We are indebted to Dr. J. L. Pinniger and the staff of the Jenner Laboratory, St. Thomas's Hospital, for much of the wound bacteriology; to Dr. R. A. Shooter for advice; to Mr. M. P. Curwen for considerable help with statistical problems; to Mr. T. W. Brandon for photography; and to Miss N. Lowater for technical assistance.

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ATTEMPTED SUICIDES ARRIVING AT A GENERAL HOSPITAL

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Patients who have tried, with varying degrees of determination, to take their own lives present special medical and administrative problems in a general hospital. Their admission may be regarded with disfavour, treatment may be narrowly confined to their physical condition, provision for aftercare or psychiatric investigation haphazard or ignored. They may even be notified to the police, and taken from hospital to court, where a prison sentence may follow. If the hospital has a psychiatric department, the reception and disposal of these patients is more likely to be conducted in accordance with the needs of their mental state.

Over the past 20 years, and markedly since the war, there has been a continued rise in the incidence of suicidal behaviour—deaths by suicide in England and Wales in 1956 were 5,262, the highest ever recorded (Registrar-General, 1956) and there were *known* attempted suicides 5,387 (*Criminal Statistics*, 1956), thus bringing to the doors of the general hospital an increasing number of patients requiring resuscitation and rehabilitation. Some of these patients came to Guy's in 1957. What they were like, and how they were dealt with, is the subject of the present inquiry.

Other Studies

The literature on suicide and attempted suicide is extensive, contributed mainly by psychiatrists and sociologists. A number of investigations on clinical series have been undertaken: of these, the most recent and most relevant for comparative purposes are those of Batchelor and Napier (1953, 1954), Batchelor (1954a, 1954b), Schmidt, O'Neal, and Robins (1954), Ettlinger and Flordh (1955), Robins, Schmidt, and O'Neal (1957), and Stengel and Cook (1958). Ecological factors affecting suicide rates in different London boroughs are examined by Sainsbury (1955). Epps (1957) analyses the social and psychiatric status of a series of 100 women committed to prison following a suicidal attempt. The preventive effect of hospital admission is discussed by Parnell and Skottowe (1957) in a study of 100 consecutive suicides.

By virtue of their setting—that is, in institutions or public general hospitals—the clinical studies have largely been limited to patients from lower-income groups. Stengel and Cook (1958) have pointed out the lack of information on the incidence and motivation of attempted suicide among better-off patients, whose action may never come to public notice. The present inquiry, covering both N.H.S. and private patients admitted to the York Clinic of Guy's Hospital, throws some light on social class differences.

Material Available

During the 12-months period January 1 to December 31, 1957, 44 attempted suicides arrived at Guy's, 34 coming to the casualty department and 10 being admitted direct to the York Clinic. Ten of the casualty arrivals were transferred elsewhere; 24 were admitted to the general wards. As the York Clinic group was so small, the previous year's direct admissions (11) were also included, giving an overall total of 55. Full psychiatric histories had been taken on all York Clinic patients: information available on ward patients was much less detailed and occasionally incomplete. No interviews were undertaken with any patient, nor were they followed up after discharge, but information was available for the 1956 York Clinic patients through the clinic's follow-up scheme.

Transfers from Casualty Department (Group 1)

This group comprised 10 patients (7 women and 3 men) who were sent elsewhere after emergency treatment, their transfer being arranged by the psychiatric out-patient department in co-operation with a duly authorized officer. Most were seen by the duty psychiatric registrar. Seven went to observation wards, three to mental hospital as voluntary patients. The patients had mostly been brought in by ambulance from the neighbouring district, either living locally or having been picked up in the street. Two had no fixed address; three came from other Central London areas. Involvement of the police was recorded in only one case. Six arrived before midday, three in the afternoon, and one at 7 p.m. Eight were conscious on arrival, one semi-conscious, one not recorded. Four required no special treatment, three had stomach wash-out, two sutures, and one an emetic. The method of the suicidal attempt was barbiturate overdose (4), slashing (2), coal gas, hanging, jumping, and other poison (1 each). Ages ranged from 19 to 66, six being between 20 and 49 years. Three were married, three single, one was separated, and three were not recorded. Occupation, where recorded, was mainly unskilled. One patient was a vagrant, two were unemployed, and one was a foreigner (Polish).

