Ethical Consideration in Dealing With Suicide in Different Populations

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Suicide is defined as death caused by injuring oneself with intent to die and is currently the 12th leading cause of death in the United States. In the United States, the rate of suicide was on the rise for many years until a small dip in 2020, with the most recent rate being 13.5 per 100,000 individuals in 2020. In 2020, 12.2 million adults had serious thoughts of suicide, and 1.2 million of them attempted suicide (1). About a third of individuals who have suicidal ideations make a plan, and roughly half of those with suicidal ideations and a plan make an attempt (2). Data from the Centers for Disease Control and Prevention show that in 2017, half the people who died by suicide did not have a prior psychiatric diagnosis, suggesting that suicidality should perhaps be an independent diagnosis. Indeed, suicide attempts are associated with several other factors, including financial trouble, relationship issues, and legal or employment problems (3). Together, these data not only emphasize the critical need to be vigilant about suicide risk across multiple settings and states but also highlight the complex nature of suicide risk assessments.

Suicide risk assessment includes ascertaining and categorizing an individual's risk and protective factors for suicide. Suicide risk formulation uses this information to "assign a level of imminent suicide risk" (3), which can then be used to determine the nature of intervention. Currently, there is no single gold-standard method to predict suicide attempts and completions reliably. Screening tools such as the Columbia-Suicide Severity Rating Scale (CSSRS) and the Ask Suicide-Screening Questions Toolkit (ASQ) are helpful in suicide risk formulation, but the clinician's judgment supersedes assessments made with these tools (3). The complexity with diagnoses spills into management of the suicidal patient, which is further complicated by the many ethical issues that need to be balanced to provide appropriate care in the least restrictive manner. In some situations, appropriate management is very clear when individuals have clear suicidal intent and behaviors. However, in other instances, the decision may not be as well defined.

Appropriate management of an individual with suicidality incorporates several ethical principles, including nonmaleficence, beneficence, autonomy, justice, respect, and privacy (4). Beneficence and nonmaleficence were described by Hippocrates as "help and do no harm." Autonomy and justice became widely accepted as the pillars of medical ethics after Beauchamp and Childress discussed them in their work, *Principles of Biomedical Ethics* (5). One challenge of managing patients with suicidality arises from conflicts between the best interests of the patients (beneficence and nonmaleficence) and the rights of patients to make decisions about their own bodies (autonomy), their rights to make choices about the care that they receive, matters of confidentiality, and involving other clinicians and agents in their care. Clinicians often struggle with determining when the risk of suicide is imminent enough to override the principles of autonomy, privacy, justice, and confidentiality in favor of beneficence and nonmaleficence. We use the following two cases to demonstrate the challenges that can arise in balancing these ethical principles and the strategies that can be used to navigate these challenges.

Case 1, Part 1

Mr. M is a 62-year-old man who has been receiving psychiatric services in the same outpatient clinic for many years. He recently transferred his care to a new physician, Dr. S. Mr. M has a history of bipolar I mood disorder. His last manic episode was 5 years ago, and over the past year, he has struggled with moderate to severe depression. He consumes three alcoholic drinks daily, is divorced, is unemployed, and has attempted suicide three times in the past; his last attempt was 4 years ago. Mr. M's comorbid conditions include chronic back pain from an old injury and a history of prostate cancer that was treated with surgery and radiotherapy 2 years ago.

At his current visit, Mr. M reports that he is more depressed than usual. He reports anhedonia and amotivation and explains that he has been experiencing trouble getting out of bed and engaging in his hobbies. Mr. M also explains that he has been sleeping more than usual and has been feeling guilt about things from his past. He states that he no longer wants to continue living and has had thoughts of

overdosing on opioid medications that he has at home. He denies any suicidal intent, saying that he is still hopeful that he can get better and that this phase of his life will pass like it has before. He adds that he is looking forward to going to a concert with his friend.

