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Research Article

Suicidality–Medical Care and Treatment in a Legal Perspective-A Question of Suicide Prevention

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Abstract

The present work is enquiring into the legal implications of suicide and suicidality in *Swedish* health and medical legislation. Most people taking their own lives have been in contact with medical care before committing suicide, most commonly with psychiatric care or with general practitioners. Can it be argued that medical law is also concerned with preventing suicide as far as possible, just as traffic safety law is concerned with reducing the number of traffic deaths? The ethical principles underpinning good healthcare include not only the principle of self-determination but also the principle of maximising good and the principle of minimising harm. Can a teleological interpretation of the meaning, scope and legal effects of the medical law enactments be said to show a preventive purpose? Furthermore, why does not the Swedish compulsory psychiatric regulation (LPT) have the general *stated* purpose of protecting a mentally ill person from self-destructiveacts endangering the own life, while retaining the purpose of protecting others from that person's aggressive acts?

The material used in answering the topics of enquiry now stated comprises material from courts of law and from public authorities. Concurrently with the legal case material, however, I also present the results of an interview survey. The case material has also been supplemented with a questionnaire study aimed at canvassing the view taken by medical science of the content of the three basic LPT concepts of "serious mental disturbance", "imperative need of care" and "absence of consent" in a suicide situation.

Both voluntary and compulsory legal regulations can be said to have a suicide prevention function. Healthcare personnel have a duty of curing and relieving the suicidal individual and, if necessary, forcibly preventing him or her from committing suicide. Implementation of correct analyses of events in connection with suicide is an exceedingly important instrument of suicide prevention.

Keywords: Suicide; Suicidality; Suicide Prevention; Principle of Self-Determination; Principle of Maximising Good; Principle of Minimising Harm; The Health and Medical Services Act(HSL); The Patient Safety Act(PSL); Compulsory Psychiatric Care Act(LPT)

Abbreviations

HSL: Health and Medical Services Act;
PSL: Patient Safety Act;
LPT: Compulsory Psychiatric Care Act;
LSPV: Former Compulsory Psychiatric Care Act;
LRV: Forensic Psychiatric Care Act;
IVO: Health and Social Care Inspectorate, a state authority with supervision of Swedish health care, succeeded 2013 the National Board of Health and Welfare, which has a normgiving function;
SOSFS: Prescriptions and General Recommendations of National Board of Health and Welfare;

HSAN: Health and Medical Services Disciplinary Board, a state authority, from 2011 without disciplinary functions;
SOU: Swedish Official Reports;
NOU: Norwegian Official Reports;
HFD: Supreme Administrative Court;
CEO: Chief Executive Officer

1. General remarks on the purpose and content of the study

Mental illness is a well-documented determinant factor in suicide [1]. Depression, with various degrees of severity, is a form of mental health afflicting a large part of the population. Psychological autopsies [2] have made clear that depression is the most frequently occurring single psychiatric diagnosis in persons who have taken their own lives. Some 1,200 persons annually in Sweden commit suicide, and of these an estimated 90% have suffered from some form of mental disturbance in connection with their suicide [3]. The present work begins by enquiring into the legal implications of suicide and suicidality in *Swedish* health and medical legislation. Suicidality has been much written about from medical and social viewpoints, but the legal aspects of the subject have yet to be addressed.

The termsuicidality, which can be said to be the main issue addressed in this paper, given the content of suicide prevention, applies to people who have attempted suicide during the past year, or are seriously contemplating suicide, and are judged to present a suicide risk for the immediate future, or who, without seriously contemplating suicide, are judged, due to other circumstances, to be in the danger zone for suicide.

Suicidality is not an illness in itself but nevertheless is a problem frequently occurring in medical care. Most people taking their own lives have been in contact with medical care before committing suicide, most commonly with psychiatric care or with general practitioners. Many of them have also been in contact with social services. Given these contacts, it ought to be possible for the suffering which a suicide entails for all persons involved to be averted.

The words “suicide and “suicidality” do not occur as independent, explicit prerequisites in such medical legislation as the Health and Medical Services Act (1982:763) HSL, the Patient Safety Act (2010:659) PSL or the Compulsory Psychiatric Care Act (1991:1128) LPT. This also applies to the Forensic Psychiatric Care Act (1991:1129) LRV, which will not be dealt with here. How, then, can suicide and suicidality be worth studying from a legal point of view when their legal connection appears at first sight to be minimal or non-existent? It will be investigated in this study.