The precipitating stress of the suicidal attempt, so far as could be judged from the scanty information available, was depression (2 cases), marital trouble (2), unemployment, desertion by girl friend, physical illness, alcohol (1 each), not known (2). Six patients had a history of previous psychiatric illness; of these, four had two or more mental hospital admissions. Three were known to have made previous suicidal attempts (one more than once). Other psychiatric abnormality included two known epileptics (one with borderline mental deficiency), a leucotomized schizophrenic, and a drug-taker. There was evidence of hysterical traits (two patients had made frequent suicidal *threats*) and general instability. Only one patient, a man of 66, appeared to have had a good previous personality. (Unemployed man living alone, in poor health, suffering pain and sleepless for weeks, put his head in the gas oven.)

It was obvious that this was a sick and socially submerged group.

Admissions to the General Wards (Group 2)

Twenty-four patients (14 women and 10 men) were admitted from the casualty department during the year (one woman was admitted twice). Sixteen lived in the neighbourhood (S.E.1), four in other S.E. London districts, and two in S.W. districts. One, from Yorkshire, was found unconscious in a local public lavatory. The source of referral to hospital was the patients' G.P. (9 cases), the police (9 cases), uncertain or not stated (6). Seven patients were brought in before midday, three in the afternoon, and 14

from 6 p.m. onwards. Thirteen were in coma on arrival, four semiconscious, and seven conscious. Emergency treatment given before removal to the wards was as follows: stomach wash-out 11, bemegride 9, nikethamide 5, amiphenazole 3, reduction of fractures 2, sutures 1, other 3; observation without specific treatment 4; wash-out combined with analeptics 6. The method of the suicidal attempt was barbiturate overdose (17), aspirin poisoning (3), coal gas (2), falling (2), slashing (1), drinking lysol (1). One male patient combined three methods; the two admissions of one woman each followed an "unintentional overdose."

Fuller notes were available on these patients than on those in group 1, and their social background could be more adequately analysed. Marital status showed a preponderance of widowed (6). Ten were married, six single, and one was separated. Ages ranged from 23 to 76, 10 being between 20 and 39, but 12 (50%) were 50 and over (a finding similar to that of the Dulwich Hospital series, where 23.6% were 60 and over). The social-class distribution, as also at Dulwich, showed an over-representation of the unskilled: 16 (66%) came from Social Classes IV and V; 5 from Social Class III, 1 each from I and II.* Occupations recorded were labouring and unskilled (13), clerical (3), professional (1), pensioners, the disabled (3), "housewives" (2). Six patients, all men, were unemployed at the time of the attempt. The police were noted as being involved in 11 cases.

Precipitating Stress.—Social factors appeared to predominate: they frequently overlapped, or were found together with depressive states. Isolation was a common feature: loneliness, living alone, life in lodgings, homelessness, occurred in 10 cases. Alcohol (getting drunk, rather than chronic alcoholism) was a precipitant in seven, followed by marital trouble and rows with violence (5), debts and money worries (4), unemployment (4), housing conditions (4), illness or death of family member (3), trouble with neighbours (2), trouble with parents (1). In the category of mental and nervous disorder there were 11 mentions of depression, two each of paranoid ideas and insomnia, and one of "nerves." Physical illness was cited in four cases (three were sufferers from chronic conditions).

Previous Psychiatric Illness.—Six patients had been in mental hospitals, two of them twice and one three times. Five had been treated, or were currently under treatment, at psychiatric out-patient clinics. One had been admitted to an observation ward. Psychiatric history was not recorded in nine. Previous suicidal attempts were known to have been made by five patients, two of them twice, and suicidal threats by two. Psychiatric diagnoses had been made in 16 cases; of these, at least five were depression, then came hysteria (3), epilepsy (2), mental deficiency (2), and one each of alcoholism, addiction, chorea, and dementia and psychopathy. Had these patients been subjected to complete psychiatric investigation, it is probable that the incidence of abnormality would have been found even higher: as it was, almost two-thirds had a known previous history of mental disorder. Again, as in group 1, it is clear that these patients who attempted suicide because of the misery and unhappiness of their lives have in almost all cases the additional handicap of instability and often were of below-average intelligence. In only two instances, and in both when under the influence of alcohol, did the attempt appear to have been made by a previously stable individual. (A married man aged 52 with his own small business was upset by the sudden tragic death of his eldest son (married, one child) two days previously. He went out drinking, and took an overdose of tablets given by the G.P. to help him sleep.)

