save life, and repair injury the very best way that we can. There is no other criterion of excellence in organizing an accident service which is worth a moment's consideration.

I am more than grateful to Mr. James Scott for producing order out of chaos in my script.

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Contemporary Themes

The Aftermath of Suicide

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Summary

Forty-four spouses of suicides followed up after five years showed no significant differences from the widowed by other causes in respect of mortality and remarriage rates. A minority were stigmatized and most found the inquest unpleasant. Outcome was evenly polarized into better off and worse off.

Introduction

Death by suicide may have special consequences for the surviving spouse because of its suddenness, the legal inquiry, and the moral disapproval, with all the personal and social censure which that implies, which the widowed from other causes do not experience. Yet there has been no systematic study of these consequences. We present here some findings concerning an unselected sample of 44 spouses bereaved by suicide between 1966-8. The findings cover their experience of the inquest, stigma incurred, effects on mortality, and long term outcome.

Method

The 44 spouses studied, 17 widowers and 27 widows, were the relicts of the married subjects of a previous inquiry which had examined the clinical and social precursors of suicide by interviewing next of kin.[1] The definition of marriage was: "the couple were living together as man and wife within six months of the suicide." The mean duration of marriage was 22 years, (range 9 months-49 years).

All the spouses were traced; 34 were alive but 10 had died. Of the 34, 31 were interviewed directly, two were ill and relations were seen instead, and one refused. For the 10 dead seven relatives were interviewed and one relation living abroad corresponded. The inquest notes and data from the first research were available for all 44. Death certificates of the 10 dead spouses and hospital notes for the terminal admissions of five were examined.

The suicides died between 1966 and 1968; the follow-up interviews took place during 1973. The mean time between suicide and follow-up was 58 months (range 54-83 months). The interviewers, two psychiatric social workers, used a questionnaire which inquired about the postbereavement aspects of the spouses' health, domestic and economic situation, need and experience of help and about the police inquiry, the inquest, the behaviour of household members, other relatives, and friends and neighbours, communication with children, social activities, and emotional responses and religious attitudes to suicide. Interviews ranged from 20 to 200 minutes (mean 65 minutes). Only a part of the data is discussed here.*

To assess reliability 10 interviews were jointly coded. One social worker interviewed and both independently coded the responses to the 141 items. Differences of coding provided a measure of reliability. Disagreement attributable to differing standards was found for 7% of codings, which was within acceptable limits.

Results

INQUEST

The inquest is a statutory requirement for those who have been bereaved by suicide, accident, or homicide, and it may be a painful experience. Thirty-seven spouses attended the inquest and 29 of them described their response to it and to the police inquiry which preceded it.

*A table showing a quantitative presentation of the data is available on request.

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The police were complimented upon their conduct. Of the 31 spouses 26 had been interviewed by the police, and only two criticized police conduct. Seven thought the police did their job adequately, but 17 (65%) said that the police had been especially helpful and described kindnesses which were outside required police duties. An aspect of the inquiry found distressing by nearly everyone was identifying the body. There are no rules as to who should do this and in practice it varies; 13 people who could have identified their spouses were not asked to do so. Only two of the 22 spouses who did make the identification were not distressed by it, and it seems reasonable that someone other than the spouse should be asked whenever possible.

To assess the impact of the inquest spouses were asked six pre-coded questions about selected aspects of it and one open question; their responses were rated on a scale from 0-7 and were used to calculate the range of disturbance each experienced. The questions covered the giving of evidence, legal procedure, hearing the pathologist's report, presence of reporters, waiting conditions, and behaviour of the coroner. A third were upset by giving evidence, and 24% found the legal proceedings distressing—that is, the use of a courtroom associated with criminal proceedings, a formal witness box, and being sworn—which caused some to feel on trial and reinforced guilty feelings about the death. Listening to the pathologist's report and also hearing for the first time from other witnesses details of the suicide's life which might better have been revealed privately beforehand gave pain to the same number. Eighteen per cent. complained of reporters at the inquest and a third of the subsequent newspaper account, on which none commented favourably. The lack of privacy while waiting and the length of waiting was criticized by 15%, and 15% criticized the coroners for their brusquerie. Disturbance ratings showed a mean of 1·7; only one spouse scored over 4 and eight scored 0. No attempt could be made to assess how severely they were upset. Most spouses interviewed were stoical in their attitude towards the inquest. They accepted the need for a formal inquiry and found that the reality conformed with expectations. But despite the stoicism the whole business was an ordeal and though little can be done to relieve this strain some causes of distress could be modified on the lines of the Brodrick Report,[2] which critically reviewed existing inquest procedure.

