

# Management of the Suicidal Patient in the Era of Defensive Medicine: Focus on Suicide Risk Assessment and Boundaries of Responsibility

Position Paper of the Israel Psychiatric Association\*

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**ABSTRACT:** Suicide is universal within the range of human behaviors and is not necessarily related to psychiatric morbidity, though it is considerably more prevalent among psychiatric patients. Considering the limitations of medical knowledge, psychiatrists cope with an unfounded and almost mythical perception of their ability to predict and prevent suicide. We set out to compose a position paper for the Israel Psychiatric Association (IPA) that clarifies expectations from psychiatrists when treating suicidal patients, focusing on risk assessment and boundaries of responsibility, in the era of defensive medicine. The final draft of the position paper was by consensus. The IPA Position Paper established the first standard of care concerning expectations from psychiatrists in Israel with regard to knowledge-based assessment of suicide risk, elucidation of the therapist's responsibility to the suicidal psychotic patient (defined by law) compared to patients with preserved reality testing, capacity for choice, and responsibility for their actions. Therapists will be judged for professional performance rather than outcomes and wisdom of hindsight. This paper may provide support for psychiatrists who, with clinical professionalism rather than extenuating considerations of defensive medicine, strive to save the lives of suicidal patients.

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Suicide and suicidal behavior are universal within the range of human behaviors and are not necessarily related to psychiatric morbidity, although they are considerably more prevalent among psychiatric patients [1]. Thus, for example, almost half the individuals with affective disorders and schizophrenia attempt suicide during their lifetime, and 10%–15% complete suicide. In Israel, there are approximately 400 deaths from suicide per year (reflecting a suicide rate of 6:100,000) and 4000 attempted suicides reported by hospital emergency rooms [2,3].

The person who commits suicide leaves his loved ones with difficult feelings of unnecessary loss, pain, frustration, anger and guilt [4]. These feelings may be projected or displaced to an external object that can bear or at least share the guilt, and perhaps may be sued for financial compensation for alleged "negligence" [5].

Suicidality should be dealt with in the same manner as other medical life-threatening situations. Considering the limitations of medical knowledge and ability, psychiatrists cope with an unfounded and almost mythical perception of their ability to predict and prevent suicide. Thus, suicide is often considered the failure of the therapist and is viewed as negligence in treatment and prevention, intensifying an atmosphere of defensive medicine (i.e., safeguarding against possible malpractice liability) among psychiatrists that may negatively affect their ability to intervene appropriately with a suicidal patient [6].

According to commonly accepted public opinion, in the media and even in the judicial system, suicide is an irrational act performed by an individual who is not responsible for his or her actions and is a victim of circumstance. The status of suicidality is conceived as dichotomous: the individual is either

suicidal or not, rather than on a continuous spectrum. Often, reference to suicide is general and undiscerning, assuming that suicide risk can always be identified and thus prevented. Against this background, the Israel Psychiatric Association set out to formulate a position paper concerning management of the suicidal patient, focusing on the boundaries of responsibility (accountability) of the patient and the therapist and on shifting the implausible expectations for prediction and prevention of suicide to the implementation of rational clinical judgment adapted to specific patients and situations. This position paper presents the opinion of the Israel Psychiatric Association regarding the principle concepts related to coping with the suicidal patient. It received positive feedback in the local press since it presents the clinician's expectations on the one hand and determines the boundaries of responsibility on the other. This position paper could be presented in court as the official stand of the Israel Psychiatric Association.

#### **COPING WITH THE SUICIDAL PATIENT**

Suicide is a complex phenomenon influenced by many factors, including mental disorders, personality, interpersonal and environmental factors, the attitude of society to suicide, religious beliefs, and more [7]. Coping with the suicide risk of a patient can be acute or ongoing, with varying levels of intervention, over long periods. Management of the suicidal patient is complicated due to the fact that he or she sometimes lacks reality testing (the ability to evaluate the external world objectively and differentiate it from the internal world) [8]. Thus, paternalistic issues such as compulsory treatment (e.g., psychiatric hospitalization) are emphasized.

There are no clear-cut solutions for suicidal risk. Even the alleged absolute means of protection – psychiatric hospitalization – is not always successful in preventing suicide. Actually, the risk of suicide may increase during psychiatric hospitalization and in proximity to discharge, resulting from feelings of frustration, helplessness, despair, and reduction of trust in the therapist and in the patient's own ability to cope with suicidal impulses. Moreover, hospitalization may impair a patient's trust and future cooperation with the therapist, thus increasing future risk for suicide.