2. Legal-ethical issues

Even though suicide/suicidality seems at first conspicuous by its absence in statutory provisions, I have enquired in this paper whether these are nevertheless circumstances to which importance is attached in actual practice. The case of persons being a danger to themselves is mentioned in Sections 11 and 19 of LPT(risk of seriously injuring themselves). Statutory provisions expressly referring to suicide may be lacking, but there is a binding prescription on the subject in SOSFS 2005:28, Prescriptions and General Recommendations of the National Board of Health and Welfare, concerning notifiability under the Lex Maria (SOSFS 2013:3), to the effect that notification must be made if a patient commits suicide in connection with examination, care or treatment, or is known by the care provider to have committed suicide within four weeks of being in contact with healthcare services (4:2). Basically, PSL 3:5 requires the Health and Social Care Inspectorate, IVO (formerly the National Board of Health and Welfare) to be notified of incidents which entailed or could have entailed serious injury from healthcare. The above mentioned SOSFS instrument further provides that an act judged by a professional practitioner responsible for treatment as attempted suicide and induced by deficiencies of examination care or treatment, is to be regarded as iatrogenic. However, all completed suicides, whether or not they are due to iatrogenic causes, are notifiable to the Inspectorate (formerly the National Board of Health and Welfare).

What stand has Swedish medical law taken regarding suicide and suicidality? Death is the clearest conceivable outcome of illness, and the prevention of premature death is a fundamental task of healthcare and medical care.

A completed suicide being irrevocable, the person concerned cannot be nursed or her/his condition alleviated and cured, as would be the case following a suicide attempt. That is where healthcare comes in. Prevention of injuries and diseases is another prime concern of healthcare. Where a completed suicide is concerned, talk of prevention may well appear cynical, but the fact remains that a completed suicide can teach healthcare professionals a great deal concerning suicide prevention. Prevention of suicide is a policy standpoint at national, regional and local levels, and efforts to this end have been progressively intensified over the past fifteen years; see below. Does the same apply in the legal context? Can it be argued that medical law is also concerned with preventing suicide as far as possible, just as traffic safety law is concerned with reducing the number of traffic deaths? If so, what would be the legitimacy of such a legal focus? Below, I will try to give answers of these questions.

Not withstanding a decline over the past three decades

(see below), suicide rates in Sweden remain high, averaging four a day, which is a good deal more than four times the number of traffic fatalities. Does this imply that suicide should be actively prevented? Of all human rights, that of self-determination is one of the most fundamental. Suicide and suicide attempt are an expression of self-determination regarding one's own life, and so preventing a person from committing suicide would be to violate their self-determination. Indeed, but this is not the whole truth. There are other ethical principles which argue to the contrary. The ethical principles underpinning good healthcare include not only the principle of self-determination but also the principle of maximising good and the principle of minimising harm [4]. Thus the principle of self-determination means that a person should be allowed to decide their own life, at all events if this does not encroach on other people's self-determination, while the second principle means that we should do good to others and the third that we have a duty of minimising other people's suffering or attempting to do so. If we prevent someone from taking her/his own life, are we thereby doing her/him good? Does work for the prevention of suicide amount to minimising other people's suffering? Is suicide or attempted suicide harmful in such a way that by preventing such an act we will have prevented harm?

Failing affirmative answers to these questions, we do not have an ethical foot to stand on when it comes, for example, to legitimising compulsory care. But we think we do have an ethical foot to stand on. The idea of human dignity as an inviolable right is a characteristic of most modern cultures. The principles of maximising good and minimising harm are a part of that idea, and they in turn form the basis of the provisions of the European Convention and the Swedish Constitution Act (aka. Instrument of Government) concerning the permissibility of compulsory care. As stated earlier, suicide and suicidality are closely bound up with mental illnesses, which make the connection with psychiatric/compulsory care seem natural. The nature of the connection will be made clear presently.

I assume, then, that prevention of suicide is ethically justified, from which it follows that existing legislation should be applied with a view to achieving ethically good results. The present paper, accordingly, is concerned with investigating the actual/potential importance of suicide and suicidality in the norm definition of Swedish medical law, and with the question of whether this norm definition has or can have a preventive effect. Does the medical legislation in HSL and PSL afford a safeguard for the purpose of saving a suicidal person's life? Can a teleological interpretation of the meaning, scope and legal effects of HSL and PSL be said to show that these enactments can be used for preventive purposes? Furthermore, why does not LPT have the general *stated* purpose of protecting a mentally ill person from self-destructive acts endangering the own life, while retaining the purpose of protecting others from that person's aggressive acts? The former purpose can be said to occur naturally in a healthcare enactment, but not the latter one.

3. Material and Method

The material I have used in answering the topics of enquiry now stated comprises material from courts of law and from public authorities such as the National Board of Health and Welfare, the Health and Social Care Inspectorate (IVO), which has succeeded the National Board of Health and Welfare as supervisory authority, and the Health and Medical Services Disciplinary Board (HSAN). Concurrently with the legal case material, however, I also present the results of an interview survey. The investigation has been based on informant interviews, which is to say that the interview subjects them and their experiences are not the actual research topic [5]. Instead the function of the interview subjects is to furnish information concerning the research topic, namely psychiatric care in practice. The seven informants have been chosen from their positions as CEO within psychiatry at Sahlgrenska University Hospital and the interviews were about organisation and planning, content of care, care personnel, voluntary care and compulsory care, continuity and co-ordination, "integrated psychiatry" and psychiatry and primary care.

