AAPL: Ask the Experts-2014

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Neil S. Kaye, MD, and Bob Sadoff, MD will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send question to nskaye@aol.com.

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Q. Is suicide predictable?

Sadoff:

The answer depends on the definition of the word "predictable". If the symptoms are severe and the risk assessment technique is conducted properly, one may predict in the short term whether a person so evaluated is a high, medium or low risk of suicide (or violence if one is assessing that risk as well). However, generally, psychiatrists are not able to predict behavior in the long term. Prior suicidal attempts may be helpful in making a risk assessment judgment but the frequency of prior suicide attempts may be viewed either as a high risk predictive factor or low risk depending on the frequency of unsuccessful attempts at suicide.

In order to fully answer the question, a forensic psychiatrist should ask the proper questions in a risk assessment technique. For example, one should ask whether that patient is thinking about suicide and if so, has he ever tried it in the past. If so, how many times, by what means and how successful or unsuccessful has he been? If one has tried frequently for attention but without serious intent on dying, the past history may be a predictor of low risk of suicide rather than one or two serious attempts at suicide that landed the person in the hospital for several days or weeks of treatment. One needs to get a comprehensive history of prior violent of self-destructive behaviors.

Once the person admits that he has suicidal thoughts and intent, then one asks the means by which the person plans to kill himself or herself. If there are five or six different ways, such as stabbing, shooting, burning, hanging or poisoning, one is not

as concerned about a high risk of suicide as if one has only one method and has also acquired the implements to carry out his intent. For example, if the person said he was going to shoot himself then one has to ask if he has a gun. If he has no gun, he can't shoot himself. If he does have a gun, the question is when did he acquire it? If he says he has had it for several years, since it is his grandfather's old relic and he is not even sure where it is or if it has bullets, there is low risk. If, however he bought it yesterday with bullets in order to accomplish his intent, his risk rises. Finally, the proper question to ask is whether the patient has practiced the act by putting the barrel of the gun in his mouth to see if he could pull the trigger or putting the barrel of the empty gun to his forehead and pulling the trigger. Practice with the implement he chooses to use as a means of his self-destruction is a high risk factor and in my opinion a suicide becomes more predictable and the patient should be hospitalized to prevent the foreseeable act.

That brings us to the difference between preventable and predictable. Most acts of suicide (or violence) if recognized in time are preventable by several means: restraint, seclusion, effective treatment. However, such acts are not readily foreseeable or predictable. Utilizing a combination of clinical risk assessment techniques and actuarial or structured risk assessment instruments, called structured professional judgment, may aid in determining if the suicidal act is foreseeable or predictable.

The law will find the doctor liable if the act is foreseeable, i.e., it is a high risk and more likely than not to occur than if it is just preventable. The proper question becomes: is it predictable, and if so, under what conditions, and for how long is the prediction accurate? It is better to err on the side of caution when suicide is a concern, or as I teach my students: “We’d rather bury our mistakes in the hospital than in the cemetery.”

Kaye:

Suicide stands alone as a most powerful, indelible event. Despite years of training and research, the thought of a patient successfully committing suicide continues to strike fear in the hearts of every physician. Yet, if a psychiatrist is in practice long enough, it is reasonably likely that the practitioner will have a patient commit suicide. Patients with an affective disorder have a suicide rate of at least 15% and those with schizophrenia have a suicide rate of at least 10%.

Suicide has also long been the number one reason for medical-malpractice lawsuits against psychiatrists. The simplistic plaintiff rationale is that if a psychiatrist is treating

someone for depression or who presents with suicidal ideation, plan, or intent, and the doctor doesn't prevent the death, that she has failed and must be guilty of malpractice. This is the common scenario of a bad outcome must mean that something wrong was done. This is known as one of the most common errors in logic, *post hoc, ergo propter hoc.*

The reality is that if the doctor has met the standard of care in assessing and documenting her work, over 90% of verdicts are for the defense. Unfortunately, many of these cases take at least two years to be tried and the emotional toll on the doctor can be severe and even disabling. Insisting on good legal counsel and the best experts possible is necessary.

Many of these cases hinge on the plaintiff's contention that suicide is predictable. The plaintiff lawyer will list a host of "risk factors" for suicide including depression, prior suicidal ideation, hopelessness, helplessness, family history, anxiety, impaired sleep, marital problems, job problems, etc. and try to get the defense expert to agree that each of these alone is a risk factor and that it was present.

The wise scientist-expert should know that even with all of the "known" risk factors present, fewer than 25% of these people actually commit suicide. Further, the real expert knows that suicide is NOT predictable. Risk stratification is not synonymous with prediction. The risk stratification approach to suicide prediction results in an unacceptably high number of both false positives and false negatives, and our limitations as scientists should be acknowledged.

The critical nuance is that while something may be foreseeable, it is not the same as predictable. It is challenging to get this across to a jury, but imperative to do so. Predictability includes a temporal element; foreseeability does not. E.g.: A 68-year old man with coronary artery disease, hyperlipidemia, hypertension, diabetes, and obesity, who has a heart attack, would not be a surprise. It would be a foreseeable event, but not predictable, because no cardiologist could tell you when the heart attack was going to happen. Similarly, the ability to predict future behavior in psychiatry is extremely limited, and the further out in time, the less accurate are such predictions.

Sadoff/Kaye:

Take home point:

Proper suicide evaluations including assessing the known risk factors as well as the known protective factors. Actuarial modeling or statistical approaches can be part of such an assessment but rarely are used and don't necessarily improve predictive accuracy. Decisions about admission, involuntary commitment, and appropriateness for discharge are discretionary and the sole purview of the treating doctor. The risk of using the "retrospectoscope" by an expert witness, to gauge if the physician's conduct met or breached the standard of care, carries the inherent risk of bias, as the outcome is known.