Married female, age 38

I can't bear the pain any longer.
I'm tired, discouraged and unhappy.

HOW NOT TO COMMIT SUICIDE

Instead of oblivion and relief, 9 out of 10 suicide attempters live through various ordeals of intense physical suffering, stomach pumping, lasting internal injury, brain damage, bureaucratization, moral condemnation, uninvited psychiatry . . . and sometimes new attitudes about life.

by Art Kleiner

This article arose from a conversation among the directors of our foundation, Point. Michael Phillips and I wanted to publish information on how to commit suicide. Hiding such information is a vicious taboo, we opined in high libertarian dudgeon. Richard Baker, abbot of the local Zen Center and one who sees a lot of disturbed people remarked drily, "If the information were generally available, a fellow I talked with last week would be dead now. He wouldn't do it this week I think. The information that people need is how not to commit suicide. They think if they take an overdose of sleeping pills they'll just go to sleep and never wake up. Instead they wake up choking on their vomit, and there's the emergency room and stomach pumping and brain damage, and it's the opposite of relief for their suffering. People try all sorts of things that don't work, all horrible."

CQ staffer Art Kleiner got the assignment and immersed himself in it with his customary zeal. (He wants noted that "four people who have worked with suicidal people helped me articulate the article, even though they weren't directly quoted in it – Mary Deems, Ron Jones, Larry Cohen, and Ben Campbell.") Journalist Kleiner also adds, "This article was probably the most rewarding I've ever done, nightmares and all." –SB

RESURRECTION, the voyage to the land of the dead and back again, is common enough in old legends and myths and in the experiences of people who live through a near-terminal illness or accident. But that journey is also made daily in hospital emergency rooms.

About 30,000 people kill themselves in the United States each year. An estimated ten to forty times that number try to kill themselves but don't die, either because they don't really want to die or because they don't know how.

I didn't realize the impact of that statistic until I talked to friends and acquaintances while researching this article. Everyone I talked to, whether I interviewed them or casually brought the subject up, knew someone who had attempted suicide.

Some of the stories are tragic. A friend of a friend jumped from a high building and hit a parked car several stories below. She broke most of her bones and punctured several of her inner organs but didn't die. Instead she was wheeled, conscious, to the local emergency room, her most privately conceived act announced to the world by the ambulance siren. She spent the next year in bed, much of it in a hospital ward allocated to critically ill victims of violence, her still-suicidal mind the only functioning part of her body. *more →*

HOW NOT TO COMMIT SUICIDE

(All these common techniques
are unreliable and have often terrible
effects on the survivor.)

Don't overdose on aspirin, Tylenol,
caustics such as lye or oven cleaner,
psychiatric drugs such as Thorazine or Elavil,
tranquilizers, or sleeping pills.

Don't slash your wrists.

Don't shoot yourself.

Don't jump from a not-very-high place
or try to hang yourself.

This article about what happens to people who attempt to kill themselves started as a brief review of a pair of new publications aimed at the terminally ill. One booklet, the widely-publicized but little-read "death manual," **How to Die With Dignity** (reviewed on p. 110), contains a chart of lethal doses of different types of pills and methods of deliberately ensuring a calm death in a suicide attempt. It was published by Scottish Exit, a northern spinoff of British Exit, the London group that has in the past year sought and won more than its share of controversy. Two of the members of the London group are now facing trial on nine charges of aiding people to kill themselves.

The other book, **Let Me Die Before I Wake** (also reviewed on p. 110), is a collection of case histories of people who have committed suicide or attempted it and failed, with detailed descriptions of the methods used. It was published this spring by a Los Angeles group called Hemlock, which also counsels terminally ill people on their other options. The book's author, Derek Humphry, is a British journalist who wrote the sentimental memoir **Jean's Way** (1978; $5 postpaid from Hemlock, Suite 101, 2803 Ocean Park Boulevard, Santa Monica, CA 90405), the first popular book to describe what Hemlock calls "Self-Deliverance." Humphry's first wife, Jean, discovered that she had bone marrow cancer and took a fatal drug overdose as she was on the verge of becoming immobile.

"Perhaps 10 percent of our members are terminally ill," Humphry told me. "The great fear of the rest of our members is that they may face a painful, awful death one day. If they can say, 'I have this cache of pills and good advice on how to use them,' they can feel prepared if they eventually do fall ill, and in the meantime can get on with the business of living."

So when I went to emergency room physicians, paramedics, and therapists, I expected to hear of many people who might have needed this information – people who, faced with a grim illness and no alternatives to it, had tried to kill themselves and ended in the emergency room instead. Wrong. People who plan deliberate suicides usually succeed – as Humphry said, everything in the suicide manuals can also be found in medical textbooks. People in emergency rooms are usually people who attempted suicide on impulse, in temporary despair or anger. Many decide later that it was a mistake.

They are the people whose fate has been thrown into sharper focus by the existence of these new books. The argument between Exit and the British suicide prevention groups played with much commotion in the press and in conversation. The books should not be published, the suicide prevention people said, because temporarily distraught people would use them impulsively and die, where without them they would probably live. Yes, said the voluntary euthanasia groups, but preparing for a rational, planned suicide as the books encourage, and thinking out its ramifications (like who will be affected by it) makes people less likely to kill themselves impulsively. Yes, but the context of the how-to-die information shows suicide as an easy way to solve problems, and doesn't encourage people to look for other options first.

Yes, but the books are available only through the mail, with a three-month waiting period, just to discourage such abuse. Yes, but with easy xerox access no one can guarantee the books won't find a subterranean following. Yes, but banning the booklet is equally manipulative – it keeps people from the option of dying easily unless they

This and other suicide notes on the following pages were gathered at coroners' offices by a suicidologist/psychiatrist who asked to be anonymous. He edited identifying details out of the compiled manuscript, and we changed the names. But the text of each letter plus the age and sex given are real. All these people did kill themselves. Were they ambivalent about it? About half the hundred or so letters we saw seemed to have some element of doubt.

(There's a strange story in computer folklore about a suicide note that appeared late one night on the Arpanet computer network. The other people on the network had regularly corresponded with the man, but always under the name of his lab not his own name. When the message saying he was killing himself flashed on the screen they tried to call the police, but nobody could identify him, and he died.) —*Art Kleiner*

are lucky enough to find people who will help them. Yes, but they might find people who will help them avoid the pain tomorrow, if they aren't encouraged to end their lives today. Yes, but . . .

The debate is fascinating to follow, because usually talk of suicide is hushed up, for fear it will create more suicide or someone will be held responsible. Psychologist intern David Gruder worked in a California high school a few years ago when one of the popular seniors killed himself. "In the next two weeks everybody pulled me aside – students, teachers, the principal – to ask me what they could have done, what he meant by it. But nobody said anything out loud to each other. Finally I gave a talk at the library about suicide and suicide prevention, and I had to argue with six levels of school administration to do it. I had to tell them the clinical truth is that talking about suicide often neutralizes it. Ignoring it always paves the way for more attempts."

When a genuine myth rises into consciousness, Ursula Le Guin wrote in **The Language of the Night** (Spring '81 **CQ**, p. 54), the message is always: You must change your life. Each suicide attempt, I'm convinced, carries that message: to the person who tries it, to the people who are close to that person, and to the rest of us as a society. I think what happens after a suicide attempt is a sort of autopsy of what's best and worst about our culture. Here is some of that story.

LIKE THE OTHER 200 SUICIDE prevention telephone hotlines in the U.S., the Marin Suicide Prevention Center holds several 11-session training classes a year. I sat in on one of the introductory sessions. It looked like any suburban adult education class – sixty fidgety people of all

Married female, age 59

Dear David,

After six weeks of streptomycin shots and a total of eleven weeks of rest in bed we have conclusive proof that the ulcers in my bronchial tubes have not healed. The short period of the streptomycin inhalations could not have brought on the results if the ulceration had even partially healed. To try further would mean many more months of bed rest -- more shots and inhalations -- I can't remain at the hospital for the winter months and a prolonged stay at a rest home is out of the question. I did some figuring -- the weekly rate there -- the amount of streptomycin for shots and inhalations plus the doctor's weekly visits would total to over $200 a week -- I can't bleed my family for any such amount of money, and that means that as soon as the money I have in my checking account runs out I would have to return home -- back to the same conditions which caused me to go downhill so steadily. It's a vicious circle from which there seems no escape. I could of course use up the money from the sale of our furnishings and silver as well as some I put aside for the furnishing of our home -- but all it put together would be like a drop in the bucket -- besides I am now convinced that my condition is too chronic and therefore a cure doubtful.

All of a sudden all will and determination to fight on has left me. I have long ago prepared myself for the time when I reached the end of the trail. I feel calm and at peace and grateful that I can go to sleep painlessly. I feel justified in terminating a life which no longer holds any hope of having the essentials which make it worth living -- I did desperately want to get well -- I still had much to live for -- hope for recovery -- hope of a reunion with the children -- work which I loved and which could have given me financial security and great satisfaction. But it was not to be -- I am defeated and exhausted physically and emotionally.

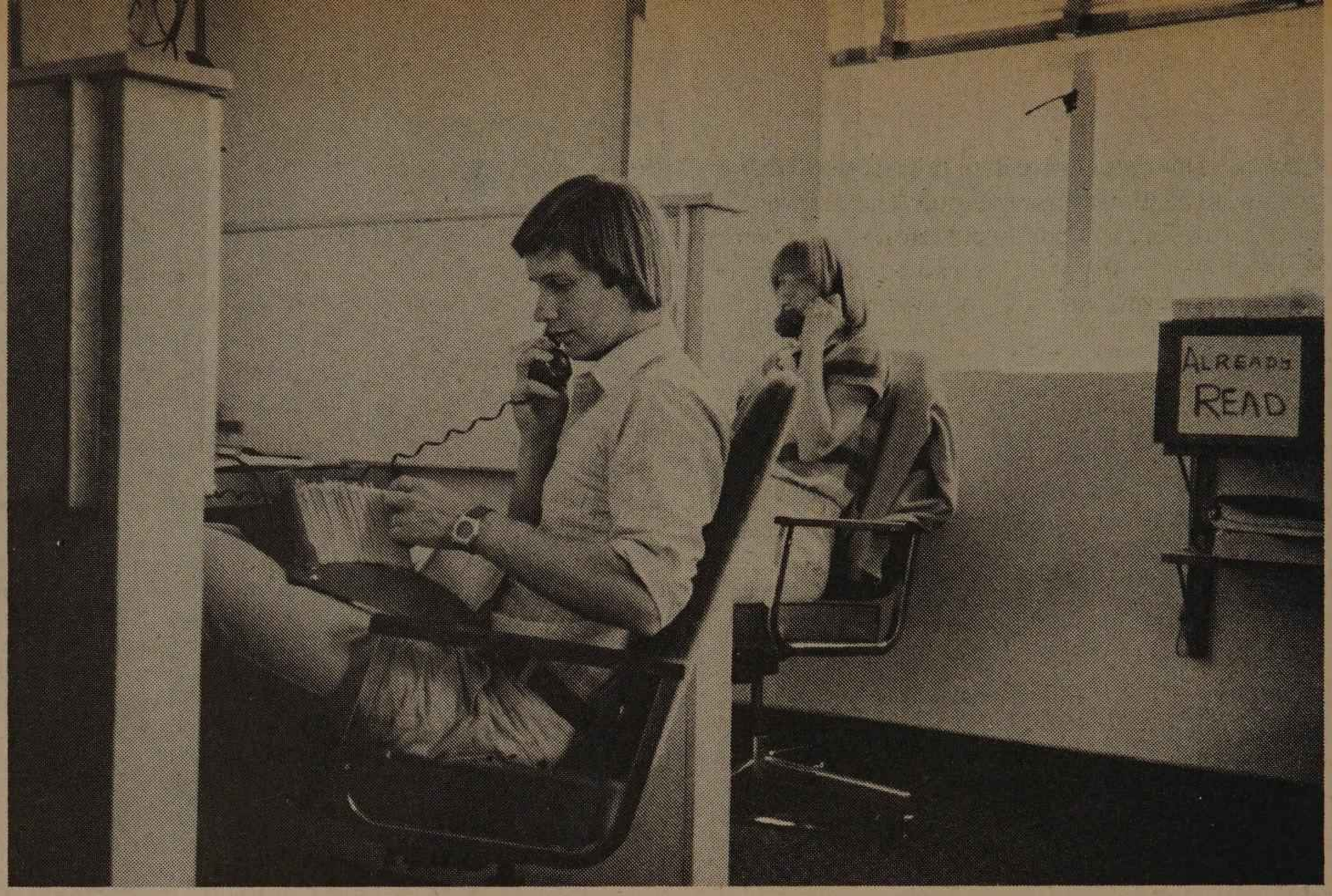
Please tell the children that I loved them always and that my love has never faltered. I grieve that I could not have had the joy of being close to our babies, but that is no one's fault. Thank God they are well -- with my passing all menace to their wellbeing will have disappeared.