Length of Stay.—Many of these suicidal attempts had not seriously endangered the patient's life or rendered him in need of prolonged in-patient medical care. The average length of stay was accordingly short: 11 days (average length of stay, Guy's general medical wards, 1957, 26 days; overall average, 1957, 15.63 days). At one extreme two patients were discharged after 24 hours; 14 stayed seven days or less; the longest stayed 40 days (surgical case with multiple fractures). Three of these patients were transferred to the psychiatric unit (York Clinic), where they remained a further 4, 20, and 69 days respectively. Another patient, from a surgical ward, was transferred to New Cross Hospital for a further 57 days.

Disposal.—The 24 attempted suicide admissions were distributed among one surgical and six medical wards, under the care of two surgeons and five physicians. It was by no means the rule that a psychiatric opinion was sought on these patients, nor could it be determined from the medical notes why apparently similar cases received different treatment in this respect. Of the 24, 12 were seen by a psychiatrist or psychiatric registrar, 4 were referred to the almoners, and 8 were discharged without further arrangements for social or psychiatric help being made. The final disposal of all patients was as follows: home in care of relatives (4), to mental hospital as voluntary patient (3), to observation ward (2), to hostel or home (2), convalescent home and other hospital (1 each); 8 were referred to psychiatric out-patient departments (5 to Guy's, 3 elsewhere); and 3 were transferred to the York Clinic for in-patient treatment.

York Clinic Direct Admissions (Group 3)

Ten attempted suicides were admitted during 1957 and 11 in 1956. As they do not differ in any essential respects they have been grouped together to give a number comparable to that of the general ward admissions. Of the 21 patients (17 women and 4 men†), 13 were married, 5 single, 1 each widowed, divorced, and separated. Ages ranged from 20 to 60, the majority (13) falling between 30 and 49. Only four were over 50, in contrast to 12 in group 2 (ward admissions). Sixteen were private patients and five free Health Service patients. Sixteen were drawn from Social Classes I and II (9 and 7 respectively), four from Social Class III, none from IV, and one (an emergency admission from the psychiatric out-patient department) from Social Class V. Occupations were professional and managerial 10, business proprietors 4, clerical workers 4, and Civil Service, domestic, and nil 1 each.

These patients' homes were distributed over a much wider area than either of the other two groups: seven lived in S.E. and S.W. London districts, six in W. and N.W. districts, three were from rural Surrey, two from the provinces, one from Eire, and two were flown direct from overseas (Basrah, Trinidad). Eleven had been transferred from a general hospital, seven were sent in by their G.P., one by an outside psychiatrist, and two from Guy's psychiatric out-patient department. Only two cases were known to the police (one in Social Class II, one in III).

Most had received emergency treatment at home or in hospital immediately after the suicidal attempt, and only four were in coma on arrival at the clinic. The preferred method of the attempt was barbiturate poisoning (14 cases). An overdose of chlorpromazine hydrochloride was taken by two patients, of aspirin by one, and of insulin by one. Slashing, stabbing, strangulation, and jumping each occurred once. Two patients, determined, combined more than one method; in other cases the injury or overdose appeared more of a gesture than a serious attempt.

Precipitating Stress.—In comparison with groups 1 and 2, psychiatric rather than social factors were predominant. This group of upper-class and for the most part economically secure patients were not exposed to the stresses attendant upon poverty, unemployment, and lack of a settled home. On the other hand, they had been selected to some extent by a previous contact with the clinic or by an obvious psychotic illness requiring psychiatric care. Depression or depressive relapse was present in 15 cases, paranoid ideas or paranoid psychosis in 3 (2 of them concerned with a spouse's infidelity), "nerves," insomnia, other neurotic symptoms (3). Worry over physical illness, real or fancied, appeared in 3.

*Married women assigned by husband's occupation.

