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Suicide Responsibility of Hospital and Psychiatrist

Irwin N. Perr*

SUICIDE IS NOW THE TENTH GREATEST CAUSE of death in the United States.¹ It has become an increasingly larger factor statistically, because, as other causes of death come under medical control, the prevalence of suicide becomes more noticeable. In the last ten years, at the very minimum, two-hundred thousand (200,000) Americans have killed themselves, and in all likelihood, more Americans have died in the last twenty years at their own hands than were killed in World War II and the Korean War combined. It is also possible that suicides outnumber those killed in automobile accidents as is clearly the case in England.²

Thus the problem of suicide is a prominent public health problem in this country. Physicians and hospitals have an obvious concern, as do the law courts, where actions for wrongful death and negligence may involve suicide as a result of a tortious act. An example of the extremes reached in law was the case of *Cauverien v. De Metz*,³ in which a diamond broker gave some diamonds to a dealer who not only refused to return them, but denied that he ever had received them. This act allegedly

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¹ Reports vary as to the ranking of suicide as a cause of death. Daniels reports that it is the ninth leading cause of death and the second greatest cause of death in medical students. Daniels, D. H., Review of Suicide Cases with Reference to Appraisal of Their Risk and Prevention. 49 *J. Maine Med. Assn.* 258 (July, 1958).

² Parnell, R. W., and Skottowe, I., Towards Preventing Suicide, 1957 *Lancet* (1) 206 (Jan. 26, 1957).

³ *Cauverien v. DeMetz*, 188 N. Y. S. 2d 627 (Sup. Ct. N. Y. County, 1959); cf. *Daniels v. N. Y., N. H., and H. R. Co.*, 183 Mass. 393, 67 N. E. 424 (1903); *Elliott v. Stone Baking Co.*, 176 S. E. 112 (Ga., 1934); *Trumbaturi v. Katz & Besthoff*, 180 La. 915, 158 S. 16 (1934), *Eckerds v. McGhee*, 86 S. W. 2d 570 (Tenn. 1935); *Ferrara v. Galluchio*, 5 N. Y. 2d 16, 176 N. Y. S. 2d 996 (1958); *Restatement, Torts, Sec. 455; Prosser, Torts*, 273 (2d ed. 1955).

Professor Howard L. Oleck comments on the *Cauverien* case, "This is a landmark decision. It points to an ultimate rule holding tortfeasors liable for many 'purely mental' injuries hitherto not deemed actionable. Adoption of so advanced a view by a major court such as N. Y. promises rapid spread of this view. Fear of uncertainties of proof, or of a flood of cases, should not protect malicious or willful wrongdoers from liability for their wrongdoing. If the wrong is morally evident, let the jury decide the sufficiency of the evidence." 5 *Negl. & Comp. Service* (7) 54 (Jan. 1, 1960).

harmed the decedents' reputation to such an extent that it caused an "uncontrollable impulse" to commit suicide. Another bizarre case was *Deitz v. Bumstead*⁴, where damages were allowed where a man killed himself twelve years after a back injury, the court holding that there was a sufficient connection between the back injury and a diagnosis of manic-depressive psychosis ten years later followed in two more years by suicide.

These cases illustrate some of the fascinating and wondrous aspects of suicide. However, this paper will restrict comment to the principles and application of present law as to the responsibility of the psychiatric hospital and the psychiatrist and a discussion of some of the applicable psychiatric factors. Thus topics which will not be discussed are trauma and suicide, suicide in general hospitals, the handling of delirious patients, or public versus private hospitals.

In any event, the psychiatrist, the state, and hospital management all have great interest in their liability in cases of suicide whether the claim is wrongful death due to negligence or malpractice.

The basic law as to hospitals is that a hospital owes to its patients a specific duty of care. If it neglects this duty and, through the neglect, the patient is enabled to commit suicide, the hospital may be liable for its negligence under the wrongful death statute. To determine if there is negligence, it is necessary to establish the degree of care required. This is usually expressed in this manner—a hospital must exercise such reasonable care and attention for the safety of its patients as their mental and physical condition, if it was or should be known, may require.