I want you to know that I have a deep affection for you. I am deeply grateful for all your kindness. I wish I could have made a happier life for you. It was mostly my fault, please forgive me.

Please write to Fran and Tony and to Marilyn and Jim and tell them that my love and gratitude could not possibly be put into words. Their generosity, devotion, love and tact made it possible for me to accept their financial help over a long period of time. I wish with all my heart that they might have been better rewarded -- All of you, my dear ones, I ask to keep my memory alive in your hearts -- To live on in the hearts of our dear ones is all that I can conceive of immortality. Please think of me kindly. Remember that which was good and lovely in our relationship and forgive me for the many mistakes I have made. Now that it is all said I feel at peace.

I want Dr. B. to officiate at my funeral. I think Joe would like to have him with him at that time.

Dear David, I am sad that I must go just a few days before your birthday -- but it so happened to pan out. I see no good in incurring the expense and misery of the bronchoscopy. I wish I could spare you the ordeal you have ahead. Try not to grieve. I ask all of you, my dear ones, not to mourn my passing. Be glad I am at least free from the misery of the bronchoscopy. I wish I could spare you the ordeal you have ahead. Try not to grieve. I ask all of you, my dear ones, not to mourn my passing. Be glad I am at least free from the miseries and loneliness I have endured for so long and that at last I'll have peace and rest...



ART KLEINER

Two of the five telephone cubicles at the Marin Suicide Prevention Center. The volunteers shown responding to calls are, coincidentally, married to each other — Chris and Joyce Lieberman.

ages in chairs too small for them, and two instructors, the Center's Acting Director Noreen Dunnigan and the Program Director David Nolan. After a warning that statistics are misleading, Dunnigan jumped in.

"For every 100,000 people in the United States," she said, "an average of 12.5 attempt suicide each year. At this center we get 1200 calls a month, from 250 clients. Most people call more than once. Wednesday is our busiest day. ("It's the day most therapists take off," Nolan interrupted.) 80% of the people call about themselves; the rest are clergy, friends, family – calling because they're worried about someone. The later the hour, the higher the number of calls. 34% of the callers are male, 66% female. Can anybody guess why?"

"Men aren't as used to reaching out for help," said a man, the only black person in the room.

Dunnigan nodded and went on: "54% of the callers are not in a suicidal crisis. 46% have problems with alcohol or drugs. 35% live alone. Once every 50 hours, in what we call active intervention, we send someone in – an ambulance or friends, or clergy, or someone else goes over to their house because we ask them to."

"What do you mean by suicidal crisis?" asked a studious-looking woman. "You don't mean 46% are actually trying suicide?"

David Nolan replied. "No, the 54% are people who don't mention suicide at all. They have some other problem – loneliness, maybe – and they want somebody to talk to. 26% have suicidal ideation. They're thinking about it. 13% are threatening suicide. 6% are attempting it as we talk to them. The rest, we don't know about; the calls are too short or we don't find out."

Noreen Dunnigan gave some statistics from the Marin coroner's office about people who did kill themselves. "The highest rate of suicide is in May. We'll talk more about what happens to people in spring. The second highest is in January, just after the holidays. The older the person the higher the suicide rate. The average age for males is 41. The average for females is 45."

"That doesn't mean anyone was actually at those specific ages," Nolan said.

"There were 47 known suicides in Marin in 1980. (There are others we don't know about.) 34 were male. 13 were female. 14 people shot themselves. All but one of them were male. Six people died from car exhaust. Four jumped off the Golden Gate Bridge. The rest were drug overdoses."

Dunnigan described the established theories about why people commit suicide. Freud, for instance, thought most people have two basic instinctual drives – the wish to live (Eros) and the wish to die (Thanatos). Karl Menninger said a suicidal person acts out a wish to be killed ("I don't deserve to live"), a wish to kill someone else, or a wish to die. Old people usually fall into the latter category ("I can't go on."). Young people usually wish to die or be killed.

"There is also a need for attention," she said. "A lot of these people have worn out their family and

friends. The coroner's office tells us that they can usually tell most people didn't really want to die. According to their suicide notes, they wanted to be rescued. Anyone here can be suicidal given the right circumstances or the proper amount of stress.

"When someone calls, we assume they are ambivalent, no matter how suicidal they say they are. Otherwise, they wouldn't call. For myself I want the right to choose to live or die – for example, if I were terminally ill I don't know how I'd choose – but anyone who calls here will have a hell of a battle.

"They let us know that there's a glimmer of hope and that's the side we work with. We feel them out – we ask if they are thinking of killing themselves. We try to find alternatives – not giving them our alternatives, but asking them what they did the last time they felt this way, getting them to remember when they didn't feel this way."

About half the people in the room were taking notes. A woman in her twenties asked, "What do you say after you ask 'Are you thinking of killing yourself?' and they say 'Yes'?"

"Well, often the simplest response is that you don't want them to die. It's not easy. Dealing with suicidal people is usually unrewarding. They're the toughest for therapists, and in fact dealing with them makes some therapists become suicidal." A bearded man in his thirties nodded his head.

A teenage girl with glasses and short-cropped brown hair said, "You say to the person, 'I don't want you to die' and the person says 'Why?' What's your answer?"

"You say, 'I don't want you to die because I care about you."

"They go for that?"

"Yes, they do, if you're sincere." She paused. Nobody said anything. The girl looked dubious. "Have you ever cared about anyone who wanted to die and not been able to come up with a reason why they should go on living? Usually by the time I'm on the phone awhile I have a rapport going, and by that time I usually do have a reason that I care about them. A very intimate relationship builds up very quickly on the phone. Some of you may not be able to dredge up any feeling for some of your callers and in that case you shouldn't lie to them. They can spot a phony right away."

The girl still looked unconvinced, but nodded. Someone else asked, "What do you do with your emotions?"

"You talk to fellow counselors, you talk to staff," Noreen Dunnigan said. "You don't let any individual callers get into a personal relationship with you. In fact, any counselor who meets a caller outside of the Center is automatically suspended – not suspended – what's the other word for final?"

"Expelled," someone called out.

"Expelled. We don't use the word terminated here."

Laughter. More talk about what to say to people on the phone. "We want to explore their death fantasies and deglamorize them. How do you know there's a life hereafter? Have you known anyone who came back? You won't be able to see your own funeral, and show everyone you were serious. If you overdose you'll probably choke on your own vomit. Your bowels will go. Who's going to find you?

"Get used to saying, 'I want you to flush the pills away now,' instead of saying, 'Would you mind putting the pills away for us?' We want to assert ourselves. We ask, what will your children think when they find you? What kind of example would this be for your children as a way to solve problems? We use all the things we can think of and sometimes they sound manipulative. They are manipulative. We want to get the person through the crisis. We want them to take the gun away and put it on a shelf where they can't see it. Or put it out of the house, better yet.

"We find out what has given meaning to their lives. Has it always been this way? What was it like when it was not this way? Sometimes people say they've always felt this way. You say, 'Let's count back and see if that's true.' "

Single female, age 21

My dearest Andrew,

It seems as if I have been spending all my life apologizing to you for things that happened whether they were my fault or not.

I am enclosing your pin because I want you to think of what you took from me every time you see it.

I don't want you to think I would kill myself over you because you're not worth any emotion at all. It is what you cost me that hurts and nothing can replace it.

Single male, age 51

Sunday 4:45 PM Here goes

To who it may concern

Though I am about to kick the bucket I am as happy as ever. I am tired of this life so am going over to see the other side.

Good luck to all.

Benjamin P.

"But isn't that denying what they just said?" someone asked.

"No, you acknowledge their feeling but you want to do a reality test with them. 'It sounds like you've always felt this way but let's talk more about it.' "

"It sounds like you're trying to instill guilt."

"We don't want them to feel any worse than they already do. But often they haven't thought about everything. It's like tunnel vision. Usually it hasn't dawned on them who it will affect or what the long-range effects of their act will be. Once they realize it they often don't want the suicide to happen. They don't want to die; they want the pain to stop. People who are sure about killing themselves rarely call the suicide hotline."

TELEPHONE CRISIS HOTLINES didn't exist until 1958, when two Los Angeles psychologists stumbled across a bulging file of suicide notes in the coroner's office. Intrigued by the lack of research on rescuing or preventing suicides, they made themselves available for emergency consultation to suicidal patients. Soon it seemed like daytime hours weren't enough, so they set up a phone where patients could call day and night, and manned it with seven staff members. This was the first telephone crisis hotline of any kind, ever. After a few months the paid staff couldn't handle the number of calls, so the doctors trained volunteers.

By trial and error they worked out the principles that most suicide prevention work is based on now. Find out first how lethal a person's intentions are and defuse their plans as quickly as possible. Don't talk about how much there is to live for; ask the callers what their options are. Encourage callers to talk to a different counselor every time they call, so one doesn't get overloaded. Assume that because they called they are asking for help and you have a mandate to save their lives however you can, including tracing the call and sending the police.

Personally, I feel suicide prevention volunteers, like volunteer firemen, are among the truest altruistic community heroes we have. Telephone hotlines are probably the readiest and least manipulative escape valves available for the lonely or depressed. A lot of their value comes from the quality of the people who put in time on them. Most work six to eight hours a week, and the people I've talked to or heard about say they volunteer mainly because they like the other people who work there.

Some volunteers got their start with the drug abuse bad-trip hotlines of the sixties, and drug and suicide hotlines co-evolved, taking methods, enthusiasm, and staff people from each other. Other hotlines like poison control or sex information developed later from these.

The upper-echelon professional suicidology scene is more like an academic industry. Edward Shneidman and Norman Farberow, those two Los Angeles psychiatrists who started it all, have 13 books in print on the subject between them. Most are collections of essays by respectable social scientists. Farberow's latest, **The Many Faces of Suicide** (1980; $21.95 postpaid from McGraw-Hill Book Company, Princeton Road, Hightstown, NJ 08520), says that sky-diving, intervening in violent crimes, drunk driving, prostitution, gambling, and taking risks in general are all suicidal, and implies they can be treated psychiatrically.

In suicide prevention much of the training is learning to listen and react to people. You have to ask direct questions, like "What happened next?" instead of trying to smooth over bad feelings. You have to learn to keep someone who sounds apathetic about everything on the phone until you dredge up something they can get excited about. You have to find out what's going on at the other end – are the callers drinking? Have they abused a child? Are they calling so they can masturbate while they talk to you? – and you have to find out without making judgment about any of those things.

The end of every call is supposed to involve a contract. The caller agrees they will call again before they try suicide, or they will set a small goal for themselves, like writing a letter, and do it. Or they'll go for therapy. The exception is the six percent of people who commit suicide before or during the telephone call. They get the police and ambulance sent to their door.

"Someone calls up and says, 'I just took all these pills, and now I don't want to die' – that's easy," David Nolan said. "They're willing to give you their address. One counselor stays on the phone with them, the other calls for the emergency vehicles. It's a code 3 – lights and sirens – but we like them to turn them off when they get near the house.

