Case Study: Suicide and Patients

Kim is a 38-year-old educator, mother of a little boy, and has been in a stable marriage for 11 years. She develops a clear depressive condition, with paranoid features. Her primary care physician begins an SSRI. After a few weeks and despite improvement, she begins referring hopelessly to the future, with comments such as “the mess I’ve created for my family.” She is referred to a psychiatrist and a two-week inpatient treatment.

John is a 46-year-old realtor. He is single with a supportive family and church community. With a nine-year history of solid abstinence from an opioid dependency, he is often perceived as a model for recovery, sponsoring many others in his Narcotics Anonymous group. After suffering from significant lower back pain, John’s orthopedist generates a prescription for oral analgesics. A precipitous return of analgesic abuse is caught by the prescribing doctor, and she asks him to come in to discuss this development.

Frank is a 60-year-old physician with no previous psychiatric history. He is married with a 30-year successful medical practice, and is seen as a quiet, but solid member of his medical community. Unexpectedly, he is served with his first medical liability complaint. He withdraws from his colleagues and refuses to talk about the lawsuit with his wife. Her concerns lead to a call to the family primary care doctor, who is also a friend. A lunch appointment with Frank is planned for the next day.

Results of these scenarios will be revealed later in the article.

Walking across the Golden Gate Bridge, one notices a small blue sign every 100 yards or so. The sign, located on a phone box, reads “There is hope. Make the call.”

Suicide is often overlooked as a leading cause of death in our country. Suicides are three times as common as homicides, and continue to rank among the top ten of CDC’s leading causes of death. Often, the last person a suicidal patient reaches out to is a health care professional, usually a trusted physician.

Common myths about suicide

1. Suicide does not exclusively emerge from depression. The dynamics that precipitate suicidal thoughts and behavior are diverse. Substance abuse, a significant life event such as new and serious medical diagnoses, loss or grief, and financial setbacks are just a few of the circumstances that can lead to the profound despair that precedes suicide.

2. Talking about suicide with a person experiencing any such circumstances does not “plant the idea.” To the contrary, opening the discussion between a patient and his or her trusted doctor can lessen the burden and begin a pathway toward hope.

3. Some suicides cannot be prevented, regardless of how accurate the diagnosis and effective the care. Death can be an inevitable outcome of a psychiatric condition. Although relatively rare compared to such conditions as cancer or cardiac illness, mental health disorders can be malignant and terminal.

4. Antidepressants, such as SSRIs, are not the sole treatment option for suicide. Suicidal behavior is a symptom of an underlying illness or circumstances, to which treatment must be individually assessed and directed.
5. Managing a suicidal patient does not always require the exclusive skills of a trained, credentialed mental health professional. A trusted doctor, nurse, or clergy are among those who can be invaluable in bringing hope to the hopeless.

6. Suicide gestures are not necessarily benign, regardless of how non-lethal the attempt might appear. They can be the harbinger of a more serious, lethal attempt.

7. Factors such as access to method, age, gender, etc. are not solely sufficient clinical parameters for predicting risk of suicide. Studies have amassed lots of data to offer projections on these factors as predictors. But, on a one-to-one basis, these parameters provide poor correlations.

**How does a professional develop the toolkit for managing such patients?**

The most critical tool we have in our medical practices for such an assessment doesn’t come out of a lab test, an imaging study, or even a well-developed questionnaire. Our own clinical instincts, reactions, and sensitivities to such patients often serve us far more reliably that any of the more objective measures. If the patient indirectly causes the doctor to worry about suicide, chances are high that his or her patient is conveying that message without words. Moreover, family or friends often provide valuable information.

Once an index of suspicion is established, there is no more effective means to assess risk than by asking direct questions.

- “Have you thought about killing yourself?”
- “Do you think about ending your suffering?”
- “Have you done anything recently to hurt yourself?”

There is no standard question to “break the ice,” but rather a plethora of ways to ask. Doctors who standardize a series of questions about suicide to prepare themselves for these conversations are often more comfortable having them.