The case material has also been supplemented with a questionnaire study aimed at canvassing the view taken by medical science of the content of the three basic LPT concepts of serious mental disturbance, imperative need of care and absence of consent in a suicide situation. A questionnaire survey was conducted at the Sahlgrenska University Hospital among representatives of psychiatry in Gothenburg. As shown by previous research, the view manifested among representatives of psychiatry impacts heavily on the processing of compulsory care cases by the administrative tribunals [6].

My analysis of court cases employs psychiatric compulsory care orders made by the Gothenburg Administrative Court between 2002 and 2012. These number 1,315, comprising appealed county administrative court/administrative tribunal decisions, giving a total of 2,630 judgements. In a previous pilot study I found, at a conservative estimate, that something like 200 out of 1,000 judgements concerned suicidal persons or persons who were "a danger to themselves". Thus, on the basis of the 1,315 administrative court decisions now mentioned, my "suicidality material" will comprise some 500 judgements. The reason why such a large volume of case material should be analysed is that the pilot study now mentioned showed the judicial decisions often to be unenlightening and repetitive. The analysis needs to be based on material as extensive as this in order to find answers to the pressing issues.

The statutory provisions of HSL, PSL and LPT, the case

material, the interviews and the questionnaires, together with material compiled by the National Board of Health and Welfare as vehicles of expression in reports (situation, interim and final reports etc.), conspectuses, recommendations, national guidelines, national follow-ups and evaluations, will be usedas tools for conveying a picture of the protection which a suicidal person is given by present-day Swedish healthcare.

In a document [3] entitled "Care of suicidal patients", the National Board of Health and Welfare has presented, on the basis of medical science and experience, a conspectus of current knowledge concerning the care and treatment of suicidal persons, aimed at if possible preventing the tragedy which suicide amounts to. This conspectus is partly descriptive, partly normative in character. As a national supervisory body with a government remit to take charge of norm definition in the field of medical law, the Board is required, within the scope of its competence, to issue binding prescriptions and also general recommendations which, without being formally binding, are nonetheless in practice intended to have a norm-defining effect. The same goes for the Board's conspectuses concerning various legal fields within its supervisory and norm-defining remit. The document referred to can accordingly be said to exist on the national, norm-definitive plane and to be addressed to healthcare personnel involved in the care of suicidal persons. Healthcare personnel are apprised of what at the time of writing can be termed science and proven experience where suicidality care is concerned, and so the material in the conspectus, insofar as it is "convertible" to legal guidelines for action, also acquires a legal content and a legal function.

Here it should perhaps be added that several of the observations made in the informant interviews have also been highlighted in the conspectus as worth emulating. Healthcare handling of different phases in a suicidality situation demands a great deal of knowledge, empathy and financial resources. The Board's conspectus concerning care of suicidal patients presents a number of different rules concerning action and approach, addressed to care providers and to healthcare personnel. These rules of approach in their turn are based on statements of fact derived from science and proven experience. The conspectus contains a variety and number of "shall" and "should" sentences concerning emergency assessment, emergency care of suicidal persons, care of suicidal persons etc. One might think that the "shall" sentences are mandatory, but this is not the case. A knowledge conspectus belongs to the large group of communications by the National Board of Health and Welfare which are not legally binding. Both "shall" and "should "sentences are recommendations with no express legal force. The supervisory authority has no sanctions at its disposal, but the recommendations recur in its decisions in connection with a complaint; see below.

Lex Maria notifications concerning suicide/suicidality will also be used as a tool. Assistance from IVO has enabled me to study all Lex Maria reports received between 2010 and 2013 by the National Board of Health and Welfare and, as from 1st June 2013, by IVO's South-western Region/Division. (IVO is also the repository for records of Lex Maria decisions by the National Board of Health and Welfare from 1st January 2010 to 31st May 2013 inclusive). The total number of decisions is 281.

The option of disciplinary sanctions for healthcare and medical personnel was abolished on 31st December 2010 through the enactment of PSL. An individual person can now formally allege the commission of an error by filing a complaint under Chap. 6 of PSL, first with the National Board of Health and Welfare and, as of 1st June 2013, with IVO. Even though disciplinary sanctions can no longer be imposed, it remains interesting to see how suicides were dealt with under that system. In order to study deliberations concerning disciplinary sanctions in connection with suicides, I have accessed 24 HSAN decisions from between 2002 and 2010 – a national sample of decisions, all of them relating to suicide assessments. Were these assessments negligently or erroneously made?