†Women constantly outnumber men in the York Clinic.

In the social sphere, difficulties leading to the attempt were marital trouble (4 cases), unhappy love affairs (4), alcohol (4), dissatisfaction with job (3), debts and money worries (2), loss of job and pregnancy (1 each). (Secretary aged 24, in good social position, took overdose of pentobarbitone sodium following broken-off love affair. Suicidal gesture at age 17, depressed for some months following broken engagement at age 21.)

Previous Psychiatric History.—Six of these patients had been under treatment in York Clinic before (2 of them once, 2 twice, 1 six times, and 1 ten times) and several had had courses of E.C.T. Five had had out-patient psychiatric treatment, 3 had been admitted to a mental hospital (2 of them twice); none had gone to an observation ward. Four had made previous suicidal attempts (1 "several" times; and 1, a psychopath, five times). Suicidal threats and gestures were recorded in 3 cases. Only 5 of the 21 patients had no previous history of mental or emotional disorder. Psychiatric diagnoses made, in addition to the depression and paranoia already noted, were psychopathy (3), hysteria (4), alcoholism (2), and 1 each of hypochondriasis, epilepsy, addiction, and schizo-affective disorder. There was considerable diagnostic overlapping—for example, psychopathy and alcoholism, depression and hysteria, etc.

Treatment and Length of Stay.—The average length of stay for this group was 43 days (average length of stay, all patients, York Clinic, 1957, 45 days). The range was from 3 days (2 patients) to a stay of 187 and another of 121 days (both psychopaths). Four patients stayed 10 days or less, two of them taking their own discharge. Psychiatric treatment given was sedation (14 patients), E.C.T. (9), psychotherapy (10), modified insulin (3), other (4); observation without specific treatment (2). Not all patients were co-operative with the medical recommendations.

Disposal and Later Follow-up.—It is general practice in the York Clinic for patients to be given an out-patient appointment two to three weeks after discharge, and 11 of this attempted-suicide group were discharged home with a definite appointment made. The remainder were dealt with as follows: home in care of relatives (7), home and referred back to G.P. (2), transferred to mental hospital as voluntary patient (1). Follow-up information available one year later on 9 of the 11 patients admitted in 1956 showed that 6 were well (2 had since married), 1 had been readmitted twice for further treatment, and 2 had finally succeeded in taking their lives.

Characteristics of Group 3 (York Clinic Admissions)

These patients, on the whole, were vulnerable immature people. They showed marked emotional instability, low tolerance for stress, and an inability to handle personal relationships. They involved themselves in divorce (4 out of the 20 had had previous marriages dissolved), in unsatisfactory pre- and extra-marital affairs, in marital strife and jealousy. Their life histories often showed a pattern of immature hysterical behaviour, and at least four of the attempted suicides in the group appeared to be of a histrionic attention-compelling nature. In a number of cases menopausal factors were considered significant (7 of the 17 women were aged between 40 and 60). A common picture was that of a married woman, childless or whose children had grown up, lacking occupation and lacking inner resources, uncertain of her husband's affection. Another feature of the group was the easy availability of drugs: many patients were on barbiturates already, prescribed by psychiatrist or G.P. (patients often arrive in the clinic with large supplies in their possession).

Three patients showed all the resistance to help of the psychopath: two had wrought a trail of havoc in their lives (and those of their distracted relatives) with drink, drugs, abortion, financial irresponsibility, and repeated though half-hearted attempts at suicide; the third, determined on self-destruction, made two ingenious attempts while still in the clinic, and succeeded in killing herself six months later, a few days after discharge from a mental hospital. While the depressive states which led up to a suicidal attempt could be treated and relieved in the clinic, for many of these patients the attempt was but one fact of a malignant underlying character disorder.

Police Intervention and Hospital Policy

In England and Wales, though not in Scotland or in any European country, attempted suicide is still a criminal offence. It is therefore the duty of the police to charge all such cases that come to their notice and to bring them before the court. In 1956, 5,387 attempted suicides were known to the police: the actual number is very much higher, since many are admitted to hospital or receive medical attention without reference to the police. Of the 55 attempted suicides arriving at Guy's in 1957,* only 13 were recorded as known to the police when brought in, and none were subsequently reported by the hospital staff. It is no part of medical ethics to disclose confidence of this sort; and, as Keith Simpson (1947) observes, "suicidal attempts will not be less likely to recur because the doctor sees that the wretched victim is haled to court and charged with the offence." The interests of the patient appear better served by treatment than by retribution.

