Journal of medical ethics, 1977, 3, 93–97

Case conference

Death my only love

There is in general a strong feeling of revulsion against suicide – against those who take their own lives and against those who fail to prevent it from happening. The present case of Sybil illustrates the old attitude and also the more modern approach by some of those looking after the girl. Sybil was determined to die – not because she was clinically depressed, not because she was without work and without family or some friends. Perhaps she loved nobody and sought with longing to embrace another state where at least her earthly problems would cease to exist. There are only hints in the case history, and each of those taking part in the discussion seize on these. Each – a philosopher, a barrister, a general practitioner – offers his own interpretation and gloss on the case. Perhaps Sybil seems more alive in their comments than she did in life.

Case history

A PSYCHIATRIST

Sybil was a 27-year-old single girl who had a good science degree from an English university and had been working in a research post for two years before her first contact with psychiatrists following an overdose. It was noted that this incident was closely related in time to her being offered a position of greater responsibility.

On admission she was thought to have a depressive illness and was treated by a colleague with antidepressant drugs, and, some weeks later when she showed no response to these, with ECT. She did not change significantly and twice tried to kill herself while in the ward. After four months she was transferred to my care as it was felt she needed more nursing supervision at night which was not available in the first ward. She remained morose, gloomy and continually confronted those around her with her wish to die. In other respects she was intelligent, quite active and did not show any classical features of depressive psychosis.

She was an only child of academic parents and had lived a rather solitary life at home, even when attending university. Although she had few friends she seemed over the years to be making a superficially adequate adjustment to life because of her prowess in passing exams. She had had polio as a child and one leg was somewhat deformed. She felt that this rendered her unattractive, particularly to men. She had had no sexual experience.

Her stay in hospital was turbulent and prolonged. She would engage nurses in long discussions about the purpose of life and present her own case for wishing to end it. Many of the nurses who were closest to her found this experience very distressing and regular team discussions usually divided between those who regarded her wish to die as an illness and those who felt it to be the outcome of her particular view of life but not evidence of pathology. This debate was also reflected in those who wished to restrict her freedom by compulsion if necessary and those who believed this to be unjustified. Initially she was under constant observation and made several further serious attempts on her life; although her attitude remained unchanged, the attempts became less frequent and she was given greater independence. She left to live in a hostel after 18 months and attended twice weekly for outpatient psychotherapy. She continued to say she would kill herself but seemed to be coping. She did successfully commit suicide after an outpatient session and was found dead in a friend's flat.

Two months later I received the first of a series of critical letters from Sybil's mother implying that I had 'let this sick girl die'.

The rite of suicide

IAN E THOMPSON

A case of suicide. Is that the correct ethical diagnosis? Or are we being misled by the presenting symptoms and ignoring the real causes of the doctor's distress? Is it not perhaps the doctor who is the patient in this case – being made to suffer at the hands of the suicidal patient who has wrested the initiative from him? The treatment meted out to the doctor by the suicidal patient leaves him with all the doubts and anxieties, role confusions and undignified helplessness of a patient. Suicide is an act which calls in question both the medical and moral authority of the doctor. Is this not the reason why the doctor finds the suicide of his patient so distressing rather than moral doubts about the issue of suicide?

As presented, the case would seem to represent not one single dilemma, but at least three levels of dilemma: theoretical dilemmas about the appropriate diagnosis in this case; practical dilemmas

arising out of the conflict of medical and custodial roles; moral dilemmas relating specifically to the issue of suicide.

The doctor's dilemma begins in this case with the absence of an unambiguous diagnosis. He is uncertain about what general principles to apply to the particular case. His helplessness begins with not knowing. However, as Friedson[1] has remarked: 'As a consulting rather than scholarly or scientific profession, medicine is committed to treating rather than merely defining and studying man's ills'. The consequence is that in the situation where no clear-cut diagnosis is possible, the doctor is bound to experience acute anxiety and helplessness. He is caught between the scientific ethic which requires of him that he should have some reasonable theoretical explanation for his intervention, and the medical ethic which urges him to act to alleviate distress.

