Suicide: Who Is To Blame?

Katherine Michaelsen, MASc, MD
Resident in Psychiatry

Chandrika Shankar, MD
Assistant Clinical Professor of Psychiatry

Department of Psychiatry
Yale University School of Medicine
New Haven, CT

The Applicability of Comparative-Negligence Defenses in Suicide Cases

Mulhern v. Catholic Health Initiatives, 799 N.W.2d 104 (Iowa 2011), is a medical negligence action brought against a hospital after an outpatient in mental health treatment committed suicide. The Iowa District Court for Polk County found the patient negligent. The estate appealed to the Iowa Supreme Court on the grounds (among others) that the act of suicide should have precluded the defense of comparative fault.

Facts of the Case

Elizabeth Von Linden was a 40-year-old executive with a history of alcohol abuse, recurrent depression, and suicide attempts. In 2003, her depression worsened, and on June 6, 2003, she attempted suicide by overdosing on prescription pills and carbon monoxide poisoning. Her husband, Todd Mulhern, found her and took her to Mercy Hospital, where she expressed continued suicidal ideation, and was voluntarily admitted to the psychiatric service. Dr. Charles Jennisch assumed her care, started medications, and made treatment recommendations, including a partial hospitalization program (PHP). Ms. Von Linden and her husband declined the PHP and requested discharge, citing improved mood and eagerness to resume work. Two days later, she was discharged and given emergency contact numbers. On June 23, 2003, Ms. Von Linden saw Dr. Jennisch in the outpatient clinic and reported minimal change since discharge, but appeared brighter and denied suicidal thoughts. She again declined the PHP and scheduled another appointment. According to her work supervisor, Ms. Von Linden was performing well and planning future appointments. However, on June 29, 2003, she hanged herself.

Mr. Mulhern and the estate brought suit against Mercy, alleging that negligent care proximately caused Ms. Von Linden's death. Mercy contended that Ms. Von Linden's own negligence caused her demise. Mr. Mulhern countered that Ms. Von Linden's fault should not be raised, because it was Mercy's negligence that caused her suicide. However, the district court overruled Mr. Mulhern's objections to jury instructions on comparative negligence and sole proximate cause. The jury found Mercy, Dr. Jennisch, and Ms. Von Linden negligent, allocating 90 percent of the total fault to Ms. Von Linden and 5 percent each to Mercy and Dr. Jennisch. The court entered judgment in favor of Mercy, because Ms. Von Linden's fault exceeded 50 percent. Mr. Mulhern moved for a new trial on the basis of instructional errors, and the district court overruled the motion. The estate appealed, and the Iowa Supreme Court reviewed the case.

Ruling and Reasoning

The Iowa Supreme Court primarily considered whether the district court erred by instructing the jury that it could compare the faults of Ms. Von Linden and Mercy. On appeal, Mr. Mulhern contended that Ms. Von Linden lacked capacity for negligence, because a person who is a danger to self can be involuntarily committed. The court disagreed and cited the Illinois Supreme Court decision in a similar outpatient suicide case, ruling that suicide does not preclude a finding of comparative negligence, because noncustodial individuals have a "duty to exercise ordinary care for their own safety" (*Hobart v. Shin*, 705 N.E.2d 907 (Ill. 1998), p 910). The court also noted that, at her last appointment, Ms. Von Linden was functioning well at her executive-level job and did not meet the criteria for involuntary commitment.

The estate further contended that Iowa Code Chapter 668 omitted intentional torts in the definition of fault; therefore, the intentional act of suicide could not be compared with Mercy's negligence. On reviewing the history of comparative fault, the court noted that the omission of intentional torts was based on the Uniform Comparative Fault Act (12 U.L.A. 125, 126 (2008)), which addresses intentional injury to others but not intentional self-harm. The court equated suicide to "unreasonable assumption of risk" (Iowa Code § 668.1(1) (2003)). It concluded that self-harm may be negligent, because outpatients have a duty of "ordinary care," in contrast to inpatients and prisoners, where the custodial institutions assume this responsibility. In support, the majority

cited precedents from various states where juries had compared the negligence of noncustodial suicide victims with that of medical professionals.

