

The psychiatrist's forensic liability for suicide

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Summary

The psychiatrist's forensic responsibility for suicide is a topical theme today. The psychiatrist must get a move on a therapeutic space between patient's treatment and control, complying with individual freedom and rights.

In this work we explain some forensic topics about responsibility and some of the most common reasons of report on the psychiatrist charge. The goal of a descriptive-clinical approach is to widen the knowledge of the topic, avoiding a self-defensing attitude and complying with a good clinical practice.

Key word

Suicide. Professional Responsibility. Judgments. Law. Good Clinical Practice

Per Corrispondenza

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The civil and criminal liability of the psychiatrist on the patient's suicide, can be looked at through different approaches.

By a juridical point of view the different definitions of negligent conduct may be taken into account (Mantovani, 1980; Antolisei, 1960; Flowers, 1999, Shuman DJ. 2006). By a forensic point of view is useful to study in depth the different concepts of causal connection, the definitions of diligence, prudence, skilfulness, as well as the complex issue between the self-determination and the psychiatrist' duty of medical care, etc.. (Florist, 1999; Bilancetti, 2006). A merely clinical approach involves the examination of variables that most often in everyday clinical practice can stimulate and determine the suicidal act, as a multifactorial event (Durkheim, 1987; De Leo, Pavan, 1999, Lester, 1990, Simon et Hales 2006). From the forensic point of view the quality and quantity of complaints against psychiatrists could be examined, and the respective judicial proceedings, form the complaint trial until the

conviction or acquittal in the various levels of judgement (Florist 1999, Bilancetti 2006, Scott et Resnick 2006).

In the following study we will highlight some useful observations to forensic psychiatrist for dealing with the issue of suicide and the most frequent reasons behind the complaints against psychiatrists in cases of suicide of patients. The overriding aim is to improve good clinical practice, even through understanding of the errors, but without intrude in psychiatry defensive.

FORENSIC REMARKS

In traditional jurisprudence the professional liability in cases of patient's suicide must respond to basic elements such as the "predictability", the "avoidance" of the event, and the "causal connection" between the psychiatrist's behaviour and the patient's suicide. In particular, liability for fault provides a generic fault (for negligence, imprudence, unskilfulness) and a specific fault (inobservance of laws, regulations, orders, disciplines). The definition of negligence ("insufficient attention, lack of commitment, superficiality"), imprudence ("inobservance of common precautions to protect own and others' safety") and unskilfulness ("deficiency of professional culture or necessary capacity to experience specific technique") are forensic concepts not always easy to define and prone to discretionary interpretations, as well as restrictive and extensive (Florist, 1999). Even though these general principles on liability, some forensic preliminary remarks will be considered in order to improve the rational and emotional approach of psychiatrist to the problem of patients' suicide.

Means obligation and no results obligation

The psychiatrist has responsibility on patient's suicide according to the means used to treat, which must comply with good clinical practice (589 cp, 42 cp, 2236 cc). The clinician may not have criminal or civil liability if, during a therapy that respects good clinical practice, the patient will commit suicide.

In fact this principle may set considerable problems of interpretation. First the definition of good clinical practice. Generally it is defined as the average capacity of a psychiatrist, derived from professional experience and does not include the automatic application of complex and sophisticated guidelines published in scientific publications. The good clinical practice must be applied without incurring in behaviours linked to negligence, imprudence, unskilfulness.

A second problem is the presence, in the courtroom, of a "drift towards the obligation of results" linked to factors such as alleged "medication errors" (hypothesized with "a posteriori" evaluation or tautological reasoning such as "since the patient has committed suicide it means that someone must have committed a mistake"; specific unworkable and unrealistic expectations in respect of medicine ("it can and must cure everyone") and uncritical "strictly psychiatric interpretation" of suicide (stripped of its multifactorial aetiology, and exclusively thought as a "result of a mental illness easily to treat and cure").