At Guy's, when the police are involved in a case, it is customary for them to accompany the patient to hospital and leave him in medical hands. During 1957 a detention notice was issued in respect of five ward patients and two York Clinic patients: this notice, sent to the superintendent's office, states that the patient is a prisoner and that the police station must be informed before the patient is discharged. After inquiries at the hospital (in one case by telephone) no further action was taken in any of these cases, and the detention notice was formally cancelled.

If a police officer wishes to take a bedside statement from a patient it is the practice at Guy's to request that the officer attend in plain clothes; if the patient is a woman, a woman officer is sent. Although the house-physician and ward sister do their best to make the interview as little disturbing as possible, it was recorded in one patient's notes that "Mrs. F. is very depressed because of a visit from the police." No patient, to anyone's recollection, has ever been charged from Guy's, but not all hospitals are so considerate. In the Epps series of 100 women sent to Holloway Prison for attempted suicide, 75 had gone straight to court from a general hospital (16 of these were teaching hospitals; Guy's was not among them) (Epps, personal communication). Hospitals having a psychiatric department would be more likely to make use of the mental health services for the care and disposal of these patients than hospitals not so equipped.

Police practice varies too from one district to another: in Southwark, which has Guy's Hospital in its area, attempted suicides are never charged except "as a last resort," and then only when it appeared that there was no other way of bringing the person (who might be a chronic alcoholic, or someone who had made repeated previous attempts) under proper care. Of the 13 cases known in Southwark during 1957, seven were taken to Guy's, two to Lambeth Hospital, and the remainder were dealt with by the duly authorized officer or sent home. There is no ruling where any particular attempted suicide casualty should be sent: it is left to the ambulance drivers to select the nearest hospital, or the one that the patient or relative requests. Hospital admissions therefore do not necessarily correspond with the police or ambulance division of the metropolitan area in which the hospital is situated.

Where York Clinic admissions are concerned it will be apparent that social class is a discriminating factor in police intervention. The patient whose doctor and relatives are in a position to arrange a discreet admission to hospital is unlikely to suffer the indignity of a police interview at his bedside or run the risk of a court appearance. Few patients, in fact, appear to know that attempted suicide is a criminal

*Includes the 11 York Clinic admissions in 1956.

offence; and, even if they did, this consideration is not likely to enter their minds at the time of the attempt.

Discussion

The findings of this study provide additional evidence that individuals attempting suicide, whether in Stockholm or South-east London, Edinburgh or St. Louis, have many characteristics in common. There is a constant excess of women (Guy's, 69%); the preferred method is barbiturate poisoning (Guy's 63%; South Hospital, Stockholm, 73% (Ettlinger and Flordh, 1955)); and a high proportion display psychiatric abnormality (of the 109 cases in the St. Louis series (Robins *et al.*, 1957) the authors say "there were probably no psychiatrically well patients in the entire group"; the Swedish study found "signs of aberrant personality" in 66%). Many will have made previous suicidal attempts, in particular the sufferers from psychopathic states, epilepsy, and hysteria (previous attempts in the Dulwich series, 21%; 45% among the group of psychopaths in the Edinburgh study, reported by Batchelor, 1954b). Alcohol is a frequent precipitant: since indulgence generally takes place in the evening, more suicidal emergencies may be expected to reach hospital at night (14 of the 24 ward admissions to Guy's were brought to the casualty department after 6 p.m.; at the South Hospital, Stockholm, the peak time of arrival was also between 6 p.m. and midnight). Many will reveal a history of persistent social maladjustment and of hysterical modes of reaction. Attempts made by the old, by those of good previous personality, or in a setting of psychotic depression are more likely to achieve a fatal outcome. The relative absence of patients of this type in the group under study supports the concept outlined by Stengel and Cook (1958) of two differing populations: those who attempt and those who commit suicide.

