MMWR
Weekly
December 23, 1988 / 37(50);773-774,779-780

Current Trends Operational Criteria for Determining Suicide

Suicide is the eighth leading cause of death among Americans (1). In 1986, suicide accounted for 30,904 deaths and for 939,104 years of potential life lost before age 65. In the United States, a coroner or medical examiner usually determines whether a death is a suicide and records that decision on the death certificate. Laws guiding these decisions vary by state and sometimes by county, and guidelines for certification decisions may be inconsistent and vague.

No explicit criteria exist to assist in determining whether a death is a suicide. Therefore, several factors, e.g., uncertainty about what evidence is necessary and pressures from families or communities, may influence a coroner or medical examiner not to certify a specific death as a suicide. Because the extent to which suicides are underreported or misclassified is unknown, it has not been possible to estimate precisely the number of suicides (2-6), identify risk factors, or plan and evaluate preventive interventions.

To address these problems, a working group representing coroners, medical examiners, statisticians, and public health agencies* developed operational criteria to assist coroners and medical examiners in determining suicide (7). Following are the working group's findings. CRITERIA FOR DETERMINING SUICIDE

Self-Inflicted: There is evidence that death was self-inflicted. This may be determined by pathologic (autopsy), toxicologic, investigatory, and psychologic evidence and by statements of the decedent or witnesses.

Intent: There is evidence (explicit and/or implicit) that, at the time of injury, the decedent intended to kill himself/herself or wished to die and that the decedent understood the probable consequences of his/her actions. This evidence may include:

Explicit verbal or nonverbal expression of intent to kill self; Implicit or indirect evidence of intent to die, such as

preparations for death inappropriate to or unexpected in the context of the decedent's life, expression of farewell or the desire to die or an acknowledgment of impending death, expression of hopelessness, expression of great emotional or physical pain or distress, effort to procure or learn about means of death or to rehearse fatal behavior, precautions to avoid rescue, evidence that decedent recognized high potential lethality of means of death, previous suicide attempt, previous suicide threat, stressful events or significant losses (actual or threatened), or serious depression or mental disorder. Reported by: LE Davidson, MD, Atlanta, Georgia. AL Berman, Washington Psychological Center; D Murray, National Association of Counties; D Jobes, George Washington Univ, Washington, DC. H Buzbee, Peoria County Coroner's

Office, Peoria, Illinois. G Gantner, St. Louis Univ Medical Center, St. Louis, Missouri. B Moore-Lewis, Washington Dept of Social and Health Svcs. DH Mills, Los Angeles, California. Registration Methods Br, Div of Vital Statistics, National Center for Health Statistics; Intentional Injury Section, Epidemiology Br, Div of Injury Epidemiology and Control, Center for Environmental Health and Injury Control, CDC.

Editorial Note

Editorial Note: For each death certificate filed in the United States, the certifier must indicate, in addition to the cause of death, the manner of death as "natural," "accident," "suicide," "homicide," or "could not be determined" (Figure 1) (8). For suspected suicide or homicide, state laws usually require a medical examiner or coroner to complete the death certificate. Because suicide is particularly subject to inaccurate determination, the incidence of suicide may be underestimated by 10%-50% (2-6).

Death certificates are the primary data source for U.S. mortality statistics, and public health priorities are influenced considerably by the perceived magnitude of problems. Thus, underreporting of suicide can affect research, prevention, and intervention efforts regarding this problem. More accurate reporting may improve understanding of the risk factors for suicide and lead to more effective prevention strategies.

The validity and reliability of certifications of suicide are decreased for several reasons (9-11). The determination of suicide requires that the death be established as both self-inflicted and intentional. For most certifiers, establishing intentionality is the most difficult criterion. A coroner or medical examiner who suspects suicide may be reluctant to impose social stigma, guilt, and loss of insurance benefits on the victim's family. Since many certifiers lack explicit criteria for assessing suicidal intent, they might search for a narrower range of evidence concerning intent (10). Thus, a certifier might conclude that a death was not a suicide because information proving intent was not collected. However, absence of evidence of intent is not evidence of absence of intent. Some certifiers require a suicide note to certify a death as suicide. Yet, only about one third of persons who commit suicide leave such notes (11). Forensic science experts also differ on the proper certification of deaths for psychotic, very young, or alcohol- or drug-intoxicated persons (12-17).

The new operational criteria for determining suicide should improve reporting by helping to standardize the information collected and incorporated into the manner of death determination. The certifier is more likely to identify a suicide correctly when the case file contains objective information regarding intent to die.

Suggestions or inquiries regarding the criteria should be addressed to Operational Criteria for Determination of Suicide Working Group, c/o Division of Injury Epidemiology and Control, Center for Environmental Health and Injury Control, CDC.

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This page last reviewed 5/2/01