1) Compilation of medical records

In the courtroom there is the so called "legal truth" that not necessarily corresponds to "clinical truth" and that is the patient's clinical condition at the time of the facts. All the elements that can not be proved, while reflecting the clinical reality, make no legal value. In a contradictory medical records have particular importance (as if the patient "was exclusively that resulting from medical records"). In particular, the psychiatrist may leave in medical records the clues for the formulation of its allocation, and sometimes of a conviction, regardless of the reality of clinical case.

First, in the medical reports there may be "*inconsistencies*" (for example, symptoms of severe mental and motor agitation are described and are not prescribed the appropriate therapeutic measures); "*lack of precautions*" (for example, the patient is described with apparent suicidal ideas and are not shown in the folder precautions taken with regard to surveillance); "*absences or shortages of clinical information*", so it is not possible to follow the course of the patient and therapy. The so-called "non-existent folders" (also "empty" or "white"), where there is "little or nothing written" can be interpreted in a courtroom as if "little or nothing done" for assistance to the patient. In the medical records also may appear "*not very credible observations*" (for example, after numerous descriptions by other psychiatrists of a highly anxious, agitated and suicidal patient, a psychiatrist record in folder: "After our conversation the patient is calm and quiet, suspend medicines and monitoring"). In the folder can be carried over "*ambiguous statements*" that often can represent, in a contradictory, the core of judicial affair (for example: "the patient claims to be tired of life"). In some cases the medical records may contain evidence of a "*tardily defensive manipulation*" of procedural documents (such as the addition retrospectively of observations, therapeutic requirements, erasures, in a folder that probably the magistrate is already in possession). In conclusion, the medical records is the main document that may mark the imputation and/or conviction of the psychiatrist, but if diligently completed, can testify the good clinical practice which was managed the patient

with. The psychiatrist is not required to compiling detailed, long and extremely sophisticated medical records, but the necessary information to understand and justify the diagnostic processes and adequacy of therapeutic measures to prevent the suicide, according to good clinical practice.

2) *The meaning of a judgement*

Often psychiatrists are particularly upset or surprised by the rulings condemning colleagues for professional liability on patients' suicide. The warped interpretation of these judgements can move feelings pushing to adopt a "*defensive psychiatry*" tending to prefer legal protection the work rather than patient care. Under the general profile is useful to know, even for practical purposes, the significance of a judgement, particularly condemnation of a psychiatrist because of patients' suicide.

First, a judgement of conviction on a single case is not a law extended to all "similar" cases. The judgement is always individual and relegated to a specific case, with all the clinical peculiarities that the case involves, and can not be applied so automatically and uncritically to other cases. This first observation does not bereave value to the general principles regarding psychiatrist's liability.

Secondly, the judgement considered in the totality of its grounds, must be interpreted according to the variability of single case. For example it has to be considered the discretion which the magistrate can benefit; problems and interpretations of laws by experts and consultants; type of objective documentation available in the case; the testimonies of different parties; the different abilities of lawyers, the welfare state and organisation of structures. Therefore a judgement must be properly contextualized in the specific environment in which the event occurred, beyond the theoretical and practical aspects of law.

Finally, the legal principles with regard to responsibility of the psychiatrist about suicide may be differently considered depending on the origin of those who drafted the judgement (a single judge or Sections of the United Supreme Court).

It is worth clarifying that more judgments that underpin the same principles have particular importance for the application of legal principles that govern the professional liability of the psychiatrist on suicide.

A correct reading and interpretation of convictions to psychiatrists on liability for the patients' suicide avoid unnecessary alarms and damaging adoptions of defensive conducts, and allows to understanding of those that are "legal requirements" that the psychiatrist must know and respect, to implement a good clinical practice.

