

Suicide, Psychiatric Malpractice, and the Bell Curve

Martin Blinder, MD

The long-recognized “risk factors” of suicide are so fraught with false positives and negatives as to be nearly valueless in anticipating and preventing suicide or suicide attempts in actual clinical practice. Suicide is no more or less foreseeable in the few patients who attempt self-harm than in the many who make no such attempts. Finally, it is difficult to distinguish retrospectively the quality of the psychiatric care provided to patients who attempt or commit suicide from that received by those who do not. Thus, simple chance may be the only statistically meaningful risk factor for these tragic treatment outcomes.

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There are two kinds of psychiatrists: those who have had patients commit suicide and those who will.—Robert I. Simon [Ref. 1, p 340]

While in midtreatment, a patient takes his own life, apparently providing an essential element of the psychiatric malpractice case: treatment ended in catastrophe. A suit is filed against the psychiatrist, the social worker, the hospital or clinic, perhaps the drug company manufacturing the patient’s antidepressant—any identifiable individual or organization at whose feet blame might be laid.

But after much investigation, expenditure, and defendant angst, plaintiff counsel finds that he is unable to discern flaws in the patient’s treatment remotely commensurate with the calamitous result. Clearly the legal “damages” are monumental, but negligence proves elusive. The attorney may yet be able to bring to bear expert witnesses who make much of the imperfections inherent in any treatment plan, but usually the case ends with a whimper—a small settlement or an outright defense verdict.

Of course, there may be instances in which a psychiatrist has made an egregious, potentially lethal error. Practicing unremittingly good medicine is hard. Most often, however, a patient’s death is not a product of poor treatment, and indeed, as litigation proceeds, discovery usually reveals at least average or “standard” treatment. For what plaintiff counsel has

most likely encountered is not incompetence but the bell-shaped curve effect.

Plot the outcome of any established psychiatric treatment procedure—say a combination of cognitive psychotherapy and psychopharmacology—in a large group of patients, and invariably one finds that most receive measurable benefits, giving the curve its bell shape. A minority, dotted about one periphery of the curve, achieve outstanding results. A roughly comparable number gathered at the other edge show no improvement or may even worsen during the course of treatment. Were the sample large enough, conceivably one patient may be so transformed by her therapeutic experience that she contemplates becoming a psychiatrist herself. But perhaps, at the other far corner, one finds a patient who has taken his own life.

What the bell curve reflects is that nearly identical treatment experiences can produce widely varied outcomes, though gathering toward the mean. Thus, when plaintiff counsel works backward from a singularly tragic result to details of the patient’s care, he usually finds little to distinguish that care from that received by other, more fortunate patients on the curve. Certainly he might find treatment to be short of ideal—unearthing less than optimum choices here and there and, of course, financial and temporal constraints. But the only truly distinguishing feature is that in this one particular case, the patient committed suicide. In other words, catastrophic outcome correlates poorly with the quality of care preceding it. Suicide, it would seem, is largely a random event.

Dr. Blinder is Assistant Clinical Professor, University of California Medical Center in San Francisco, CA. Address correspondence to: Martin Blinder, MD, 50 Idalia Road, San Anselmo, CA 94960.

Psychiatrists are less accustomed than are other physicians to thinking of the conditions they treat as lethal, but in fact, certain diagnoses, especially in combination, are associated with a relatively high incidence of death, typically (though not always) by the patient's own hand. Once again, the distribution of fatalities falls along a bell curve, with borderline and antisocial personalities and patients suffering dementia, schizophrenia, polysubstance abuse, or major depression having a higher incidence of premature or "excess" death relative to other common psychiatric diagnoses.²⁻¹⁰

Thus, a patient unfortunate enough to exhibit pronounced borderline and antisocial characteristics, and who is also a dedicated substance abuser, suffers episodes of major depression, and has impulsively made several near-suicide attempts in the past, might well be seen as having a potentially terminal illness. He is at statistical risk of coming to grave harm by design, by accident, or through the provoked hostile acts of another. With so many roads to a calamitous end laid out before him, it is not surprising that he would occupy the poorest prognostic corner of the bell curve. This is seen to hold true almost irrespective of treatment, though clearly, well-crafted psychiatric intervention can reduce the likelihood of a fatal outcome—at least in the short term. (Conversely, given the resilience of the human spirit, even marginal or novice therapists can get decent results.)

But recognizing that one's patient is situated in a relatively high-risk group is of little practical significance. So few psychiatric patients take their own lives (relative to the many with ominous signs and symptoms who nonetheless survive) that it has not been possible to develop a protocol with which one can predict which particular patients in this group will actually meet disaster. Each year approximately 5.6 percent of the general population displays suicidal ideation (and 0.7% make an actual attempt of some sort).¹¹ Yet the rate of successful suicides is a minuscule 0.017 percent.¹² In other words, most of even the most emotionally fragile individuals manage to stay alive. Consequently, the theoretical value of any risk factor as a predictor of suicide is overwhelmed by false positives. In short, the most statistically accurate prognostication as to which members of a group diagnosed at risk will actually take their lives is simply to predict that none of them will. One may be assured of accuracy well in excess of 99 percent.

