

Law and Psychiatry

Defending Suicide-Related Malpractice Cases: A Lawyer's Perspective

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Over the past 10 years, I have had the opportunity to represent psychiatrists, psychiatric nurses, inpatient facilities, and staff in malpractice cases, most often associated with allegations of wrongful death by suicide of an inpatient.

The patient was a 35-year white male with a history of paranoid schizophrenia, depression, suicidal ideation and threats, and chemical dependency (primarily alcohol and marijuana). In March, his wife, on whom he was quite emotionally dependent, told him she wanted a separation. In response, he barricaded himself in the house and threatened to stab himself with a fishing knife. The police intervened and brought him to the hospital.

This was his fifth psychiatric admission. Prior admissions involved similar distress associated with marital issues, depression, and suicide threats. His admitting diagnoses included paranoid schizophrenia, chemical dependence, and depression, with severe psychosocial stressors. He was initially confined to a locked unit, where he gradually improved. He continued to report subjective, mild-to-moderate depression. Medications appeared to lessen his depression, as measured by self-report and psychiatric observation.

In May, the patient was allowed a supervised, off-grounds pass with his estranged spouse. His wife left him alone for a period while she visited a neighbor. While alone, he stabbed himself, narrowly missing his heart and requiring emergency surgery.

Upon return to the psychiatric facility, the patient initially said he had tripped and accidentally stabbed himself; however, he eventually admitted that the act was deliberate. Although he claimed the suicide attempt was genuine, the medical staff was not sure whether or not he truly wanted to die.

Over the next month, the patient appeared to make much progress. His depression was visibly lessened and his privileges were gradually increased. One day, during a visit, his wife told him she wanted a divorce and then left. She later called to inform the nursing staff that she had given the patient "some bad news and he might be depressed." The staff interviewed the patient, who said he was depressed but not suicidal. That evening, his sisters called the staff to say that he was depressed and they were concerned. A psychiatric nurse interviewed the patient after the call.

The next morning the psychiatrist and the patient discussed his feelings about his wife's divorce plans. The patient admitted he was depressed but denied being suicidal. He was placed on non-self-harm "contracting." Around the time of an afternoon shift change, he walked away from the facility without permission, went to his home, retrieved a shotgun from underneath his bed (staff had been told the gun was not in the house), and killed himself.

The patient's family sued the psychiatrist and the treatment center for malpractice and wrongful death. The main claim made by the plaintiffs was that the psychiatrist should have placed the patient on one-to-one observation or had the patient confined to a locked unit. After two hours of deliberation, the jury found in favor of both the psychiatrist and the hospital.

I have made a number of observations about responding to suicide in an inpatient facility (bearing in mind that litigation often follows), and about how to defend such cases. This column refers to "suicide," but the principles generally apply to cases involving other kinds of self harm, and often harm to others as well.

THE PROBLEM OF DEFENSE

Many lawyers dislike defending malpractice cases that involve suicide. Some aspects of psychiatry seem impossibly subjective to lawyers and jurors. Some attorneys shy away from taking such cases to trial precisely because the elements of the case seem difficult to prove conclusively and the likelihood of success is difficult to evaluate.

Plaintiffs' lawyers seem to have an advantage in these cases, for when a suicide is viewed through the lens of hindsight, it can take on a quality of apparent predictability. How many times does one hear a family member say, "I should have seen it. I should have known it would happen"? Signs that were at best ambiguous before the suicide seem suddenly clear at trial.

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The views expressed in this guest column are not necessarily those of the regular columnist, the editors, or the publishers, and should not be construed as specific clinical or legal advice.

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Most readers of this journal know that psychiatry is not as “mushy” or subjective as laypeople may believe. Although sometimes imprecise, psychiatric diagnosis, treatment, and patient management are much more similar to than different from those of the other medical disciplines. Convincing the jury of that fact—that psychiatry is a medical discipline and that bad outcomes can happen without fault by clinician or hospital—is critical to a successful defense.

RISK MANAGEMENT: INVESTIGATION AND “PSYCHOLOGICAL AUTOPSY”

When a suicide occurs, the facility typically carries out a careful investigation (sometimes called a “psychological autopsy,” although that phrase lacks consistent definition). I believe it is imperative that the facility conduct a detailed investigation, carefully following peer review requirements so that appropriate clinical, quality improvement, and risk management needs can be met without opening all of the deliberations to “discovery” by a plaintiff’s attorney.

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There are several advantages to performing the investigation quickly and professionally. First, it preserves the treatment staff’s memory, treatment decisions, and underlying rationale while they are fresh in people’s minds. It is very important to interview treatment staff carefully, probing for nuances and details regarding the patient and his or her treatment (but without creating or suggesting any improper manipulation of the clinical record or staff perceptions). The medical record cannot possibly contain all the observations and thoughts of the treatment staff. Even if doctors’ and staff members’ memories are exceptional, careful documentation close to the time of the event—before any lawsuit is contemplated—is better than relying on memories for testimony months or years later (and avoids the suggestion that those memories were influenced by the lawsuit).