#### **CENTRAL ISSUES DISCUSSED IN THE POSITION PAPER**

- A. Evaluation of suicide risk
- B. Boundaries of responsibility in the management of the suicidal patient

The evaluation of suicide risk should relate to the following points:

- The estimated level of risk, how immediate is the risk and what is the level of urgency
- The factors that actively influence the suicidal risk and which risk factors can be modified

- The various options for treatment and management in a given case.

#### **EVALUATION OF RISK, PREDICTION AND PREVENTION OF SUICIDE**

Practice and research demonstrate the difficulty in predicting suicide risk and preventing suicide. It must be remembered that evaluation of suicide risk is valid mainly for the present and considerably less for the future. Even so, the ability to predict individual cases is not high at all, and in many cases it is not possible to prevent suicide [9,10]. Thus, for example, half the patients who committed suicide did not declare their intent or plans to anyone. Some did report suicidal thoughts but simultaneously dismissed concrete intent or plans, while others promised the therapist that he/she would not attempt suicide in a so-called contract/agreement with the therapist. It is also difficult to estimate how many cases were actually prevented as a result of therapeutic intervention, as indeed the focus of discussion and investigation is on completed suicides.

Since suicidal behavior is often related to psychopathology, it is appropriate to expect that the psychiatrist will perform a clinical evaluation of suicide risk and offer an intervention and a treatment program that aims to reduce the suicide risk as much as possible. The therapist will be judged according to whether or not he/she used judicious clinical judgment, calculated apparent risks and their ramifications, and performed professionally and with reasonable caution. It should be emphasized that the wisdom of hindsight should not determine the soundness of the therapist's professional decision.

It should be further clarified that studies examining the influence of early knowledge of the outcome on the judgment process found that this information caused an unavoidable distortion in the analysis of the incident. Statistically, it was found that knowing the outcome ahead of time doubled the number of those who believed that it was possible to predict the result from the outset. In addition, it was found that even if one is aware of the distortion, the evaluation cannot be conducted as if the outcome was not known, and the feeling that the 'writing was on the wall' prevails [11,12].

#### **THE ROLE OF THE PSYCHIATRIST: COPING WITH THE SUICIDE RISK**

This position paper does not intend to replace the professional literature, evaluate the many research conclusions on the subject, instruct what to do or not to do, or guide clinical judgment on how to cope with this complex phenomenon. Therapists must recognize their obligation to estimate the suicide risk, when needed, and at the same time recognize the limitations of their responsibility without resorting to defensive medicine that can interfere with clinical judgment and quality of professional decisions.

When there is concern regarding suicidal risk, it is important to perform risk assessment based on pertinent data and experience in practice and on the professional literature. The

aim is to facilitate a judicious decision-making process that will reduce risk and hopefully prevent suicide. It is noteworthy that there is no model for assessment that has been proven more effective than others; however, it is recommended that the assessment should include the following factors:

- A. Clarification of various expressions of suicidal behavior, such as thought, intention, plans or active suicide attempts
- B. Assessment of risk factors, such as prior suicidal behavior, psychotic disorder – especially key symptoms such as command hallucinations (auditory hallucinations that instruct a patient) – severe stressful events, availability of lethal means (e.g., weapons)
- C. Evaluation of protective factors, such as commitments to loved ones, family/social support, a therapeutic relationship.

Correspondingly, the level of risk should be assessed, and an intervention program aimed to reduce suicide risk should be offered. In addition, emphasis is placed on the importance of documenting the assessment, the considerations that led to the proposed intervention, and the instructions for further monitoring.

**POTENTIAL INTERVENTIONS FOR SUICIDAL PATIENTS**

Interventions should be considered in accordance with the characteristics of the suicidal crisis and risk level, such as (compulsory) hospitalization, removal of means with potential to inflict self-harm, recruitment of support systems (e.g., to assist with supervision, treatment), pharmacotherapy for the underlying psychiatric disorder (including reference to risk-elevating symptoms such as agitation, furious outbreaks, insomnia...), psychotherapy, environmental intervention, ongoing follow-up and monitoring. Several legal aspects are involved when considering various intervention options; these include applicability, compliance, and assessment of the risks and benefits of the various alternatives.