Given the need to act he is confronted with two different models of psychiatric illness: the clinical/medical model of disease as located in the organic or mental state of the individual, or the social/custodial model of deviance as dysfunctional or socially maladaptive behaviour. As a psychiatrist he is faced with a choice between different kinds of possible therapies based on different theoretical models – as between clinical treatment for organic disorder and psychotherapy for a psychological disorder, and behaviour therapy and social therapy for disturbances of behaviour and social deviance.[2] At the moral level he is faced with a similar choice of possible roles. To the extent that he responds to the needs of the particular patient and adopts the consultative/medical role, he tends to adopt the individualistic and personal values which go with that role. To the extent that he responds to pressures from the family and society and adopts the custodial/probation officer role, he tends to adopt the universalistic and reforming values which are appropriate to social control and behaviour modification.

What does this mean in relation to the patient with suicidal tendencies and no obvious pathology? It means that even before the issue of suicide arises as a moral issue it is viewed within the horizon of other theoretical and practical dilemmas which also have definite moral implications.

The shocking thing about suicide is that the person who commits suicide is using his death to say something. Whether what he has to say by his death is acceptable to us or not, whether his death condemns us or simply calls in question our authority over his life, can we deny him the right to use his death in this way any more than we can deny the terminally ill the right to make of their dying a significant part of their life? Can we deny to a man or woman the right, by the rite of suicide, to give a final human meaning to a life which has become humanly meaningless?

Our answer will depend on what we mean by 'rights' and to which values we give priority individualistic values or the common good. Obviously the suicidal or the terminally ill patient has no 'right' to take his own life – insofar as rights imply obligations on others to assist us. The 'right to die' is not enforceable. However, 'the right to die' can mean simply 'having the liberty to'. In that sense the question is: Do we have the right to deprive others of this liberty? This brings us to the question whether it is 'right to commit suicide'. This can either mean, Is it morally right to commit suicide? or Is it morally justifiable to commit suicide?

Even the Stoics, who argued that suicide was morally justifiable if it was the only way a man could affirm his freedom, rationality and emotional detachment in the face of overwhelming, irrational and humiliating circumstances, still insisted that the conquest of the fear of death was the goal and suicide dictated by fear or guilt was dishonourable and disgraceful. The consensus in the moral traditions of the West has been that viewed from the standpoint of the common good, suicide is an evil; that it is an act contrary to reason (Kant); that it is a product of the derangement of a man's loves (Augustine); that it is the result of compulsion not freedom (Sartre), that it contradicts man's social nature (Aristotle, Marx). However, viewed from the standpoint of charity and the desperate need of the individual, it may be morally excusable, even the last essentially human act possible in an otherwise inhuman situation.

References

[1]Friedson, Eliot. *Profession of Medicine*, p 252. Dodd, Mead & Company, 1975.
[2]Clare, Anthony. *Psychiatry in Dissent*. Tavistock, London, 1976.

A rational suicide

J T CAMERON, QC

The normal legal responsibility of a doctor is to take reasonable care to provide advice and treatment, in accordance with reasonable professional standards, to a patient who consults him. The duty probably extends to include the continuance of care or supervision until either the need for any treatment comes to an end or the patient is transferred to the care of another doctor. The doctor's obligations are, however, limited by the fact that the patient has an absolute right to decline treatment. It has long been the law that treatment carried out without the patient's consent, express or implied, amounts to assault. In the case of physical illness in an adult and responsible patient these standards are clear, however difficult it may be to apply the test of reasonableness in a particular instance in practice.

When the patient is not adult or responsible, it becomes more difficult to define the limits of the doctor's duties. It is clear that a doctor presented with an unconscious patient in need of attention is both entitled and obliged to take at least any steps necessary as a matter of emergency. Although the point has never been the subject of a direct decision in court, it is thought that it is probably the doctor's duty to take necessary steps, even if the patient refused treatment so long as he was conscious and able to do so. If the patient is conscious but not capable of taking a rational decision by reason of mental illness or physical weakness, the position is similar. The doctor's obligation is to give the necessary treatment and care to preserve the patient's life even if the patient does not actually wish (so far as he is capable) that that should be done. The obligation extends to a duty to take reasonable care, if necessary by continuous supervision, to prevent a mentally ill and suicidal patient from harming himself[1]. The doctor's duties to a patient who is not responsible thus differ radically from his duties to one who is responsible. The relevant rules are rules of common law and are designed to reflect, and probably do reflect accurately, what people in general expect from a doctor, that he will look after a patient who is unable to look after himself.

