidal tendencies. The consequence of such a ruling would be that no health care provider would want to risk the liability exposure in treating such a patient, and, thus, suicidal persons would be denied necessary treatment. Public policy cannot condone such a result.[16]

The Illinois Supreme Court concluded that focusing on the patient's competence was sound from a public policy point of view. According to the Court, the soundness of this position lies in the problems of a contrary conclusion: treaters would not wish to work with suicidal patients if they were to be held absolutely liable for whatever harm the patient might incur, with no regard for the patient's contribution to the untoward outcome.

The administrator of Ms. Hobart's estate had made other arguments against allowing the defense of contributory negligence:

> . . . that defendant knew of Kathryn's previous suicide attempts and diagnosed her as having suicidal thoughts only a few weeks before her death. . . [and] that these strong suicidal tendencies show that Kathryn was incapable of taking responsibility for her actions.[17]

Two arguments are embedded in this statement: first, that Ms. Hobart's suicide was foreseeable, and second, that her mental condition rendered her incapable of taking responsibility for her actions. The Court replied:

> By the time Kathryn was released from the hospital, she was no longer experiencing the symptoms of depression . . . . furthermore, on the day of her death, Kathryn acted in a premeditated and deliberate fashion: she left home, refused to contact her doctors, and checked into a motel under a fictitious name. Given these facts, the trial court was justified in concluding that the issue of Kathryn's contributory negligence was appropriate for the jury's consideration.[18]

The Court's reply to the plaintiff's argument again focuses on the question of Ms. Hobart's competence. The evidence presented at trial, explained the Court, suggests that Ms. Hobart's actions were those of a competent adult; as a consequence, it was appropriate to consider whether Ms. Hobart's own negligence contributed to her death. Submitting the issue of contributory negligence to the jury, reasoned the Il-

linois Supreme Court, was entirely correct and appropriate.

Commentary

In the space of a decade, the Supreme Court of New Jersey and the Supreme Court of Illinois each addressed the question of whether a mentally ill individual can be contributorily negligent in a malpractice case involving self-injury. The courts came to precisely opposite conclusions; in *Cowan*, the New Jersey Supreme Court said "no," and in *Hobart*, the Illinois Supreme Court said "yes." Perhaps most interesting about these cases is the manner in which the Courts reached their conclusions.[¶]

In *Cowan*, the New Jersey Supreme Court focused on the scope of a treater's duty. If, to use the Court's language, the scope of that duty "encompassed" or "subsumed" the plaintiff's injury, contributory negligence was not an appropriate defense. The Court reasoned that allowing the defense under these circumstances would serve to attenuate the defendant's duty to prevent the very kind of injury the plaintiff incurred, a result inconsistent with the goals of tort law. The Illinois Supreme Court shifted the focus to reach the opposite conclusion. In *Hobart*, the Illinois Court looked to whether the defendant was capable of making competent choices; if so, reasoned the Court, the patient's degree of negligence should be an issue of fact placed before the jury, as the fact-finder, to assess. The Court concluded that to rule otherwise would be to discourage clinicians from working with suicidal patients, an outcome not consistent with sound public policy.

In addition to their implications for public policy, the opinions in *Cowan* and *Hobart* provide interesting commentaries on the relationship between mental illness and individual autonomy. The *Hobart* court can be understood as relying on analysis consistent with the law's general respect for patient autonomy. The *Cowan* decision, on the other hand, can be read as out-of-step with the law's thinking in this regard.

The law shows great deference to treatment choices made by competent adults. This deference can be seen most clearly in court opinions; one of the most succinct and well known statements comes from the *Rogers* decision, where the Supreme Court of Massachusetts, discussing the legal decision-making capacity of a competent adult, remarked simply that "The patient has the right to be wrong in the choice of treatment."[19] The *Rogers* court emphasized that civil commitment, based on a mental illness, does not remove the presumption of competence; this conclusion, the Court explained, was consistent with statutory law[20] holding that civil commitment bears no necessary relationship to various competencies, including competence to manage one's affairs or to refuse treatment. Thus, both case and statutory law have "delinked" the issue of competence from the issue of civil commitment and mental illness. Competence is an issue separate from the issue of whether an individual has a mental illness and whether the individual has been committed to a hospital based on a mental illness. A patient placed in a psychiatric hospital against his will may remain fully capable of making treatment choices and managing his affairs. These matters reside in separate realms of discourse.[‖]