"Other times a caller says, 'I just took 50 valiums and I'm drinking a quart of vodka and I want to talk to you while I die.' We don't do that. If we think a life is in danger, we take over. Getting them to tell us where they are depends on the skill of the counselor. 'I need to know where you are and I need to know right now. You are dying.' It's extremely eerie when a person is told he is dying.

"If we have to we will hold them on the line and trace the call. In Marin, tracing takes 30 minutes to two hours, so we usually don't do it. Other

places, we hear, are faster. Once it's traced, we tell the people that we are sending over an ambulance. (Not every suicide prevention center tells them, but it's our policy.) 'You called suicide prevention,' we say, 'and you're dying, and I'm sending you some help.' We ask them to turn on the lights and unlock the door. We don't break contact over the phone until the emergency people get there."

MARC RUBIN, A PARAMEDIC with the San Francisco Department of Public Health, heard I was doing this article and suggested I interview him. Until then it never occurred to me to interview any of the emergency people who are sent to the scene of a suicide. I didn't realize that they are probably more involved with the suicidal person than anyone else. They're the first people who comfort them, the only people who see where they live and what they did to themselves, and they seem to get a more vivid idea of the person's personality than anyone else, until they drop them off at the hospital and never see them again. Rubin talked like he had been storing up feelings for some time. He made me wonder if working in emergencies by nature makes people impassioned and articulate.

"Half my ambulance calls just involve going to a person's house, calming them down, recommending they go to a doctor in the morning. It's a 'give me strokes' kind of call. People just want to talk to somebody. If they call emergency and say they're contemplating suicide they are sent the ambulance and the police. If there's violence the police go first – they're paid to risk their lives. Then we take the people to the hospital.

"If you talk to the police and paramedics you find they feel many of these people should be allowed to die. We're bound by our jobs to make them live, but there's a lot of distaste for it. You never know if the suicidal person was distraught or made a rational decision. It's real hard to put a value judgment on it.

"We see a lot of alcoholics, gays, recently divorced or separated people, lonely people. People that I would characterize as emotionally vulnerable. We see them at the height of their vulnerability. We see some people who cut their wrists gingerly, knowing that it won't kill them, just to try it and see what it feels like. We see others who are serious about it, actively seeking it out but not sure if they're going to do it until the moment comes. Those are the ones we have to talk to as they're about to jump off a building.

"My last call of the shift last night was a man who shot himself. I got there and saw this girl cool in the doorway: 'I think my father's shot himself. Check downstairs.' His wife said, 'I didn't want him around any more and he shot himself.' He was Chilean. In some cultures in a situation like

Married male, age 48

Elaine Darling,

My mind -- always warped and twisted -- has reached the point where I can wait no longer -- I don't dare wait longer -- until there is the final twist and it snaps and I spend the rest of my life in some state run snake pit.

I am going out -- and I hope it is out -- Nirvanha, I think the Bhudaists (how do you spell Bhudaists?) call it which is the word for "nothing." That's as I have told you for years, is what I want. Imagine God playing a dirty trick on me like another life!!!

I've lived 47 years -- there aren't 47 days I would live over again if I could avoid it.

Let us, for a moment be sensible. I do not remember if the partnership agreement provides for a case like this -- but if it doesn't and I think it doesn't, I would much prefer -- I haven't time to make this a legal requirement -- but, I would much prefer that you, as executrix under my will, do not elect to participate in profits for 2 or 3 years or whatever it may be that is specified there. My partners have been generous with me while I worked with them. There is no reason why, under the circumstances of my withdrawal from the firm, they should pay anything more.

I could wish that I had, for my goodby kiss, a .38 police special with which I have made some good scores -- not records but at least made my mark. Instead, I have this black bitch -- bitch, if the word is not familiar to you -- but at least an honest one who will mean what she says.

The neighbors may think it's a motor backfire, but to me she will whisper -- "Rest - Sleep."

Albert

P.S. I think there is enough insurance to see Valerie through school, but if there isn't -- I am sure you would out of the insurance payments, at least --

I hope further and I don't insist that you have the ordinary decensy -- decency that is -- to do so -- Will you see Valerie through college -- she is the only one about whom I am concerned as this .38 whispers in my ear.

Married male, age 45

My darling,

May her guts rot in hell -- I loved her so much.

Henry

Divorced female, age 61

You cops will want to know why I did it, well, just let us say that I lived 61 years too many.

People have always put obstacles in my way. One of the great ones is leaving this world when you want to and have nothing to live for.

I am not insane. My mind was never more clear. It has been a long day. The motor got so hot it would not run so I just had to sit here and wait. The breaks were against me to the very last.

The sun is leaving the hill now so hope nothing else happens.

that they don't think the man's a jerk if he takes his life. It's the courageous thing to do.

"I like working on the street. People in emergency rooms get patients for a length of time, but I do my medical things and get them there and then I'm done. My role is medical intervention. I make sure they don't compromise their vital functions. That means checking their airway – listening for the movement of air through the mouth and nose – and their breathing rhythm – are their lungs expanding? And checking their heartbeat – is it fast enough? Is it stopped? If it's off you have to do cardio-pulmonary resuscitation, which involves pressing on the sternum and spine to get the heart going again. A lot of times if someone's lost fluid or if they're in shock we have to replace the fluid or blood intravenously.

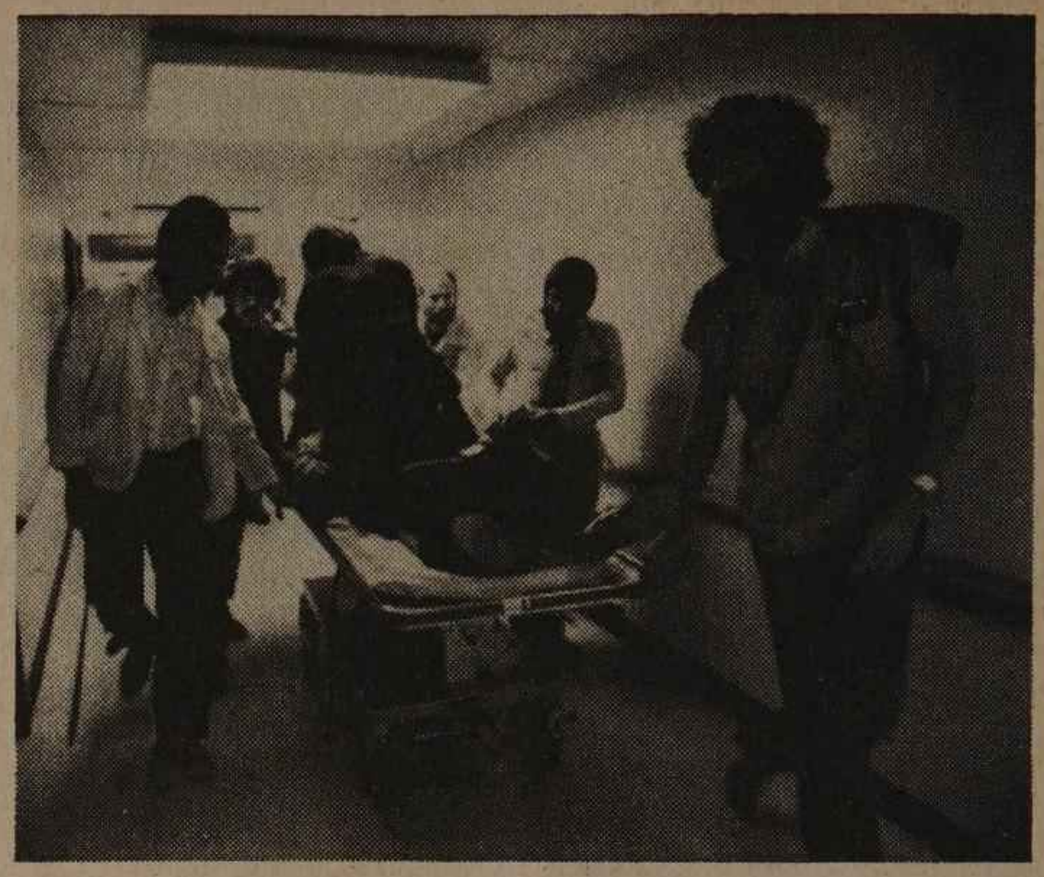
"If they're suicidal we are always required to take them to the emergency room. If they're conscious, say if I've just bandaged their arm, then as a courtesy I'll ask if they'll come to the hospital with us. If they're upset or say no, they'll still have to come, though.

"There are so many scenarios. Most of the time the police, medical people, and firemen are compassionate, but it's still scary. There are six or eight people in uniforms looking at this scared, vulnerable person. If everything goes well, they might even like giving up responsibility for themselves to the people in uniform. But otherwise, all it might take for them to go off the handle is for somebody to make a wisecrack – say if the patient's in drag. Or sometimes people get angry just because you're in a uniform. Then you have to talk them down.

"I stay professional a lot of the time – not cold, but impersonal. Then I move up or down from there to more or less professional in tone. Sometimes I'll talk to the person about why they did it, what their alternatives are. If they're hysterical I try to get them to talk about something they like to do. I'll talk about my own problems, real or contrived.

"Society doesn't support its losers. A theme I get repeatedly from suicides is 'Look at me, I've failed and I don't want to go seek help.' There's a lot of embarrassment. I tell them everybody needs help. A lot of people go to psychiatrists – doctors, police, politicians. I try to get them laughing. I don't myself but I try to get them to.

"I kind of enjoy it. As you know there are realms of thought under a psychedelic that you can't enter any other way. Psychosis is like that and that's why I appreciate it. I've sung things like quasi-Indian chants with people. I find that some policemen do the same. There's often a lesson that a psychotic person is offering me. Not to get too dependent on something – habits, jobs, people, money, family – that has let someone down. Or not to take myself too seriously. I think you have to be somewhat egocentric to attempt suicide. I ask the egocentric ones sometimes if the world is really going to care that much.



