Causes and Modes of Suicidal Attempts at JN Medical College Hospital, Aligarh Muslim University, India

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ABSTRACT

Suicide is the second commonest manner of unnatural death flanked by accident and homicide. The reasons for suicide and modes of attempted suicides vary from country to country and are also different in different races and cultures. This study was conducted at JN Medical College Hospital, Aligarh with the aim of knowing the common causes and modes of suicidal attempt.

The study was conducted over a period of 5 years from January 2007 to December 2011. A total of 1164 cases were included in the study 548 (47.08%) were males and 616 (52.92%) were females.

Poisoning was the most common mode of attempted suicide 530 (45.33%) cases, followed by hanging 252 (21.65%) cases. Domestic problems accounted for 255 (45.33%) cases as causes of attempted suicide. Regarding outcome of suicidal attempts 274 (23.54%) victims died in their suicidal attempt. The important findings in the present study included that 50% of the persons who attempted suicide were illiterates. Organophosphorus compounds (fertilizer) were used as poison and dowry related issues were important factors for attempting suicide.

Keywords: Suicide, attempted suicide, organophosphorus poisoning, dowry death, hanging, Burns.

INTRODUCTION

According to WHO, "Suicide is an act with a fatal outcome, that is deliberately initiated and performed by the deceased himself in the knowledge or expectation of its fatal outcome, the outcome being considered by the actor as instrumental in bringing about the desired changes in consciousness and/or social conditions."[1]

According to Medrad Boss "Flight from death is mere survival and flight into death is suicide"[2].

Every year throughout the world an estimated three quarters of a million take their own life and in many countries this is the leading cause of death in most productive age group[3].

All over the world, about 2,000 people end their life by means of suicide every day taking a toll of 80 to 100 deaths per hour. Around 10-15 times as many people make non-fatal suicidal attempts or perform para suicidal acts every day.

The causes suggested for suicides include childhood and family adversities such as childhood sexual and physical abuse, witnessing domestic violence, parental separation or divorce and living with substance abuse, mentally ill or criminal family members. Suicidal behavior is highly familial and heritable as well[4].

The reason for suicide and modes of attempted suicides vary from country to country and is also different in different races and cultures. The reasons reported by western authors may not be the same in the Indian context.

In the light of the above facts, the present study was conducted at JN Medical College & Hospital, Aligarh Muslim University, Aligarh, with the following aims & objectives.

1. Epidemiological profile of patients with attempted suicide

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An Epidemiological Study of Suicidal Attempt Victims at J N Medical College, Aligarh

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ABSTRACT

Suicide is the second most common cause of unnatural death. Every year three quarters of a million take their own life in many countries. This is a leading cause of death in the most productive age group (20 – 50 years). Attempted suicide is 4 – 8 times more common than suicide. The studies pertaining to Socio-demographic characteristics are helpful in formulating suicide prevention strategies at the state & National level.

The present study was conducted with the aim of studying the socio-demographic characteristics of suicidal attempt victims at J.N. Medical College Hospital, Aligarh Muslim University, Aligarh.

This study was conducted in the departments of Forensic Medicine and casualty over a period of 5 years between January 2007 till December 2011.

A total of 1164 suicidal attempt victims reported to this Hospital. Data were collected in relation to the demographic characteristics and other details and entered into a proforma specially prepared for this study.

Data were analyzed by using SPSS 17.0 (Statistical Package for social science) regarding the variables. The following results were obtained in this study.

Age: Commonest Age group was between 20 – 29 years (37.28%).

Marital Status: Majority of the suicidal attempt victims were married people (68.9%)

Religion: Hindu victims were 84.88%, Muslims 12.4% and Christians 0.6%.

Domicile: Most of the suicidal victims (66.41%) were form rural areas.

Educational Status: 50% of the victims were illiterates. Graduates and above constituted about 7.39%.

Occupation: 34.54% of the victims were unemployed.

Socio-economic Status: Majority of the victims were from lower socio-economic status 32.64%.

Location: Majority of the suicidal attempts were made at the residence 83.5%.

Time of the day: 37.2% of patients attempted suicide between 6 am to 12 noon.

Keywords: Suicidal attempt victims, epidemiology, socio-economic status, Geographic Location

INTRODUCTION

The term “Suicide” is derived from the Latin words, Sui (“of oneself”) and cidium (“killing” or “slaying”), it is an act of an individual causing its own death⁶. Suicide is the second most common cause of unnatural death. Every year an estimated three quarters of a million take their own life and in many countries this is the leading cause of death in most productive age group⁶. Attempted suicides have been on the rise all over the world and it is 4-8 times more common than suicide; it carries significant social and medical implications⁶. The studies pertaining to social, psychological and demographic factors are helpful in
THE DEFINITION OF DEATH: PAST, PRESENT & FUTURE

Saadiya Saeed

ABSTRACT

In the past, death has often been defined as the separation of the soul and body. Human death definition was much easier in the past. When the heart and the lungs stopped working the person died. With advances in medical technology the distinction between life and death has become blurred. Life support technologies introduced in the 20th century have generated a new kind of patient, one whose brain does not function but whose heart and lungs continue to work.

Life and death are not binary states, from one to the other there is a gradual transition. Cells die individually and the rhythm of life slows steadily to a halt.

'Traditional formulation' of death has been defined as the complete and irreversible cessation of the vital fluid flow i.e. air and blood.

'Whole brain formulation' of death is defined as the irreversible loss of an organism's ability to function as a whole.

'Higher brain formulation' of death is defined as the total and irreversible loss of consciousness and cognition.

