expertise offered by psychiatry is at its best when actively engaged with a holistic perspective and that it is in such engagement that it becomes more apparent that psychiatry does not have all the answers. In this way, boundary issues are highlighted and the ensuing debate offers opportunities to reduce confusion and clarify good practice.[4]

R.P. and R.H. believe that the concept of holistic care takes psychiatrists out of a domain where they have special expertise and that 'holism' undermines the important role of other agencies and individuals in helping people with mental illness by implying that psychiatrists have all the answers.[5] They believe that holistic care invites serious boundary breaches because it creates intrinsic confusion as to appropriate professional behaviour and the limitations of psychiatric expertise.

So far, this debate has been polarised and somewhat abstract. It would not be helpful to deny our differences, but we share an aspiration to understand the centre of gravity of professional and service user opinion on this matter by reference to tangible dilemmas in real-life practice.

Declaration of interest
C.C.H.C. is Chair of the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists. The views expressed here are his own and do not necessarily represent those of the Group. He is Director of the Project for Spirituality, Theology and Health at Durham University, and is an Anglican priest. R.P. is an atheist. R.H. is a Buddhist.

1 Crossley DR. Holistic psychiatry without the whole self. *Psychiatrist* 2012; **36**: 97–100.

2 Cook CCH. Self-belief: holistic psychiatry in a secular age. Commentary on . . . Holistic psychiatry without the whole self. *Psychiatrist* 2012; **36**: 101–3.

3 Poole R, Higgo R, Strong G, Kennedy G, Ruben S, Barnes R, et al. Religion, psychiatry and professional boundaries. *Psychiatr Bull* 2008; **32**: 356–7.

4 Cook C, Powell A, Sims A (esd) *Spirituality and Psychiatry*. RCPsych Publications, 2009.

5 Poole R, Higgo R. *Clinical Skills in Psychiatric Treatment*. Cambridge University Press, 2008.

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Hindsight bias and the overestimation of suicide risk in expert testimony

In *Rabone v. Pennine Care NHS Foundation Trust* the Supreme Court examined the duties that the European Convention for the Protection of Human Rights and Fundamental Freedoms might place on hospitals caring for informal psychiatric patients.[1] We have grave concerns about the quality of the expert evidence presented to court in this case.[2]

Melanie Rabone was 24 when on 4 March 2005 she attempted suicide by tying a pillowcase around her neck and was admitted to hospital diagnosed with 'a severe episode of a recurrent depressive disorder'. By 14 March she 'had shown sufficient signs of recovery' to be allowed overnight leave, and on 18 March she was discharged to accompany her family on a week-long trip to Egypt. On 11 April she was readmitted voluntarily after tying lamp flex around her neck. By 19 April Ms Rabone had again shown some signs of improvement. She requested leave and, following a meeting with her psychiatrist and mother where she agreed not to self-harm, 2 days' leave was granted. She spent most of the next day with her mother, but in the afternoon said she was going to see a friend. She hanged herself from a tree in a local park sometime after 5 pm.[2]

The court sought expert evidence as to whether there was a 'real and immediate' risk to the life of Ms Rabone on the day she was granted leave. The expert psychiatrist engaged by the claimants estimated that Ms Rabone's 'immediate risk' of suicide on 19 April was 'of the order of 70%'.[2] The Trust's expert was more conservative. He expressed the view that 'the risk was approximately 5% on 19 April (after leaving hospital) increasing to 10% on 20 April and 20% on 21 April'.[2] The written judgments do not record how these figures were arrived at, but it is hard to see how they could have been based on what is actually known about the likelihood of suicide by psychiatric in-patients on approved leave.

The suicide of psychiatric in-patients (including those on approved leave) was the subject of a systematic review and meta-analysis.[3] Its results suggest that Ms Rabone's depressed mood and previous suicide attempts would have meant that she was more likely to die by suicide than another in-patient without those features. It is possible, using these empirical data and making an assumption of the base-rate of suicide among all in-patients, to calculate the probability of such a 'high-risk' patient's admission ending in suicide. Such a calculation, even with an extremely pessimistic base-rate assumption, reveals that the likelihood of a 'high-risk' patient dying by suicide while an in-patient is probably no more than 1.2%. Since Ms Rabone's admission lasted 10 days, it is hard to see how a realistic estimation of her risk of suicide on any particular day could have been much beyond one tenth of that – 0.12%. The experts' estimates, the more conservative of which was accepted by the court,[1] were between 40 and 600 times that figure.