Models to assess a suicidal patient's competence to participate in treatment are available to both courts and clinicians. One model, developed and elaborated upon by the Program in Psychiatry and the Law at the Massachusetts Mental Health Center, calls upon clinicians to assess the degree to which a patient is able to:

> . . . weigh the risks and benefits of his or her actions—this weighing constituting a reasonable definition of socially valid responsibility. Such capacity to engage in this process with another human being is essential for the sort of deliberate, mature decision making which represents the patient's competence to inform the clinician of potential self-harm or violence or, com-

¶ One could, of course, point out that certain facts seemingly relevant to liability distinguish these cases. As an example, Marilyn Cowan was an inpatient, and courts have typically held professionals to have greater control in inpatient settings. This article, however, makes two points. First, each of these Courts—either implicitly or explicitly—assessed the plaintiff's competence for contributorily negligent action. Because the law has "de-linked" the issue of competence from the issue of inpatient status, the issue of whether the patient had been civilly committed does not provide a definitive answer to whether the patient is competent to be contributorily negligent. Second, the question of the patient's competence is a question of fact for the fact-finder to assess. Only in cases that afford no reasonable disagreement should a court prevent the question of competence for contributory negligence from being placed before the fact-finder.

‖ A Wisconsin court preserved this distinction clearly in Jankee v. Clark County, 585 N.W.2d 913 (Wis. App. 1998), when the court concluded that there would be "a bar to contributory negligence when a person institutionalized with a mental illness or mental disability *who does not have the capacity to control or appreciate his or her conduct because of that illness or disability* claims that the institution or its employees were negligent. . . if [plaintiff] *did not have the capacity* to control or appreciate his conduct because of his mental illness or disability, the jury may not consider contributory negligence" (at 924; emphasis added). Thus, the court reasoned that the issue of the patient's hospitalization and the issue of the patient's competence to be contributorily negligent were two separate and distinct issues.

parably, competence to handle responsibly a pass or some other increase in freedom.[21]

Questions designed to assess the patient's competence involve "determining whether the individual is aware of her own psychological processes, able to identify an appropriate individual to whom those processes can be communicated when they threaten the individual's safety, and capable of communicating those processes to such an identified individual."[22] Examples of questions assessing a suicidal patient's competence would therefore be:

- Do you understand that the only way I'll know what's on your mind is if you tell me?
- Do you know what to do if you feel the impulse to hurt yourself getting stronger?
- Do you know whom to call and do you have the number for the hospital (emergency room, clinician, ambulance service, etc.) if things turn bad for you?

These questions, appropriate for either inpatient or outpatient settings, are designed to assess a patient's level of competence to engage in treatment. This assessment, in turn, allows a clinician to recognize and respect a patient's right to make autonomous choices about treatment.**

The deference the law pays to the choices of a competent patient—specifically the choice concerning whether to comply or not comply with treatment—is absent from the *Cowan* court's decision. A tension between the *Cowan* court's analysis and the law's deference to the choices of a competent patient becomes apparent, however, when the court tries to lessen the tension by suggesting that the patient was not at all, or at least not entirely, competent. As examples, the Court discusses "the plaintiff's inability adequately to control her self-damaging behavior—which was indeed symptomatic of her mental disturbance. . . " The Court neither explains how it reached the conclusion that the plaintiff was unable to control her behavior nor what it sees as the relationship between such an inability and the symptoms of her mental illness. It could be that the plaintiff's self-damaging behavior was both a symptom of her mental illness and a behavior that she was at least partially able to control—a possibility the Court never appears to consider. The Court goes on to remark that the patient's jump from the window was not an intervening or superseding cause, "as it might be if her act were volitional and not attributable to her disorder or condition." Again, the Court fails to make clear why it does not consider the patient's act volitional nor why the patient's act could not be both volitional and attributable to her disorder or condition. The *Cowan* court simply declares that the patient was not competent in some relevant respect, without explaining the parameters of its definition of competence or whence its criteria for incompetence derived. A simple conclusory statement—that Ms. Cowan's act was not attributable to her because she suffers from a mental illness—seems wholly inconsistent with the law's respect for autonomy when an individual has not been deemed incompetent.†† Such a statement also seems to capture the conceptual foundation for many claims against psychiatrists during the second half of this century: "*Your* negligence caused *my* suicide."[23]