'Social death', the socially dead are those bodies lacking personhood.

The definition of death continues to evolve with adoption of modern technology the future definition will be at Gene/DNA level.

Keywords: Definition of death, Traditional formulation of death, Whole brain formulation, Higher brain formulation, Social death.

INTRODUCTION

Robert Kastenbaum', professor of communications at Arizona state university wrote in a 1989 encyclopaedia titled “Definitions of Death” in the encyclopaedia of death and dying, that.

"In the past, death has often been defined with a few confident words. Death is generally considered as the separation of the soul and body, in which sense it stands opposed to life, which consists of the union there of (1768, V.2, P.309). The confidence and concision had dissolved by the time the fifteenth edition appeared in 1973. The entry on death had expanded to more than thirty times the original length. The earlier definition was not mentioned, and the alternative that death is simply the absence of life was dismissed as an empty negative. Readers seeking a clear and accurate definition were met instead with the admission that death ‘can only be conjectured’ ‘the supreme puzzle of poets’ (1973 V.5, P.526).

There is difficulty in defining and diagnosing death. Death is no more a momentary phenomenon, technology has deconstructed death. Human death definition was much easier in the past. When heart or lungs stopped working the person died. Sometimes the brain stopped earlier than the heart and lungs. The cessation of these vital organs occurred close together in time. With advances in modern medical technology the distinction between life and death has become blurred. Life support technologies introduced in the 20th century have generated a new kind of patient one whose brain does not function but whose heart and lungs continue to work.

Technology is problematizing death and this perhaps is the greatest paradox of the present century.

“As scientific knowledge and medicine advance, a precise medical definition of death becomes more problematic”

Technology has gradually and continually expanded the grey areas between life and death. According to some, technology per se did not create this grey area, it simply extended it and made it manifest. The reality is that life and death are not binary states, one from the other there is a gradual transition. The body gradually shuts the plant doors and turns out the lights one by one. Cells die individually and rhythm of life slows steadily to a halt.

But even this halt can be restarted with defibrillator and enthusiastic inflation of the lung with oxygen. There is no point at which we can collectively and scientifically say that ‘now the patient is dead, there is no return from this state’.

As we understand more about human physiology and the technological advancements of the present century, we discover that a condition we once thought was beyond hope can routinely be recovered to a full and vibrant existence.
The definition of death: past, present & future

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Abstract

In the past, death has often been defined as the separation of the soul and body. Human death definition was much easier in the past. When the heart and the lungs stopped working the person died. With advances in medical technology the distinction between life and death has become blurred. Life support technologies introduced in the 20th century have generated a new kind of patient, one whose brain does not function but whose heart and lungs continue to work.

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Keywords

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END OF LIFE DECISION MAKING: THE INDIAN SCENARIO
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ABSTRACT

Although death is an everyday occurrence in the critical care units, there is a discomfort in confronting mortality in 21st century society. Advance life support interventions have greatly improved the prospects of treating seriously ill patients, but at the same time futile prolonged life support interventions can make death painful and agonising.

There is absence of guidelines in India regarding end of life issues especially with regards to withholding/ withdrawing advance life support.

Further, euthanasia, living will, do not resuscitate (DNR) and advance directives are not legally acceptable in the court of law. All this has created a dilemma for the doctors/patients and their relatives. Laws regarding harvesting of organs from brain dead patients are also not clearly defined. Revision of the primitive laws and introduction of new legislation on the lines of improve the western model will improve the of end of life decision making in India. Introduction of end of life issues in medical curriculum and training of physicians in ethical decision making, advance directives and counselling in the intensive care units, will improve the dismal Indian scenario.

Keywords: End of life decision, DNR, advance life support, euthanasia, advance directives, organ transplantation.

INTRODUCTION

The population of the earth is ageing and as medical techniques, pharmaceuticals and devices push the boundaries of human physiological capacities, more humans will go on to live longer. However, this prolonged existence may involve incapacities, particularly at the end of life.

Although death is an everyday occurrence in the critical care units there is a discomfort in confronting mortality in the 21st century society.

It is of paramount importance that a physician recognises when he/she is dealing with a dying patient. Besides planning for alleviation of symptoms and treatment, an ICU physician must understand ethical decision making and advance directives. Be effective in interaction with families/surrogates, understand the influence of religion and spirituality, acknowledge diversity, be facile with palliation and transition to comfort care. Communicate well with the primary care team and enlighten medical students and residents regarding end of life issues.

Role of advance life support interventions:-

Advanced life support interventions have no doubt greatly improved the prospects of treating seriously ill patients but at the same times we need to realise that prolonged and futile life support interventions can have the following effects.

1. Make death painful and agonising (Prolongs the dying process).
2. Imposes enormous economic burden on the patients and families and the national health resources.
3. Potentially salvageable patients are denied ICU care when scarce beds and resources are consumed by patients where in death appears inevitable.
4. Technologically prolonged dying process takes away the serenity and the dignity accorded to death.

Death which we all wish to be peaceful and to occur in the presence of loved ones has become artificial, away from the family surrounded by the paraphernalia of modern critical care.

Role of ICU health care team

We are confronted with the question regarding the responsibility of the physician where critical care is unlikely to save the patients life or to restore him to a meaningful existence. In other words. Is it ethical to keep someone who is in a vegetative state, on life support systems for years or months together, when the resources could be used to help someone else maintain quality of life?

For this, we need to address the major goals of the ICU health care team.

1. To save lives by intensive and invasive therapy.
2. To provide/facilitate a peaceful and dignified natural death when death is inevitable.