Patient Suicide and Death by Rational End-Of-Life Decision

written by Richard Leslie | February 1, 2018

Avoiding Liability Bulletin – February 2018

While a patient's suicide and a patient's rational and legally supportable decision to end his/her life both result in the death of the patient, these two potential occurrences require mental health practitioners to act in different ways when presented with either scenario. Some may ask why I chose to write about these seemingly separate issues in the same article. Perhaps I do so because the term "physician-assisted suicide" has been used for more than a decade, thus connecting the thought of "suicide" with physician-assisted death. As more states enact or move toward an end-of-life option for the terminally ill, mental health practitioners may see increased numbers of patients who seek death pursuant to such state laws. Some patients may seek death with dignity in circumstances not specifically covered by a death with dignity or end-of- life option statute. The reality of patient suicide will continue to be a part of the landscape. The practitioner will inevitably have to weigh whether to support or understand a patient's informed and rational decision to end his/her life or whether to attempt to prevent the patient from the intended self harm. The lines may not always be clear.

Patient suicide is typically or often the result of a serious mental disorder (e.g., severe depression) which impairs the judgment of the patient and results in death by the patient's actions and/or inaction. With respect to a suicidal patient, the practitioner's instincts and professional obligations are generally directed at prevention. What is the duty of a licensed mental health practitioner when the practitioner determines or reasonably believes that the patient presents a danger to self (possibly suicidal)? While practitioners must be familiar with the law in their particular states, the duty, generally stated, is one of due or reasonable care to do whatever may be necessary to lessen or prevent the threat of self harm or suicide. The duty is often exercised by taking one or more of the following actions (and there are others), depending on the circumstances; increasing the frequency of treatment, referral to a physician (psychiatrist) or other licensed practitioner specializing in such cases for further treatment or for possible medication, clinical consultation, voluntary hospitalization, and informing select others (those reasonably likely to be helpful in preventing or lessening the threat) of the danger of self harm.

In a state where there is a "death with dignity" law, the licensed mental health practitioner could be involved as a treating psychotherapist or, depending upon state law, as an assessing mental health practitioner or specialist. With respect to a patient's rational and supportable decision to die (as the result of a terminal illness and in accordance with a state law allowing the end of life option) the treating practitioner's instincts and professional obligations are generally directed toward understanding and support as the patient navigates the statutory life-ending process. In California, the recently enacted law allows only psychiatrists or licensed psychologists to act as the "mental health specialist" to whom

the patient may be referred if the patient exhibits signs of a mental disorder. The mental health specialist's assessment is made for the purpose of determining that the patient has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

There are innumerable scenarios that can arise, both in states where there are no end-of -life statutes and in those few states where there are end-of -life statutes. Some of the scenarios can present thorny dilemmas, questions, or concerns for the prudent and concerned practitioner regarding the duty owed and the action(s) to be taken in a particular case. The moral and philosophical beliefs and deeply held views of mental health practitioners, especially with respect to death and dying issues, together with their commitment to work in the best interest and welfare of patients, will of course influence the decisions and actions of practitioners. Additionally, one's fear or understanding of the legal and regulatory system in the particular state involved will also influence the actions taken by a practitioner in a particular scenario. Ultimately, the treating practitioner may either attempt to prevent or lessen the likelihood of the patient's death or will support the patient's rational, informed, and understandable decision to end his or her life.

In a death with dignity situation (where there is no statute authorizing an end-of -life option), the treating practitioner who wants to be supportive of the patient's intentions must, at a minimum, be certain that there is no serious or debilitating mental disorder present, or if there is a mental disorder, it does not impair the patient's judgment. Another thorny scenario might occur for a treating mental health professional where a physical illness is not considered terminal, but there is long-existing severe physical pain and suffering. This could occur in a state where there is a statutory end-of -life option but the conditions and requirements of the statute have not yet been met, or it could occur in a state where there is no statutory end-of- life option. In these thorny situations, it is important to ascertain if it is a crime to aid, advise, encourage, or assist another to commit suicide in the state involved. The important question that arises is whether continued treatment of the patient, with understanding and support for the patient's decision, constitutes the unlawful or criminal rendering of aid or assistance to a suicide.

Are there risks involved in being the supportive therapist or counselor under such circumstances? Of course there are risks – there usually are. Each of these scenarios presents a variety of concerns for the treating practitioner who seeks to avoid liability. One never knows who might learn of the practitioner's actions and who might be interested in filing a lawsuit, complaining to the licensing board, or filing a criminal complaint with a law enforcement agency. Each scenario presented could engender a different approach by the practitioner based upon the various factors mentioned above. Consultation with expert clinicians and an attorney familiar with the legal issues involved would likely be necessary and certainly wise in such thorny situations. Referral to a mental health practitioner for an independent assessment that may corroborate the treating practitioner's assessment of rationality and lack of impairment of judgment as the result of a mental disorder would likely be helpful in the event of civil or criminal litigation related to the action or inaction of the practitioner.

An entirely different scenario would occur where an anorexic and severely depressed patient refuses to

see a physician, despite the entreaties from the treating practitioner, and desires to continue to lose weight until there is a failure to thrive. The patient seeks the treating practitioner's understanding and support. The anorexic and severely depressed patient seems to me to be one involving intended suicide, where the practitioner would attempt to prevent the self harm and, at a minimum, attempt to inform the patient's physician of the patient's stated intent and current condition. Written permission from the patient to communicate with the physician or other health care providers or family members would typically not be required. Moreover, the practitioner would likely consider hospitalization of the patient, whether voluntary or involuntary, and taking other actions aimed at preventing the intended death of the patient. The practitioner would be required to render reasonable care – that is, the care that a reasonably prudent practitioner of like licensure would render under the same or substantially similar circumstances.

The primary purpose of this article is to stimulate thought and discussion rather than to definitively answer specific questions about particular end-of-life scenarios. This article represents the first time I have thought or written about end-of-life related issues (other than suicide) that may affect treating practitioners. It was triggered by a recent question from a licensed mental health practitioner. Most practitioners, I suspect, may not have yet encountered situations where they provided supportive care to a patient or client who chooses to die pursuant to the applicable statutory option, or who chooses to die without the specific statutory authority or in possible violation of state law. As new laws are passed, and as this issue is more often encountered, therapists and counselors will seek clarity and understanding from – among others – colleagues, educators, codes of ethics, and professional associations.