1.1. What should Dr. S do at this point?
A. Hospitalize Mr. M
B. Discuss lethal means restriction
C. Complete a safety or no-harm contract
D. Make, review, or update a safety plan
E. Answers B and D

Case 1, Part 2

Dr. S observed that Mr. M's last safety plan was completed a year ago. Dr. S and Mr. M decided to review the safety plan and update it. Mr. M had trouble identifying a person he could reach out to for help. The only listed person on the plan was his brother, who passed away 6 months ago. He agreed to reach out to a neighbor and the 988 Suicide & Crisis Lifeline, and he agreed to meet with Dr. S weekly. They agreed to remove the medications he had at his home to make his environment safer. He also identified that the two foreseeable factors that would make the risk of suicide imminent include a recurrence of cancer or an exacerbation of pain. They discussed a plan to mitigate the crisis in the event of one of these changes, and Mr. M decided that he would reach out to Dr. S if he felt more suicidal or that he would take himself to the hospital.

During their follow-up appointment a month later, Mr. M continued to feel depressed. He reported that his cancer had recurred and had metastasized to his spine. He denied feeling suicidal to Dr. S but appeared very anxious, fidgety, and hopeless. He explained that he had been drinking more to medicate both his depression and pain. He had not been able to sleep because of the pain and anxiety and could not identify any reasons for living. When Dr. S inquired into his decision to reach out in the event of a crisis, Mr. M gave a noncommittal explanation. Dr. S grew concerned with these developments and recommended hospitalization to Mr. M. Mr. M got angry and left the office.

1.2. What should Dr. S do next?
A. Issue a pickup order
B. Arrange for a welfare check
C. Wait for the next appointment with Mr. M

Case 1, Part 3

Dr. S issued a pickup order, and Mr. M was brought to the comprehensive psychiatric emergency program (CPEP) by the police. In the emergency room, Mr. M denied suicidal ideation, plans, or intent. He denied any worsening in his depressive symptoms over the past few weeks and minimized his alcohol use. He refused hospitalization, explaining that he wanted to be discharged. He was discharged from CPEP on the basis of these statements. Five days after he was discharged from CPEP, he was coincidentally found by a neighbor. He had taken an overdose of his opioid medications after drinking a bottle of vodka.

1.3. What are some other interventions that could have been implemented under the circumstances?
A. Safety plan intervention
B. Follow-up contact
C. Hospitalization on an involuntary status
D. Coordinating care with the outpatient psychiatrist
E. All of the above

Case 2, Part 1

Ms. C is a 25-year-old woman who was referred to the psychiatry clinic by her obstetrician for management of worsening depression. She is currently 4 months pregnant with her second child. During her first meeting with Dr. S, Ms. C explained to her that she has a long history of major depressive disorder, anxiety, and borderline personality disorder and had been on sertraline for many years until she got pregnant. She stopped the medication 2 months into her pregnancy for fear of the medication harming her baby. She explained that, after her first pregnancy, she struggled with severe postpartum worsening of depression and was hospitalized at 4 months postpartum for a suicide attempt.

2.1. Which of the following is part of informed consent regarding medication use in pregnancy?
A. Evaluating whether Ms. C understands the nature and severity of her illness
B. Informing her about the risks and benefits of antidepressant use in pregnancy
C. Informing her of the risks of no treatment or alternatives
D. Evaluating whether Ms. C can make a consistent choice that she can express
E. All of the above

Case 2, Part 2

Ms. C decided to not restart sertraline. She agreed to engage in therapy and followed up on a regular basis. Unfortunately, at 28 weeks, Ms. C's depressive symptoms started worsening, and Ms. C started experiencing anhedonia, poor appetite, and insomnia. Her mental state was further impaired by intimate partner violence and loss of social support systems. She was offered psychopharmacological treatment again, but she refused the option once again because of her concerns about fetal malformations. Ms. C had a preterm baby at 32 weeks who was diagnosed as having congenital heart anomalies. She continued to follow up for therapy in the postpartum period and refused medications, as she was worried about breastfeeding and medications. During one of these follow-up visits, around 3 weeks postpartum, Ms. C explained that the depressive symptoms had worsened and that she was having trouble taking care of herself and her baby. Ms. C confessed to feeling like a bad mother and having intrusive thoughts of dropping her baby or injuring her with a knife by mistake. Ms. C explained that she was distressed

and ashamed of these thoughts. She added that she had never dropped the baby, denied any intent to harm her, and explained that she was very careful with the baby. She acknowledged that sometimes she forgets to clean her baby for the entire day and has missed some feeds because she was too tired to get out of bed.