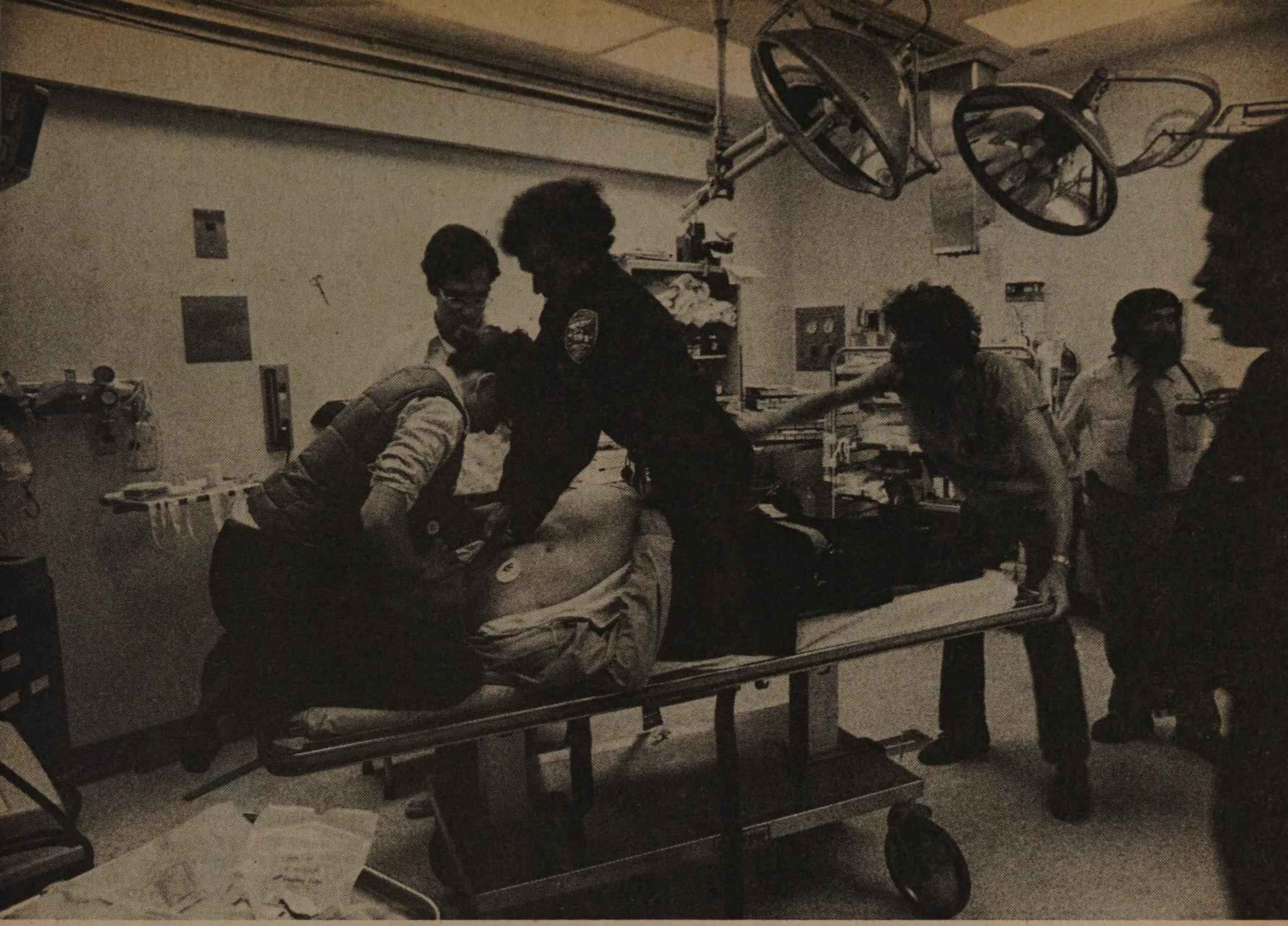
ROBERT FOOTHORAP

Though this patient at San Francisco General Hospital was not suicidal the scene is similar to what happens when a suicide attempter comes into the emergency room in a coma. The man on top of the patient's chest is a paramedic who has been doing cardiopulmonary rescuscitation (pumping his chest to get the heart going) all the way from inside the ambulance. The woman on top of the cart is trying to open the patient's airway. The room he has been wheeled to is one of the quick intensive care wards in the emergency room. (The attempts to revive this heart attack victim were unsuccessful.)

"There's a lot of voyeurism in it. I find that with a lot of medical people. They'll hear a hot call – a knifing, maybe – and really want to see it. Anytime you have a collection of fire and ambulance equipment, people gather on the street.

"A lot of people don't want to take the responsibility. A friend of mine had a call downtown – a man on a roof twenty stories high. She stayed up there talking with this man. Can you imagine how you'd feel if he said, 'No, no, you're wrong' and jumped off?

"That guy who shot himself in the head last night – I wouldn't feel comfortable trying to resuscitate him. He was warm but the chances of living were too low. If he had had any other signs of life – blood pressure, pulse, respirations – I would have had to do something. It's hard to do heroics to bring someone back to life for a day or two. I had a man a couple of months ago who had been shot in the head and I did resuscitate him. I felt



bad that he had the trauma of being slapped in an ambulance. Things like that you have to try to do – you have to try.

"The whole idea of trauma centers is to take people who would die otherwise and bring them back to life. Whether their life is meaningful or not doesn't matter. We go for everybody. You're usually naked when you go in. I can't put it down, but in a way it's barbaric. I wouldn't want to go through it. If I'm that close I'd just as soon let it go."

UNTIL RECENTLY, EMERGENCY room doctors were people who'd rather be elsewhere. Even now, a lot of emergency room doctors are moonlighting residents or specialists forced by their hospitals' rotating assignments to do occasional "trauma duty." But emergency medicine is becoming a specialty of its own, perhaps because four times as many people per capita visit emergency rooms as did twenty years ago. If someone you know is in danger of dying, call emergency services, not your family doctor, because that's what the emergency room does – keeps people from dying.

The basic principle for keeping suicides from dying is to do as little as possible. Most drug overdosers

Married male, age 74

What is a few short years to live in hell.
That is all I get around here.

No more I will pay the bills.

No more I will drive the car.

No more I will wash, iron, & mend any clothes.

No more I will have to eat the leftover articles that was cooked the day before.

This is no way to live.

Either is it any way to die.

Her grub I can not eat.

At night I can not sleep.

I married the wrong nag-nag-nag and I lost my life.

W.S.

to the undertaker

We have got plenty money to give me a decent burial. Don't let my wife kid you by saying she has not got any money.

Give this note to the cops.

Give me liberty or give me death.

W.S.

are left unconscious in a place where they can heal. The more the hospital has to do, the more chance of infection or accident. Drugs, including psychiatric drugs, are avoided, because they might react with drugs the patient already took. Before the 1940s, when Swedish doctors discovered this, about 45% of the barbiturate overdose patients in emergency rooms died from attempts to wake them up with drugs. Now more than 95% of people who come into the emergency room on a drug overdose live. Many suffer no more than a day or week of discomfort in a hospital bed, like a teenager I heard about who tried to kill himself with 100 vitamin tablets. Others compound their problems with severe medical damage that may be permanent or take years to go away.

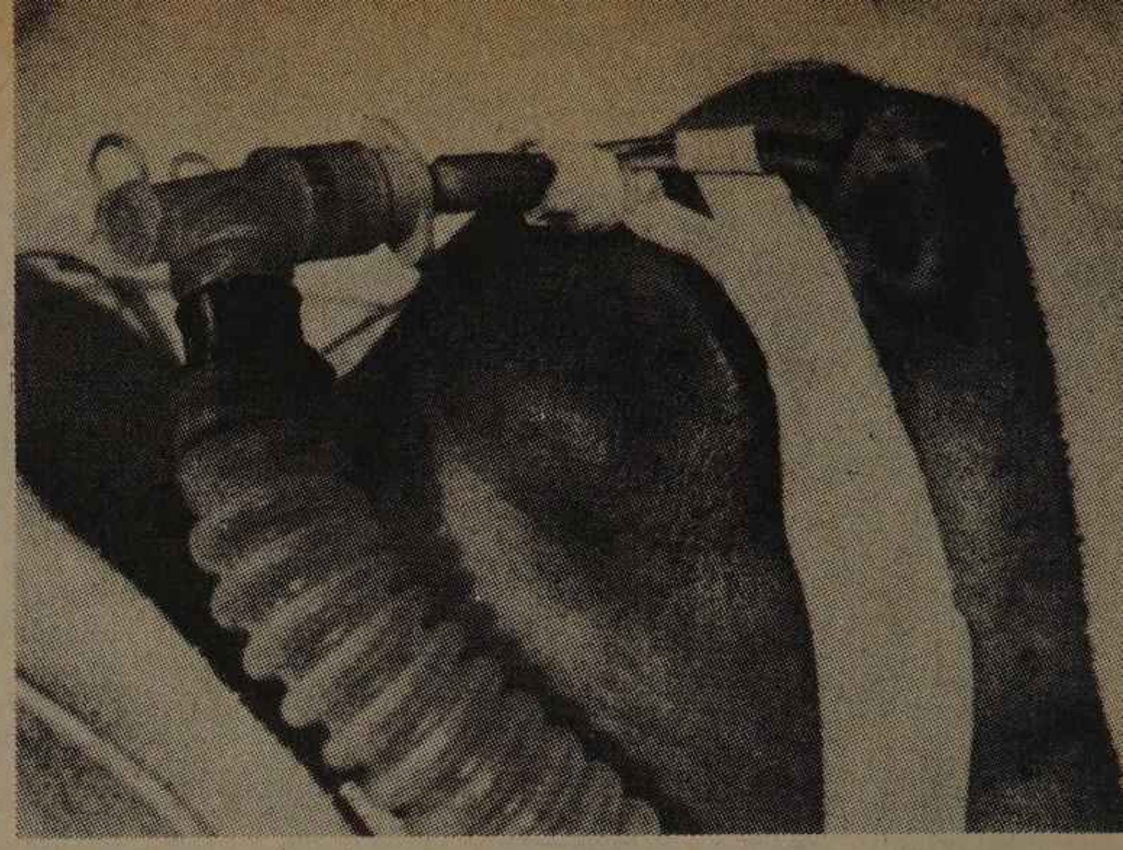
My information on the medical aftermath of suicide comes from half a dozen interviews with emergency room staff people, but two were especially helpful – Larry Bedard, M.D., a former psychiatric resident who now manages the emergency room at Marin General Hospital, San Rafael, and Howard McKinney, Pharm. D., a pharmacologist with the San Francisco Poison Control Center, who answers telephone inquiries and consults with emergency room staff. Like other emergency room staff people I talked to about this article, both these men are among the most thoughtful, direct people I have met.

This is not an exhaustive survey; anything less than a medical textbook is bound to be sketchy, misleading in places, and oversimplified.*

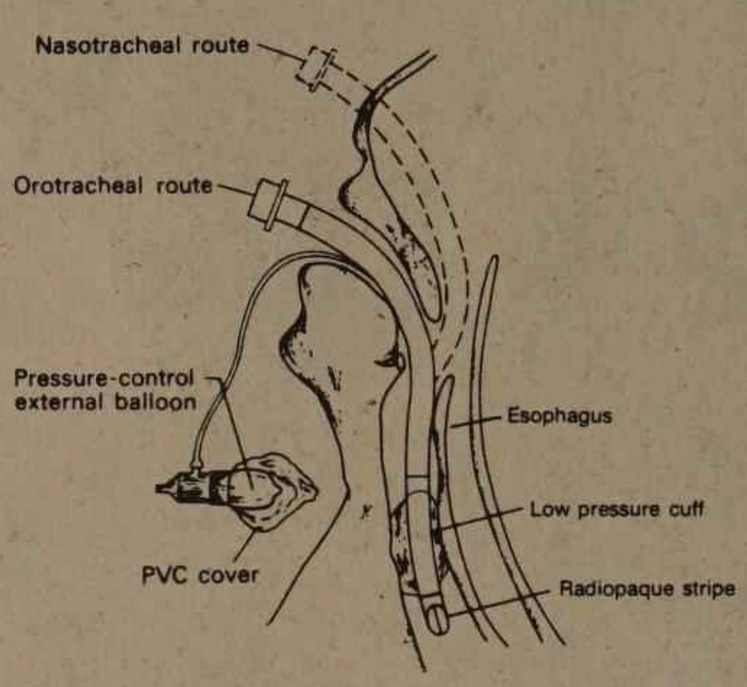
Most suicides are drug overdoses, and many drug overdose patients reach the hospital in a coma. The danger in all drug overdoses is that the brain may not get enough oxygen. The airway to the lungs may get blocked off by the patient's vomit, or by the tongue falling back into the throat, or by drug-induced slowdown in the part of the deep brain that controls the rate and depth of breathing. Or the heart may seize and fibrillate – all the heart muscle fibers quiver, but none in rhythm with each other. The blood doesn't move, so it doesn't take oxygen to the brain or carry away waste.

It only takes three to five minutes without oxygen to do permanent damage to the brain, starting at its most sophisticated sections. The memory is destroyed; the ability to read or speak is cut back. The longer it goes on, the more severe the retardation. So any poisoned patient is constantly monitored to make sure they can breathe and their heart is beating. If they can't breathe, they are intubated. A physician slides a tube down their mouth or nose, through their throat, into their lungs for air to pass through.

Drug overdose patients are usually given sugar (in case they have low blood sugar), thiamine (which might have been depleted from the blood by alcohol) and Narcan, an antidote for opiates. They're given because the deficiencies or drug effects they correct are hard to spot right away and can be quickly lethal. Compared to the very few other antidotes that exist, these are considered low-risk. Patients are often given Ipecac, which makes them vomit. Then they are given activated charcoal, which looks like gruel and soaks up some of the poison in the intestines before coming out in diarrhea induced by a cathartic, magnesium citrate. The cathartic also increases the rapidity with which the poison goes through the intestines, thus cutting down the amount absorbed by the body.



