Patients' Responsibility for Their Suicidal Behavior

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Psychiatrists' liability for their patients' suicides seems qualitatively different than many other forms of medical malpractice. When a surgeon makes an incision in a clumsy fashion, an orthopedist misaligns the parts of a bone while setting a fracture, or an internist fails to detect a breast lump that turns out to be cancerous, the physician's negligence is clearly the direct cause (the law would say "proximate" cause) of the harm suffered by the patient. Few would quarrel with the general rule that physicians should be held liable for the consequences of their negligence in these cases.

Suicide, however, is different in at least one relevant respect: whatever the failings in the psychiatrist's treatment of the suicidal patient, it is the actions of the patient, not those of the psychiatrist, that are the ultimate cause of the harm. Without the patient's decision to take an overdose or stand in the path of an oncoming train, no adverse consequences would occur. Should the contribution of the patient to the unhappy outcome not be recognized in some way that diminishes the degree of responsibility assigned to the clinician?

Precisely this question was raised by a recent series of decisions in a case from Illinois, *Hobart v. Shin* (1,2). The case arose in the aftermath of the death by suicide of Kathryn Hobart, a 27-year-old student at the University of Illinois' Chicago campus. Ms. Hobart, who had a long history of depression, sought care from Dr. Shin, a family practitioner at the student health service. She complained of fatigue, loss of appetite, sleep disturbance, and a general sense of hopelessness. Concerned about the patient's potential for suicidal behavior, Dr. Shin had Ms. Hobart examined by a psychologist, who persuaded her to admit herself voluntarily to a psychiatric unit.

After a three-week hospital stay, Ms. Hobart was doing better and showed no overt expression of suicidal intent; she was released from the facility on the antidepressant doxepin at a dosage of 150 mg a day. Although she was followed both by the psychiatrist who oversaw her inpatient care and by Dr. Shin, it was the latter who apparently supervised her medication. Thus when the patient expressed concern about running out of medication and about the cost of filling the frequent prescriptions, Dr. Shin wrote her a prescription for a one-month supply of medication, with a single refill.

Ms. Hobart did well for roughly three weeks. Then, less than a week after her last session with the psychiatrist, she took a sudden turn for the worse. The theft of her backpack, which contained her notes from school, precipitated a recurrence of severe depressive symptoms. Ms. Hobart resisted her mother's entreaties that she contact her doctor, saying that she didn't want to be rehospitalized. Two days later, she was found dead in a motel room that she had rented under an assumed name, having ingested more than ten times the usual lethal dose of doxepin. Her mother brought suit alleging, in part, that Dr. Shin had been negligent in writing a prescription for the substantial quantity of doxepin and in not communicating with the patient's psychiatrist about his actions.

In his defense at trial, Dr. Shin contended that Kathryn Hobart's own negligence was the primary cause of her demise. Under Illinois' law of contributory negligence, a person has a duty to use "ordinary care" for his or her own safety. If a person fails to do so—that is, if that person behaves in a negligent manner and is responsible for more than 50 percent of the proximate cause of the injury suffered—no recovery of damages will be permitted. Instructed on this issue, the jury—apparently believing that the patient bore the majority of responsibility for her own death—brought back a verdict in favor of Dr. Shin.

Contributory negligence as legal doctrine was developed as part of common law in response to the perception that a person who fails to act reasonably to protect his or her interests has no legitimate claim for compensation by another party. As originally applied, the doctrine banned recovery if the injured party was negligent even to the slightest degree. Thus any taint of incautiousness by the plaintiff that could be said to have contributed to the unfortunate outcome precluded compensation, even in the face of massive and uncontested negligence by the defendant. Illinois adopted a modified and more reasonable version of the rule, requiring that the injured person be responsible for more than half of the negligent behavior before compensatory damages would be denied. This was the rule applied by the jury in *Hobart v. Shin.*

Mildred Hobart, Kathryn's mother, appealed the decision to Illinois' intermediate-level appellate court, partly contending that the trial court had

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erred in allowing Dr. Shin even to raise the issue of the patient's contributory negligence (1). The appellate court agreed: "Since it was for this condition [i.e., depression with suicidal ideation] that Kathryn sought treatment, defendant should not be permitted to allege that Kathryn was contributorily negligent for acting in a manner consistent with her disorder."