2.2. Should Dr. S call child protective services (CPS)?
   A. Dr. S should call CPS because Ms. C might harm the baby because of her intrusive thoughts.
   B. Dr. S should call CPS because of her concerns for neglect.
   C. Dr. S should not call CPS because Ms. C seems to care for her baby, and this would damage Dr. S's relationship with Ms. C.

Case 2, Part 3

Dr. S called CPS because of her concerns for neglect. CPS visited Ms. C and offered her support services to help care for her baby. Ms. C continued to blame herself for her child's congenital anomaly and continued to struggle to take care of herself. She arrived at her next weekly visit with Dr. S looking tired and disheveled, clutching her baby. She reported that she has not been sleeping because she feels that her partner is trying to kill her and her baby, and she would rather kill herself than allow that to happen. She was observed to be agitated and hypervigilant, with rapid speech and increased psychomotor activity.

2.3. What should Dr. S do at this point?
   A. Call CPS again because of concerns for the baby's safety
   B. Recommend inpatient hospitalization
   C. Start Ms. C on an antipsychotic medication and ask her to follow up in a week
   D. Start Ms. C on an antidepressant medication and ask her to follow up in a week
   E. Answers A and B

Discussion

Together, the cases highlight the ethical dilemmas that practitioners face when they work with individuals struggling with suicidality. The second case also highlights the ethical and legal responsibilities that treating psychiatrists have toward a dependent child when managing suicidality in birthing individuals. With rising suicidality across the country, recognizing ethical issues and navigating dilemmas becomes critical.

Answers

1.1. The answer is E. Dr. S should explore the least restrictive method to ensure safety and balance the principles of beneficence and nonmaleficence on one hand and autonomy and justice on the other. Mr. M has several risk factors for suicide and is reporting active suicidal ideation. However, he also has protective factors: He has a lack of intent to act on his thoughts, is hopeful, demonstrates future-oriented thinking, and is actively engaged in treatment. Although his risk for suicide is elevated, he does not pose a significant and imminent risk of harm to himself. Hence, hospitalization would be too restrictive. Dr. S and Mr. M should work on other nonrestrictive methods to mitigate the risk of suicide. Lethal means reduction is an evidence-based suicide prevention method that involves putting time and distance between the potential means identified to attempt suicide (6–8). A safety plan is a brief crisis intervention that includes lethal means reduction and other strategies, including identifying individual warning signs and triggers; internal coping skills to manage distress; and social supports and emergency contacts, including friends and family, clinicians, and emergency services (9, 10). Suicide safety contracts (or no-harm contracts) have been shown to have limited evidence for effectiveness and do not protect the physician from liability (11, 12). They should not take the place of appropriate suicide risk interventions.

1.2. The answer is A. The challenge here is to balance protecting the patient's life and safety according to the principle of beneficence with safeguarding the patient's autonomy over his body and the care that he is receiving. A pickup order and subsequent involuntary psychiatric hospitalization would be the appropriate action per the ethical principle of beneficence but would overrule the patient's autonomy. At this point, it would be reasonable for Dr. S to consider that Mr. M is an imminent threat to himself, given several dynamic risk factors such as increased substance use, worsening depression, hopelessness, anxiety, insomnia, terminal medical illness, and the occurrence of a self-identified foreseeable factor that can put him in crisis.

   An important clinical pearl to be considered is that up to two-thirds of patients who attempted suicide denied suicidal ideations, and one-half of these patients died by suicide within 2 days of the denial (13). This study also makes the argument that relying solely on verbalized suicidal ideations as a gateway for a more comprehensive suicide risk assessment is not adequate. "Foreseeable changes are events or stressors, which, if they occurred, could reasonably be expected to increase or decrease risk of suicide" (14). Early discussion and identification of risk and protective factors, and of foreseeable changes, can help clinicians remain vigilant about changes in dynamic factors. Dr. S notes that the two foreseeable changes that Mr. M identified have been met, which further confirms her assessment. Arranging for a welfare check is not adequate because of the risk level. Similarly, waiting for the next appointment, although ensuring autonomy, is not adequate considering the imminent risk.