A brief review of various cases reveals much contradictory law or contradictory application of law. In *Stansfield v. Gardner*⁵, a patient jumped from the stairs of a hospital and later he himself sued the hospital for the injuries that he suffered. The court stated that a hospital is not an insurer against a self-inflicted injury, but that the hospital is only required to use ordinary care and diligence. If the hospital may reasonably conclude that a patient may harm himself unless preclusive measures are taken, the reasonable care in the circumstances to prevent such harm is indicated. One is not required to guard against

⁴ *Deitz v. Wm. H. Bumstead, Inc.*, 168 N. Y. S. 2d 669, 5 App. Div. 2d 739 (1957). See also *Wood v. Samaritan Institution*, 156 P. 2d 470, Revd., 26 Cal. 2d 847, 161 P. 2d 556 (1945).

⁵ *Stansfield v. Gardner*, 56 Ga. App. 634, 193 S. E. 375 (1937).

an action which a reasonable person under the circumstances would not anticipate as likely to happen. Thus, where a person came to a hospital voluntarily⁶, was mild and docile, and suddenly ran away from the hospital, the hospital was not liable for the effects of exposure suffered by the patient.

In *Mills v. Society of New York*,⁷ a patient going for a walk with nine other patients and two aides suddenly ran in front of a bus and was killed. The patient had been in the hospital for three months and had been considered as improved. Held—no liability.

On the other hand, in *Noel v. Menninger Foundation*,⁸ a seventy-one year old man while going for a walk with an attendant threw himself in front of a bus and was killed. On his admission to the hospital there was no noticeable suicide tendency, though it was thought that he might become a suicidal risk. His diagnosis was "hypochondriacal psychoneurotic" of long standing. He became more paranoid, and electric shock therapy and lobotomy were being considered. While he later threatened suicide, he had left the hospital on occasion with his wife. Held—the Menninger Foundation was liable—a result opposite to that in the *Mills* case.

In various cases where patients left the hospital and were found dead⁹, drowned in a lake¹⁰, or hit by a railroad train¹¹, these later acts were held to be subsequent and independent acts with the allegedly negligent act of the hospital not the proximate cause of the death, or that the acts were not foreseeable and thus that there was no negligence. In the *Hohman* case, above, where the decedent had twice previously attempted suicide, the court held that the hospital had only a duty to observe him and give him medical treatment. This is an interesting case as it implies the distinction which has become so important—are hospitals places to treat sick people or are they maximum security prisons? The changing role of the hospital will be enlarged upon below.

⁶ *Dahlberg v. Jones*, 232 Wis. 6, 285 N. W. 841 (1939).

⁷ *Mills vs. Society of New York Hospital*, 274 N. Y. S. 233, 242 App. Div. 245, 270 N. Y. 594, 1 N. E. 2d 346 (1936).

⁸ *Noel v. Menninger Foundation*, 180 Kan. 23, 299 P. 2d 38 (1956).

⁹ *Hohmann v. Riverlawn Sanatorium*, 103 N. J. L. 458, 135 A. 817 (1927).

¹⁰ *Hawthorne v. Blythewood, Inc.*, 118 Conn. 677, 174 A. 81 (1934).

¹¹ *Hebel v. Hinsdale Sanitarium and Hospital*, 2 Ill. App. 2d 527, 119 N. E. 2d 506 (1954).

The courts have commented that suicide is "an accompaniment" of manic-depressive psychosis,¹² or that one of the characteristics of schizophrenia is a tendency to commit suicide.¹³ These erroneous concepts will be dissected below.