Other complaints between 2011 and 2013 from, respectively, the National Board of Health and Welfare and IVO Southwest have also been analysed. How does the supervisory authority go about things now that disciplinary sanctions are no longer an option?

The Lex Maria reports, HSAN decisions and IVO complaints from the basis for deciding the shape of responsibility under Swedish healthcare and medical law for suicides and suicide attempts.

4. Some facts concerning suicide/suicidality

A suicide is defined in Sweden as an intentional, self-inflicted, life-threatening act leading to death. This tallieswith the WHO International Classification of Diseases (ICD). The tenth version of the classification(ICD-10) has been in use since 1997. Where suicides are concerned, a distinction is made between certain and uncertain diagnoses. Certain suicides are cases in which there is no doubt of the deceased person having intended to take their life, while the classification uncertain suicideis used when there is uncertainty regarding intent, i.e. as to whether or not the act was intentional. Out of 100 certain and uncertain suicides, about 20 cases are uncertain, with little difference between men and women.The term was introduced in 1969 in ICD to establish a category which would facilitate diagnosis of a group of deaths differing from natural and accidental deaths but not meeting the requirements for designation as suicide, manslaughter/unlawful killing or murder. In Swedish

medico-legal precedent, at least 80 per cent of this category consists of suicides. The remainder comprises accidents in unclear circumstances, assault and battery causing death, or unclear cases of manslaughter/unlawful killing [3].

Suicide figures in Sweden have fallen since the beginning of the 1980s [7]. This is a trend which has been noted in several Western European countries[8]. Suicide attempts, however, have not diminished in number. Many of the patients attempting suicide come into contact with healthcare in that connection. Given that a suicide attempt is one of the very strongest risk factors for suicide, contact with healthcare affords a possibility of achieving suicide prevention through the high quality of emergency care.

The statistics show a clear difference between women and men. Women have lower suicide rates than men. The gender ratio, i.e. the ratio between men's and women's suicide rates, in Sweden in 2010 was 2.6:1. Thus for every suicide committed by a woman, 2.6 suicides were committed by men. Previously, the differences between men and women were greater still. The ratio at the beginning of the 20th century was 5:1.

For all EU countries, with few exceptions, we see declining suicide rates following a stable trend. The steepest decline appears for countries starting from a high level, *viz* Lithuania, Estonia, Hungary, Latvia and Slovenia. It is also clearly apparent that the falling trends are steeper for men than for women. The slowest decline in suicide incidence for men is found in Slovakia, Greece the Netherlands, Spain, the UK, Sweden and Poland. In recent years rising suicide rates have been reported from Greece, due to the economic crisis there, but it is too early yet for any firm conclusions to be drawn. Other EU countries, unlike Sweden, show signs of falling suicide rates among teenagers between 15 and 19 years old. Very few countries indeed show a tendency resembling Sweden's, i.e. an increase [7].

Suicide is recognised in many countries as a major public health problem. According to the WHO, something like a million people annually die by their own hands [9]. This applies particularly to regions of Asia and Africa.

Quite clearly, the number of persons attempting suicide greatly exceeds the number of completed suicides. Altogether some 8,800 suicide attempts were recorded in 2010. For every suicide, then, some five suicide attempts entailing hospitalisation are recorded. At least the same number of cases is presumed to go undiscovered or unrecorded. Roughly speaking, for every single person dying through suicide we may assume there are ten persons who have survived a suicide attempt and a hundred who are planning one.

The Swedish Government and Riksdag (parliament) have intensified their suicide prevention efforts in recent years. In 2008 the Rikdag resolved on a zero vision for suicide. In Government Bill 2007/2008:110, "Renewal of public health policy", the government stated: "No one should find themselves in such a precarious situation that suicide is felt to be the only way out. This Government has a vision of nobody needing to take their own life."

As stated above, nearly all suicides/suicide attempts are preceded by a mental illness/disturbance. Retrospective surveys show between 90 and 96 per cent of the persons concerned to have shown signs of mental disturbance at the time of their committing or attempting suicide [10]. Depression, substance abuse/addiction (alcohol especially), personality disturbance and schizophrenia are the dominant diagnoses [11]. Patients with mental disturbances are common in primary care, even if they present physical symptoms. Diagnosing the underlying mental disturbance is part and parcel of suicide prevention. This being so, the duty of conducting good healthcare is a vital concern of both somatic and psychiatric care.