Facilities often interview only treatment staff assigned to the particular patient. It is important to immediately interview all staff who may have encountered the patient during the days before the tragedy. In the case described above, a technician recalled a chance meeting with the patient shortly before he left on the day he killed himself.

The technician’s testimony suggested that the patient was not acutely suicidal, but probably left the facility impulsively to talk to his wife about her decision to seek a divorce. I argued that it was only after he entered his home that he formed the intent to kill himself. The lesson to be drawn here is that all staff who may be relevant should be interviewed while the tragedy is still fresh in their memories.

Some facilities have an attorney participate in the investigation, or even carry out the entire process. Information gathered by an attorney may be protected from discovery under attorney/client and/or attorney work-product doctrines. In states with robust peer-review protections, conducting the investigation entirely within the facility, by a peer-review body, may afford greater protection.

THE IMPORTANCE OF THEMES

Every trial lawyer knows that, to persuade the jury, one must articulate themes that tie the evidence in the case to the “great truths” of life and that lead the jury to find in favor of the defendant. Articulating defense themes is particularly important in cases involving self-harm because the plaintiff comes armed with two powerful themes of his own: 1) “Psychiatry is mumbo-jumbo” and 2) “The defendants should have seen it coming.” The first recognizes that most people (and therefore most jurors) view psychiatrists as high-falutin’ cerebral types who use a lot of fancy words and Freudian theory (with emphasis on the “theory”). The second plaintiff’s theme reflects the guilt-based thought processes of anyone who has ever been close to a person who attempted or completed suicide. Together, they suggest that the defendant was negligent.

Fortunately, there are several effective defense themes as well:

The plaintiff’s case is hindsight. It is important to acknowledge that suicide *looks* predictable, but that this is the view of hindsight. *Hindsight, erroneously, can make the unpredictable seem inevitable.* It *seems* obvious that this was going to happen, but that is only because we now know that it did. Every action and word of the decedent is—unfairly—reinterpreted in light of our knowledge of the outcome; they all seem to have pointed directly toward suicide.

The jury must be made to understand that hindsight is both powerful and deceptive. I ask jurors to put themselves into the doctor’s shoes before the suicide, and remind them that a great many psychiatric patients display similar thoughts and make similar statements. I tell them to judge the evidence from *that* perspective, not from the vantage point of hindsight, and ask themselves “Would I have thought that this patient, out of all patients, was going to commit suicide?”

Suicide and other tragedies are rarely predictable.

The psychiatric literature demonstrates that, while a psychiatrist or psychologist should consider reasonable indices of risk, individual suicide is almost never predictable. Studies show that when psychiatrists are asked to predict individual suicide, they are likely to over-predict it (i.e., to erroneously predict that someone will commit or attempt suicide when in fact the person does not). It is true that proper diagnosis, treatment, and clinical protection are based on relative clinical risk and not on individual prediction, and we accept that clinical and commitment decisions rest on a reasonable assessment of that risk; however, one can almost never say that a person will kill himself within some period of hours or days.

The patient's dignity and free will are very important. Even if the jury believes that hindsight is deceptive and unreliable, they may still reason that, if the doctor had any doubt, then he or she should have taken no chances. The doctor should have physically or chemically restrained the patient, placed the patient on suicide precautions, or something similar. In other words, the jury will think that all doubt should be resolved in favor of the patient's safety and that the doctor must always err on the side of protecting the patient from any chance of self-harm.

This reasoning is powerful, but often incomplete or simply erroneous. The defense lawyer can counter it with themes of patient dignity, proper weighing of the risks, acceptance of clinically reasonable risk in the service of substantially greater gains, patient preference, and patients' rights. Patients are ethically and legally entitled to the least restrictive clinically appropriate alternative. That concept is not only a recognition of the patient's rights, it is part and parcel of good therapy. Proper therapeutic process gives patients as much liberty as they can reasonably manage in the context of the treatment program. Part of the psychiatrist's job is to weigh suicide risk against the benefits of recognizing the patient's own responsibility for his or her affairs and life.

Psychiatrists often work with the subjective, but they must do so through objective means. Because one can never completely discern a patient's subjective intentions, the psychiatrist must rely on objective factors such as history, diagnosis, current condition, current treatment, and current words and deeds. The doctor is entitled to rely on those factors to assess potential for suicide and is not expected—or indeed often allowed—to predict suicide in the absence of objective indications in that direction.

Hospital policies and procedures embody these principles, and the staff complied with the policies and procedures in this case. Well drafted hospital poli-

cies do embody the principles of good care, and often go beyond what is required; however, it is a mistake to rely on mere compliance. Juries decide cases based on what they think is the right result. The policies are a way of presenting the defense themes, not a substitute for them. The attorney (and the doctor) should explain *the principles underlying the policies*, demonstrate why they are sound, and then show how they were followed. Hospital policies often leave room for judgment, and the case may involve professional judgement, which leads one to consider the next two themes.