The Court's confusion seems most apparent when it refers to Ms. Cowan as "mentally disturbed but not totally incompetent." Here, the Court creates a new category, that of "quasi-competence." Such a concept is not wholly unknown in tort law. While the vast majority of adults are held to the standard of a "reasonable person" in their conduct, and can be held liable for injuries or harms that result from behavior that falls below such a standard, the law does allow a "sliding scale" for certain categories of individuals. As an example, minors are held responsible only for harms that result when they do not act according to how a reasonable person of their age would act—a

** For a fuller discussion of assessing a patient's competence to engage in treatment, see: Gutheil TG: Medicolegal pitfalls in the treatment of borderline patients. Am J Psychiatry 142:9–14, 1985; and Gutheil TG: Suicide and suit: liability after self-destruction, in Suicide and Clinical Practice. Edited by Jacobs D. Washington, DC: American Psychiatric Press, 1992, pp 147–67. The questions cited in the text are extracted from these two articles.

†† The language of court opinions is enormously telling. In Cole v. Multnomah County, 592 P.2d 221 (Or. 1979), an Oregon court addressed the issue of whether contributory negligence should be submitted to a jury in a case involving an attempted suicide. The court reasoned that: "Defendants' allegations of contributory negligence simply restate what plaintiff alleged in his complaint—that he was driven by mental illness to attempt suicide. Under these circumstances, the acts which plaintiff's mental illness allegedly caused him to commit were the very acts which defendants had a duty to prevent, and these same acts cannot, as a matter of law, constitute contributory negligence" (citations omitted)(at 223). In this passage, the court places the locus of agency in the plaintiff's mental illness rather than in the plaintiff. In doing so, the court implies that the patient is devoid of autonomy, and so of responsibility, regarding self-injurious acts. It may well be that the plaintiff is devoid of autonomy, and so should not be held contributorily negligent for injuring himself. The point, however, is that the court should submit this question to some sort of analysis rather than presenting it as a simple and uncontested fact.

four-year-old must act like a reasonable four-year-old, a 12-year-old like a reasonable 12-year-old. Certain state courts have applied a similar sliding scale on the basis of mental illness.[§§] In those states, an individual with a mental illness is not held to a "reasonable person" standard. Rather, the individual is held to the standard of a person with that particular mental illness; such an individual can be held liable in tort only when his behavior falls below how a person with that mental illness would behave and harm or injury results.

The language of the *Cowan* court suggests that it approves of the "sliding scale" approach to assessing the duty of a person with a mental illness.[¶¶] The problem with the Court's analysis, however, is that whether an individual's conduct met the relevant standard of care—be it a reasonable person standard or a variable standard based on mental illness or age—should be a question of fact for the fact-finder to assess.[||||] By not allowing the defendants even to raise the defense of contributory negligence, the *Cowan* court prevented the jury from considering whether plaintiff's negligence had contributed to her injury. Thus, the Court turned what should have been a question of fact into a question of law, to the treaters' possible disadvantage.

The *Hobart* court avoided these mistakes. First, the Court made Ms. Hobart's competence central to its analysis. The Court emphasized that ample testimony presented at trial suggested she was capable of making informed decisions; the Court thus showed respect for Ms. Hobart's autonomy and reasoned in a manner consistent with the law's deference for the choices of a competent adult. Second, the Court concluded that Ms. Hobart's apparent competence made the issue of contributory negligence appropriate for the jury to consider. The latter point is enormously important. If, as the *Hobart* court pointed out, the patient is "completely devoid of reason. . . so mentally ill that he is incapable of being contributorily negligent," then the issue may be settled by the court as a matter of law. In other cases, however (probably the vast majority), the degree of a patient's competence and whether the patient behaved reasonably according to the appropriate standard of care are questions of fact, questions that should be placed in the context of the law's general presumption in favor of competence.[***] The *Hobart* court's analysis shows how allowing the defense of contributory negligence will ensure that these two issues are preserved as questions of fact and placed before the appropriate fact-finder.[†††]