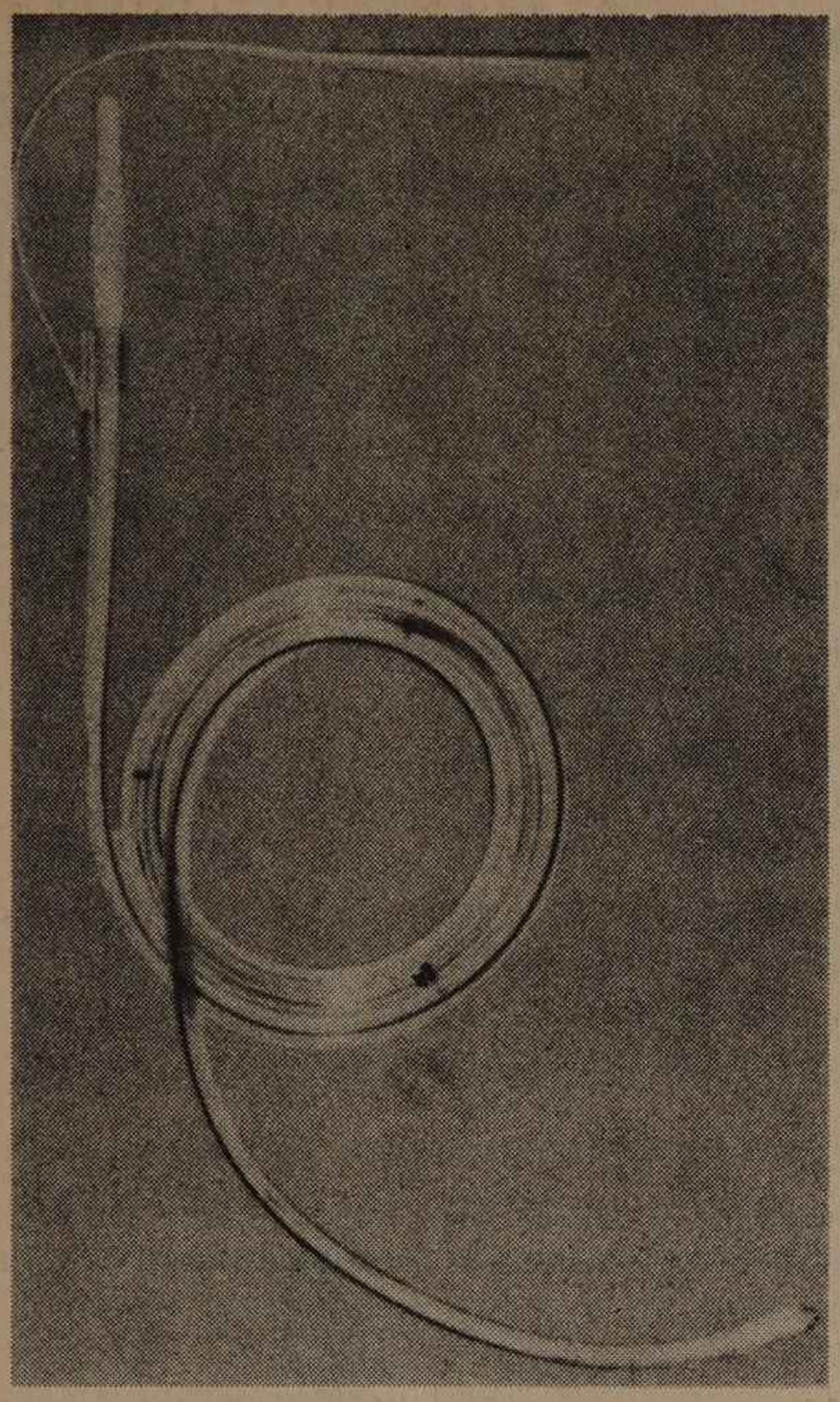
PULMONARY EMERGENCIES



MOSBY'S MANUAL OF CLINICAL PROCEDURES

Drug overdoses can cause inability to breathe, which in turn can cause brain damage. The immediate remedy, intubation, involves running an endotracheal tube through a patient's nose or mouth to their lungs — thus clearing an airway. The photo shows a "properly secured ET tube"; the diagram shows the path the tube takes down to the lungs.

*Some books in **The Next Whole Earth Catalog** which I found useful for information are **Licit and Illicit Drugs** (p. 579), **The Essential Guide to Prescription Drugs** (p. 326), and the emergency medicine textbooks reviewed on p. 311. A good book to browse in for the technical story of drug effects on people (along with anything else in pharmacology) is the classic medical text **Pharmacological Basis of Therapeutics** (Louis S. Goodman and Alfred Gilman, Editors; 1941, 1980; $45 postpaid from McGraw-Hill Book Company, Princeton Road, Hightstown, NJ 08520). A good emergency room guide with illustrations is **Atlas of Diagnostic and Therapeutic Procedures for Emergency Personnel** by James H. Cosgriff, Jr. (1978; $26 postpaid from J.P. Lippincott Company, Keystone Industrial Park, Scranton, PA 18512).



The Salem sump tube, one of the several types that are passed down a patient's esophagus in gastric lavage, or "stomach pumping." The process is usually used only with patients in comas or conscious suicidal patients who are being "punished."

Married male, age 45

Dear Claudia,

You win, I can't take it any longer, I know you have been waiting for this to happen. I hope it makes you very happy, this is not an easy thing to do, but I've got to the point where there is nothing to live for, a little bit of kindness from you would of made everything so different, but all that ever interested you was the dollar.

It is pretty hard for me to do anything when you are so greedy even with this house you couldn't even be fair with that, well it's all yours now and you won't have to see the Lawyer anymore.

I wish you would give my personal things to Danny, you couldn't get much from selling them anyway, you still have my insurance, it isn't much but it will be enough to take care of my debts and still have a few bucks left.

You always told me that I was the one that made Sharon take her life, in fact you said I killed her, but you know down deep in your heart it was you that made her do what she did, and now you have two deaths to your credit, it should make you feel very proud.

Good By Kid

P.S. Disregard all the mean things I've said in this letter, I have said a lot of things to you I didn't really mean and I hope you get well and wish you the best of everything.

Cathy -- don't come in.

Call your mother, she will know what to do.

Love Daddy

Cathy don't go in the bedroom.

If the patient is in a coma a tube may be run through the nose or mouth and passed bit by bit down the esophagus into the stomach. A saline solution flows through it into the stomach, and then is sucked back through the tube with some of the poison. Emergency room staff call this "lavage"; on the street it's known as getting your stomach pumped.

"If you come in awake and alert you should not have your stomach washed out," Bedard said. "But some doctors and nurses don't like to take care of overdoses. They feel like suicidal people should be punished, so they stick a tube down. It's not pleasant – the tube is about the size of your thumb. Most people feel like they're choking to death."

The two most common types of drugs in suicides, McKinney said, are those found around the house and those used in psychotherapy. Seemingly innocent aspirin is "one of the messiest, most complicated overdoses you ever hope to see," he said. People who swallow lots of aspirin react first by getting sick to their stomachs. Beyond that, it affects nearly every system in the body unpredictably, and two different people who took 100 aspirins could get sick in completely different ways.

Aspirin is an acid. It burns the gastrointestinal tract from the inside. It changes the blood's pH level, which is normally at 7.4 (close to neutral). It sometimes makes the blood acidic, but it also accelerates the brain's breathing control center, which puffs out carbon dioxide twice as fast as it normally would, and thus makes the blood alkaline. Either way, it throws off the metabolic balance among kidney, lung, and blood. "It produces fever," McKinney said. "The fever, in turn, if it goes on long enough to overheat the brain, can cause seizures. You can burn out parts of your nervous system." Aspirin also carries a high risk of gastric hemorrhage. Occasionally people on aspirin overdoses become deaf or develop a ringing in their ears that doesn't go away.

The pain-reliever acetaminophen, sold as Tylenol, also makes people sick to their stomachs at first, but then gets more deadly. The drug changes into toxic particles that are usually neutralized by glutathione, one type of coenzyme found in the liver. In overdose, if it isn't pumped out in time, the toxic particles deplete all the glutathione, causing the painful death of an hepatic coma. Even relatively late in the process surrogate glutathione can save the liver, but if the organ

does become diseased the results can be similar to those of hepatitis: jaundice, itchy skin, depression, long-term listlessness, inability to eat much.

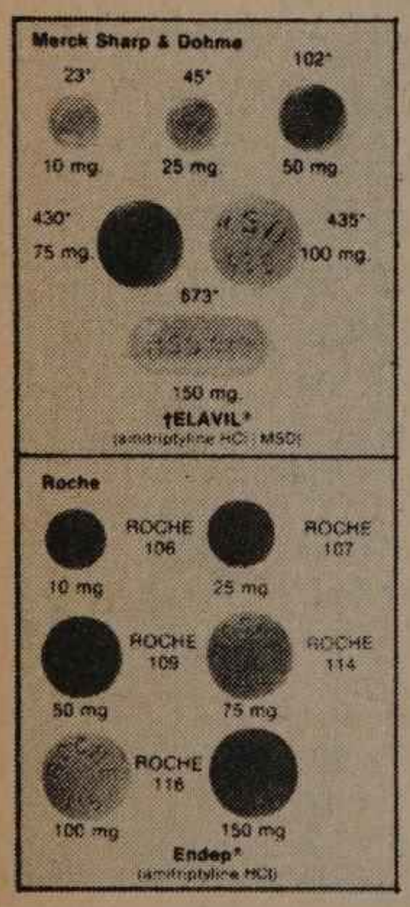
"The liver detoxifies poisons that build up in the body," McKinney said. "If you destroy the liver it's like never taking the garbage out. Specifically the most common build up is ammonia in the blood, which you know if it goes too far will put you in a very deep coma, and then kill you."

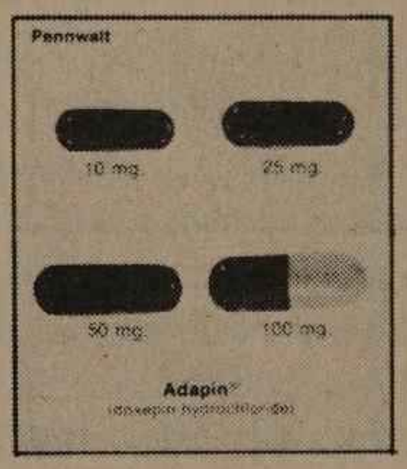
Both McKinney and Bedard told me about people who took Tylenol or phosphorus, which also destroys the liver (and incidentally produces phosphorescent vomit). In both cases, they slept off the initial sickness, and recovered for five days – during which time they decided suicide was a mistake after all, and they wanted to live. But the liver had been destroyed, and after five days each of them started to feel very sick, passed into deep coma, and died. "He knew it would happen, and that there was nothing we could do about it," Bedard said, "and his friends and family knew it, and for five days they sat in the hospital together waiting for it."

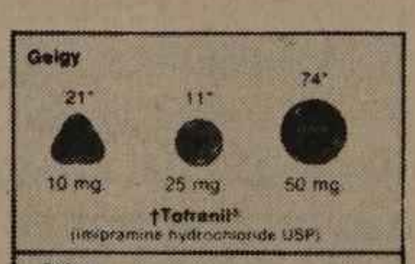
Probably the most painful form of suicide attempt, whether or not it ends in death, is swallowing lye, Drano, oven cleaner, and other household caustics. Most of us know how painful these are because scare stories have been passed down in household lore from 100 years ago, when caustics were the preferred suicide method. Unlike suicides today, who visualize themselves slipping off into oblivion, people who killed themselves in the 19th century expected to suffer along the way.