There have been cases in which hospitals and/or physicians have been held liable in addition to those above mentioned.¹⁴ Other cases have denied liability.¹⁵

In a New York case,¹⁶ a chronic schizophrenic had been hospitalized for seven years. There had been one suicide attempt in his history. In the last two years of his hospitalization he left the hospital frequently on passes. While away from the hospital on a days' pass he committed suicide. His schizophrenia was considered to be "incurable," but he had shown no suicidal tendencies prior to his suicide. The state prevailed because at that time it was immune to suit, but the court made the statement that "under such a situation and in view of his past history, it was negligence to permit the patient to leave the hospital unattended." This fantastic statement on the part of the court can reflect only its ignorance. The feeling that all chronically ill patients should be constantly locked up and guarded is a relic of medieval thinking and represents an attitude long since demolished in mental health circles. Hospitals abroad and in this country have increasingly "opened up," and given patients more freedom, with great improvement in discharge rates. The irony of the situation is indicated by the fact that the New York State Department of Mental Hygiene has been leading the country in progress in the treatment of the mentally ill and in developing the open ward hospital, while its courts render opinions almost perverse in view of the progress in the twentieth century.

A case which shows much greater insight into the nature of the problems involved is a Tennessee case of 1942, *James v.*

¹² *Supra*, note 10.

¹³ *Supra*, note 5.

¹⁴ *Gries v. Long Island Home*, 83 N. Y. S. 2d 728, 274 App. Div. 938 (1948); *Fowler v. Norways Sanitarium*, 42 N. E. 2d 418 (Ind. 1942); *Lange v. U. S.*, 179 F. Supp. 777 (1960), *Re Apicella's Estate*, 140 N. Y. S. 2d 634, 207 Misc. 743 (1955); *Rural Education Ass'n. v. Anderson*, 37 Tenn. App. 209, 261 S. W. 2d 151 (1953); *Hirsch v. State of N. Y.*, 183 N. Y. S. 2d 175 (Ct. Claims, 1959). And see generally, suicide (not hospital) cases: *Ackerman v. Dairymen's League Coop. Assn.*, 10 App. Div. 2d 112 (N. Y. 1960); *Prudential Ins. Co. v. Redwine*, 332 S. W. 2d 643 (Ky. App. 1960).

¹⁵ *Tisinger vs. Woolley*, 78 Ga. App. 18, 50 S. E. 2d 122 (1948), *Lewis v. State*, 152 N. Y. S. 2d 161, 1 Misc. 2d 1078 (1956)—a senile psychosis case.

¹⁶ *Kubas vs. State*, 96 N. Y. S. 2d 408, 198 Misc. 130 (1949), *aff'd.* 104 N. Y. S. 2d 856, 278 App. Div. 887 (1951).

Turner.¹⁷ Here a patient who had voluntarily admitted himself to a private sanitarium, while walking with an attendant suddenly ran to a water reservoir, climbed up, jumped in, and drowned. He was a chronic alcoholic who had threatened suicide previously.

The physicians were held not guilty of negligence that would render them liable for the patients' death. The court stated that "It might well be said that the use of ropes or handcuffs or other restraining forces would have retarded his natural progress in regaining his health, both mental and physical." The accuracy of the court's words, written in 1942, is attested to by the fact that physical restraints in hospitals have since been almost totally abolished.

In this specific case, the patient had earlier had some flexibility of movement, such as going to the barber shop in town. The court further commented, "Can it be said that it was within reasonable contemplation that the patient would suddenly dash away, climb the tank ladder and end his life, any more than it can be said that he could have run off and into a public street or thoroughfare and purposely allowed an automobile to run over him; or any more than it can be said that it could have been reasonably anticipated that he would see a knife or razor hidden in the grass and there suddenly take it and end his life? These things are possibilities, not probabilities."

Thus cases on sudden impulse suicides have reached opposite conclusions on similar factual situations. The basic law involves questions of foreseeability and controllability. For example, in one case¹⁸ the court stated, "The attendant could not have prevented the assault. The presence of almost twenty-five other patients did not prevent the assault. At a matter of law, the state is not compelled to provide individual supervision for every mental patient. The state is not an insurer of the safety of such patients. Claimant has not sustained the burden of proving that the state has failed to use reasonable care against a foreseeable occurrence."