Some risk factors are more paradoxical than predictive. For example, many depressed patients are known to exhibit a marked increase in anxiety and agitation just before a suicide attempt.¹³⁻¹⁵ Others, however, are reported to have noticeably brightened prior to the day of their deaths, to have seemed more relaxed, most likely because they had definitively resolved their agonizing conflict between living or dying.¹⁶ Conversely, we are all given to reassurance when a patient "denies suicidal ideation." But alas, there are two reasons for such denial: either in fact there is no suicidality, or antithetically, the patient is quite intent on taking his own life and knows that revealing what he has in mind is likely to bring constabulary measures to interdict those plans.

Consider the following two cases, selected for their many clinical parallels—save for the final outcome. Identifying data have been altered to preserve the confidentiality of all parties. The relevant psychodynamics and course of treatment remain unchanged.

Case I

In October 1982, Josie L., age 26, was admitted to the inpatient service on a 72-hour hold from the emergency room following an intentional overdose of diazepam. This had been her third such overdose in two years.

Ms. L. had spent her childhood and adolescence on a farm. Her father was an alcoholic who is known to have sexually abused Ms. L.'s oldest sister. The patient "could not recall" his ever having molested her. She reported a congenial if undemonstrative relationship with her mother and three siblings.

Apparently quite bright, she obtained good grades in high school with minimal effort, but recreational drug use and frequent truancies brought her schooling to an end three months prior to graduation. During the eight-year interval between her leaving school and her October 1982 hospital admission, she had been almost continuously employed, a series of positions in retail sales—eight different jobs in as many years. Attractive and well spoken, she had no difficulty getting hired, but her frequent emotional storms, tardiness, and unauthorized absences and, in several instances, tumultuous romances with fellow employees, precipitated her terminations. It was the simultaneous breakup of one such romance and her summary firing from her last position that had triggered her most recent suicide attempt and her October 1982 hospitalization.

Her admission mental status was greatly informed by emotional lability. She was tearful, at times angry, and expressed persistent suicidal ideation. There was no impairment of sensorium or cognition, however, once she cleared the diazepam. Commerce with reality was good throughout, with no stigmata of psychosis or organicity.

Her admitting diagnoses were:

1. Major depression, recurrent, without psychotic features; rule out bipolar disorder;
2. Polysubstance abuse, primarily marijuana, alcohol, and diazepam;
3. Borderline personality disorder with histrionic features.

During her second week of hospitalization, Ms. L. gradually became euthymic, her suicidal ideation faded, and she began what was to be a two-and-a-half-year therapeutic alliance with a psychiatrist. Bipolar disorder was definitively ruled out.

After discharge, she was seen twice a week for outpatient psychodynamic psychotherapy and medication management (bupropion, subsequently replaced by fluoxetine) for the first month, then weekly for approximately a year and a half. Treatment proved a challenge for both patient and doctor. Five months after initiation of outpatient therapy, the patient inflicted numerous cuts on both of her arms, a mutilation without lethal intent but vigorous enough to require numerous stitches. Three months later she responded to her psychiatrist's announcement that he was taking a month's sabbatical by consuming all of her medications at one time, though she again denied suicidal ideation, maintaining that she was "merely bereft and confused." She was held on the crisis unit for 72 hours and then referred to her psychiatrist's colleague for outpatient follow-up. When her regular doctor returned, she continued with him for eight months on a weekly basis, then twice a month, and finally once a month, with the patient free to increase frequency in the event of crisis—which she did briefly on three occasions.

In the course of her second year of treatment, the patient entered into a (relatively) stable, durable, intimate relationship with a 53-year-old man. A successful mortgage broker, he helped Ms. L. get training and then a job in his field. She proved a quick study and within a year, now far less prone to emotional turmoil, succeeded in increasing her income to approximate that of her mentor. When last seen in May 1985, she had been offered a middle-manage-

ment position, had discontinued all drug use (both recreational and prescribed), and was engaged to be married.

Case 2

In June 1997, Claudia E., age 23, was referred to the crisis unit from the county jail. She had tried to hang herself in her cell the day she was arrested for shoplifting and possession of methamphetamines.

Ms. E., an only child, was raised in a university town, having been adopted at birth. Her adoptive parents both held administrative posts at the university. By Ms. E.'s account, they were unable to conceive but very much wanted a child. After she was adopted, however, they apparently had second thoughts, and though always "correct" as parents, were preoccupied primarily with their work and with each other, leaving Ms. E. essentially to raise herself.

In school she had difficulty staying focused, but the individual attention she received at her exclusive private high school compensated sufficiently for her to maintain college-entry grades. In 1991 she was accepted at a state college (her parents were disappointed, having had far higher expectations) and managed to get an undergraduate degree in English, though it took her six years to do it. Her college days were notable for an affair she had with her married faculty advisor and for her discovery that methamphetamines not only enlivened her day but made her less distractible and greatly aided concentration. She was soon addicted.

