Why Exempting Negligent Doctors May Reduce Suicide: An Empirical Analysis

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This Article is the first to empirically analyze the impact of tort liability on suicide. Counter-intuitively, our analysis shows that suicide rates increase when potential tort liability is expanded to include psychiatrists—the very defendants who would seem best able to prevent suicide. Using a fifty-state panel regression for 1981 to 2013, we find that states which allowed psychiatrists (but not other doctors) to be liable for malpractice resulting in suicide experienced a 9.3% increase in suicides. On the other hand, and more intuitively, holding non-psychiatrist doctors liable decreases suicide by 10.7%. These countervailing effects can be explained by psychiatrists facing liability choosing not to work with patients at high risk for suicide, whereas other doctors do not have that ability and instead avoid liability by providing better care.

The Article makes important contributions to the law of proximate cause and to the more general phenomenon of regulatory avoidance. Traditionally, one could not be liable for malpractice that caused another's suicide—the suicide was considered a superseding and intervening cause. About half of states retain the old common law rule. Others have created exceptions for psychiatrists only or for all doctors, and some have abandoned the old rule entirely. Our findings suggest that expanding liability for psychiatrists may have an adverse effect. Accordingly, this Article suggests that the best policy might be to retain or revive the traditional no-liability-for-suicide rule for mental health specialists. The implications are enormous: over 40,000 people in the United States die each year from suicide.

Keywords: *Regulatory Avoidance, Suicide, Screening, Actual Causation, Proximate Cause, Superseding Intervening Force, Activity Levels, Care Levels, Deterrence, Psychiatrists, Doctors, Mental Health Providers, Torts.*

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INTRODUCTION

Suicide is a large and growing public health problem in the United States. Over 42,000 people killed themselves in 2014, roughly one person every twelve minutes.[1] And since 1999, the suicide rate has been climbing.[2] Two leading theories for the increase are easier access to painkillers and weak family and social support, particularly among middle-aged whites.[3] As to the high rate generally, the availability of firearms is commonly cited.[4] Poor mental health care is another plausible candidate given the strong association between mental illness and suicide.[5]

This Article examines a new theory for why suicide rates rise and fall: allocation of the costs of suicide by the legal system—specifically, tort law. The traditional rule is that one cannot be liable for negligence that causes another's suicide.[6] Under this rule, a psychiatrist or non-psychiatrist doctor ("NPMD") who commits medical malpractice resulting in her patient's suicide is exempted from liability.[7] A leading case

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1. *10 Leading Causes of Death by Age Group, United States – 2014*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2014-a.pdf [https://perma.cc/N2KY-33BW].

2. SALLY C. CURTIN, MARGARET WARNER & HOLLY HEDEGAARD, CTRS. FOR DISEASE CONTROL & PREVENTION, INCREASE IN SUICIDE IN THE UNITED STATES, 1999–2014, at 1 (2016), http://www.cdc.gov/nchs/data/databriefs/db241.pdf [https://perma.cc/9YXA-AX4R].

3. Mike Stobbe, *'Deaths of Despair' Drag Life Expectancy Lower for Whites*, U.S. NEWS & WORLD REP. (June 3, 2016, 12:55 PM), http://www.usnews.com/news/news/articles/2016-06-03/deaths-of-despair-overdoses-drinking-suicides-hit-whites [https://perma.cc/B5WR-NQ7E].

4. Matthew Miller, Deborah Azrael & Catherine Barber, *Suicide Mortality in the United States: The Importance of Attending to Method in Understanding Population-Level Disparities in the Burden of Suicide*, 33 ANN. REV. PUB. HEALTH 393, 401 (2012).

5. E. Clare Harris & Brian Barraclough, *Suicide as an Outcome for Mental Disorders: A Meta-Analysis*, 170 BRIT. J. PSYCHIATRY 205, 222–23 (1997).

