to the museum in Hamburg. The squatters refused but she nonetheless got hold of six "pelts." These may now be in a Liepzig collection.

And yet, in terms of the restitution debate, the fact that an unknown proportion of human remains was procured illegally is surely a red herring. Aborigines—or at least the campaigners—claim that no portions of their ancestors belong in museums because, where they do so, the dead remain exiled from the spirit world of the Dream Time. Strongly encouraged by the Australian government, a number of Australian museums have worked out compromise solutions. In Britain, however, the issue has been current only for some five years. It is hardly surprising that institutions are still feeling their way gingerly.

The Natural History Museum, with its collection of 103 aboriginal skulls, is right in the firing line. It was brave of the museum even to field a spokesman. The museum's position, affirmed by Dr Robin Cocks, keeper of paleontology, is that its human material is actively studied and is of real scientific importance. (This is not by any means true of all collections.) He must surely also have pointed out that the British Museum Act of 1962 does not permit the Natural History Museum to opt for deaccession. Yet this crucial point was omitted entirely from the programme. Would the museum add to its collection? Yes, said Dr Cocks. Properly accredited aboriginal remains would be welcome. After all, an aborigine is as entitled to leave his or her body to science as anyone else. Unfortunately, the slant given to this closing interview was such as to make Dr Cocks seem like the spokesman for a downright sinister museum faction.

Ironically, techniques such as DNA testing have given new importance to human remains from both prehistoric and historic times. I felt, however, that the scientific arguments for retaining human remains were so skimpily presented as almost to obscure the case. For the programme merely to observe that aborigines themselves have benefited little from science was breathtakingly glib. Compromises must be made on this poignant and sensitive issue, but they must not be rushed. The encouraging fact is that a good deal of ground has already been travelled—although you would hardly know it from *Darwin's Bodysnatchers*.—PATRICIA MORISON, *All Souls College, Oxford*

PERSONAL VIEW

When ethics do not help

Ron Harris

When our daughter committed suicide we had no idea she was mentally ill. In fact she had made two previous attempts during her brief spell of college life away from home.

After the second attempt she was seen by the college doctor and a local hospital casualty officer who asked if she would like her brothers or parents to be told. She replied "No." Consequently we were told, "Because your daughter was over 18 without her expressed agreement we couldn't let you know for reasons of medical confidentiality."

Yet if a brief knowledge of her family and social history had been available to her medical advisers it would at least have aroused their suspicions. Acting as they did, we are sure with the utmost integrity, this background knowledge remained undisclosed because of the requirement of medical ethics. Her college doctor was apparently not aware of the first suicide attempt and being restricted by his code of confidentiality did not discover that she had reported to a member of college staff that she was hearing voices.

Fiona was a solitary person, not mixing easily or having much interest in her friends. From about the age of 12 she became an avid writer of her "secret diaries," which she kept hidden, and we respected her privacy. But after her death they revealed to specialist psychiatric examination a degree of disturbance which, had our daughter been alive, would have warranted a full psychiatric investigation. Even to lay people such as ourselves the diaries showed strange ideas of thought transference. She believed she was responsible for the bad moods of others and there were several references to suicide.

She became interested in the magical and mysterious at the age of 15, inquiring, "What is an hallucination?" She prophesied that she would not live long and spent a lot of time seeking the reasons for other people's behaviour by reference to her influence over them. All this was revealed by her diaries after her death.

By the age of 18 Fiona wrote "Getting better" and this coincided (we now know) with a change in her personality. She became at last loving, friendly, and, as her mother described, "like other people's daughters."

. . . we can see a pattern of mental difficulties, which would have been sufficient to alert any doctor.

With relief we thought that the difficult teenage years were over.

Her academic career was always a struggle although she was described as a clever girl by independent ability assessors. She was a determined person, however, and by her own persistent efforts gained entry to an agricultural college at the age of 19. Her first term was hard work so we did not attach particular importance to her mentioning a changed sleep pattern, and during her first holiday at home she slept for long periods on several occasions. We were concerned that perhaps things were too much for her but she always maintained that she was enjoying college life. We noticed a large healing scar on her left wrist, which she explained occurred during sheep shearing. Suspecting nothing sinister, we suggested that she take great care in future. As we were to discover from her diaries after her death this had been her first suicide attempt.

Our continuing concern over her low state prompted a heart to heart chat when she volunteered the statement that she was bothered by people. This was not surprising to us as her lifelong preference was for a solitary existence. But as her diaries showed these people were in fact hallucinations and she had told a member of the college staff that she could hear voices.

January 1988: Fiona returned to college looking well and apparently cheerful although still unemotional. She telephoned home frequently and by the end of the month was looking forward to a skiing trip. At this time she had attempted suicide a second time and had been seen by college and hospital medical staff.

1 February 1988: Our first indication that anything was amiss—the police told us that Fiona had been found dead in bed. Forensic evidence showed that she had self administered a massive overdose of veterinary lignocaine. She was just 20.

You might well ask how we did not realise that something was wrong during her young life. There seemed to be perfectly sensible explanations on every occasion for all her little habits, none of which seemed bizarre. Now with the knowledge we have we can see a pattern of mental difficulties, which in the words of a psychiatrist would have been sufficient to alert any doctor.

There seems to be a particular problem in applying medical confidentiality to a case such as our daughter's. For a possible vital history to be obtained medical ethics required a rational decision from a patient who was currently conversing with a hundred or more imaginary people. Should any rule so confine a doctor's freedom that he or she is unable to seek information that could help the patient's treatment? Perhaps the decision not to seek information from relatives and friends of those attempting suicide should be taken only when there is positive confirmation that the patient is not mentally ill.

Those confronted with cases of attempted suicide often have to make difficult decisions, possibly in the middle of the night and on their own. A reappraisal of the criteria used to make decisions in such cases may help all concerned. It does not seem right that the application of any rule should result in the mentally ill being discarded to cry in a wilderness of despair.—RON HARRIS, *retired dental practitioner, Ross-on-Wye*