It would be a counsel of perfection to suggest that all attempted suicide emergencies arriving at a general hospital should be admitted and fully investigated before discharge. The casualty officer has to make his decision in the light of the physical condition of the patient and the limited number of beds at his disposal. It would be equally impracticable to recommend that all such patients, once admitted to the general wards, be transferred as a routine to the psychiatric unit: shortage of beds is again the limiting factor. The South Hospital in Stockholm has met this problem of the initial reception of acute cases (not confined to attempted suicides) by providing a 10-bedded admittance ward with a maximum observation period of 24 hours. Appropriate measures of treatment can then be decided in consultation with the psychiatric department, and the medical and surgical units, if required; and transfers to other hospitals arranged (50% of the 500 attempted suicide cases coming to the admittance ward were referred for psychiatric in-patient care, 30% of them in the South Hospital's own unit).

At Guy's, as in any busy general hospital, it is inevitable that the criteria for retention of an attempted suicide patient in the wards is the somatic rather than the psychic gravity of his condition. But, since all suicidal behaviour implies some degree of mental disturbance, it would seem advisable that these patients, however brief their stay, should have the benefit of a psychiatric interview.

A study of this nature leaves the observer with an overwhelming sense of the unhappiness and frustration in which these unfortunate people live their lives. Handicapped as most of them are by an unfavourable mental and emotional constitution, often friendless and alone, when stress becomes intolerable they seek solace in alcohol or oblivion in drugs. To dismiss in a contemptuous manner some of their unsuccessful suicidal attempts as "not serious" or "hysterical" is to fail to understand the meaning of the act, its significance (often totally unconscious) as a desperate and final appeal for help. Admission to hospital and referral for psychiatric investigation enables such help to be mobilized where required; it may even prevent a repetition of the attempt if the patient's life situation is explored and he is assisted to make a more satisfactory adjustment.

In this clinical scene police intervention, however tactfully conducted, is irrelevant and in no way helpful. If, as is argued, compulsory powers must be retained to ensure that unwilling attempted suicide cases undergo treatment, this can far better be achieved by recourse to the duly authorized officer than by taking the patient to court. With the present development of the mental health services, and the more general understanding of suicidal behaviour as a symptom of mental disorder, punitive measures are seen to be inappropriate and unnecessary. Two recent editorials in the medical press (*British Medical Journal*, 1958; *Lancet*, 1958) have condemned the existing law and urged its reform. The latter journal sums up in these terms: "It seems clear that this outdated law is as inconsistent and inequitable in its application as it is damaging in its effects. Its virtues are hard to discover: its vices are blatant. The sooner it is done away with the better." The study of these 55 attempted-suicide patients who came to Guy's endorses that trenchant conclusion.

Summary

A series of 55 patients coming to a general teaching hospital following a suicidal attempt is described, and their reception, treatment, and disposal are analysed.

Approximately 18% were transferred elsewhere on arrival, 45% were admitted to the general wards, and 37% were admitted direct to the psychiatric unit (York Clinic). The preferred method of the suicidal attempt in all three groups was barbiturate overdose (63%) followed by other poisoning (17%).

The group of patients dealt with by the casualty department was found to contain a very high proportion of mentally handicapped and unstable individuals, of poor social background, living in poverty. More than half were aged between 50 and 70. Isolation, alcohol, marital friction, money worries, and physical illness were the chief precipitants of the attempt.

In a comparable group of private patients, social difficulties were minimal, but psychiatric illness appeared in excess. Many had previously been under psychiatric care; depression, hysteria, and personality disorder formed the setting of the attempt. Immaturity and inability to handle personal relationships were marked; easy access to drugs was another feature.

Patients admitted to the general wards stayed an average of 11 days; those admitted to the psychiatric unit, whether N.H.S. or private, 43 days. Referral for psychiatric opinion would be justified in every case of attempted suicide coming into hospital.

Police action was never initiated from the hospital. Criticism of the present law with regard to attempted suicide is inevitable in the context of these findings.

I thank Dr. D. Stafford-Clark, director of the York Clinic, for permission to publish this paper. I am grateful to Dr. A. Angus, officer in charge of medical records; Miss Elphick, head almoner; Mr. Hagen, security officer; and Sister Jarvis, casualty department, for assistance in tracing cases.

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