The inquest ends with the coroner's verdict, and it was accepted as valid by all but two spouses One dissenter, in hospital at the time and not present at the inquest, maintained that his wife, who poisoned herself, froze to death. The other, who saw her husband die, acknowledged he had taken an overdose but believed he took a second dose having forgotten in his drugged condition about his first. Four years later she was still angry at not being permitted to advance this feasible explanation at the inquest. Coroners' decisions can be reversed, a fact known to only six spouses but which ought to be appreciated by all.

STIGMA

The spouses of suicides might be stigmatized, stigma being defined as the attribution of a mark of shame or disgrace because death was self-inflicted. There is no systematically collected information about this aspect of suicide, and it is of interest now that suicide is no longer criminal. Spouses were asked about the attitudes towards suicide encountered in others and their answers were grouped into negative attitudes—critical, unsympathetic, shocked, or frightened—and positive attitudes—sympathetic, helpful, and tolerant. Twenty-two spouses answered the question about attitudes, and nine could not answer. Thirteen (59%) described meeting positive attitudes and nine (41%) described negative ones; thus for most the recollected experience was benign. Asked whether they felt themselves to have been criticized by others seven said they did. Part of her husband's suicide note which thanked her for caring for him was printed by one widow to give to those who criticized. Another spouse felt he could not go back to the town where he had lived with a suicide because of the gossip and blame he incurred, and a third with three young children, was, even when ill and alone, refused help by her mother because she held her responsible for the suicide. But these were the most extreme reactions described.

A consequence of stigma might be early move of house. Eight spouses moved within one year of the suicide. When the householder spouses were compared with a national sample[3] there was no higher mobility in the suicide group. There are therefore no grounds for supposing experience of stigma prompted any large scale migration though the spouses who moved did report more encounters with negative attitudes ($P = 0{\cdot}05$).*

Newspaper reports also stigmatize, and 10 out of 29 described much distress caused by them. To a detached observer they were brief and factual, but to the spouses they made private problems public, provoked gossip, and disparaged tragedy by stripping it of feeling or sensationalizing it. A rather different form of stigma may be the treatment accorded by insurance companies in honouring their clients' life insurance policies. In the 17 cases where the suicide was known to be insured four spouses reported delays or difficulties in obtaining payment though none was refused outright.

But, lest the picture drawn has been too gloomy, it should be remembered that few encountered stigma and more met positive attitudes. So if suicide causes gossip, even more it stimulates compassion.

OUTCOME

As assumption about suicide is that it causes damage to the survivor. To assess this supposition the interviewers evaluated "outcome," comparing the spouses' situation at the time of the suicide and at interview, rating them better off, worse off, or in an indeterminate position. Fourteen spouses were rated better and 14 worse off, and the position of three was indeterminate. Examples of good and bad outcome may be seen from the following cases:

Case 1.—A woman of 22 lived with her husband, who had an abnormal personality, and their two young children. Her short married life had been unhappy and the suicide persistently struck her and the children; at the time of death she was taking steps to obtain a separation. Despite the shock and grief she said her main reaction was relief. She is now happily remarried, has a 21-year-old son, more friends, more social activities, and is training for a profession. She says her new life is "better in every way."

Case 2.—A 50-year-old mother of three children was happily married; her husband's health was good. She was badly shocked by his sudden death and feels she has never recovered. She feels blamed by her husband's relatives and has a reduced social life since she did everything with him and has no heart to do things on her own. She takes pleasure in recalling their joint activities and thinks about him often. She finds little to stimulate her now.

Men and women had similar outcomes but younger spouses did significantly better; the mean ages were 40 for the better off and 52 for the worse off (two tailed test: $t = 2{\cdot}17$; D.F. $= 26$; $P = 0{\cdot}05$).

Clinical factors associated with good outcome derive from the burden they caused the spouse Thus spouses of alcoholics were more likely to be rated better off ($P = 0{\cdot}05$), as were spouses of suicides with abnormal personalities ($P = 0{\cdot}025$) or with illnesses that had lasted longer than two years before the suicide ($P = 0{\cdot}025$). Spouses of suicides with hypochondriacal symptoms were also better off ($P = 0{\cdot}025$). Previous suicide attempts ($P = 0{\cdot}01$) and threats ($P = 0{\cdot}05$) were related to good outcome as well. Suicidal behaviour might have contributed to the spouses' burden, but possibly it prepared spouses for what was to come.

The quality of the marriage might influence outcome. If the rather crude criterion of separation is taken as a measure of an unhappy marriage those who had separated at some time had a better outcome ($P = 0{\cdot}025$). Two events after the suicide influenced outcome; remarriage and the first research interview.

*Significant levels were assessed with the Fisher test.