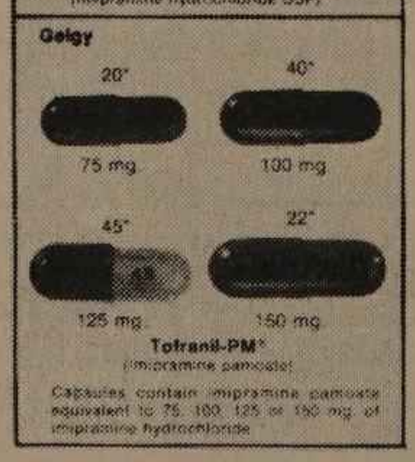
"Very few people that ingest caustics die," McKinney said. "If they do die, it's days, weeks, or even months later, of infection. I'm pretty immune to most gore, but I draw the line at the burn unit." Caustics scar the mouth and tongue, puncture holes in the esophagus, burn the chest from the inside and block the gastrointestinal tract with scar tissue. Even the process of treating inner burns is painful; surgeons drop an endoscope, or fiber-optic camera, down the person's throat, unavoidably scraping it against the raw nerves there, to see what the damage is. Repairing an inner burn can take 15 or 20 years worth of surgical operations, plus fluid therapy and antibiotics to keep infections from growing. Swallowing can be painful for the rest of a person's life, and some survivors of such attempts have to be fed intravenously for years afterwards.

Psychiatric drugs – phenothiazines like Thorazine or Haldol, tricyclic antidepressants like Elavil – cause what are probably the most morally offensive overdose cases. "It's a built-in irony," McKinney said. "The very population of patients currently under therapy to supposedly avoid suicide are often handed enormous quantities of medication. You might as well give the guy a gun. Except for child abuse, nothing outrages the emergency room staff as much as when someone comes in with an overdose on Thorazine and you go through their pockets and see the same doctor has prescribed

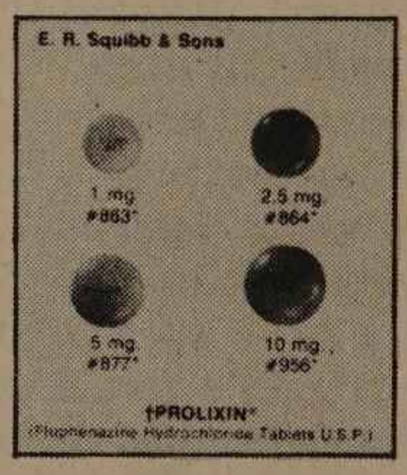


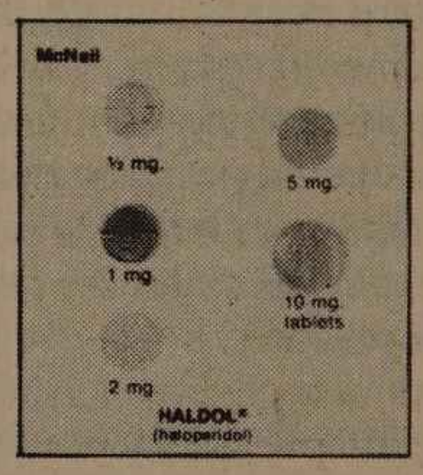


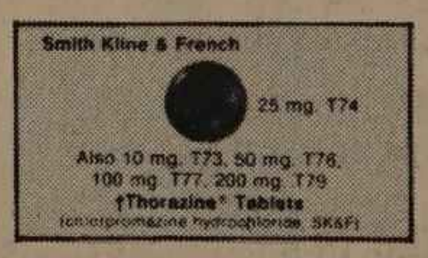


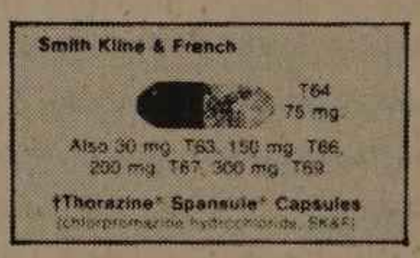


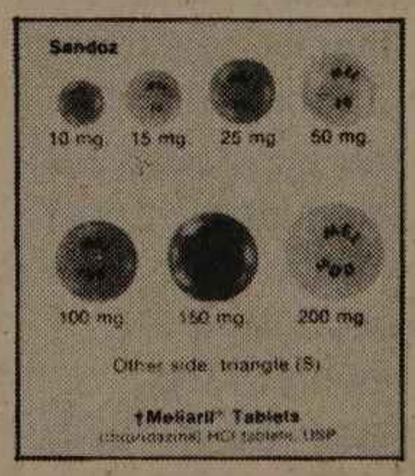
Some common tricyclic antidepressants or "mood elevators," a type of psychiatric drug often found in suicidal overdoses. Symptoms of overdose: "Dry mouth, blurred vision, bladder paralysis, coma vigil (light, arousable coma; may be interrupted by myoclonic convulsions and epileptic states), severe sweating, hyperpyrexia (high fever), cardiovascular conduction and rhythm disturbances. . ." All drug pictures and quotes are from Psychotropic Drugs **(Manual for Emergency Management of Overdosage) by Nathan Kline, M.D. and Jean-Pierre Lindenmayer, M.D. (1974, 1981; $15.95 postpaid from Medical Economics Company, Book Division, Oradell, NJ 07649).**











Some phenothiazines or major tranquilizers, a type of drug used to calm down upset; disturbed or unruly psychiatric patients. In overdose: "Drowsiness, disorientation, dry mouth, blurred or double vision, hyperactive tendon reflexes, parkinsonism (tremors, various degrees of rigidity, motor retardation, excessive salivation), dystonia and dyskinesia (tics, perioral spasms, drooling), akathisia (motor restlessness, inability to keep still, compulsion to be on the move), convulsions, bladder or bowel paralysis."

three or four hundred tablets in a two-week period. Those are the doctors who get a phone call at three a.m. saying, 'You better get down here now and see your patient.' " (Hardly ever does the psychiatrist show up, McKinney and other doctors told me; it's more common for the answering service to find out who's calling and why and then say the psychiatrist is out of town.)

"Tricyclic antidepressant patients are in a particular high-risk situation," McKinney said. "Typically a person is depressed over a long time; he goes to a psychiatrist and after some psych workshop procedures it's decided he needs an antidepressant. Classically, Elavil is prescribed. Elavil takes three to eight weeks to work, and an average of four weeks. The person may not be told clearly enough or may not want to hear that the drug takes a long time. Two weeks later he bolts upright and says, 'This is the biggest crock of shit,' and swallows the rest of them."

The phenothiazines, or major tranquilizers, are used to calm down psychosis or extreme anxiety. The tricyclic antidepressants are chemical mood elevators. Both work by somehow altering the minute bursts of chemicals which neurons send across the synapses, or gaps between nerves, to carry impulses from one nerve to another.

Because they affect the nervous system which in turn reacts with every other system in the body, psychiatric drugs have lots of side-effects – dilated pupils, dry mouth, feverishness, speeded-up heartrate, slowed down digestive muscles, breakdowns in coordination, rolling eyes. Overdose can accelerate these in any part of the body. I once met a man whose hand muscles had contracted violently after a phenothiazine overdose, leaving his fingers permanently warped. Tardive dyskinesia, a Parkinson's Disease-like condition caused in some patients by long-term use of the drugs, can be accelerated by an overdose. Probably the most common permanent damage from overdose is brain damage, caused by seizures and fibrillation.

The exotic drugs of mystery novels, strychnine and cyanide, are painful and deadly but rarely show up in emergency rooms. What shows up all the time are sleeping pills and mood pills – the sedative hypnotics – barbiturates like Seconal, mild tranquilizers like Valium. Typically, a sedative overdose will do nothing more than put you

Married female, age 50

When a "man" doesn't know where to take his wife -- then she isn't a wife any more --

I hope you will be "free" to take anyone any place and I'm sure you will not have any trouble as to places --

Please don't tell my mother the truth -- your whole tribe is partly responsible for this -- from your mother on down -- hope they are satisfied.

Married female, age 56

About the Evil god (yes)

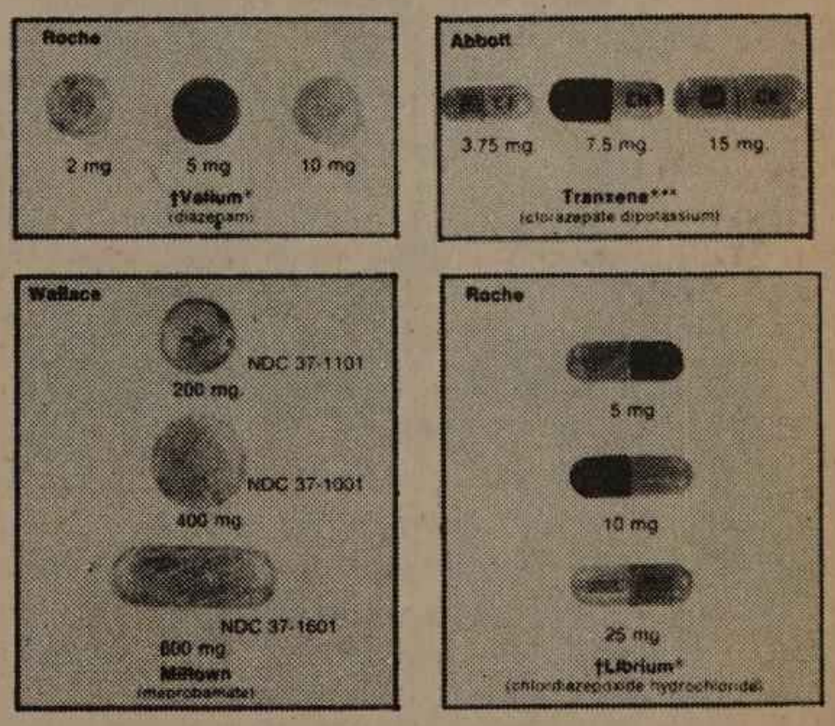
About the Evil Seers killing people for their money (yes)

I am a profit at my death

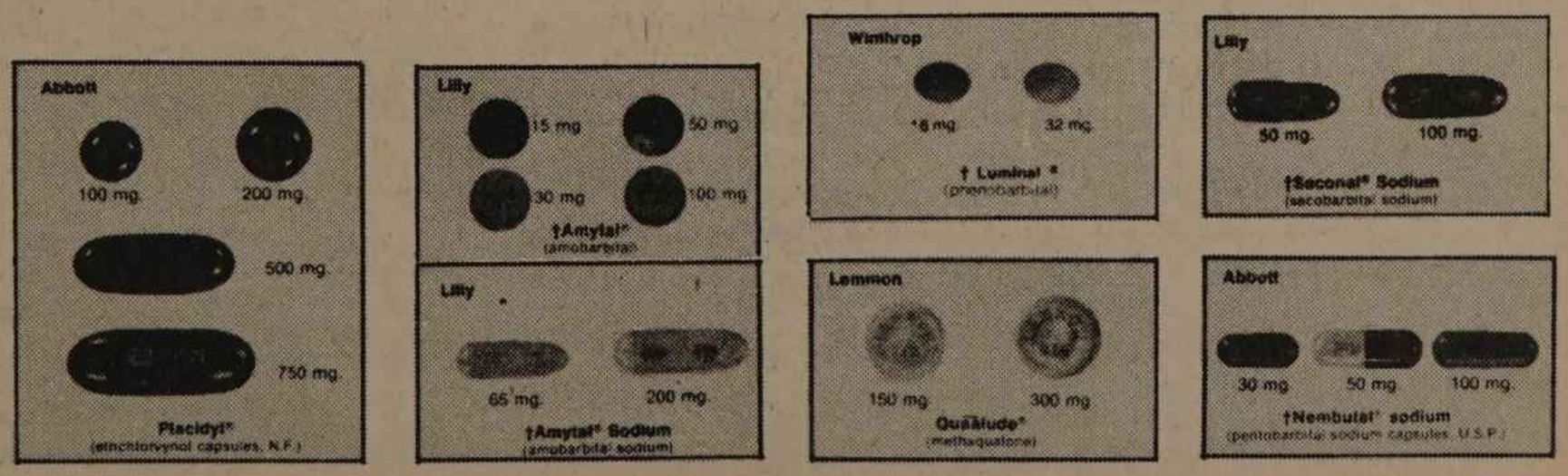
I am a root of the stem of Jesse (yes)

We have made many discoveries. We have found out who the people with the mark of the beast are. And the devil was a human being now killed and cast into hell and the angel with the keys of the bottomless pit is in hell casting out all the good souls which these evil people have cast into hell for no reason. The good Seers who serve our God are 1/3 to 2/3 of the evil ones in this world. We are better than holding our owne but in Heaven God is almost over come and I kill myself so I may go and help him, because I have a funny little quirk in my brain which helps.

