Suicide: who to blame? (A personal view)

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Abstract
Background: When suicide (inevitably) occurs, clinicians who have attempted to assist the deceased are often blamed.
Aim: To develop and present concepts to help in the blaming process.
Conclusion: Four types of triggers are described: severe mental disorder, mild-moderate mental disorder, non-mental disorder triggers with which non-clinician may be helpful, and non-mental disorder triggers with which non-clinicians can offer little. An analogy is drawn with murder. People with severe mental disorders who kill themselves may not be responsible for their actions, and clinicians may be responsible for patient protection. However, for mild-moderate mental disorder the patient is responsible for his/her actions, and clinicians are neither responsible nor blameworthy. The same applies to non-mental disorder trigger events.

Introduction
Suicide is a common cause of death – the world rate is 11.4 per 100 000 population per year (WH0 2014). The rates in different countries are widely different – the Philippines has a rate of around 0.5/100 000 and Lithuania has a rate of around 42/100 000. These differences have been sustained for more than half a century (Ka-yuet, 2009) - proving that cultural factors greatly influence the occurrence of suicide.

Ignorance of the nature of suicide has clinicians unjustly criticised (Friedman et al, 2018), sometimes leading to premature retirements. In private practice, the management of risk (of being sued) has led to nurse counselling services being discontinued.

When suicide occurs clinicians often find themselves blamed. Blame is deserved when there is responsibility for a fault or wrong. Here we present facts to assist in a better standard of blaming.

Triggers of suicide
Suicide is the result of "deep unhappiness but not necessarily mental disorder" (WHO, 2014). "Mental pain" as the core clinical factor of suicide was described in 1993 (Schneidman) and has been confirmed "even in the absence of a diagnosed mental disorder" (Verrocchio et al, 2016).

The triggers of suicide may be categorized:
1. Severe mental illness featuring severe symptoms (including mental pain)
2. Moderate and mild mental illness featuring less severe symptoms
3. Non-mental illness problems for which others may be able to provide much help
4. Non-mental illness problems for which others are not able to provide much help.

In severe mental illness (particularly of the depressive type) the individual may have delusions of guilt (for example, incorrect that he/she was responsible for the death of his/her

parents). The individual may experience hallucinations (possibly accusatory or urging suicide), and the thinking processes may be so slowed down that logical conclusions cannot be reached. The individual may experience sadness so painful that the drive to suicide (to end this experience) cannot be resisted.

In moderate and mild mental illness, hallucinations and delusions are absent. There may be low self-esteem, sadness and some (but not irresistible) drive to suicide.

Non-mental illness problems for which others may be able to provide much help are common – for example, a person whose house burns down will be distressed and in the immediate aftermath may think life is not worth living - but may be comforted by friends and family and even given financial assistance by one or more charity.

Non-medical illness problems for which others may not be able to provide much help are not uncommon – for example, a person who has been convicted of many heinous crimes and is incarcerated may refuse to live in prison (such as Dr Harold Shipman, general practitioner multi-murderer).

Responsibility

Responsible is defined as being answerable or accountable for something within one's power, or control. In the event of suicide, three levels of responsibility can be identified

1. Responsibility for performing the act of killing – suicide and murder are acts – in suicide the killer is killed, in murder another person is killed
2. Responsibility for preventing the act of killing
3. Responsibility as a member of the social group/culture – each has a tiny role in shaping the culture (which involves customary responses to events).

If a person has "committed" suicide – he/she has succeeded in the act of killing him/herself. Compare this event with murder.

The killer is responsible for the act of killing. But, from a moral/legal perspective, a killer may be "not legally responsible". A soldier who kills another soldier during war, or a civilian who kills an attacker in self-defence, is not responsible for murder.

A civilian with a mental disorder who kills another person may be not guilty of murder on the grounds of insanity. The insanity defence requires the killer to suffering a mental impairment (disorder) and also, to meet at least one of the following criteria:

1. not know the nature and quality of their act, or
2. not know that the act is wrong; or
3. not have the ability to control the act.

These are not trivial symptoms/features, they are symptoms of severe mental disorder. Appropriately, the insanity plea is relatively rare – in the USA, being raised in about 1% of all criminal cases (Schmalleger, 2001) - and it is successful in only 25% of applications.

In suicide the killer may also be influenced by mental disorder, but not as commonly as formerly claimed - the prestigious US Centre for Disease Control and Prevention (2018) found that over half of those who completed suicide had no history of mental disorder.

There is a vast array of "mental disorders" – many are normal behaviour which has been incorrectly labelled as 'mental disorder' (Francis, 2013). There are various types and grades of low mood (depression) problems.

As described above, severe mental illness of a depressive type may feature delusions, hallucinations, and impaired thinking processes with inability to reach logical conclusions. In addition, the mental pain may be so great that the drive to suicide cannot be resisted.

To retain the similarity with murder, the killer in suicide would not be responsible for his/her behaviour should he/she be so mentally disordered that he/she could not know the nature of the act – which is not a feature of depressive disorder, other than in the rare condition of psychotic depression.

Should such an individual kill another person, while responsible for the act in a mechanical sense – he/she may not be legally responsible for the crime of murder. That is, the individual may not have been able to make the decision not to kill the other person.