We can only speculate as to how the experts arrived at their estimates, however, the most obvious possibility is that they utilised their clinical judgement based on reviews of Ms Rabone's file. Clinical judgement about the likelihood of future events is known to be affected by a range of well-established weaknesses including the failure to consider known risk factors, an inability to consider co-variation between risk factors, underutilisation of base-rate data, and a range of cognitive biases including confirmatory bias supporting an initial hypothesis.[4] In this case though, the most potent influence was probably the tendency to see events that have already occurred as being more predictable than they were before they took place. This is referred to as hindsight bias and is one of the strongest and most ubiquitous of the cognitive biases.[5]

The Pennine Care NHS Foundation Trust was found to have failed to avoid a 'real and immediate' risk of death by allowing Ms Rabone home on leave when, the court reasoned, her doctors should have refused that leave. The court also reasoned that had she insisted on leaving against advice, her doctors could have, and should have detained her using the coercive treatment provisions in the Mental Health Act 1983. This failure, the court held, amounted to a breach of her human

rights. The psychiatrists' risk calculations formed the basis of the court's finding that there was a duty to protect Ms Rabone's 'right to life' under Article 2 of the European Convention, and the breach lay in the hospital's failure to detain her against her will.

The decision in *Rabone v. Pennine Care NHS Foundation Trust* means that risk calculations have the potential to affect the rights of all psychiatric patients to access leave or to refuse hospital admission or lengthy hospital stays where their suicide risk is thought to be 'real' – that is 'significant' and not 'remote' or 'fanciful' – at the time they request to leave the hospital.

The principal duty of the expert witness is to provide accurate, objective and unbiased testimony about complex matters before the court. Now that hospitals have a clear responsibility to protect psychiatric patients thought to be at immediate risk of suicide, if necessary by invoking coercive powers to detain and treat, psychiatric experts must make realistic estimations of the likelihood of suicide based on the facts of the case, knowledge of the literature and careful avoidance of hindsight bias.

1 *Rabone v. Pennine Care NHS Foundation Trust* [2012] UKSC 2.

2 *Rabone v. Pennine Care NHS Trust* [2009] EWHC 1827 (QB).

3 Large M, Ryan C, Nielssen O. The validity and utility of risk assessment for inpatient suicide. *Australas Psychiatry* 2011; **19**: 507–12.

4 Ziskin J. *Challenging Clinical Judgement*. Law and Psychology Press, 1991.

5 Fischhhoff B. Hindsight not equal to foresight: the effect of outcome knowledge on judgement under uncertainty. *Qual Saf Health Care* 2003; **12**: 304–12.

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We wouldn't judge a patient for being mentally unwell, so why judge ourselves?

I thought the paper by an anonymous doctor with a mental illness[1] was a breath of fresh air and highlighted key common problems surrounding medicine and mental health. I could fully empathise with the author.

I became unwell while at medical school and initially refrained from seeking help, fearing that I would be asked to leave. In fact, when the truth came out the school was extremely supportive and I regret not seeking help earlier.

I agree with many of the comments made regarding treatment by other professionals. My husband is a doctor, which doubled the amount of doctors we know. Usually, I was left with little option but to be treated by someone I know. Sometimes this worked out well, and sometimes it left me feeling foolish and upset. I feel 'stigma' is much the essence of our own prejudices and that especially as medics we tend to set the bar rather high for ourselves. For this to be broken down, the more openly mental illness is discussed in medicine, particularly within training schemes and in medical school, the less daunting it becomes. This will of course involve medics speaking out about their illnesses and acknowledging that we are not infallible, yet perhaps more vulnerable.

It was indicated to me on many occasions by healthcare professionals that I must avoid admission as an in-patient 'as it would not be good for me as medic'. I can see why the act of protection was thought best for me. My husband too had extra pressure placed on him to care for me at home. In the end the inevitable came; I became extremely unwell and had a lengthy in-patient stay. I do often wonder whether my illness would have taken the same progression if I had been admitted earlier.

One benefit of working within the National Health Service is the access to the occupational health service and so I have had treatment funded that I would not have got otherwise (e.g. psychotherapy).

Regarding the General Medical Council references, the situation is incredibly delicate. When you have worked so hard for many years and your career could be in jeopardy, you may think twice before turning to a professional body. Yet would you shy away from seeking help if you broke a bone? I very much think honesty is the best policy and if at the end of the day you are not fit to work (for whatever reason), then patients' safety is paramount. However, admitting there are problems early on and being honest and seeking help through the correct avenues leaves you in good stead. I think the more medics do this the better. We can prove you can have mental illness, recover and continue a career in medicine and then speak out, which holds great hope. I also believe that suffering from any illness can provide you with valuable skills and empathy.

I wish the author well and thank you for making that step at being a medic and speaking out.

1 Anonymous. Medicine and mental illness: how can the obstacles sick doctors face be overcome? *Psychiatrist* 2012; **36**: 104–7.

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Correction

Evaluation of teaching an integrated case formulation approach on the quality of case formulations: randomised controlled trial. *The Psychiatrist* 2012; **36**: 140–145. The last line of the second introductory paragraph should read: 'We are not aware of any published UK studies on this subject; however, in an unpublished British study, M.A. examined 150 new assessment letters, of which only 6% included any formulation, showing that case formulation is rarely attempted in routine psychiatric practice.' In addition, the Case Formulation Scale is available as an online supplement to this correction.

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