which may be observed even when their intrauterine growth, assessed by the mean birth weight, is reduced.

This argument is compelling when considering populations in whom normal growth of totally breast-fed babies occurs. It is highly questionable whether a purely nutritional explanation of intrauterine growth retardation is compatible with successful lactation as judged by good growth in early infancy. Thus good maternal nutrition during pregnancy is not the only prerequisite for normal fetal growth: it is also important that the mother is not subjected to heavy physical demands and is allowed adequate periods of rest in the weeks before birth.

I thank Dr M G M Rowland and Dr R G Whitehead of the Dunn Nutrition Unit (MRC, University of Cambridge) for their encouragement and advice in the preparation of this paper. Requests for reprints should be addressed to AB, Division of Perinatal Medicine, Clinical Research Centre, Harrow, Middlesex HA1 3UJ.

References

- ¹ Gruenwald, P, *American Journal of Obstetrics and Gynecology*, 1966, **94**, 112.
- ² Campbell, S, and Newman, G B, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1971, **78**, 513.
- ³ Evans, H E, and Sack, W O, *Anatomia Histologia Embryologia*, 1973, **2**, 11.
- ⁴ Campbell, S, *Fetal Physiology and Medicine*, ed R W Beard and P W Nathaniels, p 271. London, Saunders, 1976.
- ⁵ Gruenwald, P, *American Journal of Obstetrics and Gynecology*, 1964, **89**, 503.
- ⁶ Pinkerton, J H M, *Journal of Obstetrics Gynaecology of the British Commonwealth*, 1973, **80**, 97.
- ⁷ Jordaan, H V F, *American Journal of Physical and Anthropology*, 1976, **44**, 271.
- ⁸ Hytten, F, and Leitch, I, *The Physiology of Human Pregnancy*, 2nd edn. London, Blackwells, 1971.
- ⁹ Karn, M N, and Penrose, L S, *Annals of Eugenics*, 1952, **16**, 147.
- ¹⁰ Gruenwald, P, *The Placenta and its Maternal Supply Line*. Lancaster, Medical and Technical Publishing Company Ltd, 1975.
- ¹¹ Haldane, J B S, *Journal of Genetics*, 1957, **55**, 511.
- ¹² Darlington, P J, *Proceedings of the National Academy of Sciences of the USA*, 1977, **74**, 1647.
- ¹³ Coon, C, *The History of Man*. London, Jonathan Cape, 1955.
- ¹⁴ Rhodes, P, *Lancet*, 1962, **1**, 389.
- ¹⁵ Bienarz, J, Maqueda, E, and Caldeiro Barcia, R, *American Journal of Obstetrics and Gynecology*, 1966, **95**, 795.
- ¹⁶ Thompson, W O, Thompson, P K, and Dailey, M E, *Journal of Clinical Investigation*, 1928, **5**, 573.
- ¹⁷ Tuckman, J, and Shillingford, J, *British Heart Journal*, 1966, **28**, 32.
- ¹⁸ Suonio, S, et al, *Annals of Clinical Research*, 1976, **8**, 22.
- ¹⁹ Naeye, R L, et al, *Pediatric Research*, 1971, **5**, 17.
- ²⁰ Perissé, J, Sizaret, F, and Francois, P, *FAO Bulletin of Nutrition*, 1969, **17**, 3.
- ²¹ Bergner, L, and Susser, M W, *Pediatrics*, 1970, **46**, 946.
- ²² Smith, C A, *American Journal of Obstetrics and Gynecology*, 1947, **53**, 599.
- ²³ Lechtig, A, et al, *Pediatrics*, 1975, **56**, 508.
- ²⁴ Thomson, A M, and Black, A E, *Bulletin of the WHO*, 1975, **52**, 163.
- ²⁵ Widdowson, E M, in *Breast Feeding and the Mother*, Ciba Foundation Symposium, 1976, **45**, 103.
- ²⁶ Tanner, J M, *Foetus into Man*, p 40. London, Open Books, 1978.