A few words on "malpractice." A physician is liable for bad or unskillful practice resulting in injury to the patient. He must use a degree of skill comparable to that possessed by others in his profession or medical specialty. In determining the learn-

¹⁷ *James v. Turner*, 201 S. W. 2d 691 (Tenn., 1942).

¹⁸ *Robinson v. State of N. Y.*, 17 Misc. 2d 775 (N. Y., 1959).

ing and skill necessary in the treatment of a particular case, regard must be had to the state of medical knowledge at the time. A physician is not liable for injurious consequences if he exercises the required degree of skill and care. It should be noted that where there are several accepted methods of treatment, the physician may adopt any one of them even though the one not chosen is not the one most generally used.

There are few cases involving malpractice and suicide, since ordinarily the failure claimed is one of lack of watchfulness over the patient in the hospital, and this is a duty of the hospital, not the doctor; secondly, a doctor is not the insurer of a good result nor must his judgment be correct. It must only be reasonable and in accord with accepted practice. And of course, there is the factor that most people cannot accept the irrationality of attributing the behavior of one person to others who have no control over the acts of another.¹⁹ A physician need not be omniscient nor insure a good result. As statistics will show, he can do neither.

Thus far in this paper, we have encountered the words, "reasonable," "anticipated," "foreseeable," "preventable," and "controllable." Since these words cover the essence of any legal case involving the standards of care in a potential suicide, let us turn to the information available to decide what they mean.

The starting place in any effort to relate law with suicide is a study of suicide itself.

Hirsch,²⁰ a Professor of Environmental Medicine at the Albert Einstein Medical Center in New York, reports that while the reported number of suicides per year is sixteen thousand (16,000) to twenty thousand (20,000), a substantial number of suicide deaths are not so recorded on death certificates because of religious, social, or moral stigma, and he estimates the actual number of suicides a year at fifty thousand (50,000) to sixty thousand (60,000), or a rate of about 35/100,000 in contrast to reported rates of 10-15/100,000. Using Hirsch's estimates, the number of suicides is higher than the number of those killed in auto accidents. Statistics vary widely from place to place. Civilized countries such as Denmark and Japan lead the world, although suicides in the large California cities exceed even these.

¹⁹ A physician is not liable for an injury caused by the act of the patient. *Dunman v. Raney*, 118 Ark. 337, 176 S. W. 339 (1915); *Richards v. Willard*, 176 Pa. 181, 35 A. 114 (1896).

²⁰ Hirsch, J., *Suicide*. 43 *Ment. Hyg.* 516 (Oct., 1959).

Why the rate in Denmark is three times that of Norway raises puzzling questions.

It must be recognized that many physicians or families do not report overt suicides or do not recognize them. In many areas there is no coroner's office to evaluate the possibility of a barbiturate death, or other hidden causes of death. Even when cases come to autopsy it is often difficult to decide between accidental overdosage or overdosage while under alcohol or purposeful overdosage. Due to social factors, doubts are usually resolved in favor of such more socially acceptable solutions as accidental death. Another group that can be mentioned only in passing is the variety of unrecordable forms of suicide—the diabetic who refuses to take insulin and eats ravenously, the alcoholic found dead of overexposure, the driver who passes a car on a curve going uphill.

An acquaintance of mine had marked suicidal tendencies which blossomed forth only when he was drinking. While there was no indication of this during his frequent periods of sobriety, when drinking he would fall down stairs, out second story windows, off fire escapes, or if driving, he would crash into trees. Only "fate" and the positive factors in his psyche prevented his becoming another accidental death statistic.