Behind the *Cowan* and *Hobart* decisions were considerations having to do with public policy. Both Courts discussed these considerations openly. Allowing a treater to raise the defense of contributory negligence, reasoned the New Jersey Supreme Court, and so to argue that the plaintiff was at least partly responsible for her injury, might permit a treater to fall below the standard of care and yet escape liability. Such was not an acceptable outcome to the New Jersey Court, insofar as doing so would remove a powerful incentive for treaters to ensure that they provide reasonable treatment.[‡‡‡] The Illinois Supreme Court looked to a different kind of public policy incentive. The Court reasoned that not allowing the defense of contributory negligence would be tantamount to holding a treater absolutely responsible for any patient who is suicidal. That ruling, concluded the Court, would be a powerful disincentive to provide treatment, and so was not acceptable. What is striking is that neither Court saw the issue of the patient/plaintiff's autonomy as a public policy consideration that merited discussion.

Individuals with mental illness are perfectly capable of forming and acting upon intentions. Whether an individual lacks autonomy—and so should not be held responsible for injury to self or others—is a question related to, but distinct from, whether the individual suffers from a mental illness or whether the individual has been committed to a psychiatric hospital. From a public policy perspective, just as the law can create incentives for treaters to provide care

§§ See, e.g., Champagne v. U.S., 513 N.W.2d 75 (N.D. 1994), where the court remarked that the jury's "[c]omparison of fault depends on the factual extent of the patient's diminished mental capacity" (at 80).

¶¶ Early on in the opinion, the Court explicitly approves of a sliding scale approach. See *Cowan* at 458–60.

|||| See e.g., Miller v Trinity Medical Center, 260 N.W.2d 4 (N.D., 1977), where the Supreme Court of North Dakota remarked that "[i]ssues of negligence, proximate cause, and contributory negligence ordinarily are questions of fact for the trier of fact unless the evidence is such that reasonable minds can draw but one conclusion" (at 6).

*** Certain courts reverse this presumption in favor of competence, creating a presumption *against* competence when the individual suffers from a mental illness. In Psychiatric Institute of Washington v. Allen, 509 A.2d 619 (D.C. App. 1986), for example, the court remarked: "We reject the Institute's contention that it was entitled to an instruction on contributory negligence. When an injured party suffers from a mental infirmity, as in this case, the defendant is not entitled to such an instruction *unless there is evidence that the injured party was capable of exercising reasonable care for his own safety and failed to do so*" (citation omitted) (at 627; emphasis added). Competence should be presumed in the absence of evidence to the contrary. The mere fact of mental illness should not reverse this presumption.

that is reasonable (*Cowan*), and to provide treatment to suicidal patients (*Hobart*), so the law can create incentives for patients to behave in certain ways or not. Indeed, numerous mental health professionals, from a variety of theoretical perspectives, have written on the clinical value of encouraging patients to assume greater responsibility for their behaviors.[§§§]

The law can create incentives for patients to assume the degree of responsibility for themselves that they are capable of assuming.[¶¶¶] When the law treats patients as non-autonomous, it removes a motivation for individuals to exercise their autonomy as fully as possible[‖‖‖] and unfairly burdens others who then must assume additional responsibility. And when courts fail to include the idea of individual autonomy in their discussion of public policy, they neglect a central aspect of the "public" whose behavior they wish to shape. To put the matter another way, patients, like treaters, respond to incentives. Incentives relevant to patient behavior are as important to the public policy discussion as are incentives relevant to treater behavior. Only by including the former can the public policy analysis be complete.

Conclusions

The issue of contributory negligence in cases that involve self-injury raises complicated questions about the legal relationship between mental illness and individual autonomy. It is enormously helpful if, in their analyses, courts are mindful of the law's strong presumption that mental illness, civil commitment, and competence are separate issues that require distinct analyses. It is the issue of *competence*—of the capacity to make autonomous decisions for which one may legitimately be held responsible—that speaks to the question of contributory negligence. The decision to allow or deny the defense of contributory negligence therefore requires a discussion of the patient's competence. That the patient is mentally ill, has been committed to a hospital, or even has engaged in behaviors symptomatic of the illness does not answer the question of whether the patient has the legal capacity to be contributorily negligent.