5. The legal investigation - good psychiatric healthcare, patient safety and suicide prevention

5.1 Point of departure

As previously stated, HSL is a goal-rational enactment addressed to the care provider. The goal of healthcare is good health and care on equal terms for the entire population. This is also relevant to psychiatric care, whether compulsory or voluntary. HSL, which is a framework enactment, applies to all forms of healthcare, compulsory psychiatric care included. Care shall be provided with respect for the equal worth of all human beings and the dignity of the individual, and priority shall, as has already been made clear, be given to the person in greatest need of care (Section 2, HSL). The legal quality "good care" constitutes a point of departure for the manner in which care is to be provided, which the statutory text defines as good-quality care which caters to the patient's need for continuity and safety in care and which is based on respect for the patient's self-determination and privacy. There would seem to be a value consensus to the effect that care must be in harmony with science and proven experience, at the same time as it must be provided in the most efficient way possible. If healthcare resources are limited, the traditional attitude as expressed in the preamble of HSL may collide with the requirements of freedom of choice and individualisation. Formal security under the law may collide with material security under the law, and vice versa. If we assume that the basis of both formal and material security under the law is the provision of good healthcare, then from a rule-of-law viewpoint it is important to note that the way in which this good care is to be provided is not regulated in detail by statute. The care provider is free to achieve it in the way found appropriate, which of course generates

difficulties from the viewpoints of both predictability and controllability.

But even if HSL does not provide rules on the way in which good care is to be achieved, the healthcare sphere has a very large number of legal standards, including prescriptions and general recommendations by the National Board of Health and Welfare (see above), all of them aimed more or less directly at the achievement of good, safe care. Financial, structural and organisational measures too ultimately have the best interests of the patient as their guiding star. Respect for moral precepts, often based on such fundamental values as solidarity, justice and self-determination, is a pivotal factor in healthcare, and its moral values are deeply rooted there. Medical ethics acquires a very prominent role, with a regulatory function of great importance to care-seekers and patients.

Material security under the law, as I have defined it, cannot be fully existent so long as formal security under the law is lacking. Material security under the law emanates from formal security, whose demands for predictability and controllability, and especially appealability, is perceived as values which, along with other ethical values, go to make up material security under the law. Other ethical values include, for example, care on equal terms, care in proportion to the need for it, and care for those in greatest need of it – values with which the law enjoins compliance. Patient safety values also come under this head. If we disregard the fact of predictability and controllability values not being fully realised, owing to the lack of appealability, a number of other ethical values included in a material concept of security under the law are probably satisfied.

Section 1 of LPT lays down that the provisions of HSL apply to all psychiatric care, both outpatient and compulsory. Supplementary provisions on psychiatric care combined with deprivation of liberty and other coercion (compulsory care) are contained in LPT. HSL defines health and medical services as measures for the medical prevention, examination and treatment of diseases and injuries, which is to say that psychiatric care shall also be provided for the purpose of prevention [12].

PSL requires the care provider to notify IVO, formerly the National Board of Health and Welfare, of incidents which have entailed, or could have entailed, serious iatrogenic injury. The term "iatrogenic injury" refers to suffering, physical or mental harm or illness and fatality which could have been avoided if adequate measures had been taken when the patient contacted healthcare services. A serious iatrogenic injury is iatrogenic harm which is of an enduring and more than slight nature or as a result of which the patient has come to be in substantially greater need of care or has died. IVO shall ensure that incidents reported to it are investigated to the extent necessary and that the care provider takes the measures needed in order to achieve a high level of patient safety. The Prescriptions and General Recommendations of the National Board of Health and Welfare concerning notifiability under Lex Maria (SOSFS 2005:28) describe the procedure to be followed by the care provider in making such a report, as well as the required content of the report.

5.2 The outcome

In the investigated cases, the care provider has analysed incidents in the course of activity which have entailed iatrogenic harm or could have done so. The most important thing about an incident analysis being carried out as soon as an incident has entailed an iatrogenic injury or could have done so, is not to find out whether an individual person has acted wrongly but to ascertain what can be taken to prevent the same thing happening again. The purpose of incident analyses is to clarify the course of events and the causes of incidents or adverse occurrences as far as possible and to provide a basis for decisions on measures which will prevent similar occurrences in future, or at all events will limit the effects of similar adverse occurrences if they are not entirely avoidable.

As has already been made clear, all Lex Maria reports of suicides received between 2010 and 2013 by the National Board of Health and Welfare and, as from 1st June 2013, by the South-western Region/Division of IVO have been obtained from IVO. In nearly all cases, improvement measures of different kinds have been remarked on either by the care provider or by the Board/IVO. Care providers range from specialist departments of university hospitals, regional hospitals and primary care health centres to private medical practices. The informant is the CEO or senior consultant of the establishment concerned. A matter classed as a Lex Maria report ends with a decision being taken by the supervisory authority. That decision is often very brief, e.g. "Matter closed".

The cases reported under Lex Maria show IVO/the National Board of Health and Welfare to have used different turns of phrase when following monitoring the actual rectification of shortcomings established. If, in the course of internal investigation and analysis of events, the care provider has already observed the errors and shortcomings, then follow-up, as a rule, is left to him. The same applies to errors observed by IVO/the National Board of Health and Welfare, if these are few in number and perhaps are not considered very serious.

