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Ethical Legal Feature

# The Suicidal Outpatient: Balancing Autonomy, Trust, and Responsibilities

**Guest Discussants: Elizabeth E. Sita, MD, R. Brett Lloyd, MD, PhD, Lynne C. Brady Wagner, MA, CCC-SLP, Vu Q.C. Nguyen, MD, MBA, Eric Swirsky, JD, MA**
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## Feature Editor Introduction

The intersection where mental health and rehabilitation care converge can raise ethical questions involving boundaries, duties, and perhaps more importantly, our role in recovery, adjustment, and flourishing. The patient with a stroke-related depression is one prototypical example. We know that damage to specific parts of the brain can cause depressive symptomatology as well as the fact that the adjustment process during rehabilitation itself can impact well-being and a sense of self-efficacy. In this column, we explore a case of when a patient becomes severely depressed and suicidal and expresses this ideation during an outpatient physical therapy session. What are our responsibilities, and who follows up to make sure that the patient is safe? This can become particularly complicated in an outpatient setting, where the episodic nature of care and social supports vary. In this column, I have invited 5 columnists to comment on a case that is very loosely based on a case that our ethics consult service was contacted about. I sent them the following writing prompt:

> During an outpatient physical therapy session, Mrs. A (not her real initial) expresses suicidal ideation. She is adjusting to her impairments due to a recent stroke and she feels hopeless and helpless. She is 35 years old and has been married for 10 years. Mrs. A's stroke has not impacted her capacity to make her own decisions. She has an established relationship with the physical therapist, attending physician, and outpatient clinic staff and states that she trusts them enough to be honest with them. She reports that she has thought about killing herself before, but in the past few days, she cannot get the thought out of her head. When asked about a plan, Mrs. A states that she will overdose on a specific medication that is stored in her medicine cabinet and she knows where she can get a gun. The clinic manager and attending physician are consulted by the physical therapist, and the patient agrees to go to the emergency department to seek services. As Mrs. A is leaving, she asks the therapist, manager, and attending physician not to tell her husband. He has been so overwhelmed with her illness and he is exhausted. She does not want him to worry. Mrs. A is approved for 15 more physical therapy sessions and her husband checks in every week to see how she is progressing. She pleads with the staff not to break her confidence. This case raised questions of duties, responsibilities, trust, boundaries, among others. What would you advise when the clinic manager calls for guidance on how best to weigh the options and proceed?

The first columnists, Elizabeth E. Sita, MD, a resident physician in the Department of Psychiatry at Northwestern University McGaw Medical Center and R. Brett Lloyd, MD, PhD, an Assistant Professor of Psychosomatic Medicine and Associate Residency Program Director in the Department of Psychiatry and Behavioral Sciences at Northwestern University Feinberg School of Medicine, focus on the psychiatric emergency and the importance of maintaining a therapeutic alliance. The second columnist, Lynne C. Brady Wagner, MA, CCC-SLP, the Chief Learning Officer at Spaulding Rehabilitation Network, the Associate Director of the Spaulding Stroke Research and Recovery Institute, and the Chair of the Ethics Advisory Committee at Spaulding Rehabilitation Hospital, considers the complexities of confidentiality and underscores the importance of the family. Vu Q. C. Nguyen, MD, MBA, Vice Chair of Academics in the Department of PM&R and Residency Program Director in the Department of PM&R at Carolinas Medical Center, and Medical Director of Stroke Rehabilitation and of

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Specialty Clinics at Carolinas Rehabilitation, Atrium Health, discusses the balance and tensions between the principles of beneficence and respect for autonomy. The fourth columnist Eric Swirsky, JD, MA, Clinical Assistant Professor and Director of Graduate Studies in the Department of Biomedical and Health Information Sciences in the College of Applied Health Sciences at the University of Illinois at Chicago, addresses the legal duties to warn, report, and protect. All of the columnists underscore the underlying issue of the incidence of depression poststroke and the complexities and nuances of the provider—patient relationship. I hope this column offers key points to consider for outpatient settings when a patient expresses suicidal ideation. As always, I welcome comments and suggestions for the PM&R Ethics/Legal column at dmukherjee@sralab.org.

## The Suicidal Patient: Maintaining Safety and Breaking Confidentiality

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The suicidal patient elicits strong and emotionally charged reactions among health care providers, which may cloud otherwise sound clinical judgment. Suicide is counter to what drew most of us to medicine and is antithetical to the preservation of life at the core of our profession. Hearing a patient voice a desire to die often leaves providers feeling overwhelmed and ineffective at a time when decisive and thoughtful intervention is critical. Although suicide prevention is generally viewed as the domain of psychiatry, most patients who die by suicide do not see a psychiatrist during the year leading up to their attempt [1]. Perhaps more sobering, it has been estimated that 64% of individuals who complete suicide had visited a nonpsychiatric health care provider during the month before their attempt and 38% within the week of their attempt [2]. It is accordingly the duty of all providers to demonstrate competency in the detection of suicidal ideation and the procurement of further evaluation based on a basic understanding of risk. To this end, The Joint Commission provides concise recommendations for the management of suicidal ideation in all health care settings [3].

### A Psychiatric Emergency

The information elicited by Mrs. A's outpatient team highlights the fact that this scenario represents a psychiatric emergency. Here we have a 35-year-old woman facing new and serious physical impairment after an unexpected cerebrovascular accident. The nature of her injury and decline in function are important risk factors for depression and suicide. Although we are not told if she has a comorbid history of mental illness, she is endorsing cardinal symptoms of a major depressive episode, namely, hopelessness and suicidal ideation. Moreover, she reports acute intensification of ideation, identifies methods with high likelihood for mortality, and describes access to means.

Mrs. A's willingness to disclose her thoughts and seek further evaluation is reassuring; it suggests she is ambivalent regarding immediate action and desires help. However, this is the beginning, not end, of a longer conversation. More thorough assessment by a psychiatrist is required and will include evaluation of her current mental state, screening for diagnosable psychiatric illness/comorbid substance use, history of self-harm, family history of mental illness/suicide, evidence of any preparatory steps or behaviors, patient-perceived likelihood for lethality, and identification of intrinsic and psychosocial strengths and vulnerabilities [4]. It is the responsibility of the outpatient team to ensure this conversation is promptly continued with a professional trained in suicide risk assessment. Mrs. A should not be assumed able to present independently for this assessment and requires a staff escort or emergency medical services to ensure safe patient handoff.

### Confidentiality and Suicide

Mrs. A's plea for confidentiality strikes at the heart of the Hippocratic Oath sworn by all physicians: "Whatever I see or hear in the lives of my patients...I will keep secret... considering all such things to be private [5]." When health care providers find themselves uneasy with such a request, it is often the result of dissonance with other sacred duties, namely, our obligations to "...benefit...patients according to my greatest ability and judgment...and do no harm or injustice to them [5]." Indeed, this tension is frequently encountered in the management of the suicidal patient, where the request for autonomy is often at odds with the principles of beneficence and nonmaleficence in the setting of imminent self-harm. Although state laws vary, patient confidence may be sacrificed when necessary to protect the patient and mitigate acute risk [4].

In the case of Mrs. A, such sacrifice is not yet required. It is possible for the outpatient team to maintain her confidence and take appropriate steps to manage risk. Procurement of an emergent psychiatric evaluation does not in any way necessitate the team's disclosure of Mrs. A's suicidality to her husband. The patient is physically present and visualized by staff, demonstrates decisional capacity, and is amenable to the team's proposed intervention. Disclosure by the team would only be requisite were these circumstances to change. Although we advise the team keep Mrs. A's