Frequently, the first response from the patient is a denial. If such a denial seems inconsistent with the clinical picture, a return to the questions later in the interview might yield more data. Many times, the suicidal patient is uncertain about how comfortable his or her doctor might be with such a discussion, and returning to it after an initial denial might reassure patients that their doctor can be receptive.

Being receptive and unafraid of the discussion can lead to the beginnings of not only an assessment, but also of treatment. By opening the door to an often taboo subject, patients can feel relieved of the burdens of keeping their intentions secret. Through this process, the conditions that have led to suicidal ideas are then fleshed out. Depressive symptoms, despair over a relapse in abstinence, hopelessness around a medical diagnosis, distress over a recent death of loved one...each situation lends itself to a different approach for treatment. Various treatment options that serve to direct the patient toward hope include SSRI’s, evaluation of addiction treatment options, open discussion about a medical illness’ prognosis, and comfort or reassurance to the grieving.

In many instances, suicidal behavior and thoughts are ways by which a patient might express something other than despair. Adolescents often find behavior more demonstrative than words. Patients with character
disorders might have developed a repertoire of such behaviors to create a secondary gain, otherwise unattainable through healthy modes of communication. Once again, the instincts of the professional, more than any checklist of risk factors, can add to the determination of risk.

If open discussion and accurate diagnosis don’t lessen the risk, then of course more aggressive interventions such as psychiatric assessment, inpatient treatment, or involuntarily interventions may be necessary.

**Follow up and documentation**

Creating a follow-up plan is important in managing a suicidal patient regardless of the assessment and actions taken. By establishing a specific appointment or follow-up connection, the doctor extends himself or herself to the patient, leaving a door open for future discussion. Even if the acute risk is lessened, a return of hopelessness can often be anticipated and a follow-up visit will enable a continuing assessment.

Documentation of the steps taken to assess, diagnosis, and intervene with a suicidal patient is critical to the medical record. Adequate documentation enables other professionals to coordinate their follow up. In addition, the professional’s documentation of rationale for actions taken will protect him or her should an adverse outcome develop, and complaints or claims follow. The doctor does not have to be correct in his or her thinking, but has to have thought about, asked, and documented what the thought process was as it relates to suicidal risk. Checklists are fine, and EHR fields to complete are helpful, but most useful is a brief narrative in the chart about the process that took place. How a decision was reached is more valuable than what the decision was.

Retrospective bias is hard to overcome when we are called on to defend cases of how the health care professional dealt with the case prospectively. Good documentation of what factors were considered and the thought process of the professional are critical to the subsequent defense.

It is important to accept that we might fail to protect a patient from the tragedy of a suicide. When death is an outcome, whether to our own patient or a patient of a colleague or friend, we must take note of the personal impact it will have. Caring for ourselves and each other at such a moment in a career is so strengthening.

And finally, as caretakers, we are as vulnerable to such despair and even suicide as our patients may be. Reaching out to others for help, or reaching out to help a colleague can be difficult, but lifesaving.

**Back to the three case studies**

- Kim received a full course of aggressive treatment, with solid follow-up plans. Shame and guilt escalated one weekend when her son and husband were off camping, and she died of carbon monoxide poisoning in the garage.
- By the time John’s orthopedist called him, his relapsed addiction was out of control. His final note prior to the self-inflicted gunshot wound addressed the hopelessness of his illness.
- Frank’s friends and doctor were never able to offer him the support over his medical liability complaint. He overdosed on samples from his office the night before the lunch date.
All three patients died by suicide, and these situations illustrate the different circumstances that may lead a patient to suicide.

Those blue phones on the Golden Gate Bridge speak to our task with suicidal patients, just as with any of our patients’ other conditions. There is hope. More often than not, our efforts to reach out are rewarded by bringing patients back from the brink. And as physicians, we always have ourselves and our concern to offer our patients.

This article was written by David Wahl, MD, a practicing psychiatrist who often collaborates with COPIC on addressing mental health issues.