I read the account of Sybil's case as indicating that she did not exhibit any signs of mental illness or of inability to take a rational decision other than her persistent determination to end her own life. I also take it that there was no reason to expect that a release from or reduction of supervision would or might have any beneficial effect upon her. If so, the case is sharply distinguished from the more normal case in which the risks of releasing a patient from supervision have to be balanced against possible therapeutic benefits, and the following comment has no application to that more normal type of case. In Sybil's case the problem comes to be whether the determination to die in itself is sufficient to show that she was not responsible.

Clearly, such a thing as a rational suicide is conceivable. It would be rational for a man to kill himself to avoid certain death by torture, although no doubt opinions might differ on whether it would be morally right for him to do so. At one time, in English law, the property of a convicted felon was forfeit, and forfeiture could be avoided by suicide before conviction. It might therefore be rational for a man to commit suicide to preserve the benefit of his property for his family. Nevertheless it seems probable that the general and normal reaction is that, in the absence of some clearly defined reason of the sort indicated in these examples, suicide indicates mental disturbance. The popularity of the verdict of suicide while the balance of the mind was disturbed in coroners' inquests was one indication of that view, even though the prevalence of that verdict was in part a result of the fact that suicide ultimately became, in English law, a felony which itself brought forfeiture of property.

In my view, a court considering a case such as this would be likely to reflect this normal reaction. It would not be easy to convince either a judge or a jury that a persistent determination to die, such as Sybil exhibited, was not in itself sufficient evidence that she was not 'responsible'. That is, in effect, to say that a court would be likely to begin by regarding her commitment to ending her life as such a serious limitation of her ability and freedom to manage her own affairs that she should fall into the class of patients who must be looked after. In this particular case, the total absence of any other sign of mental disease might well make it possible to convince a court that Sybil was 'responsible', but the case remains difficult from a legal point of view.

Reference

[1]Selfe v Ilford and District Hospital Management Committee, 1970. 114, *Solicitors' Journal*, 935.

A terminal illness

A GENERAL PRACTITIONER

We meet Sybil after the first attempt on her life. We do not know how long she had been contemplating this act but the trigger, at least, seemed to be her change in status at work. She was considered to be suffering from depression. Are suicides invariably depressed? Recent studies in Britain certainly indicate that the vast majority of those who wish to take their own lives are mentally disturbed in some way. We have emerged from a long period of history when suicide was covered with religious and legal taboos, and we can now view it more rationally. Perhaps we are in danger of being too rational: uncertainty about their style of thinking seems to have dogged Sybil's helpers through her last two years of life. Depression certainly seemed a reasonable diagnosis to start with, however, and she was treated in a reasonable medical manner. Repeated attempts on her own life might be thought to have confirmed this diagnosis: but in fact her doctors seemed to have changed their minds.

We are not told in detail her symptoms, but apart from being lugubrious and constantly looking for attention, she apparently showed none of the classical features of depressive psychosis. This could be further explored, but is not within my scope. However, in general, one sometimes detects in psychiatric treatment and follow up a boredom or frustration factor in the doctors which seems to alter diagnosis in a subtle but important way. Psychiatric diagnoses are still often a matter for debate, and though we are more sure of many than we were there are still no unequivocal tests or invariably successful treatments that enable a

diagnosis to stand as firmly as in other areas of medicine. Thus labels may hinder as well as help. Sometimes a patient admitted sympathetically as 'depressed' or 'psychotic' may, when treatment fails, be discharged as a 'personality disorder', and further help somehow blocked. Perhaps a disturbed mind, undiagnosed, should be allowed to stay 'mad' or 'miserable' until further events clarify the picture.

That Sybil was not helped by antidepressant treatment, however, does not seem to have influenced her psychiatrists adversely and care was intensified. Everyone was laudably patient with her, but now doubts creep in. If she still insisted on taking her life, but did not have the features of depressive illness, was she mentally ill at all? We need to know whether her mood and outlook had changed from earlier life, what arguments she was using, how she saw herself. The question was crucial to the psychiatric team in its discussion, for if she was not mentally disturbed but simply wishing to die, did they have any right to prevent her?