Seven spouses had remarried of whom six were considered to be better off and one was in an indeterminate position. This finding reflected age, the mean age for the six with the good outcome being 32. Since successful remarriage undoubtedly conduced to favourable ratings the finding may be tautologous. But as four of the six had previously been separated, all thought their present situation happier, and no separations in the current marriages were recorded a valid relation probably does exist between outcome and remarriage. A marriage ending in suicide might preclude or at least delay subsequent remarriage, but there is no difference in "remarriageability" between the spouses and other relicts of comparable age and sex. Expected remarriages per year, allowing for age and sex, were calculated on the analogy of life tables.[4] The expected frequency for men was 7·4, for women 3·4, for both 10·7, and the observed frequencies were 3, 3, and 6. The differences are not satisttically significant.

A favourable response to the first research interview was related to better outcome. Of the 31 spouses 28 had been interviewed before and were asked their reactions; those 15 who said they had been helped had a better outcome ($P = 0·025$). It is tempting to infer that the research interview influenced outcome favourably, but a good outcome may have caused some to look back benignly.

Finally, only one spouse was referred for psychiatric treatment in the years after bereavement. She had psychotherapy because of difficulties with her boyfriend. One other was readmitted to a mental hospital because of dementia which had been present before the suicide.

MORTALITY

Widows and widowers have an increased risk of death.[5] To see if spouses widowed by suicide have an even greater risk we compared the observed mortality of our sample, allowing for age and sex, with the expected mortality calculated from English life tables[6] (see table). Observed deaths numbered 10, the expected 6·3. As the probability of that difference occurring by chance is 10% the hypothesis that the widows and widowers of suicides have an even greater risk of death cannot be rejected out of hand. The mortality experience of the widowed was used as the comparison standard, but seven spouses remarried who were all, bar one, aged under 38. An adjustment to the expected mortality to accommodate the reduction caused by the decreased risk associated with the change from widowed to married status is too small to influence the findings.

Expected and Observed Numbers of Deaths for Spouses of Suicides (n = 44)

	Expected (National Data)	Observed (Present Series)	P
Average	5·25	10	0·04
Married average ..	4·41	10	0·02
Widowed average ..	6·30	10	0·11

Widowers' excess mortality is confined to the year after the bereavement.[7] In the first year after bereavement the expected number of deaths for our sample was 4·1 and the observed 3, providing no evidence of an excess of deaths in the period immediately after the suicide. The remaining deaths were randomly distributed and clustering of deaths around anniversaries of the suicide was not observed.

Arteriosclerotic heart disease was the chief cause of the increased death rate of English widowers,[7] and suicide contributed to the increase in an American study.[8] Five of our spouses died of heart disease, but in only one, who died 12 hours after the suicide, could a direct link via sudden emotional distress be inferred. No survivor killed himself, nor attempted to, so far as is known, though several spouses reported suicidal preoccupations. The five other deaths were caused by cerebrovascular accident (two cases), multiple sclerosis, corpulmonale, and uraemia. There seems nothing remarkable in this distribution.

The mortality pattern of the widows and widowers of suicides does not therefore seem too different from that associated with widowhood due to death from all other causes.

Discussion

Suicide is suspected of damaging the survivor, but our findings did not altogether support this conjecture. The remarriage and mortality experience was not significantly different from that of the widowed of comparable age in the general population. The inquest, though upsetting, was accepted as a necessary and unavoidable consequence. Stigma attaching to suicide was reported by only nine out of 22 spouses who commented on attitudes and was not particularly burdensome. Outcome was evenly divided between better and worse.

The conclusions about mortality and remarriage may, however, be qualified by the nature of the available controls used—the English widowed—which were not the ideal. The widowed population is underestimated at census and overestimated at death, and official statistics take no account of length of widowhood before death or remarriage. The correct comparison is with a cohort of widowed people not subject to additions and subtractions, data which are not available. The death rate of Young's[7] widowers was excessive only in the first year of bereavement, and thereafter it reverted to the married rate. By using the widowed rate, 40% higher than the married rate, for each year post-bereavement we applied a severe test. The appropriate standard would probably show the mortality experience of our group of suicide spouses to be excessive. It would then have been interesting to note that five spouses were mortally ill before the suicide and the consequences of that illness seemed to have increased the risk of the suicide.

Nothing is known of length of widowhood between marriages in the general population, and the comparability of the interim widowhood of our sample must remain a matter for conjecture. We believe that in our sample remarriage was not greatly delayed as compared to the general population because that would have reduced the observed frequency of remarriage as compared with the expected frequency, resulting in a significant difference. Should a more adequate control become available, an important factor may be the incidence of remarriage in cases where the spouse had found another partner and so, in part, precipitated the suicide.