1.3. The answer is E. Coordination between the emergency room and the outpatient psychiatrist would have provided a more complete picture of the circumstances and highlighted the imminent risk. Without this information,

the emergency room psychiatrist's decision was based on Mr. M's denial of worsening psychiatric symptoms, suicidal ideations, and intent. A second option is a brief safety plan intervention (SPI) in the emergency room, with subsequent follow-up contact by telephone. A comparative study showed that this combined intervention reduced suicidal behavior in the postdischarge period by 45%, and there was an increased engagement in aftercare. Structured follow-up telephone calls include a brief check-in with regard to suicide risk and mood, revision of the SPI if required, and facilitation of engagement in aftercare (10). This scenario also highlights that the risk of suicide is the highest in the postdischarge period, particularly within the first 3 months (15).

2.1. The answer is E. A complete informed consent should have "disclosure, comprehension, voluntary choice, and authorization" (16). Disclosure would include informing Ms. C of the risks and benefits of both the proposed treatment as well as the alternative treatments and the option of declining treatment. Comprehension involves evaluating whether Ms. C understands the nature and severity of her condition. Voluntary choice and authorization are determined by Ms. C being able to make a consistent decision that she can express and ensuring that she is not under any coercion. It is important that Ms. C recognizes the consequences of untreated perinatal mood and anxiety disorders for both her and her fetus, as well as the increased vulnerability to suicide, particularly because of her past history of a suicide attempt in the postpartum period. During this period, it is also often helpful to engage support systems, including significant others.

2.2. The answer is B. Because there are significant concerns for neglect with Ms. C forgetting to feed and clean her baby, Dr. S should inform CPS. The ethical principles that Dr. S is adhering to here are beneficence and justice to the baby, which takes precedence over the mother's autonomy, nonmaleficence, and confidentiality. Physicians treating young parents dealing with peripartum or other psychiatric illnesses have an additional responsibility for the child's safety and welfare. Physicians are mandated reporters and have a legal and ethical obligation to report cases of suspected abuse and neglect. Reporters often struggle with the decision, worried that this may affect their relationship with the patient (nonmaleficence) and concerned about breach of confidentiality; separation of the child from the family, which may worsen the patient's mental state (nonmaleficence); and the credibility of their suspicion. In an overwhelming majority of cases, reunification or keeping the child with the parent is the goal for CPS. CPS often provides services to support the parent's ability to provide for their child's health and safety (17). A majority of mothers, more than 70%, report intrusive thoughts related to infant harm (18), and initial data show that this does not correlate with actual infant harming behaviors (18, 19). Because Ms. C is clearly able to verbalize that she does not intend to harm her baby and that she is distressed by these thoughts, it does not qualify as a reason to call CPS. Dr. S has valid concerns here regarding child neglect, and that overrides concerns of how a CPS call would affect the mother.

2.3. The answer is E. Ms. C is reporting worsening symptoms of both depression and emerging psychosis, which place her at imminent risk of suicide. Ms. C has some other relevant factors that are associated with a high risk of perinatal suicide, including younger age, being single, having preexisting and current mental illness, intimate partner violence, poor social support, and psychological problems related to pregnancy complications (20). Her current presentation also warrants consideration of psychiatric hospitalization. Dr. S and Ms. C recognize the need for hospitalization, thus averting the need for an involuntary hospitalization. However, they are now faced with the dilemma of placing the baby in someone else's care. Ms. C notes that she can call the baby's father; together, Dr. S and Ms. C place the call. They also call CPS and inform them of the situation. Emergent psychosis in the postpartum period is a medical emergency that can change rapidly and increase the risk of harm to the baby as well, and it is ideally treated in an inpatient setting (21–23).

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