At this point she was presumably detained under one of the sections of the Mental Health Act (1959) '. . . for treatment . . . in the interests of the patient's health or safety'. There was a threat to safety, but if there is no treatment possible, is detention justifiable? Drugs and ECT made no difference. Psychotherapy could hardly consist of more than support in the hope that her attitudes might change, as the staff were distressed and exhausted by her arguments, cogently presented, that she should die. To their credit, they soldiered on. Clearly time, and the hope that they might learn more while the intensity of her desires settled down, were the most active factors in any possibility of treatment. Any other ways in which her ideas could be changed were beyond their control or could not be condoned. So Sybil was really committed to hospital confinement for, or to, life.

The situation could be redeemed provided that there was a continual attempt to understand her apparently twisted thoughts. Her actions could not be seen as impatient gestures, gambles with life, delusions, or manipulative attention seeking – although obviously attention needing. As Camus observed, 'An act such as this is prepared within the silence of the heart, like a great work of art'. So we must know more about Sybil herself.

Her upbringing was hardly a normal one. The crippled only child of academic parents, she had few friends. We know little more but many questions instantly spring to mind. Why an only child? Was the home one of constant tension? Were her parents totally 'unphysical' people? Was she invested with some major unfulfilled hope of their own? Did she lose her father, or anyone else important, when she was young? What was her relationship like with her mother? Why was she always alone? And so no, and so on. From the mists gradually emerges a child, lonely, ugly, infinitely unhappy. Her only prowess was in exams, and her life in no way allowed her physical, emotional, or sexual self any satisfaction and fulfilment. Unlike Beatrix Potter, for her there was no Lake District. Her over-compensating, controlling mind, faced with yet another burden which provided no answer to the poverty of her existence, sought solace in death.

If this view of Sybil is anywhere near the truth she was as 'incurable' as someone with acute leukaemia or terminal chronic bronchitis on a respirator. The end could be put off, but not altered. The physician, while struggling with all his might, must prepare himself and the relatives and help to create a 'good' death. Only when this had been faced could the ethical problem of discharge be considered.

It is not clear that it was, and something does seem to have gone wrong between psychiatrist and mother. It may have been important to keep mother from daughter, but not from psychiatrist. Her attitudes were vital both to the legality of compulsory admission and to understanding Sybil. Did she choose to remain aloof or was the psychiatric team so disturbed by the cries of the patient that they could not hear those of her family? In hospital practice it is often hard to do otherwise. Once it was clear, however, that so little progress was being made, then the mother should have been clearly told of the likely outcome. However little she wanted to hear this, it had to be said, to protect her, to protect the psychiatric team.

Whether Sybil had such an abnormal upbringing as I have supposed or not, her mother must somewhere within herself be blaming herself for her daughter's condition. This had to be dealt with, but it is not surprising that when death actually came (and Sybil is at a hostel or at friends, not at home) mother's guilt was expressed as anger. Not only is this not an unusual way of reacting to grief, but I feel she was right to be angry, as her own natural feelings had been managed so badly, and she had expected too much of what the doctors could do.

Ultimately, as many prison records bear eloquent witness, it is impossible to prevent suicide in a really determined person by custodial means. Medicine has no alternative answers here either. The basis of medicine is to preserve life and health. In some circumstances these two aims may conflict, and although we have made massive advances in our abilities to preserve life, we have not made the same progress in our ability to offer health within that preserved life. In line with the desires of every age in history for total answers to difficult problems the public today have been overwhelmed or 'mystified' by doctors' supposed abilities. Governments of all shades have been impressed, and doctors are invoked as agents of 'social control'. I think we are not that good or that powerful and

hope we never shall be. But unless doctors point out their limits there is a danger that medicine will be blamed for the things it cannot prevent and will be rejected altogether. There are signs in some quarters that it is happening already, and I think it happened to Sybil's mother.

If the general public are deceived, it is still vital that the professions should not be about their own actions. Social workers and magistrates, entangled in cases of non-accidental injury to children under their care, face the same dilemma. To try to the limit of one's capacity, to be as available as possible to help, but to be reconciled to the possibility of failure, is part of what professionalism means. If there has been no mistake, to react with guilt rather than sorrow when the outcome is tragic is not professional, and helps no one. I think that the psychiatric team here, in the terrible time that they had, deceived themselves as to their strength. 'The right to die . . . there is a feeling one has to prevent it'. With the power of Sybil's passion for death, that concern is like milkmaid Elizabeth worrying about keeping her feet dry, as the warning bells 'Brides of Enderby' ring out and the waves curl over the Lincolnshire flood walls.