Whether an individual has certain capacities and has behaved according to the appropriate standard of care are questions of fact, unless the answer is so clear that reasonable people could not disagree. It is appropriate, therefore, that these questions be placed before the trier of fact, usually a jury. The jury will then be instructed to assess the level of the individual's capacity to act autonomously and to determine

††† See also Badrigian v. Elmcrest Psychiatric Institute, 505 A.2d 741 (Conn. App. 1986), where the court said: "The plaintiff's claim that the decedent, due to his mental disability, could not have properly been charged with comparative negligence, is unpersuasive. The cases which relate to this issue indicate that in order for an individual's mental disability to impinge upon whether that person is chargeable with negligence, the individual must be incapable of exercising reasonable care [citations omitted]. Thus, a person's mental disability is not an automatic bar to that person's liability [citation omitted]. *The circumstances and facts of the particular case* will determine *whether an individual possesses the mental capacity required to be charged with negligence, or whether that individual is incapable of exercising reasonable care and is not responsible for his actions.* . . . The jury had evidence as to the mental capacity of the plaintiff's decedent and could reasonably have concluded that he possessed sufficient mental capability to be charged with comparative negligence" (at 745; emphasis added).

‡‡‡ See also the policy conclusions set forth by the Massachusetts Supreme Judicial Court in McNamara v. Honeyman, 546 N.E.2d 139 (Mass., 1989): "Mentally ill people who are capable of forming an intent and who actually do intend an act that causes damage will be held liable for that damage [citation omitted]. It follows that a mentally ill person can be comparatively negligent in some circumstances. . . . This court has not before examined the question of comparative negligence arising out of conduct for which a person has been hospitalized or committed. 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 [citations omitted]. Clearly, the duty of care that the defendants owed to an institutionalized patient. . . 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*" (at 146–7; emphasis added).

§§§ See e.g., Gutheil TG: Medicolegal pitfalls in the treatment of borderline patients. Am J Psychiatry 142:9–14, 1985; Linehan M: Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York: Guilford Press, 1993; Schwartz DA, Flinn DE, Slawson PF: Treatment of the suicidal character, *Am J Psychother* 28:194–207, 1974.

¶¶¶ See, e.g., Champagne v. U.S., 513 N.W.2d 75 (N.D. 1994), where the court reasoned: "We are not persuaded by [plaintiff's] argument that, when a patient's act of suicide is a foreseeable result of a medical provider's failure to treat reasonably to prevent the suicide, it is never appropriate to compare the victim's act of suicide with the medical provider's fault. Rather, if the evidence shows that the patient is incapable of being responsible for his own care and that the medical provider has undertaken the duty of care for the patients well-being, there would be no allocation of fault to the patient [citations omitted]. If the medical provider has taken on the duty of caring for a patient with diminished capacity, and *if the patient is capable of being responsible for his own care,* allocation of fault is in order" (at 80; emphasis added). The court went on to conclude that: "If the patient's capacity for self care *is so diminished by mental illness that it is lacking,* we agree that an allocation of fault *is not appropriate*" (at 80; emphasis added).

‖‖‖ In Hunt v. King County, 481 P.2d.593 (Wash. App. 1971), the court made explicit the effect of not allowing the defendants to raise the defense of contributory negligence. The *Hunt* court reasoned that barring a contributory negligence defense would absolve the patient from any duty to avoid self-injury: "Such a duty [of a hospital, to prevent self-inflicted injuries] contemplates the reasonably foreseeable occurrence of self-inflicted injury whether or not the occurrence is the product of the injured person's volitional or negligent act [citation omitted]. . . . the necessary effect of such a duty. . . may be said *to absolve the injured party from the performance of his otherwise existing duty to take reasonable care to avoid self-injury*" (at 598; emphasis added).

whether the individual acted according to the appropriate standard of care. This position is consistent with the law's presumption in favor of patient autonomy. It also makes good sense from a policy perspective, by ensuring that the autonomy of all of the actors, patients and treaters alike, is part of the law's discussion.

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