For those who think that suicide is recognizable, predictable, or preventable, the unfortunate fact is that the highest rate of suicide is found in physicians. While psychoanalysis provides one of our best means of psychiatric treatment, no less than seven of Freud's early disciples died by suicide.²¹

It is well known that a person can commit suicide despite all precautions. Clothes, eating instruments, any type of glass or metal, access to heights or moving objects, all can provide the means of self-destruction. Now with open hospitals such as those in New York, where for example, in one hospital of two thousand (2,000) patients 96 percent have free ingress and egress, suicide is available to almost any patient. Nonetheless, the protective nature of the hospital, the removal from stress, the emotional support, and the treatment programs, all act to lessen urges to suicide. Even in old and large state hospitals with relative absence of supervision, suicide assumes a role scarcely different from that in the general population. In California²²

²¹ Gibbs, W. F., *Therapy for Suicidal Patients*. 85 *Virginia Med. Month.* (3) 139 (Mar., 1958).

²² *Annual Report, California Department of Mental Hygiene* (1955).

state hospitals of all types in 1955, there were ten suicides in a hospital population of thirty-seven thousand (37,000) mentally ill and eight thousand (8,000) mentally deficient. In Ohio²³ in 1958, there were fourteen suicides in a population of thirty-six thousand (36,000) of whom twenty-seven thousand (27,000) were mentally ill and nine thousand (9,000) epileptic and mentally deficient. Twelve occurred while the patients were away from the hospital—for example, at home on Trial Visit. Only two occurred in hospitals. In New York²⁴ in 1959, there were twenty-nine suicides in a hospital population of ninety thousand (90,000). Thus in these three large systems with one hundred and seventy-one thousand patients (171,000) the suicide rate in the hospitals was 24/100,000—a rate not greatly different from that of the general population.

Apparently as hospitals have loosened up and treated patients more humanely, the suicide rate in mental hospitals has dropped. For example, in 1958 in Ohio the rate in hospitals was 1.6 per ten thousand (10,000) admissions and even including those on trial visit, the rate was eleven per ten thousand (10,000) admissions. The rate in New York was 11.6 per ten thousand (10,000) admissions. In contrast, in a Washington State Hospital over a period from 1891 to 1949, the rate was thirty-eight per ten thousand (10,000) admissions.²⁵ In 1959 the suicide rate in New York was 32/100,000 resident patients per year, compared with an average rate of 42.3/100,000 in the decade of 1919-1929.²⁶

Unfortunately, study of the attempted suicide group has not furnished material particularly applicable to suicide itself, and the difficulties of analyzing the successful suicide are obvious. One can only speculate in retrospect. The *attempted* suicide represents a vastly different type of problem and a different type of individual. For instance, while women attempt suicide at least

²³ Personal Communication: Division of Business Administration, Ohio Department of Mental Hygiene and Correction.

²⁴ Personal Communication: Director, Statistical Services, State of New York Department of Mental Hygiene.

²⁵ Levy, S. and Southcombe, R. H., Suicide in a State Hospital for the Mentally Ill. 117 *J. Nerv. Ment. Dis.* (June, 1953). In the Eastern State Hospital, Washington, there were 15,999 admissions from 1891 to 1949 with 58 suicides. Another interesting statistic is that in 1945, of 14,782 reported suicides in the United States only 284 (1.9%) occurred in mental hospitals as compared with 2,783 (18.8%) in general hospitals.

²⁶ Rosen, A., Detection of Suicidal Patients: Example of Some Limitations in the Prediction of Infrequent Events, 18 *J. Consult. Psychol.* 397 (Dec., 1954).

three or four times more frequently than men, men kill themselves three times more often than woman.²⁷ A study at Yale illustrated that suicide attempts or gestures are often utilized by patients to alter their environments, and the surprise fact was that such individuals were most successful in manipulating family or friends.

While I was at Bellevue Hospital in New York, we would admit as many as a dozen attempted suicides a night. Typically these were Puerto Ricans who had made impulsive hysterical suicidal gestures. After an hour or two the patients calmed down and they were usually sent home the next day. We saw so many of these immature hysterical people that we called this, "the Puerto Rican Syndrome."