COMPLAINTS AGAINST PSYCHIATRISTS

The most frequent reasons of complaints against psychiatrists after patients' suicide are showed below grouped into four types. These reasons can change in the course of judicial course and find "nucleus of accusation" focused on specific problems (such as the adequacy of qualitative or quantitative pharmacological treatments; a posteriori-made correction in medical records; the non-adherence to one or more guidelines during therapeutic process). These possible "lines of juridical evolution" can then lead to complicated and sophisticated forensic discussions; counterfactual reasoning; definitions of skilfulness, diligence, prudence; negligent responsibility on probation of tasks; scientific limits of psychiatry, etc. They can focus media attention and determine elements of judgement in a courtroom. In case of patient's suicide the psychiatrist may be charged for manslaughter (Article 589 cp); murder (Article 575 cp); abandonment of a minor or incapable person (Article 591 cp); failure to rescue (Article 593 cp); murder of consentient (Article 579 cp); instigation and assisted suicide (Article 580 cp); neglect of an official duty, omission (Article 328 c.p.).

Apart from accusation evolution, the knowledge of reasons for the complaint is useful as a stimulus to the application of good clinical practice and the legal protection through the prevention of complaints.

1) Precautionary measures in the frames and in the assistance institutions

The psychiatrist (as well the clinician) toward suicidal patients is in a "*position of guarantee*" (art 40 c.p., Fiori, 1999). The psychiatrist's condition implies both a "*position of protection*" (in order to preserve physical and the life itself of patient) and a "*position of control*" (in order to avoid all predictable sources of danger on the basis of clinical experience).

The position of guarantee might be "extended" (with an unjustified increase in professional liability). Among reasons that can lead to a complaint in cases of suicide we include: the absence of precautionary measures, particularly those related to the place of hospitalization (for example, windows which let pass the body and thus make possible a defenestration; outlets that allow easy contact with electric current; projections appropriate to suspend his body for a hanging; easy accessibility to drugs that can be used for suicide). In these cases the welfare structure must be in compliance with laws and regulations and must not facilitate suicidal behaviour. The psychiatrist, in the case of an inadequate welfare, owing to its position of control, must take all possible precautions to avoid a complaint. For example, in the case of

lacking resources, must make written reports to the head office with a request for regularization of the situation.

2) Monitoring

The liability of the psychiatrist in monitoring a patient who commits suicide ("*culpa in vigilando*"), has not precise guidelines to be observed, the violation of which constitutes an objective of a negligent conduct. The skilfulness, diligence and prudence of the psychiatrist suggest, in any clinical case, a correct and proper monitoring of the suicidal patient following good clinical practice. However some important comments have to be done.

a) Inconsistency between clinical symptoms and degree of surveillance

Not all patients can and must be subjected to constant surveillance, with visual control 24/24 hours. It 'important, however, that there are not inequalities between the description of the clinical condition and type of surveillance used that must always be written clarified (such as in clinical report appears "patient in serious state of mental and motor agitation with trends suicidarie" and does not appear any surveillance measure).

b) Absence of written documentation of surveillance required and/or made

Often, regardless of the reality of a surveillance carried out, in medical records does not appear any information on it. Sometimes, this lack of documentation is an important fact in determining the beginning and the continuation of legal proceedings against the psychiatrist.

c) Absence of written documentation on roles and task assignment in the medical equip.

This shortcoming, in the case of patient's suicide, leads the magistrate to involve all department professionals ("*shoot in the bunch*"). It involves, during juridical trials, a "*rebound of liability*" by a professional to another. It is therefore important to establish skills and roles with relative responsibility between the various professionals involved in patient care.

d) Inadequate discharge requirements

Psychiatric liability does not end at the time of patient discharge and/or transfer, but implies that the specialist, especially in the case of a suicidal patients, make sure himself that who receives the patient (i.e. family members) is aware of clinical problems and suicidal risk. It is useful to document in medical records these communications between colleagues, even with the day and time of the interview, with its contents and the person with whom there was communication (for example, a psychiatrist was charged for manslaughter because the patient, transferred to a medical ward, has committed suicide after a few minutes of his arrival. The psychiatrist did not warned the responsible for the welcoming ward about the suicidal risk of patient. In particular, the discharge letter, with all the useful information by the psychiatrist did not accompany the patient, but was delivered after the suicide occurred).