**DEFENSIVE MEDICINE AND COPING WITH SUICIDE RISK**

Placing all-encompassing responsibility on the therapist and reducing the personal responsibility of the patient can force the therapist to defensive medical considerations, and consequently limits the range of appropriate and correct interventions.

Expressions of defensive considerations in psychiatry when facing suicide risk may include: selection of patients (overt and covert), diversions in diagnosis, excess (compulsory) hospitalization, excessive or deficient pharmacotherapy, biased management of treatment (i.e., not taking calculated therapeutic risks even when appropriate in order to initiate constructive change or breakthrough), and alterations in medical documentation. Undoubtedly these practices may significantly harm the patient.

Indeed, increasing numbers of Israeli physicians report the influence of defensive medicine on their clinical considerations (According to a survey of the Israel Medical Association and the Courts in 2007, about 70% noted defensive medicine as a factor that may limit the physician's work). Thus, an attempt to chart the boundaries of responsibility between the therapist and the suicidal patient is crucial in order to provide optimal care.

**LIMITATIONS OF RESPONSIBILITY AND AUTHORITY OF THE PSYCHIATRIST**

Limitations of responsibility and authority of the psychiatrist concerning dangerousness are defined in Israeli Law [13], for the individual who is "mentally ill," who is "ill and as a result of his illness his capacity for judgment or reality testing is significantly impaired"... and "if the patient may endanger himself or another, with imminent physical danger, and there is a causal relationship between the illness and the risk, the psychiatrist is authorized to issue a written warrant for urgent hospitalization."

The legal definition of mental illness, such that there is a marked impairment in the capacity for reality testing, is directed primarily at the psychotic patient. Thus, the question whether it is appropriate to apply these boundaries of responsibility and authority to additional mental disorders when there is significant impairment in the capacity for judgment together with high suicidal risk remains unclear, and the circumstances of each specific case need to be dealt with according to the Law for the Treatment of the Mentally Ill.

**DIMENSION OF PERSONAL RESPONSIBILITY**

A most important factor for suicide prevention is the patient-therapist relationship and the "therapeutic alliance" (the relationship between the therapist and the healthy part of the patient, in a mutual effort to cure the patient). This alliance may promote psychological developmental processes, the patient's trust, and treatment compliance. The therapeutic character of this alliance may be severely impaired when total responsibility for the patient's suicidal decision is placed on the therapist. In this case, the decisions made by the therapist will most likely be affected by so-called defensive considerations of "risk management," impairing the capacity for empathy and for practical considerations (sometimes including taking calculated risks in the therapeutic process). An example may be excessive referrals to closed psychiatric wards.

Expropriation of personal responsibility from the patient may contribute to his or her regression and to his/her already impaired self-image. It is therefore important to preserve the dimension of personal, legal and moral responsibility of the patient who has the capacity for judgment and reality testing, for his/her personal decisions, including those regarding suicide. In view of the above, the suicidal patient whose judg-

ment or capacity for reality testing is not markedly impaired must bear responsibility for his/her decisions and actions, including compliance with the therapist's recommendations and guidance, e.g., informing and recruiting support systems, removing lethal means, taking medication, and cooperating with the therapeutic program, etc.

Therapists can choose to assist beyond the formal limitations of their responsibility (e.g., to offer to contact a relative). However, even if the therapist chooses to do so the burden of responsibility remains in the hands of the patient. This situation is similar to physicians in other specialties who explain, guide, and recommend treatment plans, including medication and change of environment or lifestyle, but cannot take responsibility for the actual implementation of their recommendations by the patients.

## CONCLUSIONS

Having clarified our position concerning the boundaries of responsibility between the therapist and the suicidal patient, we summarize our standpoint regarding what is expected from the psychiatrist. The psychiatrist is expected to examine relevant information, assess suicide risk, use clinical judgment based on professional knowledge in the field, and choose from the potential alternatives for intervention those that seem most appropriate and suitable for the specific needs of the patient at that time. The psychiatrist should make a reasonable effort to gain the patient's cooperation. In cases where the patient does not cooperate, giving rise to concern for significant risk, the psychiatrist should consider involving additional professionals in decisions. In addition, the psychiatrist should consider involving family members and other relevant agencies, taking into account the anticipated benefit and the patient's will while maintaining the patient's rights and dignity, according to law. Finally, it should be emphasized that the therapist will be judged irrespective of whether he or she performed as expected, in a professional manner, exercising appropriate judgment and not necessarily with the wisdom of hindsight, and whether this intervention was successful.

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