In one study of 1817 attempted suicides²⁸, the incidence of psychosis was 6.7%; in another of 1147²⁹ only 5.9%. Other smaller studies have indicated higher rates of psychosis.³⁰ Thus, even for immediate treatment most patients are not committable, nor can they thus be held in a hospital against their will. Only a very small proportion of those who attempt suicide finally die by suicide—one study gives a number of 6%. There is marked disagreement as to the apparent seriousness of the suicide attempt being of diagnostic significance. Two studies based on psychological testing of three groups of patients—(1) those with suicidal thoughts, (2) those who had attempted suicide and (3) psychiatric patients in general—showed that the patients who attempted suicide as a group were similar to patients in general,

²⁷ Tuckman, J. and Lavell, M., Study of Suicide in Philadelphia, 73 Pub. Health Rep. (6) 547 (June, 1958).

Suicides in Philadelphia were analyzed in the period of 1951-1955 by the Medical Examiner's office. Philadelphia had three male suicides to one female suicide. Other interesting facts are that the rate in whites is two to three times that of negroes (with apparent reverse relationship to homicide). In Cleveland the rate in whites is 14.8/100,000 compared with 5.7/100,000 in non-whites. Reported rates in various cities are Philadelphia (7.2/100,000), Cleveland (12.8/100,000 in 1953-54), Detroit (9.8/100,000 in 1955), and Baltimore (10.0/100,000 in 1955).

Hirsch's figures for males and females were 16 and 4.6 per 100,000 respectively.

²⁸ Piker, P., Eighteen Hundred and Seventeen Cases of Suicidal Attempt. A preliminary statistical survey, 95 Am. J. Psychiat. 97 (July, 1938).

²⁹ Moore, M., Cases of Attempted Suicide in a General Hospital—a study in social and psychologic medicine, 217 New Eng. J. Med. 219 (Aug. 1937).

³⁰ See Vitanza, A., Church, E., and Offenkrantz, W., Suicide: A Review of the Literature 1945-1956, 170 Internat. Rec. Med. (12) 678 (1957). This report reviews 107 articles on the subject.

while the suicidal thought group was more seriously disturbed.³¹ Though the possibility of suicide exists with depression, the number of suicides is small in comparison with the vast number of depressives. At the Fairhill Psychiatric Hospital of Cleveland, about 15% of the patients in the Out-Patient Department show clinical depression. In our hospital population, there has been one patient suicide. This patient was diagnosed as a chronic undifferentiated schizophrenic; he had demonstrated no suicidal tendencies, had gone home on passes and was being considered for discharge. Following four days at home, he went looking for a job and that afternoon jumped off a bridge in downtown Cleveland. Frustration and rejection in his job seeking may have been a factor in this impulsive suicide. Thirty percent of our admissions have had diagnoses involving some type of depression, though most were mild or moderate in degree. Many were neurotic depressions, which seem to have a very low suicide rate.

Of the fourteen suicides in Ohio hospitals the breakdown by diagnosis was:

Neurotic Depressive Reaction	0
Psychotic Depressive Reaction	0
Involutional Psychotic Reaction	2
Manic-Depressive Reaction	1
Schizophrenic Reactions	
Schizoaffective type	1
Other Schizophrenic Reactions	6

Since schizophrenics usually make up about one-half the hospital population, the incidence would show no great significance. Other diagnoses were:

Psychoneurotic Reaction, Other	1
Alcoholism	1
Passive Aggressive Personality	1
Paranoid State	1

This goes along with general experience that suicide does not follow diagnostic categories in any predictable manner.

Of all suicides in Philadelphia in a five year period, one-eighth showed some evidence of mental disorder with one-sixteenth having been under psychiatric care.

³¹ (a) Rosen, A., Hales, W. M., and Simon, W., Classification of "Suicidal Patients," 18 J. Consult. Psychol. 359 (1954).

(b) Rosen, A., Detection of Suicidal Patients; an Example of Some Limitations in The Prediction of Infrequent Events, 18 J. Consult. Psychol. 397 (Dec., 1954).