3) Tasks assignment

The psychiatrist present a negligent liability when "chooses" so inadequate his collaborators in the therapeutic management of suicidal patient ("*culpa in eligendo*"). This observation has to take into account that often a psychiatrist with top positions has in his department staff that has not been chosen by him. Other times the psychiatrist directs structures whose structural and organizational deficiencies not depend on his will. Despite these limitations, is useful for the psychiatrist, to consider certain parameters to avoid negligent conduct in the case of patient's suicide.

a) Tasks assignment on the basis of competence

The psychiatrist, which entrusts the patient to people who are unable to manage granted tasks (for qualifications, training, etc), incurs a negligent conduct (for example entrust suicidal patient to a person that lack of training and information to manage him).

b) Respect of principle of " bound autonomy "

The duty of psychiatrist with top positions is to provide to his collaborators guidelines while respecting the autonomy of professional specific skills and different professions. This autonomy remains bound and is linked to the directives that the chief psychiatrist drew up and distributed to staff. If the generic or specific fault falls on subordinates' tasks, generally the chief psychiatrist is not legally liable (regardless of the supervisory function). For example, if the psychiatrist write that the nurse must check the patient regularly and he does not do this prescription, in case of patient's suicide the nurse

must meet its negligent conduct. On the other hand if the directives of the chief psychiatrist are grossly wrong and contrary to elementary rules of diligence, prudence and skill, the subordinates, including others psychiatrists, have the right and duty not to implement a bad clinical practice (for example, the chief psychiatrist not knowing the patient arrange for its discharge while in the presence of suicide risk, if the subordinate psychiatrist considers this a serious mistake, has the duty to intervene and be liable for negligent conduct, if obeys the orders).

4) The precautionary management of possible prosecutors

Some complaints seem justified, while others are useful stimulus to avoid professional mistakes and improve clinical practice through accountability. It is worth to note that for some family members the complaint may be an attractive expectation of economic compensation. Without neglecting what above mentioned, the numerous complaints to the psychiatrist by relatives of suicidal patient can not be ignored. We can highlight some of the most important factors that led to complaint of the psychiatrist.

a) Insensitivity to family demands

The importance of the ability to listen and handle the demands of family and the patient is crucial in the relationship with the patient and his family. Numerous complaints were motivated, at manifest level, by the perceived insensitivity and contempt with which some demands of family were handled (regardless of their legitimacy and usefulness for therapeutic purposes).

"During hospitalization they did not permit to speak with my father and then him commit suicide... "

"They never wanted me to stay with my brother in crisis, but they threw me out of the ward, telling that I gave annoyance to persons who were cleaning and to patients... And then my brother commit suicide because he was left alone and so easily hung himself". "They never wanted to talk with us... They were always in a hurry, they thought only to give medicines, drugs and medicines but not speaking with anyone, either with us or with my mother, who she did not understand anything, for this reason she thrown out the window.... "

b) Deficient or absent information about suicide risk

The forensic experience teaches that family members, if not warned by the psychiatrist about the suicide risk, have got claims often more pronounced than the families adequately informed, prepared and involved in the management of the patient.

"My husband killed himself but no one had warned me of this danger... they have been irresponsibles, we had the right to be warned of the danger... we could have done something useful for my husband and he would not have killed himself... been silent, psychiatrists have ruined my whole family.... "

The quality and quantity of participation of family members to prevent suicidal argument is not unique vision in psychiatric and requires, in any case, many care and sensitivity by the psychiatrist.

c) Inadequacy in managing acute reactions of mourning

The patient's suicide requires deep discomfort and suffering for families and for the treating psychiatrist. In fact, clinician faces the loss of a person who had to offer relief from suffering and a good quality of life. The frustration is linked to emotional and professional setback and initially perceived as a formal discussion of their professional identity, which is added the fear of possible juridical claims by family members. Some psychiatrists, immediately after the death of the patient, literally "escape" the relationship with the family or express themselves with inadequate comments. These behaviours may be perceived and/or distorted by family as unfair, disrespectful, degrading, non-professional or frankly offensive and depreciative against their pain.