In order for the content of Lex Maria reports to be made known in psychiatric care and produce effects in a wider context than that of the parties involved in the individual case, the reports have to be disseminated in various ways, e.g. through compilations, research summaries (conspectuses), reports and so on. The digests prepared by the National Board of Health and Welfare between 2006 and 2012 have probably had a widespread knowledge-dissemination effect

[13]. IVO has now announced that it will be discontinuing these publications, which would be detrimental to normatively oriented suicide prevention work. Medical law being to a great extent goal-oriented, norms of a more detailed nature is needed. If this norm-defining activity were to cease, the result would be a depletion of medical law in this field.

As mentioned, PSL entered into force on 1st January 2011. Prior to that date, healthcare personnel could incur disciplinary sanctions if they had been negligent in their care of a suicidal person. HSAN could administer a warning or reprimand if personnel had acted negligently. By presenting a number of HSAN decisions concerning suicide risk assessments between 2002 and 2010, a picture can be conveyed of its view as to how liability issues should be resolved with regard to the responsibility of healthcare personnel for suicidal patients.

The HSAN cases often triggered tensions between HSL and LPT. In the matter of compulsory care, HSAN could find that, at the time in question, the patient did not meet the requirements for such care. It might have been the case that the patient was suffering from a severe mental disturbance and was in absolute need of round-the-clock care, but, the patient having consented to care, compulsory care was ruled out. In the case of persons disposed to harm themselves, the protective aspects are less well provided for in voluntary than in compulsory care.

A patient consenting to voluntary hospitalisation in the realisation that they constitute a danger to themselves should be subject to the restrictions in care which are needed in order for adequate protection to be providable, even if the situation is one of voluntary care. Care under HSL must not be inferior to LPT care in suicidal situations. If the patient does not consent to the restrictions which the physician considers suitable for purposes of care, the feasibility of compulsory care must be tested. The damage minimisation principle should override the self-determination principle.

Now that HSAN is no longer in a position to impose disciplinary sanctions on healthcare personnel for errors or omissions in care, following the advent of PSL, IVO has, as mentioned, been tasked with assessing, on request, complaints against healthcare services and their personnel. IVO determines complaints cases by administrative decision. In a decision of this kind, IVO declares whether a measure or omission on the part of healthcare personnel is contrary to law or some other prescription and is inappropriate, having regard to the safety of the patient. No sanction is imposed, however. IVO's pronouncement, which is perceived as an administrative decision, means the conclusion of the matter. So a complaint case carries less punch than an HSAN decision.

The advent of PSL has given the importance of patient safety a new kind of visibility. This need not *per se* imply that suicide and suicide attempts have been explicitly highlighted as a central area of patient safety, but the enactment of PSL and work on the zero vision for suicide coincided in time. A review of the *travauxpréparatoires* of PSL suggests that suicide prevention has not been very closely discussed in them [14].

The same situations can become a subject of both Lex Maria reports and, previously, reports to HSAN, and also, nowadays, complaints. This may seem unnecessary, but in my opinion it is not, partly because Lex Maria reports are addressed to the care provider and concern structural and systemic issues of various kinds, which exist at care provider level, and also because HSAN decisions/complaints are primarily directed at healthcare personnel and relate to nursing and caring issues of various kinds, including science and proven experience, documentation etc.

The same applies concerning healthcare personnel. They also need concretisation and elucidation of the norms of the statutory text, so that the norms can be applied uniformly and with respect for the rule of law. Legal guidanceis needed in the field of medical law, to endow both formal and material legal security with substance. This is important to personnel and patients alike. Having access to reports and complaints has a pivotal bearing on highlighting the patient. Personnel must have a chance of learning what has happened, so that erroneous treatment, if such be the case, will not recur. A person who has already committed suicide will, sadly, not benefit from efforts to achieve the best possible care, but even so, penetration of Lex Maria reports, HSAN decisions and complaints is very important indeed if any mistakes made are to be avoided in future. The statutory amendments which will probably be coming into force fairly soon concerning Lex Maria reports will, hopefully, not be to the detriment of this learning context.

6. The legal investigation-compulsory psychiatric care and suicide prevention

6.1 Point of departure

Attention was already drawn during the mid-1980 [15] to the "absurd consequences" of the socially protective function of compulsory psychiatric care for the party charged with judging the necessity of compulsory care. Care "must exist for the sake of the individual patient, and … it is a mistake and an anachronism to use the caring organisation as an institution for the protection of the community at large" [15]. It is already clear from the statements made in SOU 1984:64 that the patient's own need of care must be the point of departure for implementing the law. "Obviously, in assessing this point one must above all factor in an imminent risk to the patient's health or life in the event of his need for care not being accommodated" [15].