Of those who attempted suicide, about 94% do not later die by suicide. Of those who die by suicide, 90% have no previous history of suicide attempt. Thus attempted suicide is of little value as a means of prediction. Parnell and Skottowe³² state, "From the preventive point of view the most significant fact in the present findings is the small number of patients showing disorders of thinking, the change so often regarded by the general public as a *sine qua non* for admission to a general hospital."

The stress on involuntional and manic-depressive depressions in the past has probably been because, of all conditions, here there is the best predictability however poor, and also because these cases must be hospitalized usually because of the overall collection of symptoms which respond well to treatment. Even here it is known that these patients may die by suicide after their illness has improved. It is an upsetting situation when the patient recovers from his disabling symptoms, goes home, and then kills himself. Wall³³, in giving criteria for severe depression meriting hospitalization, points out, "families of suicidal patients should know that no hospital can guarantee the absolute safety of a patient even though precautionary measures and vigilance of the highest type are maintained."

Many psychiatrists have stressed the difficulty in predicting the possibility of suicide in a particular patient. The old equation of suicide and manic-depressive depression has long since been demolished.

Carr, Professor of Legal Medicine at the University of California, points out ³⁴ that "there have been many clinical attempts to establish criteria that would be of assistance in predicting suicide in certain types of mental disorders, but so far no reliable guide has been found." The main problem in prediction lies in the uncertainty one feels as to whether or not a patient will commit a suicidal act and also whether that act will take the form of a suicidal demonstration, a suicidal attempt, or suicide. . . . It seems rather doubtful whether we shall be able to predict precisely what suicidal action an individual is going to take clinically because the disease is not fully developed until the moment of decision."

³² Parnell, R. W., and Skottowe, I., *Towards Preventing Suicide*, 1957 *Lancet* 206 (1) (Jan., 1957).

³³ Wall, J. H., *The Psychiatric Problem of Suicide*, 101 *Am. J. Psychiat.* 404 (Nov., 1944).

³⁴ Carr, J. L., *Suicide*, 170 *Internat. Rec. Md.* (11) 613 (Nov., 1957).

Zilboorg, in several articles on suicide, pointed out the unpredictable nature of suicide. Since suicide is such a rare event statistically, prediction becomes impossible. For instance, Rosen, a psychologist,³⁵ postulated in a much criticized article, a series of events worth consideration. In one series of twelve thousand (12,000) patient admissions, there were forty suicides. A prognostic test of 75% (and nothing that good exists) would pick up 30 of the 40, but it might also give 2,990 false positives. While his reasoning is fallacious, it points out that prediction of events of low incidence is fraught with difficulty. He also points out that there is the same difficulty in a prediction based on "clinical judgment" and states "a suicide detection device is not feasible until much more is learned about the differential characteristics of patients who commit suicide."

Thus, in any given case the psychiatrist deals with possibilities of a remote and unpredictable but ever present nature. He never deals with probabilities—only possibilities of unmeasurable degrees. Unlike the situation elsewhere where a disaster occurs because of an act by the physician—for example, leaving scissors in the abdomen during surgery, here the disaster arises from the act of the individual patient. Not only can the disaster not be accurately anticipated, but the patient himself changes from day to day, week to week, and month to month.

The patient's problems—whether they be alcoholism, a sex problem, economic difficulties, chronic physical illness, or any other condition in the gamut of psychiatry—may show marked improvement. How does one predict from that point?

Here are some typical situations:

(1) A middle aged female alcoholic with severe environmental problems has been taking excessive barbiturates. In a financial panic, she takes thirty nembital after heavy drinking. She is brought to the general hospital unconscious. The next day, conscious but somewhat confused and depressed, she is brought to a psychiatric hospital. In a few days the depression has lifted considerably and she is back to her normal character pattern, which dictates troubles in the future similar to those in the past and not especially subject to alteration. She is not mentally ill by any definition. What will be the course of events in this case?

³⁵ *Supra*, note 31 (b).

