'The Health of the Nation': suicide

John Crammer

The study of fatal suicides in York, 1990–1994, by Elwood & De Silva (1998) is valuable confirmation that other people than general practitioners (GPs) and psychiatrists have responsibilities in averting such deaths, but does not go far enough. It is assumed that the GP or general hospital doctor has failed to recognise the suicidal risk, and better teaching would have increased their diagnostic awareness and so saved lives. But examining the detailed sequence of events leading up to death (medical audit) will show that in a number of cases medical diagnosis was not lacking, and the problem lay elsewhere.

A few decades ago I looked at all 109 suicides occurring in a three-year period (area population at risk 360 000) (further details available from the author upon request): at the time of death 40 were not in any medical contact, 27 were attending their GP only and nine (like Elwood & De Silva's cases) were in addition under general hospital care (33 were in touch with psychiatrists). Let me quote three cases.

Case history 1

A woman of 30 with two young children, and a history of in-patient treatment for depression some years earlier, came to her GP complaining of dizziness, fainting and impaired memory. She maintained she was not depressed but suffering from blood pressure, and absolutely refused to see a psychiatrist or enter a psychiatric ward, so the GP referred her to a general physician. She was in a general ward for a week. The physician 'reassured' her that her cardiovascular system was normal, she refused to see any other doctor, and she was discharged home. A week later she was seen acting strangely on the platform of her local railway station, and when the London train came in she threw herself under it.

Case history 2

A man of 57 was left by his wife because of his heavy drinking. He started to gas himself, did not carry it through, and in the morning went to see his GP, who telephoned the psychiatric hospital for an emergency consultation. After a short delay the hospital replied they would admit him forthwith. The patient had meanwhile left the surgery, so the GP went round to his home to tell him. He could get no reply to his knock so he scribbled a message and put it through the front door, and left. The man meanwhile was inside, ending his life. (Incidentally, there were others in this series who killed themselves in the short period between referral to a psychiatrist and the actual interview with him.)

Case history 3

A woman of 49 was seen by a psychiatrist in a general hospital following a barbiturate overdose. She ascribed her depression to worry over her daughter, and was allowed home. The same night she took another overdose, and was returned to hospital. On revival she was transferred to a psychiatric ward. Her husband visited that night; she insisted on discharge with him and was allowed home again. A week later she wrote to the psychiatric ward doctor asking if he would see her as an out-patient. He replied that he did not do out-patient work, and sent her an appointment with a third psychiatrist. She cancelled this, took her car into the hills and gassed herself.

These are three examples out of a number where it was not lack of knowledge/awareness of the illness but the doctors' attitude which resulted in the deaths. Compulsory admission and psychiatric treatment would probably have saved these lives, but the use of compulsion is often unacceptable to many doctors. To them it may appear punitive or aggressive and contrary to the patient's right to self-determination; as well as socially disabling, and possibly provoking of complaints by families and civil liberties lawyers.

So they begin to down-rate the risk of death. Other factors may push in the same direction. A lonely old widow, or a sufferer from severe rheumatoid arthritis or other chronic disablement, perhaps with a short life expectation, becomes a focus for pity: what quality of life have they got left, these patients, why should they not die if they want to?

Sympathy can be dangerous. One wants to believe in the patient's reasonableness and capacity for sensible decisions, and prefers to hear explanations for the depression – 'worry over daughter' for instance. In the above series, one psychiatrist recorded severe depressive symptoms of a man he saw as an out-patient and even added the note "wife a perfectly dreadful woman, I'd commit suicide if I had to live with her". (Was he surprised when the man did so a few days later?) There were other cases too where the doctor down-rated suicidal risk in proportion to the greater degree of stress in the

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social emotional situation instead of being guided by the patient's detailed symptoms.

And on the other hand withdrawal of all sympathy (rejection in case history 3) can provoke death. The chronic complaining, self-willed patient who finally exhausts the sympathy of relatives, nurses and doctor, commits suicide on recognising this loss, as Professor Morgan (1979) has pointed out ("malignant alienation"). Suicide often contains a social or anti-social component, and clinical audit may reveal that on occasion a nurse, social worker, hospital porter, telephonist or administrator has played a key part in a death. It is not just doctors who need further education. Acceptance of a share of responsibility, and changes in the general attitude to suicide which more open knowledge might bring may do more to reduce the fatal suicide rate than any amount of better-medical education.

How can this be done? One step might be to establish a commission on the use and limits of compulsion in medicine: churchmen, social workers, lawyers, forensic psychiatrists, GPs, trade unionists, working together to publish a consensus view for our society, how far "am I my brother's keeper?". We need to raise public awareness and define acceptable concern.

Reference

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John Crammer, *Reader Emeritus in Biological Psychiatry, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF*

Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People

The Confidential Inquiry into Homicides and Suicides by Mentally Ill People was set up in 1992 by the Department of Health following consultation with the Royal College of Psychiatrists. The remit of the Inquiry is:

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- to identify factors in the patient's management which may be related to the deaths
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