Reasonable doctors can differ, but the treating psychiatrist or other qualified clinician is almost always in a better position to make clinical judgments than after-the-fact experts or plaintiffs' lawyers. This theme emphasizes the subjectivity of the discipline while highlighting the doctor's clinical deliberation. Despite all that's been said, in the end the clinician who is on the spot with the patient must do the best he or she can with the available information. Treatment and clinical protection decisions come down to individual judgment that cannot be read from an x-ray or seen under a microscope. Unlike surgeons, who outline risks and benefits for competent patients' informed consent, the psychiatrist must weigh the risks and benefits himself, for patients who, unlike you or me when we are contemplating surgery, may or may not be hiding important information from the doctor. Then the psychiatrist must decide how to proceed.

Reasonable psychiatrists can differ in these highly complex judgments but no one—not the jury, not the opposing expert, not even the defense expert—can truly recreate the situation in which the treating psychiatrist had to make the decision. He was there. He looked into the patient's eyes. He listened to the patient's words. And he did his best to consider both the objective and the intangible. He was not perfect, but he was doing his best to help.

The hospital staff cares about its patients. Times of true crisis are very painful. The plaintiff will suggest that the hospital staff and the doctor were too busy or too accustomed to suffering to care. The defense must counter this by "humanizing" the hospital and its staff, emphasizing, for example, that the doctors and nurses were there during the patient's crisis, trying to understand and help. The last thing they wanted was to lose this patient. If they had thought he was in serious danger, they would have taken appropriate action.

Never blame the family or the victim. Lawyers defending psychiatric malpractice cases are sometimes tempted to blame estranged family members. The flaw in this strategy should be obvious. The patient is in the

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hospital because he is suicidal. It was the hospital's job to protect him. If family members made the patient more suicidal, the hospital should be doubly concerned. If the hospital knew of this additional stress, it does no good to blame the sources of that stress while denying that it made the victim suicidal.

THE TRIAL

Jury Selection. Jury selection in a suicide case is intrinsically delicate because suicide is extremely emotional. There are often a host of issues overlying it, including chemical dependency and sexual abuse. A written jury questionnaire is a valuable tool. The questionnaire should ask potential jurors whether or not they, or any of their family or friends, have attempted suicide, and if so whether or not they are willing to discuss the matter. Other sensitive areas, such as chemical dependency, mental illness, and physical or sexual abuse, should be handled in the same way.

Several factors determine whom the defense lawyer should try to retain or strike (eliminate) from the jury. Experience with suicide does not automatically suggest a difficult juror; he or she may often believe that suicide is neither predictable nor always preventable. Likewise, experience with mental illness and chemical dependency frequently predict good defense jurors; they see the insidiousness of many serious diseases and know the limitations of treatment. Ironically, mental health professionals can be (but are not always) difficult jurors. They sometimes believe they could have prevented the tragedy, their training to the contrary notwithstanding. Older jurors are generally better for the defense, as life's experiences impart a certain wisdom and mature perspective. Contrary to conventional defense wisdom, women are perhaps better defense jurors than men in these cases. Men are sometimes action oriented; they may believe the psychiatrist didn't "do" anything.

Evidence and the Hospital Record. The chart will be the central documentary evidence in the trial. Certain passages will be critical; both sides will read and re-read them during the course of testimony. Nuance is important; the meaning, or implication, of a passage can vary with the way it is read. The words may sound hopeful or

ominous, depending on emphasis. The lawyer and defense witnesses should read the passages aloud as they prepare for trial. Doctors should read the chart several times and try to view it through the eyes of a juror rather than through their own.

Since juries sometimes view psychiatrists as something less than "real" doctors, the lawyer should establish the defendant's credentials as a knowledgeable medical physician. One technique is to have the defendant give the jury a "crash course" on psychotropic medications—what they do, how they function, and why they were or were not used with this patient—or on psychiatry itself. On the other hand, the physician-defendant may be a good doctor but a terrible educator, or a good doctor but not have a scholarly command of psychotropic medications. Since much of this effort is designed to encourage the jury to see the defendant as a competent, likeable doctor rather than the crass and bumbling fool the plaintiff's lawyer is trying to paint, his or her credibility can be also enhanced by discussing more comfortable topics (e.g., a brief description of his medical and psychiatric training).

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CONCLUSION

When tragedy strikes, investigate it thoroughly but with an eye toward the possibility of litigation. A good attorney stresses certain strategies and themes in malpractice defense which are designed to highlight the care that doctors take in diagnosing and treating patients and the futility of expecting clinicians to be either prescient or omnipotent in the real world in which they must practice.