Analogously, a severely mentally ill person with suicidal ideas may not be able to resist performing the act of self killing. Should other people know of the mental state and suicidal ideas of the person in question, they have a measure of responsibility to care for the individual and prevent the killing. This applies with particular force to clinical staff with expertise in the area of mental health.

Responsibility in less severe mental illness is quite different – but, regrettably, all too often the assumption is made that any mental illness excuses the individual from responsibility of killing (or not killing) him/herself (making the clinician responsible for prevention). If the mildly to moderately depressed individual goes to a football match, gets in a fight with a supporter of the opposing team and hits and kills him with bottle, the killer will probably be found responsible for manslaughter or murder. That he suffered low mood and occasional suicidal thoughts would not excuse the formal charges.

The fact that an individual has mild to moderate low mood disorder and a degree of suicidal ideas does not indicate that he/she cannot and cannot be expected to resist these ideas. As such an individual can (or can be reasonably expected to) resist killing him/herself, others people should not be tasked with the responsibility of preventing the killing.

The circumstances of the rapist are relevant to this discussion – the fact that he has a very strong desire does not excuse the act – the perpetrator has a responsibility to resist.

Returning to non-mental illness problems for which others may be able to provide much help by offering support and even financial assistance. When a person in a painful situation kills themselves, doctors are sometimes blamed because they did not put that person in the secure ward of a hospital, against his/her will. This is complete nonsense – for a person to be involuntarily detained in hospital they must first suffer a severe mental illness - and represent a danger to themselves or others. The people we are talking about here are in psychological pain, but they are not sick. Accordingly, they are responsible for their own safety – others will frequently assist, with excellent effect – but they are not obligated so to do.

People with non-mental illness problems for which others are not able to provide much help have also been mentioned. Some people with special skills may be able to give some comfort

in this situation, but there is no obligation so to do, or to prevent suicide in a non-mentally ill individual.

Now to blame

When self-killing is achieved, blame (responsibility for a fault or wrong) can be determined using the opportunities offered by the particular trigger:

1. Serious mental illness – of the order of being not guilty if a murder had transpired – especially in cases of an irresistible desire to be dead - clinical staff, if they are fully aware of the symptoms, have a responsibility to arrange for the individual to be placed in a secure facility so that thorough assessment and appropriate treatment can be provided. If they fail to do so, a measure of blame may be justified.

It is easy to make such statements. But, patients in these circumstances frequently deny symptoms and guarantee their safety.

Symptoms may not be detected because of lack of expertise or experience – in which case, those who roster inexperienced clinicians to difficult positions bear some responsibility/blame. However, it must be remembered that determined individuals can kill themselves in the most protective environments – such as forensic prisons and the Guantanamo Bay Facility.

Blame is appropriate only if a fully trained professional either does not bother to perform a proper assessment, or, while fully aware of the situation takes the gamble that all will be well – such behaviour is unknown in our experience.

2. In moderate and mild mental illness there may be low self-esteem, sadness and some drive to suicide. However, if the killing was a murder, these symptoms would not secure a verdict of not guilty on the grounds of mental disorder. The individual has the responsibility (because they are capable) to resist killing.

In these circumstances, should self-killing occur, any clinician who has had contact with the individual in recent times is likely to be blamed.

It can be expected that the clinician assessing such an individual clarifies the strength of current suicidal ideas and takes appropriate steps to reduce these when they are pressing. It can be expected that the clinician arranges some form of follow-up. But the primary responsibility remains with the “patient”.

3. Non-mental illness problems for which others may be able to provide some help – responsibility (legal and otherwise) rests with the patient. Righteous and kindly people will help, and by some codes may have some moral obligation to help the suffering individual.

4. Non-mental illness problems for which others are not able to provide much help – again, responsibility (legal and otherwise) rests with the patient. While righteous and kind people may willingly provide support – there is little they can do to alter the events which have worked toward this unhappy state.

5. The suicide rates of the countries of the world vary greatly – proving that culture plays a massive role in the rate/occurrence of suicide. Thus, each member of society has a responsibility to shape their culture such that suicide is reduced around the world.

Salute

The author conceptualizes suicide as an occasional accompaniment of mental disorder, but more commonly as a life puzzle/option like celibacy or mountaineering. Along with gambling and obesity it has become progressively 'medicalized' – a process driven by the clinical professions. However, this paper was examined by a medico-legal expert who pointed out that "torts", "reasonable foreseeability" and "the contract between clinician and patient" had been overlooked. These topics are beyond the ken of the author and he/she can only add that 1) this medicalization has now been fossilized by law and the courts, and 2) "a personal view" to the title.

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	Serious mental disorder	Mild-moderate mental disorder	Non-mental disorder – some help possible	Non-mental disorder – little help possible
Killer	Not responsible for killing	Responsible for killing	Responsible for killing	Responsible for killing
Clinician	Responsible for safety	No responsibility	No responsibility	No responsibility
Well-meaning others	No responsibility	No responsibility	No responsibility	No responsibility
Members of society in general	Responsible for tiny contribution to culture	Responsible for tiny contribution to culture	Responsible for tiny contribution to culture	Responsible for tiny contribution to culture

Table 1. Summary of responsibilities associated with suicide. When suicide occurs those with a responsible role may deserve some blame.

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