In our conclusions about the inquest we suggest no one should unwillingly have to identify the corpse, and the inquiry should be private, informal, and less the trial it once was and more the inquiry it is supposed to be. Reporters should not be admitted and no account be published without special reasons, which should relieve distress and remove the implications that death by suicide is disgraceful. Procedure could be speeded up; the inquest may be delayed—sometimes for weeks—postponing cremation funerals which cannot take place before the inquest is closed and possibly making necessary the additional expense of embalming. Though distress over inquest procedure was not correlated with outcome that does not weaken the case for procedural changes on humane grounds to lessen the ordeal. The implementation of the Brodrick Report's [2] recommendations would result in inquests being held in only a very few cases of suicide, and this would substantially meet our recommendations.

The equal polarization of outcome between better and worse makes its prediction a matter of importance for prognosis. Outcome reflected two main elements; degree of adjustment to a new life and relief from the burden caused by the suicide's mental disorder, so that the greater the burden the greater the relief in being released from it and the greater the energy to invest in the future. The factors associated with better outcome included relative youth of spouse and a history of unstable marriage; and those derived from the suicide himself were

alcoholism, abnormal personality, chronic mental illness, hypochondriacal symptoms, and a history of suicidal behaviour in the past. Nevertheless, spouses with good outcome did suffer after the suicide. One spouse, now happy, said that though relieved she experienced waves of grief that completely overcame her, but their frequency slowly decreased. At the time of the first research inquiry the interviewer was pessimistic about her future. She found that visit so helpful she now thinks that interviewing spouses after suicide should be "an essential social service."

The validity of the finding about the helpfulness of the first research interview could have implications for the counselling of bereaved spouses. The benefits of catharsis, reflection, and explanation suggest that the chances of a good outcome might be improved by giving such help soon after the death.

Bereavement through suicide is accompanied by shock and distress, but the worst effects that might be expected, increased mortality, psychiatric ill health, social criticism, and social dysfunction were not observed. The spouses of suicides resemble more the widowed from all causes, but may be polarized into those with good and bad outcome to a greater extent.

We thank Mrs. Molly Knowles for her help in planning the project and sharing the interviewing; Mr. Peter Fayers, M.R.C. Statistical Research and Services Unit, who estimated the expected numbers of deaths and advised; and Mrs. Veronica Kewell for the clerical work. The field work for the study was undertaken during the attachment of D.S. to the M.R.C. Clinical Psychiatry Unit, Graylingwell Hospital, Chichester, while on sabbatical leave from the University of Southampton.

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Medicine in China

Medicine and Society

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Western attitudes to Chinese medicine have changed very quickly in the last two years. First there was incomprehension and disbelief, when the early reports emerged of feaures such as acupuncture and of the eradication of diseases such as cholera and syphilis. Later, when observers confirmed that most of the claims made were soundly based, there was a swing of the pendulum, and some enthusiasts claimed that China had solved all the problems of population control and health care facing developing countries. Most of what has been written (and more is published every month) is based on brief visits to China by official or semi-official delegations who have been shown the best features of medical care in China. Are there any valid conclusions to be drawn?

China certainly seems to have avoided the more obvious mistakes made by some other countries. By concentrating on preventive medicine and public health measures in the early years, the state has laid the essential foundations for satisfactory health standards; and the emphasis on immunization campaigns and the elimination of major disease vectors has paid obvious dividends in the control of endemic disease. But these achievements—just like the effective population control and the decentralized medical system described in earlier articles—are firmly based on the political system in China.

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The organization and delivery of medical care cannot be separated from the whole way of life in the People's Republic. In fact the main impact on a doctor visiting China may well come from the society rather than the medicine.

Peking

Peking itself is an amazing experience. Arrival at the deserted airport (only a handful of flights each day) is followed by an hour-long drive through the suburbs to the city centre. Peking is low and sprawling—in former times no ordinary citizen's house was allowed to overlook the high red boundary wall of the Forbidden City, the central complex of imperial palaces. A few massive hotels, government offices, and exhibition halls built in the last 20 years punctuate the sky line, but the vast mass of Peking is made up of one or two storey houses, themselves protected from the cold winds of winter by high courtyard walls. One enormous avenue, wider than the Champs Elysées, runs east to west, straight as a die for 24 miles from one side of Peking to the other (fig. 1). At its midpoint is the entrance to the Forbidden City, through the Gate of Heavenly Peace (T'ien An Men). This imposing entrance gives its name to the 100-acre square, flanked by the Great Hall of the People and the Museum of the Revolution, that seems to be the natural centre of Peking. Indeed until very recently the square was used for ceremonial meetings and parades—but these now seem out of fashion. Whenever we passed through the square it was almost deserted except for a few Chinese families up from the country having their photographs taken.

Away from the formal buildings, however, Peking lived up to our expectations of teeming millions. No private