In LPT, protection from oneself occurs only as a ground for commutation (Section 11) from voluntary to compulsory care, and in situations where special coercive measures are resorted to. The commutation provision expressly governs situations where there is a risk of the patient harming himself. As regards the general prerequisites of compulsory care under Section 3 of LPT, it is stated in the travauxpréparatoires alone that danger to the patient's own life or health is to be taken into account in accordance with Section 3 (1) 1, 2. Thus no provision is made in the statutory text itself.

In a review of compulsory psychiatric care (SOU 2012:17), the terms of reference indicated that the Commission was to take a closer look at the protection of society. There was no mention of "self-protection". This is surprising, for two reasons, namely the close connection between mental disturbance and suicide/suicidality, and the connection with the national suicide prevention programme, the express purpose of which was zero tolerance of suicide. A number of suicide prevention measures with accompanying remedial programmes have been devised, but the question of legal regulation of care as a structure factor in society has not been highlighted. Ought not compulsory legislation such as that in LPT have a suicide-preventive effect?

6.2 The outcome

The study has established that patients have a need for protection implying protection from them. The court cases have shown that the danger from which a patient is to be protected is above all the suicidality which the patient expresses, but also medication abuse, abuse of diet or lack of diet intake, alcohol or drug abuse, etc. In most cases there is a causal connection between the patient personally and the danger which now faces him or her, a danger rooted in a serious mental disturbance of some kind. The protection offered against the danger of suicide and other situations where the individual is a danger to himself, is compulsory care. The protection considered justified is a form of protection linked to an absolute need of round-the-clock care, as has emerged from all the judicial cases investigated. In those cases, the matter is very often expressed in the words: "it is the coercion in care that is needed."

In previous legislation [16] the patient's endangering of her/his own life was expressly governed by one of the special indications for committing a patient to compulsory care [17]. No empirical reasons for abolishing this provision were ever advanced when LPT was introduced. If, in the *travaux préparatoires* of LPT, it is stated that the risk to the patient's life and health must be the crucial consideration, it may seem appropriate for this also to be expressly provided for in Section 3 of LPT, so that the legislation expressly governs the situation in which there is a risk of the individual harming himself.In the light of the suicide-preventive public health work in progress, it ought, therefore, to be appropriate to clarify the intervention prerequisites of Section 3 of LPT, so that the legislation will make genuine provision for the situation of the individual being liable to harm herself/himself [18].

One pivotal conclusion to be drawn from the above is that caring measures must be taken to prevent suicide, either in voluntary or in compulsory care. The measures taken must be appropriate and must come within reasonable limits of legal security. The extensive scope in both voluntary and compulsory care for intervening in connection with suicide attempts is rooted in the conviction that life is the supreme good and must therefore be hedged about by the supreme law. Compulsory care entails more interventionist measures than voluntary care. In several of the above mentioned HSAN cases, the balance has teetered between the two forms of care, and, from a layman's point of view, compulsory care should have been resorted to for the prevention of suicide. The *travaux préparatoires* afford scope for a more extensive interpretation of the self-endangering prerequisite than is the case with present-day implementation. If anyone in voluntary care is caught in the act of trying to take her/his life, healthcare personnel are considered entitled to endeavour by main force to thwart the attempt. The notion of life as the supreme legal good embodies in itself a very important suicide-preventive dimension. This ethical norm, however, needs to be elucidated.

Even though prevention of a suicide constitutes interference with private life under Art. 8 of the European Convention, there is widespread unanimity, both nationally and internationally, concerning the rectitude of preventing people, as far as is possible, from completing planned or incipient suicide attempts [19]. Allowance for personal privacy demands that the measures taken be appropriate to the purpose and that they come within reasonable bounds of legal security. The right to personal privacy and the right to self-determination must defer to the right to save life. Inmany cases, the intention of dying by one's own hand is of relatively brief duration. Healthcare experience shows that, following a suicide attempt, a large proportion of patients accept or are grateful for being prevented from taking their lives and surviving a suicide attempt. Many put a premium on life for a long time after having had a serious desire to die and acting accordingly.

7. Legal-political considerations

It ought to be self-evident that people with suicide problems who seek help, support and care should be well received and offered good support, good help and, above all, good and safe care. All providers of care, assistance or support should be observant of risk and support factors and take steps to reduce the risk of suicide. It is possible, by investigating the course of events preceding a suicide, to discover shortcomings of routines, health and safety conditions, staffing, leadership or organisation.

An analysis of events in connection with suicide yields information about the circumstances attending the suicide and affords an opportunity of identifying any shortcomings which may have facilitated the suicide. On the basis of the aggregate knowledge yielded by the analysis, operational units can take steps to counteract and prevent further suicides. It is essential for public activities to analyse suicide and take steps to improve safety. Every analysed suicide in which remediable shortcomings are identified can help to prevent further suicides occurring.