Finally, Mr. Mulhern argued that Mercy was negligent in allowing Ms. Von Linden's premature hospital discharge and should not be permitted to raise a defense based on the very act it had a duty to prevent (suicide). The court held this to be a question of fact for the jury and cited other states' precedents of duty of self-care. Noting that Ms. Von Linden failed to call Dr. Jennisch or the Help Center or return to the clinic before her suicide, the majority opined that comparative-fault defenses are allowed in medical malpractice actions where the plaintiff failed to follow physician instructions. Finally, the court voiced concerns that barring comparative-fault defenses could result in lack of appropriate care for suicidal patients and in unnecessarily long hospital stays. The court affirmed the lower court's decision.

Dissent

The separate dissents by Justices Wiggins and Appel took stricter legal stances with less public policy consideration. Justice Wiggins, relying on the Iowa Legislature's definition of fault, opined that suicide is intentional and is neither negligent nor reckless and therefore should not be considered under Chapter 668. Justice Appel argued that, while several states included intentional misconduct in their comparative-fault statutes, the Iowa legislature did not. Justice Appel found the majority's distinction between custodial and noncustodial care irrelevant to the meaning of fault and argued that suicide is not an intervening or superseding cause when the defendant has the duty to protect against it. Finally, both justices argued that the case was not tried or appealed on issues relating to Ms. Von Linden's behavior before suicide, nor was her duty to call the emergency contacts established, so the case should not be decided on this basis.

Discussion

Mulhern illustrates important challenges in assessing fault in mental health malpractice cases. Many providers will agree that Dr. Jennisch provided care consistent with professional standards, whereas others might argue that he should have lengthened the patient's hospitalization. Even with excellent care and despite known risk factors, psychiatrists are poor predictors of whether an individual will ultimately harm himself. In reality, mental health providers have few objective markers with which to assess safety and must rely on patients' descriptions of their internal states. So, how do we divide responsibility between patient and physician?

Both the *Mulhern* and *Hobart* courts opined that suicide victims' negligence should be determined individually on the basis of the evidence and that only individuals "completely devoid of reason" (*Mulhern*, p 112) lack capacity. The courts reviewed behavior before suicide for evidence of capacity for negligence. The *Hobart* court cited the individual's actions—refusing to contact physicians, leaving home, and checking into a motel under an assumed name—as evidence of capacity. However, this "premeditated and deliberate" behavior standard implies that only individuals who impulsively commit suicide lack capacity (Appelbaum PS: Patients' responsibility for their suicidal behavior. *Psychiatr Serv* 51:15–16, 2000). In contrast, the *Mulhern* court did not assess the degree of planning for suicide, but viewed Ms. Von Linden's level of professional performance and unsuitability for involuntary commitment as evidence of capacity. Policy concerns and cases like these suggest that patients ought to bear some responsibility, but the next question is: how much?

The *Mulhern* and *Hobart* courts agreed that a suicidal individual has the duty to use "the care . . . a reasonably careful person would use under similar circumstances" (*Mulhern*, p 114). The dissent in *Hobart* argued that this standard overlooks suicide victims' mental states and suggested a lower standard: "a person of like mental capacity under similar circumstances" (*Hobart*, p 914). Although the *Mulhern* standard excludes mental state, the court made a distinction between the duties of custodial and noncustodial patients. In a separate case, the Illinois Supreme Court argued against this distinction and proposed that patients' duty of self-care should be determined by the evidence in each case (*Graham v. Northwest Memorial Hospital*, 965 N.E.2d 611 (Ill. App. Ct. 2012)). *Graham* and the *Hobart* dissent allow a more nuanced and flexible approach to assessing the duty of self-care than does *Mulhern*. To guide these assessments, Dr. Appelbaum advocated for a focus on the negligent elements of patients' behavior leading up to the act of suicide, when they might "still [retain] the mental capacity to act otherwise" (Appelbaum, p 16). These elements would include failure to follow treatment recommendations and, in *Mulhern*, would cover Ms. Von Linden's refusal of PHP and failure to call emergency resources.

