

prevents psychiatrists wasting valuable time which could be spent seeing other patients. In this study almost 30% of new appointments were wasted. However the percentage of patients referred that are actually seen in out-patient clinics does not improve. Patients who do not attend appear to be the same patients who do not request an appointment. Such individuals are found more often in particular diagnostic groups and from particular patterns of referral but unfortunately cannot be predicted with certainty. It may be that they do not need specialised psychiatric assessment at all or if they do an ordinary psychiatric out-patient appointment is not the way to reach them.

It is suggested one way to improve attendance at out-patient clinics is to ask patients to say if they want an appointment. This leaves a significant proportion of patients whom a referring agency asks to be seen but who do not reply or do not attend if sent an appointment; an alternative method of service provision is needed for this group.

### Acknowledgements

I wish to thank the hard working receptionists at the Munro Clinic Guy's for their valuable help and to Professor J. P. Watson for his comments and advice.

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*Psychiatric Bulletin* (1993), **17**, 348–349

## Assisted suicide or culpable suicide: is there a difference?

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In 1991, Derek Humphry published *Final Exit – The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*. The book was written for mature adults who were suffering from terminal illnesses and required guidance in committing suicide, but it has encouraged suggestive and susceptible people to attempt suicide (Lavin *et al.*, 1992). There appears to be a thin line between assisted suicide and culpable suicide. 'Culpable suicide' is used here to describe contributory negligence attributed to persons who unknowingly assist another person's suicide.

Trinidad and Tobago has a population of 1.3 million, of whom 43% are Indians. Most Indians are Hindus, comprising approximately 30% of the total population. The suicide rate is highest among Indians, and paraquat poisoning is the main cause of death. Legislation to restrict the availability of paraquat (a herbicide) has never been implemented. This substance, therefore, is readily available in the agricultural regions, where most Indians live.

Theories put forward for the high rate of suicide among Indians in Trinidad include marginalisation and ethnic disadvantage (Parasram, 1992), stress, the high rate of unemployment, family discord, and an increase in reporting of suicides by the media (Maharajh, 1992). Religion and culture appear also to contribute.

Two cases of culturally determined culpable suicide are presented.

### Case 1

An 18-year-old female student from an orthodox Hindu family was admitted to the medical ward of the general hospital after swallowing paraquat. She died two weeks later. At interview she had revealed that her father had arranged a marriage for her of which she had disapproved. When she attempted to leave home to visit her boyfriend of another religious persuasion, her father insisted that the only way she was going to leave his house that day was in a box. That night she drank the paraquat.

### Case 2

A 22-year-old Indo-Trinidadian, recently employed as a bank clerk, developed a relationship with an Afro-Trinidadian worker unknown to her family. A few months later, news reached the family that their daughter was having a relationship with someone they found unacceptable. Her mother, a devout Hindu, pleaded with her daughter to end the relationship. She went to a restaurant where she found her daughter having lunch with her boyfriend. She became angry and said to her daughter, "You have disgraced the family, it is better for you to die with dignity than to let us live in this disgrace." That evening her daughter drank two teaspoonfuls of paraquat and subsequently died.

### Comment

In these cases, the parents acted in accordance with their orthodox religious instructions that denounces the "intermixture of caste" (*Bhagwad gita*). After 147 years of arrival from India, Indo-Trinidadians still hold their religious and cultural beliefs. There is much resistance to change and cross-cultural fertilisation is unacceptable to most Indians. Marriages are still arranged on the basis of caste, and adherence to religion is a source of hope in this subculture that perceives itself to be alienated.

With this background, older members of families feel justified in pronouncing death sentences on offspring who deviate from the cultural norms. They appear to experience little guilt and seem to have poor insight into their culpability. They are assisted by an existing religio-cultural framework that has prescribed a certain amount of defensive aggression. Undoubtedly, the parents perceived a threat to their families and that which they hold as sacred. Fromm (1974) supported this view when he wrote "The individual or the group reacts to an attack against the 'sacred' with the same rage and aggressiveness to an attack against life." Their behaviour is therefore, understandable.

Such occurrences, however, have generated much debate among the 'traditionalists', who are intent in preserving their beliefs at any cost, and the 'modernists', who perceive parental adherence to religiously and culturally sanctioned behaviour as being too rigid. Attempts to introduce change is challenged

by a belief in Karma, cycles of births and deaths, reincarnation, and other Hindu philosophies.

Similarly, assisted suicide is justifiable to some on the basis of the avoidance of pain and suffering of patients with terminal illnesses. Guidance on committing suicide is a Western notion, where the preservation of life is weighed against economic cost, physical burden and absence of emotional attachment.

Trinidad and Tobago has a high rate of suicide, especially among Indians. For the first nine months of 1992 one newspaper has reported 13 suicides by paraquat poisoning. There has been an increase in the reporting of suicidal behaviour by the media, accompanied at times by the depiction of live, televised suicides. Legislation has not been implemented, and there are no prevention programmes or poisoning treatment centres, despite an estimated 300 suicides annually. There is an urgent need to address this major public health problem. According to Parasram (1992), "the state is generally insensitive to marginalised groups, the people at most risk".

It is important to differentiate between the end of one's suffering and the end of one's life, since in the two cases presented both patients sought forgiveness for their actions and wanted to live after their suicidal act. It is unacceptable to resolve such conflict through the publication of guides to suicide. In such deaths, responsibility must lie somewhere; if there is assistance, there is culpability.

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