The present-day duty of healthcare services to carry out an incident analysis in the event of suicide is going to be discarded from the Lex Maria system, following complaints that linkage to this system results in all suicides with a medical connection being perceived as iatrogenic injuries. There are, of course, several suicides in healthcare which do not come under the heading of iatrogenic harm, and so it is judged better to exempt suicides in healthcare from the requirement of Lex Maria notification and instead to introduce a corresponding obligation in a separate enactment which can be expanded so as also to include social services, while at the same time requiring a national agent to carry out independent integral incident analyses in certain cases [20]. In this way a uniform system of incident analysis could be achieved for suicide, a system adaptable to the special demands made on analyses of this kind.

Furthermore, the guarded attitude towards coercion expressed by the *travaux préparatoires* of LPT is significant. As soon as care can be provided without coercion, this shall be done, even if non-coercive care is "inferior" from a suicidal point of view. In Norway, suicidal persons (persons "hovering in danger of suicide") but not suffering from serious mental disturbance are admitted for "compulsory observation" (psykisk helsevernslov § 3-2). This possibility does not exist in Sweden. For compulsory care, all three prerequisites have to be satisfied, as explained above, namely: grave mental disturbance, absolute need of round-the-clock care, and absence of consent. By the time one has reached the point of being able to establish the presence of these three prerequisites, it can often be too late. Suicide is a fact, and the disaster to next-of-kin is abundantly evident. Introduction of such provisions in Sweden would require changes in many spheres of society, e.g. medicine, law and, above all, politics. This question is connected with the Swedish attitude to compulsory psychiatric care in general.

If Swedish legislation on compulsory care is to be serviceable in work for the prevention of suicide, the "fear" of using compulsory care in situations of imminent suicide must be overcome, without this necessarily legitimising the flouting of considerations of legal security. Material security under the rule of law is just as important as the formal security, i.e. provision of good psychiatric care including a high protection factor must be observed to the same extent as the formal rules concerning, say, appeal, oral proceedings and communication. Courage must be forthcoming to highlight "loving" compulsion and to allow one to see that compulsion need not be intrinsically evil. The principles of maximising the good and minimising harm are essential to suicide prevention work and carry the same weight as the self-determination principle.

Care, both voluntary and compulsory, must afford the individual protection when he or she is in a suicidal situation. HSL, PSL and LPT can all be said to have a suicide prevention function. Healthcare personnel have a duty of caring for, i.e. preventing, curing and relieving, the suicidal individual and, if necessary, forcibly preventing him or her from committing suicide (compare the Swedish Penal Code chapter 24 § 4 concerning necessity). But if the worst has come to the worst and the suicide is a *fait accompli*, the responsibility of the healthcare services enters. Implementation of correct analyses of events, based on partnership, in connection with suicide is an exceedingly important instrument of suicide prevention. This expresses the responsibility of healthcare services for the suicidal individual, as well as the seriousness with which Swedish society contemplates the importance of good suicide prevention. But much remains to be done.

Key Points

1) Suicide figures in Sweden have fallen since the beginning of the 1980s. This is a trend which has been noted in several Western European countries. Suicide attempts, however, have not diminished in number.

2) In 2008 the Swedish Riksdag resolved on a zero vision for suicide.

3) Most people taking their own lives have been in contact with medical care before committing suicide, most commonly with psychiatric care or with general practitioners (91-97 %).

4) Can a teleological interpretation of the meaning, scope and legal effects of the medical law enactments be said to show a preventive purpose?

5) Can it be argued that medical law is also concerned with preventing suicide as far as possible, just as traffic safety law is concerned with reducing the number of traffic deaths?

6) The ethical principles underpinning good healthcare include not only the principle of self-determination but also the principle of maximising good and the principle of minimising harm.

7) Prevention of suicide is ethically justified, from which it follows that existing legislation should be applied with a view to achieving ethically good results.

8) Both voluntary and compulsory legal regulations can be said to have a suicide prevention function.

9) Healthcare personnel have a duty of curing and relieving the suicidal individual and, if necessary, forcibly preventing him or her from committing suicide.

10) Implementation of correct analyses of events in connection with suicide is an exceedingly important instrument of suicide prevention.

11) Several suicides in healthcare do not come under the heading of iatrogenic harm. It is judged better to exempt suicides in healthcare from the requirement of Lex Maria notification and instead to introduce a corresponding obligation in a separate enactment.

12) In Norway, suicidal persons (persons "hovering in danger of suicide") but not suffering from serious mental disturbance are admitted for "compulsory observation". This possibility does not exist in Sweden but it ought to.

13) If Swedish legislation on compulsory care is to be serviceable in work for the prevention of suicide, the "fear" of using compulsory care in situations of imminent suicide must be overcome, without this necessarily legitimising the flouting of considerations of legal security.

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