In other words, when a physician—or any other health care professional—assumes responsibility for the care of a suicidal patient, the patient's failure to act reasonably will bar recovery if the clinician was negligent and suicide ensues. Presumably this position is based on the view that mentally ill persons' self-destructive behavior is always compelled by their underlying disorders and does not represent free choice. Hence it would be unfair to hold them responsible for actions they were powerless to control.

Dr. Shin, in turn, took the case to the Illinois Supreme Court, which overturned the appellate court's ruling (2). The court held that there might be cases in which it would be unjust to examine the behavior of a person with mental illness, but only, as in the California case cited (3), "if he is so mentally ill that he is incapable of being contributorily negligent." The decision continued, "To rule otherwise would be to make the doctor the absolute insurer of any person exhibiting suicidal tendencies."

This approach reflects the historic way in which claims of contributory negligence were dealt with when the decedent or plaintiff was mentally ill. Courts generally required them to be "totally insane" or "utterly devoid of intelligence" before precluding inquiry into their contributions to the negligent behavior and its sequelae (4). Thus the jury's decision in favor of Dr. Shin, which implicitly assigned to the patient responsibility for her own behavior, was upheld.

A minority of the justices, while agreeing that contributory negligence could account for the death of a suicidal patient, would have made it somewhat easier for plaintiffs to prevail in these cases. Rather than considering the patient to have been negligent if he or she failed to conform to the behavior expected from a reasonable person, the minority would have ruled "that such a person should be held only to the exercise of such care as he or she was capable of exercising, i.e., the standards of care of a person of like mental capacity under similar circumstances [citation omitted]." Under this approach, if Kathryn Hobart had acted as well as one could expect of a depressed person in her condition, she could not be said to have been negligent, even if a nondepressed person would have taken greater care for her own well-being.

It is interesting to consider a question that neither of the opinions in this case addressed directly: what was it about the patient's behavior that might have constituted negligence? The Illinois Supreme Court's decision pointed to Ms. Hobart's "premeditated and deliberate" behavior on the day of her death: "She left home, refused to contact her doctors, and checked into a motel under a fictitious name." But if deliberate intent to commit suicide and actions in furtherance thereof constitute negligence, then arguably only persons who commit suicide impulsively would be said not to be contributorily negligent. It seems unlikely that the court intended to narrow the grounds for liability quite so far.

More reasonable would be an interpretation that focuses on the patient's behavior before and leading up to the decision to commit suicide, when the patient still retained the mental capacity to act otherwise. Here, Kathryn Hobart, faced with the recurrence of depressive symptoms and urged by her mother to contact her doctors, declined to take this reasonable precaution for her own care because of a desire to avoid hospitalization. In other cases, it might be a patient's decision to discontinue medications or cancel appointments, with resulting unmonitored deterioration, that could constitute contributory negligence. But it hardly seems fair to characterize as negligent the actions taken by a person in the grip of a severe depressive or psychotic episode. This interpretation seems consistent with the Illinois Supreme Court's willingness in its opinion to recognize that some patients truly are incapable of being contributorily negligent as a matter of law.

What are the implications of the *Hobart* decision? Defendant physicians in Illinois accused of responsibility for their patients' suicides will be able to argue to juries that their patients' contributions to their own deaths should be examined to determine if the patients should bear responsibility for the outcome. Other states differ in how welcoming they are to contentions about patients' contributory negligence, although the Hobart decision may have some impact when the issue is reconsidered in other jurisdictions. (Some states have replaced the doctrine of contributory negligence with a rule of comparative negligence, which avoids an all-or-nothing approach, apportioning responsibility between plaintiff and defendant and awarding the amount of compensation accordingly.)

A renewed focus on the contributory negligence of psychiatric patients could also have important implications for allocation of responsibility for acts of violence toward others. Beginning with the California Supreme Court's decision in *Tarasoff* (5), clinicians who have been found to have acted negligently in failing to predict or prevent acts of violence have been held liable for the consequences. Yet it would seem that at least as strong an argument could be made in many of these cases as in *Hobart* that the patient's own negligence—for example, discontinuing medications, consuming alcohol, or other actions—contributed substantially to the tragedy that followed. Indeed, in some of these cases, the act of violence was the deliberate choice of patients who would otherwise be considered competent to direct their actions as they choose. Perhaps *Hobart* and the commentary it provokes will stimulate a closer look at the rationale underlying these "duty-to-protect" cases as well. ♦

References

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