The goal for courts and legislatures is to maintain reasonable treatment standards while not overburdening physicians or encouraging overzealous hospitalization. The *Mulhern* case highlights the difficulty of predicting suicide and the limits of a physician's control over a patient's behavior, especially when the patient does not meet the criteria for commitment. While the *Mulhern* decision supports the idea that patients should have some responsibility for their care, these responsibilities should be more clearly defined. Further, other cases and literature suggest that malpractice evaluations should be individualized both to account better for a spectrum of circumstances (e.g., avoiding dichotomies between in- and outpatients) and to widen the focus from suicide itself to the neglected responsibilities leading up to it.

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Lay Witness Testimony Is Substantial and Competent for Determination of Elder Abuse

John Bonetti, DO
Fellow in Forensic Psychiatry

Kevin V. Trueblood, MD
Assistant Clinical Professor of Psychiatry

Law and Psychiatry Division
Department of Psychiatry
Yale University School of Medicine
New Haven, CT

Expert Testimony Not Required in Missouri Department of Health and Senior Services Determination That a Health Care Worker Knowingly Abused a Resident

In a Missouri nursing home, a licensed practical nurse (LPN) used physical force when attempting to medicate an elderly woman with cognitive deficits. In *Stone v. Missouri Department of Health & Senior Services*, 350 S.W.3d 14 (Mo. 2011), the Missouri Supreme Court was tasked to decide whether lay testimony was adequate to find that the resident had experienced harm and whether statutory requirements for placement on the Employee Disqualification List were established.

Facts of the Case

On November 3, 2007, Catherine Ann Stone, LPN, was observed by other staff force-feeding medication to a female resident, K.S., who had diagnoses of dementia and mental retardation. Ms. Stone's behavior was reported to the Department of Health and Senior Services (DHSS) central registry hotline on November 7, 2007 by one of her coworkers; on November 8, 2007, she was terminated from the position. On February 19, 2008, after an investigation by Mary Jane Garbin, a department facility investigator, and pursuant to Mo. Rev. Stat. § 198.070(13) (2006), Ms. Stone was found to have "knowingly or recklessly abused or neglected a resident," and she was informed of the department's intention to place her on the Employee Disqualification List (EDL) for 18 months. The department also concluded that although there were no physical sequelae from the incident, Ms. Stone "abused" K.S. by inflicting "emotional injury or harm" (Mo. Rev. Stat. § 198.006(1) (2006)).

Following the department's notification, Ms. Stone requested an administrative hearing, which occurred on August 28, 2008. At the hearing, there were several contested facts. Ms. Stone and her sole witness, an LPN, asserted that she was acting in a defensive manner, and not an aggressive one. Ms. Stone also reported that she was struck on the left arm by K.S. and that she therefore "could not have used it to forcefully hold back K.S.'s forehead" (*Stone*, p 18). Ms. Stone denied knowledge of any specific care plan for K.S. that directed staff behavior in the event of medication refusal.

The department, relying on the investigation by Ms. Garbin and her witness interviews, reported that on November 3, 2007, Ms. Stone was attempting to medicate K.S. During the attempt, K.S. struck Ms. Stone on the arm. Ms. Stone instructed a nursing assistant to restrain K.S.'s arm while Ms. Stone held her head back and forced medication into her mouth with a small wooden spoon. The department's witnesses also testified that the care plan was posted at the nursing station and that Ms. Stone had training on resident abuse and residents' rights. A dietary aid at the facility testified that she saw Ms. Stone forcefully restraining and medicating K.S. and that K.S. was "screaming differently than usual" (*Stone*, p 17). At the conclusion of the hearing, the hearing officer found that the department's decision was justified, and on October 28, 2008, affirmed Ms. Stone's placement on the EDL.

After the hearing, Ms. Stone filed for a judicial review in the Cole County Circuit Court, which re-