6. Scheffer v. R.R. Co., 105 U.S. 249, 252 (1881).

7. Of course, psychiatrists are doctors, but are sometimes treated differently than other doctors for purposes of tort liability for suicide. Hence, this Article generally uses three terms:

explains that, as a general rule, "the act of suicide is considered a deliberate, intentional and intervening act which precludes a finding that a given defendant, in fact, is responsible for the harm."[8] Plaintiffs have sought exceptions to this general rule with varying success in different states over time.[9] Some states have gone so far as to abandon the traditional rule entirely.[10]

It is plausible to think that tort liability might affect suicide rates. Doctors, and psychiatrists in particular, are likely aware that post-suicide claims account for a large proportion of malpractice lawsuits and the highest settlement amounts.[11] Doctors may change their behavior in response to tort liability, and such changes matter for at least two reasons. First, doctors very often have contact with people at risk. About one in five of suicide victims had seen a mental health professional, and forty-five percent saw a primary care provider, *within a month* of dying by suicide.[12] Second, contacts with health providers can clearly make a difference. A recent comprehensive review concludes that the pharmacological treatment of psychiatric disorders contributes substantially to suicide prevention.[13] Psychotherapy and electroconvulsive therapy also appear to be effective.[14] "Education of primary care physicians targeting depression recognition and treatment was identified as one of the most effective interventions in lowering suicide rates."[15]

Expanding liability for suicide has at least two possible effects, both motivated by a desire to avoid that liability: (1) increasing the level of care exercised toward people at risk for suicide;[16] and (2) decreasing activity levels—that is, leading others to avoid, if possible, interacting with people at risk for suicide.[17] An example of the first might be a doctor prescribing fewer pills at a time to avoid intentional overdoses.[18]

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(1) psychiatrists, (2) non-psychiatrist doctors ("NPMDs"), and, together, (3) all doctors.

8. McLaughlin v. Sullivan, 461 A.2d 123, 124 (N.H. 1983).

9. *See* Patricia C. Kussman, Annotation, *Liability of Doctor, Psychiatrist, or Psychologist for Failure To Take Steps to Prevent Patient's Suicide*, 81 A.L.R. 5th 167, 180–81 (2000).

10. *E.g.*, Fuller v. Preis, 322 N.E.2d 263, 265–66 (N.Y. 1974).

11. Albert R. Roberts, Ianna Monferrari & Kenneth R. Yeager, *Avoiding Malpractice Lawsuits by Following Risk Assessment and Suicide Prevention Guidelines*, 8 BRIEF TREATMENT CRISIS INTERVENTION 5, 5 (2008).

12. Jason B. Luoma, Catherine E. Martin & Jane L. Pearson, *Contact with Mental Health and Primary Care Providers Before Suicide: A Review of the Evidence*, 159 AM. J. PSYCHIATRY 909, 912 (2002).

13. Gil Zalsman et al., *Suicide Prevention Strategies Revisited: 10-Year Systematic Review*, 3 LANCET PSYCHIATRY 646, 648 (2016), http://dx.doi.org/10.1016/S2215-0366(16)30030-X [https://perma.cc/R268-EN7G].

14. *Id.* at 649.

15. *Id.* at 651.

16. *See infra* Part II.B.

17. *See infra* Part II.B.

18. *See* Hobart v. Shin, 705 N.E.2d 907, 909 (Ill. 1998).

An example of the second might be a psychiatrist refusing to accept new patients who are at high risk for suicide.[19] Which strategy practitioners employ will depend in part on their ability to effectively screen out high-risk individuals.[20]

The uneven evolution of tort law on suicide presents an ideal setting in which to test which of these two effects dominates. One of the authors of the present Article predicted that suicide rates would decrease in jurisdictions that expanded liability on the theory that the level of care would increase. Another of us hypothesized that the second (screening) effect would mitigate or even reverse that result, such that suicide rates could climb in jurisdictions after expansion. The third author, an empiricist who remained neutral, judged the contest by testing the predictions using panel regression techniques.

It is a split decision. We find some evidence that expanding liability to psychiatrists, who are in a relatively strong position to screen patients, was associated with an increase in suicide rates. It must be conceded that very few jurisdictions fall into this category. Most states that expanded liability did so for both psychiatrists and NPMDs. This shift in legal regime did not significantly affect suicide rates. Neither did eliminating completely the old no-liability-for-suicide rule. Evidence for the increased-care-decreased-suicide position was a significantly lower suicide rate associated with NPMD liability modeled separately. In other words, the data suggest that doctors who are less well positioned to screen high-risk patients respond to expanded liability by providing better care.