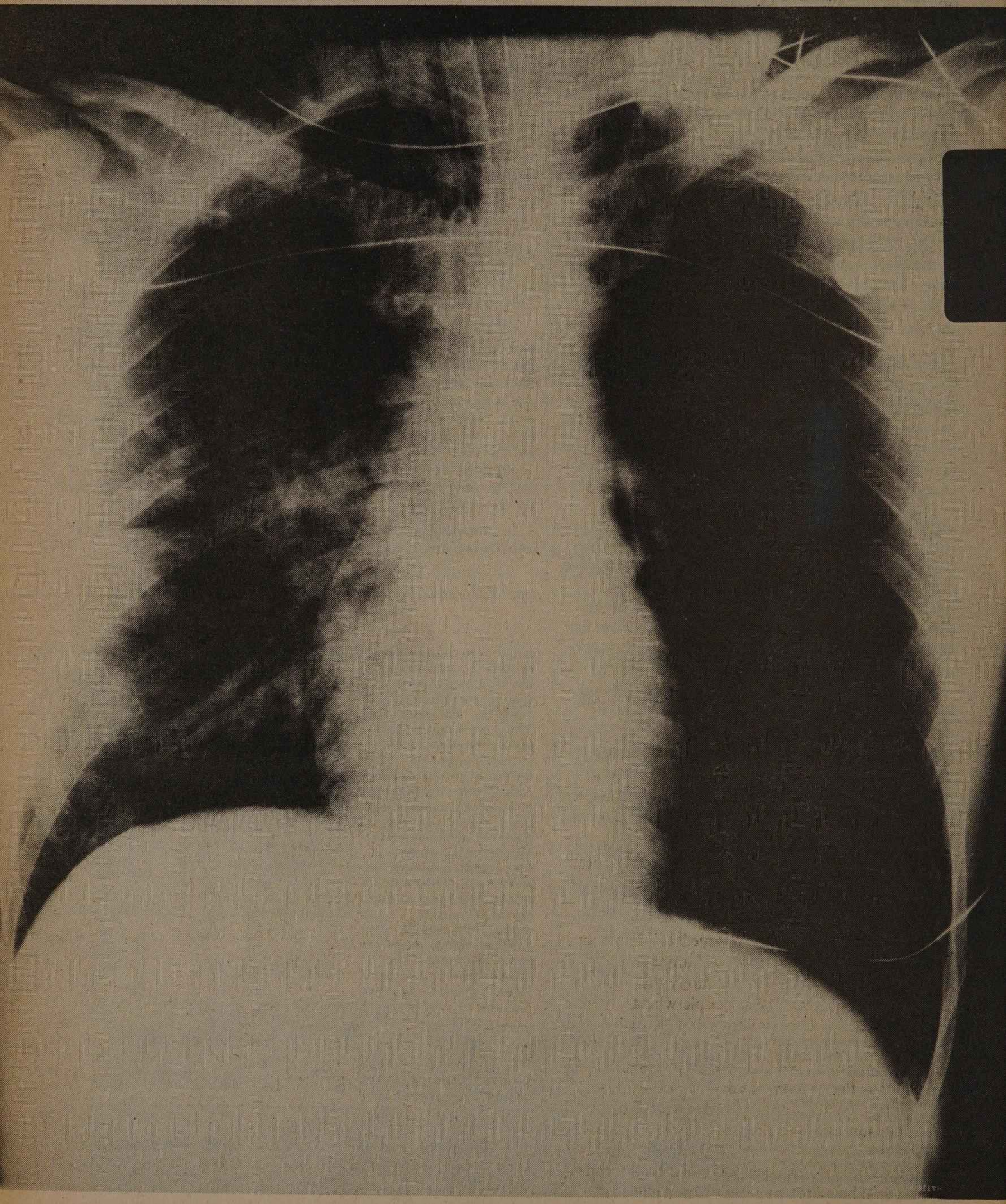
6 palmy each at a few years sport. Our god will send them into the world.

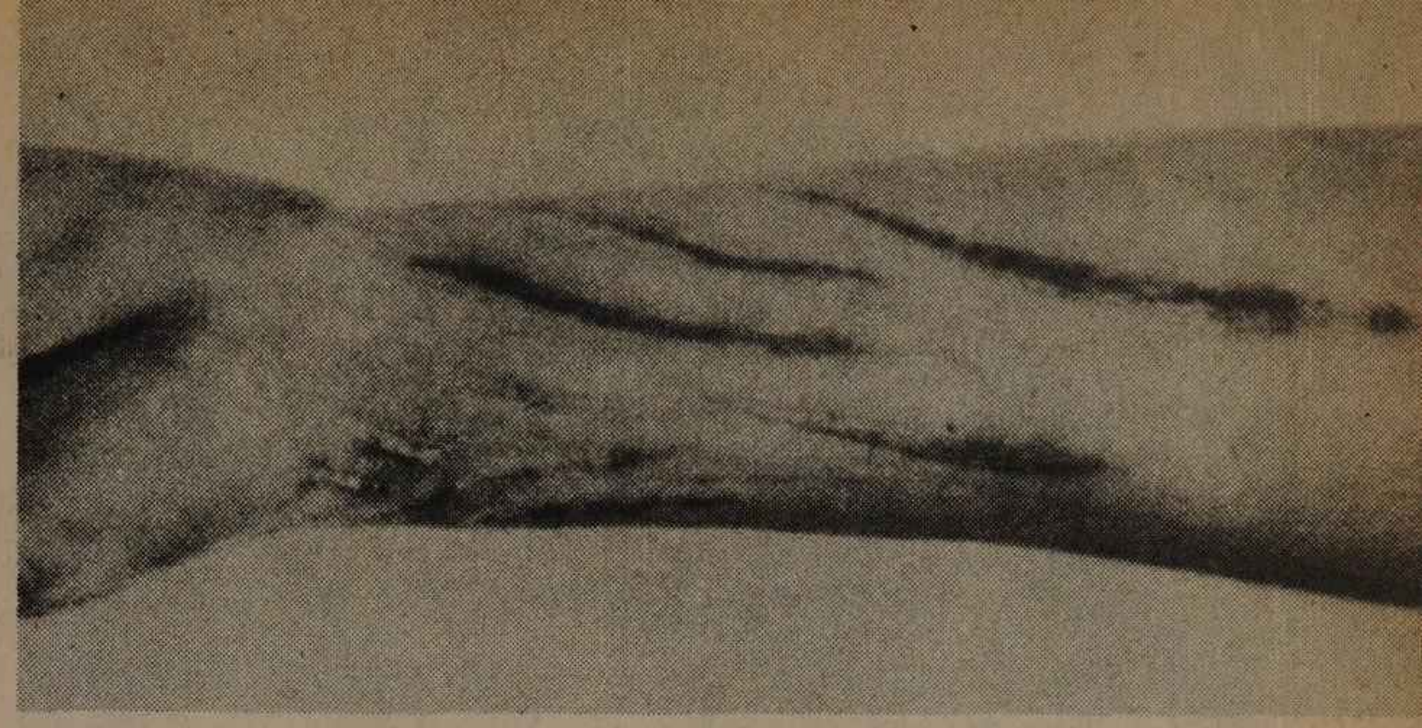


Some mild tranquilizers or "anti-anxiety drugs," the kind often found around the house. In overdose: "Drowsiness, nystagmus (rapid, involuntary movement of eyeball), weakness, lassitude, muscle relaxation, tintinnitus (ringing or buzzing noise in ears), mental confusion, hallucinations, hyperactivity, convulsions in some cases, hypotension/shock, coma with cyanosis (a bluish coloration of the skin caused by lack of oxygen), rapid, weak pulse, respiratory depression."



A few of the many brands of barbiturates and sedative/hypnotics. In overdose: "Slow, shallow respirations, disorientation, unsteadiness of gait, deep coma, flaccid muscles, shock; there always is a possibility of pneumonia associated with lung congestion of any duration."





A chest X-ray of someone who came into a large city hospital unconscious and aspirating after a drug overdose. The X-ray looks into his front, so the lung on our left is actually the patient's right lung. That's where the trouble is. What looks like grey and white bubbles floating inside is vomit that dripped down from his throat. His left lung (on our right) is comparatively clean. In a normal X-ray both sides would look like that. At the top of the throat is the bronchial tube through which they are trying to help him breathe. The sharp white dots (electrocardiogram probes) and the thing that looks like a telephone cord (part of the intubation machine) are both outside his body.

I saw this man. He had been running a 106 degree fever for more than a day when this picture was taken and his rib cage jerked spasmodically every time he tried to take a breath. His eyes stayed half-open. They expected him to die. But he was still alive, in the same state, two weeks later. It's doubtful he will ever be conscious again. If he stays alive like this he'll be transferred to a chronic ward in a mental hospital. —Art Kleiner

The scars of a young woman who cut herself on the wrist. "Intensive individual case work suggests that self-laceration may involve an altered state of consciousness akin to a dissociative state. . . . There may be no experience of pain until after the event when there is subjective relief of tension mixed with feelings of disgust and regret at what has happened." —Picture and quote from the clinical psychiatry text **Death Wishes?** by H.G. Morgan (1979; John Wiley and Sons).

to sleep for a day or two, and leave you with a bad hangover and a case of the slows when you wake up. But like many other overdoses, sedatives are often taken with alcohol, which makes people nauseous. Anyone who vomits when they're passed out risks sucking some of the vomit into their lungs, which is called aspiration.

It's as dangerous as it sounds disgusting. Vomit contains enzymes from the stomach that destroy tissue, and those go to work on the lung walls. It also contains a rich broth of food, perfect for pneumonia bugs to grow in. People can also drown in vomit, which keeps air from getting to the brain, which once again causes brain damage. An aspirating patient goes into intensive care; a device called a bronchoscope is used to look into their lungs and pull out whatever pieces of vomit it can.

Drug overdoses are always unpredictable. The drugs react with other drugs people take at the time, with alcohol, with odd allergies and drugs lingering around in the bloodstream from years before. "One fellow took four cold tablets," McKinney said, "and went to an emergency room complaining of a headache. He blew the blood vessels behind one of his eyes out."

Violent death is so often portrayed as sudden and painless, but the human body is harder to kill than it seems. For instance, people rarely die from slashing their wrists. "Most people who try it aren't really suicidal," Bedard said. "Usually it's a cry for help. A few want to see what it feels like to cut themselves. We just sew them up and call in the psychiatrist." Even if you cut your artery, which most people don't, it's hard to bleed to death because the bleeding stops on its own unless the cut is extremely severe. Popular wisdom says sitting in hot water makes you bleed faster, but Bedard said he's known people who tried it,

Single male, age 13

I know what I am doing. Annette found out. Ask Cara. I love you all.

Bill

Widowed female, age 52 (Her husband died three months before.)

Please tell Ron's folks I love them very much but my heart breaks when I see or hear from them. Also all our friends especially Irene and Charles and Ella I love them also. Forgive me for not seeing them.

Everyone seems so happy and I am so alone. Amy. I wanted to visit you but I am going around in a dream. Alice I wanted to help you paint but how could I with a broken heart. And my head aches so much any more my nerves are ready to break and what would happen if they they did.

You will say I am crazy and I can't go on this way just half living.