In My Own Time

Suicide and attempted suicide

W H TRETHOWAN

British Medical Journal, 1979, **2**, 319-320

One of the many changes which have taken place in our society since I first started as a medical student is the public's attitude towards suicide. Medical opinion has also altered. It hardly needs saying that for centuries (in many countries as well as Britain) people who committed or attempted to commit suicide were stigmatised. In England, until the passage of the Suicide Act 1961, suicide was a felonious act equated with murder—although the actual verdict of *felo de se* (self-murder) seems to have fallen into disuse (probably during the mid-1930s), most coroners preferring the verdict of suicide “while the balance of mind was disturbed,” thereby avoiding the pronouncement of a felony. This was as well, because a verdict of *felo de se* led to forfeiture of the victim's life insurance policy, thus perhaps causing even greater hardship to his family as well as denying him a prayer book burial.

Attempted suicide, too, was a criminal offence until 1961: not a felony, but a misdemeanour punishable by a fine or imprisonment. Although, according to Stengel,¹ the law was implemented capriciously, the number of prosecutions for

attempted suicide was far from negligible: during 1946-55 some 45 000 cases were known to the police. Of these, almost one in eight were brought to trial; 5447 (94%) were found guilty, of whom no fewer than 308 were sent to prison without the option of a fine, the last instance being as late as 1955. Small wonder, then, that to have a suicide in the family was a skeleton in the cupboard to be concealed at all costs, while an attempt at suicide particularly by a close relative—was also likely to be regarded as something of a disgrace.

The Suicide Act of 1961 undoubtedly brought about changes for the better so that, although hardly a topic for discussion at the tea table, the stigma that is now attached to suicide and attempted suicide has undoubtedly lessened. Attempted suicide has become largely a medical matter, following a memorandum issued by the then Ministry of Health shortly after the passing of the Act which said that it was to be regarded as a problem calling for the attention of a psychiatrist. Possibly also this change of attitude may, in part, have been responsible for changes in the pattern of suicide and of suicidal attempts in Britain.

Cause or effect?

When I was a student (long before the 1961 Act) I cannot recall attending a lecture directly devoted to the subject of suicide, or even being offered one. The matter only really came to notice during a somewhat perfunctory study of forensic medicine, and then it was the manner of self-destruction and its

Department of Psychiatry, Queen Elizabeth Hospital, Birmingham B15 2TH

W H TRETHOWAN, FRCP, FRCPSYCH, head of department

pathological consequences rather than the circumstances that led to suicide which were the focus of attention. Likewise, in the unsuccessful attempts—whether these ultimately proved fatal or not—it was the more immediate after effects which excited the greatest clinical interest—such as the cicatrization which might follow corrosive poisoning, or dealing with the partial exsanguination and various surgical complications in those who had made more-or-less determined attempts to stab themselves or cut their throats. My impression is that such violent attempts at self-destruction may have been commoner then than they are now. Any such change may well be due not only to an overall fall in the incidence of suicide but also to a vast improvement in methods of resuscitation—together with the fact that self-poisoning with (on the whole) less lethal agents than Lysol or spirits of salts seems to have become fashionable. But no doubt there is more to it than that.

The suicide caution card

In 1948, after I had undergone a metamorphosis from physician to trainee psychiatrist, suicide began to take on an entirely different aspect. In dealing with psychiatric patients it became a risk to be reckoned with. In psychiatric hospitals, attention was drawn to this risk by the suicide caution card. This document, which began to disappear during the 1950s and seems to have vanished completely by the time of the Mental Health Act 1959, consisted of a card bearing the patient's name and such other particulars as were necessary, and which accompanied the patient wherever he went within the hospital. This card was carried by the nurse-in-charge, who on transferring her charge to the care of another handed over the card. Likewise, the doctor who interviewed a potentially suicidal patient in his office was handed the card, and then he handed it back to the nurse-in-charge when the interview was over. If I remember rightly, all who had charge of such patients had to sign the card to indicate that they had read it and thereby acknowledged that they were aware of the risk.

Today the suicide caution card, like most other trappings of restraint, bears the hallmark of a bygone age and we do not seem to be any worse off without it. Suicide still occasionally occurs among inpatients in mental hospitals and other psychiatric units, but abolition of the caution card does not seem to have led to any increase in this regrettable happening. Likewise, there seemed little evidence when the card was in use that it prevented the occurrence of suicide in inpatients. While it is true that vigilance on the part of medical and nursing staff is probably the most potent factor in preventing suicide in hospital, there seems little reason to believe retrospectively that this was enhanced in any way by the relatively impersonal means of a piece of cardboard; direct verbal communication in a setting of teamwork was almost certainly more effective. Apart from this, the card may well have tended to perpetuate something of the stigma still attached to suicide.