This Article sheds empirical light not only on fundamental questions in tort law, but also illustrates the broader phenomenon of regulatory avoidance. Take the Americans with Disabilities Act ("ADA"), which was intended to improve employment opportunities for people with disabilities.[21] It has been less successful than hoped and our theory may help explain why. The ADA prohibits discrimination against persons with disabilities and mandates reasonable accommodations in the workplace for such individuals.[22] Because a hiring claim is more difficult for a plaintiff to prove than a failure to provide accommodations or a discriminatory discharge claim, employers may avoid hiring persons with disabilities.[23] Some empirical studies suggest that employers may be acting this way, and the employment rate for

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19. *Id.* at 911. Some mental health care providers might even leave the field. Thomas L. Hafemeister, Leah G. McLaughlin & Jessica Smith, *Parity at a Price: The Emerging Professional Liability of Mental Health Providers*, 50 SAN DIEGO L. REV. 29, 87 (2013) ("To the extent that providers feel that the delivery of [mental health] care has become too onerous, it may drive them from the field and make critically needed services less available.").

20. Other commentators have noted these two competing effects, though not with respect to suicide specifically. *E.g.*, Joanna M. Shepherd, *Tort Reforms' Winners and Losers: The Competing Effects of Care and Activity Levels*, 55 UCLA L. REV. 905, 908 (2008) ("On the one hand, increased liability should increase doctors' incentives to take care, decreasing deaths from medical malpractice; on the other hand, increased liability should reduce doctors' willingness to supply their services, increasing death rates.").

21. 42 U.S.C. §§ 12101–12213 (2012).

22. *Id.* § 12112.

23. SAMUEL R. BAGENSTOS, DISABILITY RIGHTS LAW: CASES AND MATERIALS 171–72 (2d ed. 2014).

persons with disabilities has not increased since passage of the ADA.[24] Appreciating the potential for regulatory avoidance is absolutely essential in incentivizing behavior across all areas of law.

The rest of this Article proceeds as follows. Part I outlines the evolution of tort law on suicide. Part II first places this story in the context of literature on causation, then sets forth two competing hypotheses about how changes in tort law might impact the suicide rate. Part III tests the hypotheses with a broad set of panel data. Finally, we offer discussion and suggest directions for future research in a brief conclusion.

I. THE LAW

The starting point is the United States Supreme Court's 1881 decision in *Scheffer v. Railroad Company*.[25] In that case, the executors of decedent's estate alleged that his suicide was the direct result of injuries sustained earlier in a train accident.[26] The Court affirmed dismissal of the claim as a matter of law, explaining that "[t]he proximate cause of the death of Scheffer was his own act of self-destruction."[27] The suicide was a "new," "sufficient," and "intervening" cause of the harm.[28] *Scheffer* has been interpreted to mean that suicide always breaks the causal chain—that is, there can be no liability for negligence resulting in someone else's self-harm.[29]

Tort liability for suicide has expanded since *Scheffer*.[30] This Article focuses on three expansions.[31] Under the first expansion, a patient or the patient's family may sue a psychiatrist for negligence resulting in suicide in a non-custodial setting.[32] The second expansion applies this principle to all physicians, not just psychiatrists. The third expansion jettisons *Scheffer* completely and applies the usual foreseeability principles for every type of defendant. In every jurisdiction following the third approach, psychiatrists and NPMDs are potentially liable. What may be less apparent is that the second approach means both NPMDs *and* psychiatrists can be liable. No jurisdiction has extended liability to NPMDs and not psychiatrists.

A hypothetical illustrates. Suppose a person discusses severe depressive symptoms with their primary care physician. The doctor prescribes a low dose of antidepressant medication. After a near-lethal suicide attempt a month later, the person is seen in the hospital by a psychiatrist, who increases the dosage but declines to initiate civil commitment proceedings. A few days later, the person nervously

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24. *Id.* at 172–73.

25. 105 U.S. 249 (1881).

26. *Id.* at 250.

27. *Id.* at 252.

28. *Id.*

29. Allen C. Schlinsog, Jr., *The Suicidal Decedent: Culpable Wrongdoer, or Wrongfully Deceased?*, 24 J. MARSHALL L. REV. 463, 471–73 (1991). Other cases reached the same result on the ground that suicide is wrongful. *Id.* at 471.

30. Victor E. Schwartz, *Civil Liability for Causing Suicide: A Synthesis of Law and Psychiatry*, 24 VAND. L. REV. 217, 226 (1971).

31. *See infra* Table A2.

32. A custodial relationship—medical or nonmedical—is always "special" for this purpose.