(2) There are fifteen thousand schizophrenics in the hospitals of a state (in addition to at least thirty-thousand not hospitalized). Seven of those hospitalized will die by suicide in a given year. Who are they? Who will suddenly jump from a bridge or from a height, or hang himself? What can be done to recognize and stop such act on a permanent basis? Are you going to lock up and tie the arms and legs of 15,000 people as an absolute preventive measure? And if you did this would you then increase the suicide rate by such inhumane handling of people?

(3) A severely depressed patient is brought to the hospital. The patient is restricted to the ward for the first few days. Despite frequent observation, numerous opportunities for self-destructive actions are present due to the nature of the hospital construction, the staffing, and the fact that you can control a person against his will only to a limited degree. The patient wears clothes. These can be twisted into a rope and used as an instrument for hanging. Are clothes to be removed? If you watch the patient closely, how long? After one day the patient seems more comfortable, is partaking of ward activities, does not seem so depressed. He may be placed on drugs, electric shock, or individual psycho-therapy. He seems better and wants to go home. The family is faced with a large bill and is under considerable pressure from the patient. If he is kept in the hospital, what good will further hospitalization do? Will it merely postpone things? What will happen?

These are only sample situations with innumerable potential variations. They raise questions to which no one, at this stage of development of human knowledge, has the answers.

Thus, a mass of confusing data has been presented to illustrate our relative helplessness in the face of suicide—a social problem that has not been particularly altered by time. The causes and treatment of this act of complex etiologies are not yet defined, nor, by its nature, does any solution seem very likely. Therefore, we must accept the fact that suicide is a problem characterized by marked limitations in predictability and control—not only in hospitals but throughout our society, of which the hospital aspect represents only a minute element.

These are factors which must be considered by the court and the jury in deciding the liability of a hospital where a suicide occurs. In the past, isolated legal decisions indicated that the standard of care was close observation, restriction, and restraint. This standard of care has fallen into complete dis-

repute in modern hospitals as being anti-therapeutic and so aggravating of feelings of worthlessness as to possibly provoke suicidal acts. In contrast, reversal of this policy in hospitals, in addition to aiding in the treatment of all types of mental illness and shortening the periods of hospitalization, has apparently resulted in a somewhat lessened suicide rate as well as a decreased rate of destruction and violence. For example, in the older prison-like hospitals, destruction of hospital equipment and property was great. In the modern psychiatric hospital with a decent atmosphere and good treatment, the patient does not feel so strongly the urge to strike out at the environment or himself. In former times, glass was an item covered by screens or wire mesh or was made unbreakable. In many hospitals today, there are numerous chandeliers, paintings in glass frames, and other types of glass fixtures. At the Fairhill Psychiatric Hospital there has been practically no destruction of property by patients, who in general appreciate the advantages of a therapeutic environment.

It would be the height of irony if the courts, in their effort to promote the public welfare, would by legal decision force the continuance of harmful and outdated practices. For example, in Wasmuth's study on anesthesiology³⁶, he has pointed out how, by adverse legal decisions, California anesthesiologists have been intimidated into abandoning as too dangerous procedures which are often accepted elsewhere in the country as procedures of choice.

In conclusion, it is obvious that psychiatrists and hospitals are much concerned with the problem of suicide. Part of this concern and anxiety is based on a feeling of helplessness in that there is no control, nor predictability as to what will happen, when, where, how, or by whom.

The law demands reasonable care in foreseeable situations. This is a sound and logical principle. A civilized society can ask only that the law be applied in an intelligent and rational manner. However, we cannot cover up our ignorance and our inability to control our social problems by proclaiming the misinformation and prejudice of the past. After all, in both law and medicine, recognition of ignorance is the first step to knowledge, and only from knowledge does there come method, instead of the madness so prevalent in our society.

³⁶ Wasmuth, C. E., Court Dictation of Choice of Anesthesia, 6 Clev.-Mar. L. R. 461 (Sept., 1957).