Parasuicide

During and immediately after the war it appears that attempted and completed suicide were usually regarded as being different only in that in the former death did not occur and the attempt was most often regarded as having been bungled. Thus, although some minor attempts were even then regarded as hysterical—that is, relatively trivial—failed attempts at suicide were, as a whole, taken much more seriously by psychiatrists than perhaps most of them are today. At that time, reliable statistics in respect of attempted suicide were difficult to obtain, but the number of such attempts appears always to have been more than actual suicides—probably by a ratio of 6 or 7 to 1. Since then, and particularly during the last two decades, this ratio has increased greatly so that it is now probably in the region of 12 to 1, or even higher if the whole truth were known. This seems to be

accounted for by an appreciable decline in the actual suicide rate, and an even sharper rise in the rate of attempted suicide. Possibly this has occurred more in England and Wales than in most other countries in Western Europe—where the actual suicide rate has risen.² The reasons are complex and not fully understood, although there are some who believe that the detoxification of coal gas is at least one factor.³

Owing to the pioneer work of the late Professor Erwin Stengel in Britain in the early 1950s,¹ it has also become clearer that, despite some overlap, the difference between attempted and completed suicide is much greater than was originally thought. Whereas a considerable proportion of those who actually kill themselves (probably about one-third) do so on account of overt mental disorders, an even higher proportion of those who make unsuccessful attempts do so primarily for social reasons and, on resuscitation, cannot be seen as mentally ill in any formal sense—this is not to say, however, that they are without personality problems. This knowledge has led not only to changes in medical and psychiatric practice but also to efforts to redefine unsuccessful suicide attempts in different terms. Thus Kreitman has suggested the term parasuicide largely to describe suicidal behaviour which does not end in death when real intent appears to be lacking.⁴ Nevertheless, a patient's intention may often have to be inferred because he may either be unable or unwilling to be more explicit.

Parasuicide—and, in particular, self-poisoning—has, as every casualty officer well knows, now reached epidemic proportions. Indeed, it has become something of an embarrassment to all those whose lot it is to resuscitate seemingly suicidal patients and later to assess the seriousness of the attempt so that satisfactory treatment may be arranged. It has also become increasingly clear that the DHSS recommendation that all who have made a suicide attempt should be assessed by a psychiatrist cannot be implemented because there is neither the time nor the psychiatrists available. Recently, however, it has been shown that much assessment can be done adequately by non-psychiatric medical personnel, or even by nurses or medical social workers—provided there is adequate psychiatric back-up available to deal with doubtful cases. In any event, where a suicidal attempt is largely the outcome of social distress rather than mental illness, it seems logical that the social services should play a prominent part in deciding what to do with the patient.

Apart from this, whether anything can be done to stem the rising tide of parasuicide remains to be seen; punitive measures have proved undesirable and ineffective. It appears that attempts at suicide have become such a well-established form of communication between a person in distress and his environment that a satisfactory substitute is almost impossible to find.

References

- ¹ Stengel, E, *Suicide and Attempted Suicide*. Harmondsworth, Penguin Books, 1964.
- ² *British Medical Journal*, 1978, **2**, 1246.
- ³ Hassall, C, and Trethowan, W H, *British Medical Journal*, 1972, **1**, 717.
- ⁴ Kreitman, N, *British Journal of Psychiatry*, 1969, **115**, 746.

WORDS There are two sorts of limb. LIMB (1) a leg, arm, or wing (of obscure etymology). LIMB (2) LIMBUS, an edge or border, describes this feature in a heavenly body (astronomically speaking), and in anatomy as, for example, the margin of the cornea and of the fossa ovalis in the right atrium of the heart. LIMBO, ablative of limbus, from "in limbo," is, in the theological topography of Catholic belief, a region on the border of Hell, and the abode of unbaptised infants who remain suspended indefinitely neither in the one place nor in the other, and by metaphorical extension, to analogous situations in this world. Hence, to be "out on a limb" does not mean "held at arm's length"; it means to be on the periphery or outside the desired area of personal involvement.