"That psychiatrist has never talked to my father before the suicide... After the suicide he never wanted to receive me, he sent a nurse to explain how the events occurred... That psychiatrist is an incapable and deserves a punishment, so I've denounced him.... "

"That psychiatrist told me that my son killed himself because he was a drug addicted and was too aggressive toward the world and to himself... but all this is not true, my son has always been sweet in family, was fond on me, on his brothers, on his sister and then was not a criminal, was only depressed... The psychiatrist was aggressive, angry with all drug addicts that sees as criminals... The psychiatrist is a criminal who has not been able to treat and gave the blame to my son... This psychiatrist should be brought before a judge.... "

d) Inability of the psychiatrist to set up a psychological profile of potential prosecutor

For the psychiatrist is not easy to predict if the family of a suicidal patient will decide to denounce him. Apart from this objective difficulty, the forensic experience highlights that there are families more prone than others to use the complaint to the psychiatrist as a reaction to suicide in front of a person which they are emotionally tied. Indeed, there are people claiming that flood doctors and nurses of criticism, complaints, claims often illegal and unworkable. Furthermore, should be regarded carefully, people who say "too much" and "immeasurable love" for their loved ones (which in fact has "ruined" or "used up their nerves" for years and that they in general " have always avoided" or "treated badly"). These "great loves" towards unconsciously disliked persons often linked to defence mechanisms such as "reactive training" ("I hate this person but I behave as if I love him a lot") may, when they realize the death of this family member, stimulate feelings of guilt that are projected on the psychiatrist (*"I'm not the one who wanted the death of my family, but it is the psychiatrist who wanted the death of my familiar, I'm not the one to be punished but I must punish the psychiatrist"*). Similarly there are people who in fact are extremely suspicious, often for personal facts, and scared by the category of psychiatrists and capture any opportunity to make them "scapegoats" of all their personal problems.

These and other types of person, which we have provided only a few examples, are those who then argue with great authenticity: *" I did not have claimed the psychiatrist for money but because it is a matter of principle, is a question of my mental balance, I feel that I must denounce the psychiatrist and that the psychiatrist must be punished... if I did not I feel terribly guilty for the death of my father"*. This statement was made by a woman of 52 years who had occupied his alcoholic and violent father, convicted of maltreatment in family.

Faced with these possible prosecutors, the psychiatrist as in all clinical situations of risk, can not fail to give specific attention to set his work, thereby providing a good clinical practice, but also a careful forensic protection, in anticipation of possible claims.

CONCLUSIONS

For the deepening of the topics addressed see the texts of criminal law, civil and legal medicine, forensic psychiatry and the rich scientific documentation relating to suicide. The above comments only have had the practical and functional purpose of providing ideas for improvement of good clinical practice and to avoid not only convictions and civilians, but

also complaints and referrals. A proceedings for professional liability because of the severe discomfort psychic, the identity crisis that involves professional staff in itself, constitutes a "punishment" even when solved with a acquittal.

The care in drafting the medical records is the best written test and objective of sound and good clinical practice and is the most effective means to avoid legal problems linked to suicide of the patient. Important also put diligence, prudence and skill when examining: 1) the condition of the structures and organization of assistance, 2) monitoring of the patient, 3) the assignment of the tasks in staff 4) management of mourning families.

It also has to be noted, however, the need for psychiatrists to follow the general rules of good clinical practice for suicidal risk management. To wait operational rules and guidelines dictated by the law on a good clinical practice in the management of suicidal patient, could have the meaning to surrender to improve its training and delegate, so uncritical and irresponsible, to the discretion of others, though legitimate, its legal protection and method of clinical work.

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