After graduation, employment proved problematic. There seemed to be little market for the skills she had acquired as an English major and none whatever for her literary passion—writing nihilistic poetry about emptiness, futility, and death. Her parents were able to secure a low-level administrative position for her in the university, however, where she helped to prepare course descriptions for the annual catalog.

Ms. E. marked the beginning of her psychiatric history with her 1993 consumption of a bottle of aspirin when her college paramour's wife learned of the affair and brought it to an abrupt, acrimonious end. Ms. E. was hospitalized for five days and then discharged to weekly outpatient visits supplemented by sertraline and methylphenidate. (The latter drug was discontinued after a month when the patient concluded that it was ineffective.) Her discharge diagnoses were:

1. Major depression, recurrent, without psychotic features;
2. Methamphetamine abuse;
3. Rule out adult hyperactivity attention deficit disorder;
4. Borderline personality with narcissistic features.

Her attendance at individual outpatient sessions was spotty, and after eight months the patient unilaterally discontinued. There were no further mental health contacts until her 1997 arrest and admission to the crisis unit.

By both Ms. E.'s account and that of her therapist, she maintained a solid therapeutic alliance during most of her ensuing five years of treatment. Such support was all the more crucial given her emotional volatility and persistent suicidal ideation, the absence of close family ties, and her great difficulty forming—or perhaps more accurately—sustaining friendships with either men or women. Repeatedly, promising relationships would end when an angry Ms. E. became convinced that she was not being shown “sufficient respect.”

Between 1997 and 2002 there were four occasions when Ms. E. informed her therapist, either face to face or over the phone, that she was about to kill herself. Each time Ms. E. was comprehensively evaluated for the valance of her suicidal ideation, the sturdiness of her impulse controls, and her levels of dysphoria and anxiety. On two such occasions the decision was made to rehospitalize her.

The second of these admissions, to a locked ward, occurred in July 2002, shortly after her job with the university fell victim to budget-dictated downsizing. She became profoundly despondent, returned to methamphetamines after a five-year abstinence, and e-mailed her therapist a dark poem that was tantamount to a suicide note.

Ms. E. spent her first three hospital days on Level 3 (the most restrictive) suicide precautions. On the fourth day, 24-hour surveillance was reduced to 30-minute checks, and on the seventh, she was permitted to rejoin the general ward population (Level 1). Each day she underwent two mental status evaluations with particular attention to her suicidality, one conducted by her psychiatrist, and the second, an independent assessment by another member of the hospital staff. Both examiners then compared notes, literally in the chart, and during morning staff meetings. Relaxation of suicide precautions was in each case a joint decision.

By the beginning of Ms. E.'s second week in the hospital, it was staff consensus that she had recompensated and was entirely euthymic. Even fleeting suicidal ideation had been emphatically denied for several consecutive days. She was optimistic about finding a new job and expressed confidence that she was ready for discharge. Her sole complaint was that of increasing pain in her left foot. An orthopedic consult was obtained. The orthopedist diagnosed a bone spur and arranged for an appointment with radiology the next morning, after which the patient was scheduled for discharge.

The following day, at about 9:00 AM, the patient left the unit, unaccompanied, for her scheduled visit with radiology. Shortly before 10:00 AM an x-ray assistant called the nursing station to inquire if the patient was going to keep her appointment. An hour later the mental health staff learned that Ms. E. had departed the hospital and jumped to her death from a freeway overpass. Subsequently, her parents brought suit.

Comment

These two women gave rise to much the same difficult clinical challenge. Note that both shared diagnoses, an ominous prognosis countered by a strong therapeutic alliance, and prompt and appropriate clinical responses to their suicidal crises. The one significant difference between Josie L. and Claudia E. appears to be the outcome.

So far as can be determined, Ms. E.'s therapists were every bit as competent and conscientious as were Ms. L.'s. The former found themselves in litigation, not because they were in any way at fault, but solely because their efforts were followed by a catastrophic result. Neither patient's ultimate course was more or less “foreseeable” than the other's.¹ In short, a side-by-side comparison of these two cases demonstrates how the overriding “risk factor” for patient suicide may simply be chance.

In summary, it is the thoroughness by which a psychiatrist explores a patient's degree of risk and provides an appropriate remedy that determines the clinician's competence, not treatment outcome. That is, a psychiatrist ought not be judged negligent because a patient ended his own life, but only because the patient was not carefully assessed or had failed to receive a proper course of treatment.

All any therapist can do is assume that there is a certain indefinable but real possibility of clinical risk

to the lives of each of his or her patients. That risk calls us not to try to predict the unpredictable, but to bring diligently to bear a proven protocol of diagnostic assessment and therapy. The ultimate success or failure of our efforts may in part be attributable to dynamics not susceptible to scientific measurement.

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