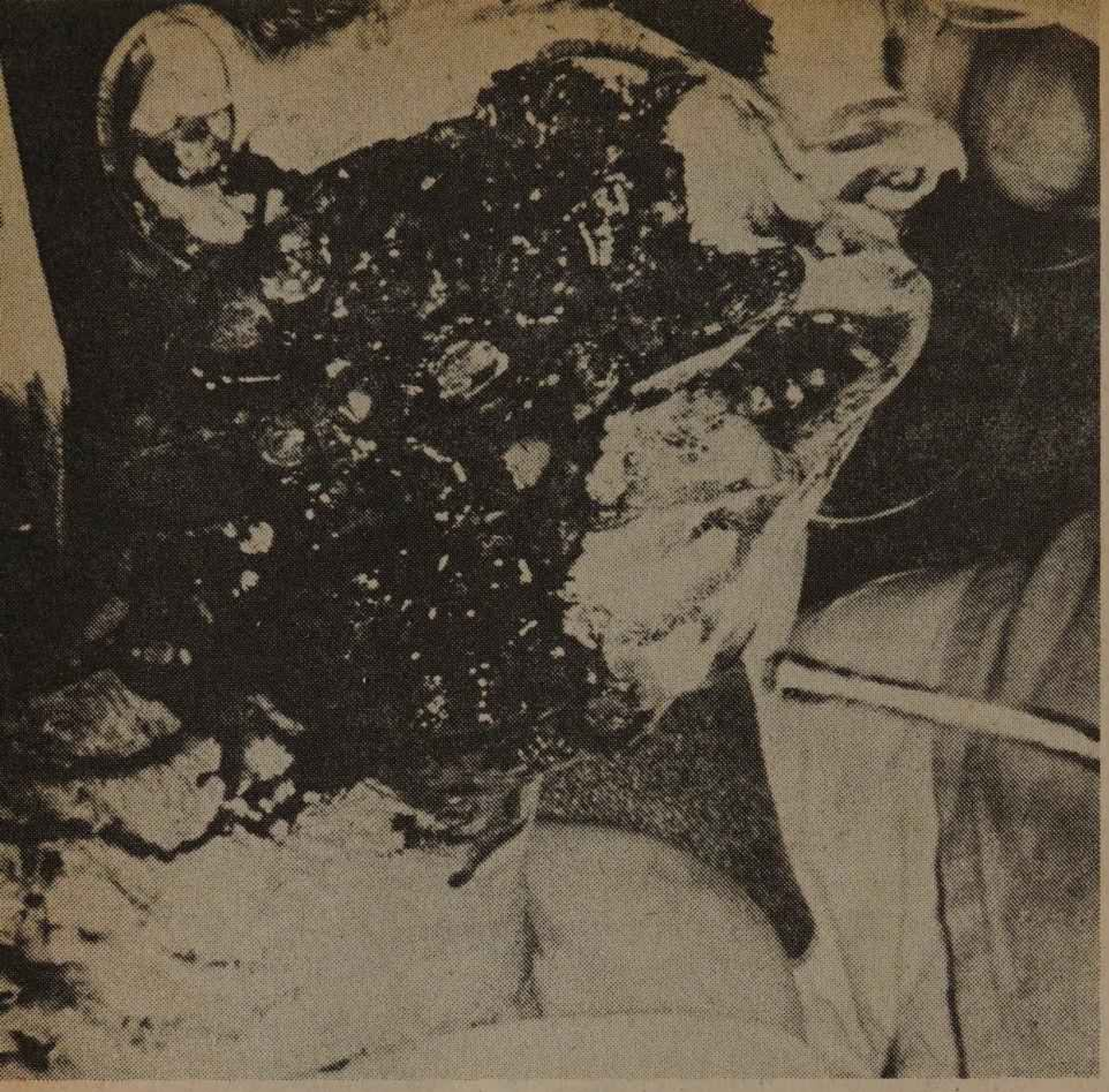
I loved this house once but now it is so full of memories I can't stay here. I have tried to think of some way to go on but can't. Am so nervous all the time -- I loved Ron too much but is that a sin, with him gone I have nothing. Oh I have the girls and family but they don't fill the vacant spot left in my heart ...

Xmas is coming I can't go on I'm afraid I would break down. I've thought of this so many times. I love every one but I can't be one of you any more. Please think kindly of me and forgive me. I only hope this is fatal then I can rest and no more trouble to any one. Do with Lisa whats best I know she has been a lot of worry to mama and I'm sorry. I tried to keep the yard up that seemed to be the only comfort I had. I loved it but that wasn't anything. I've lost every thing so why go on. I worshipped Ron and when he went I lost my whole world and everything.

I'm so tired and lonely.

There goes a siren. Oh how can I stand being left. I need to go to a Dr. but I am afraid. I'm so cold.

Mother Love, Louise



A 1980 gunshot suicide attempt that failed. This woman held a rifle to her ear, but pressure on the trigger pulled the rifle forward, so the bullet went through her jaw instead. "This is not uncommon in gunshot suicide attempts," said the anonymous doctor who gave us the photograph.

passed out, and woke up in a bathtub full of cold bloody water.

"But it's an easy way to hurt yourself," he said. "You can damage the tendons and median nerve which control the muscles of your hand. People end up with claw hands. Lots of times, with microsurgery, that can be repaired, but it means six to twelve months out of your life, and you still end up with a weak or deformed hand."

The few people who cut their throats also rarely die. "They often cut the recurrent laryngeal nerve," Bedard said, "the nerve that goes up to the voicebox and larynx, and lose their voices. Or they cut themselves and bleed beneath the surface until they choke on a buildup of blood inside the trachea."

Bedard said most suicide shootings he's seen were hostile, done while someone else was around to react to it. Interestingly, you can shoot yourself in the head and miss the brain but merely blow out an eye or part of your jaw. If you die, the death is usually drawn out and painful.

"People can live eight hours with a hole in their head the size of a half dollar," Bedard said. "If you shoot yourself in the temple, the primitive parts of your brain that control breathing will go on for a long time, from minutes to hours. Eventually they may be shut off by pressure from the swelling of the upper brain that was shot. Or they may not be shut off at all. One man I treated is completely paralyzed on his left side, and can't speak, walk, or feed himself. It's as if he had a major stroke. He hit the area of the brain which controls motor function."

Jumps and hanging, again from Bedard: "I'm amazed at how far you can fall after a jump and not kill yourself. Some people have fallen 150 feet and lived. They'll break many of their bones, or rupture an organ like the spleen. Many people who try to hang themselves don't fall far enough to jerk their neck back and snap their airway. They strangle themselves instead, and don't always die; they get brain damage from lack of oxygen." People who try to poison themselves with gas or carbon dioxide may also get brain damage for the same reason.

And finally, just falling into a coma can lead to permanent damage. "If you're slumped on a table, leaning on your arm for a day and a half," Bedard said, "you put pressure on the armpit. You can permanently damage the nerve there and make it hard to use your arm. Or your muscles might start to dissolve into your bloodstream and clog up your kidneys. The muscle damage probably eventually returns to normal."

These clinical generalizations make suicidal people seem like statistical ciphers who made a mistake and suffered the immediate, appropriate retribution. But it doesn't feel like that at the time. Whether or not you are glad you were rescued, recovering from a suicide attempt is like being in the emergency room for any other reason. The flash that brought you there was over in a moment. The waiting, being embarrassed, wondering what will happen next, and bearing sharp or dull pain go on for hours.

How, according to people who work with them, do suicide attempters feel when they wake up in the hospital? Glad they were saved. Convinced that suicide was a mistake. Angry they were saved. Angry at the friend or neighbor who betrayed them by calling emergency. Eager to to get out of the hospital so they can try it again. Embarrassed. Relieved. Happy to be taken care of. Eager to start taking care of themselves again. Unwilling to think about it. Wondering what everyone else they know thinks about it. Wondering if the person they were trying to reach will finally pay attention to them.

"A lot of what I hear in the emergency room is hostility towards a specific person," Dr. Bedard said. "Once they know they're not going to die, they go out of their way to talk to me about it. 'I'll show that son of a bitch. He didn't think I had the guts to do it.' A lot of these people fantasize about seeing themselves at the funeral. 'The whole world's going to be upset.' "

There are people who get ignored repeatedly until they attempt suicide. One woman I heard about tried to kill herself six times in one year. "My

husband says he's too busy if I ask him to take me out to dinner," she told the emergency room staff. "But for this he makes time."

If it isn't the attention of a particular person, it might be the emergency room staff. Sadly, many people can only get a lot of paid professional people to notice them by threatening their own life. "A lot of people we see are repeaters," Bedard said. "They might come in 20 times in five years. To them it's a game. 'Either you take Ipecac and vomit or we'll have to do gastric lavage,' we'll say. 'You know and I know it'll hurt, so why don't you take the Ipecac?' Sometimes you see the same people so often it's like visiting an old friend."

Other people take a pill overdose not to risk their lives, but to find a place where they can be taken care of and forget their problems for a little while. "People want time out," said Temple University psychiatry professor Michael Simpson, who ran the emergency psychiatric service at Guy's Hospital in London. "That's why sometimes they'll seek psychiatric support but leave in a day or two. They used to be able to do it more freely in the drug culture by finding a crashpad. Now the medical model is one of the few excuses for going away and lying around and having people be kind to you that is seen as a valid reason to leave work. Maybe we need other ways to legitimize that."

PEOPLE WHO ATTEMPT SUICIDE are almost never arrested, but they lose their right to decide what happens to them. In every state, being a possible danger to yourself, in the opinion of the psychiatrist who interviews you, is cause for being held for psychiatric care for a limited period of time. In California, the period of time is three days; it can be followed, with an application to a judge, by a 14-day period, and after that by another 14-day period. Beyond that, the regular rules for entering a mental hospital voluntarily or being committed apply. Clearly, how you act at the initial interview with a psychiatrist has a lot to do with how long you stay under psychiatric care. So does the attitude of the psychiatrist who examines you and the availability of good or bad psychiatric facilities in your area.

Rarely are patients held longer than three days for psychiatric reasons. In fact, some hospitals send more than half of the suicidal patients home as soon as they can go. Some patients are routed to state or private psychiatric hospitals; some go to local board-and-care homes or halfway houses or outpatient clinics or nowhere at all. "The only generalization you can make," said Ed Hamell, a senior psychiatric specialist at a private psychiatric hospital in Washington, DC, "is that people who find themselves in hospitals following suicide

Married male, age 40

Jimmy!

Remember what I told you and always respect, protect and obey your mother and always remember that I love you so much. I am going to leave you forever because I am too sick to go on. God bless you my Son and when your time comes to go to Heaven you will find your ole Pappy waiting for you.

Daddy

Single female, age 16

Dear Mother & Dad,

Please forgive me. I have tried to be good to you both. I love you both very much and wanted to get along with you both. I have tried.

I have wanted to go out with you and Dad but I was always afraid to ask for I always felt that the answer would be no.

And about Bud, I want to dismiss every idea about him. I don't like him any more than a companion, for a while I thought I did but no more, in fact, I am quite tired of him, as you know, I get tired of everyone after a while.

And mother, I wish that you hadn't called me a liar, and said I was just like Hap. as I'm not. It is just that I am afraid of you both at times, but I love you both very much.

So Long
Your loving daughter
that will always
love you

Mary

P.S. Please forgive me. I want you to, and don't think for one minute that I haven't appreciated everything you've done.

Single male, age 35 (He committed suicide after he killed his girlfriend.)

Mommie my Darling,

To love you as I do and live without you is more than I can bear. I love you so completely, wholeheartedly without restraint. I worship you, that is my fault. With your indifference to me; is the difference. I've tried so hard to make our lives pleasant and lovable, but you didn't seem to care. You had great plans which didn't include me. You didn't respect me. That was the trouble. You treated me like a child. I couldn't reach you as a man and woman or man and wife as we've lived. I let you know my feelings toward you when I shouldn't have. How I loved you, what you meant to me. Without you life is unbearable.

This is the best way. This will solve all our problems. You can't hurt me further and anyone else. I was a "toll" while you needed me or thought you did. But now that I could use some help, you won't supply the need that was prominent when you need it. So, good bye my love. If it is possible to love in the hereafter, I will love you even after death. May God have mercy on both our souls. He alone knows my heartache and sorrow and love for you. Daddy

Department of Mental Health

DETAINMENT ADVISEMENT

CONFIDENTIAL PATIENT INFORMATION
SEE CALIF. W&I CODE SEC. 5328

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
FORM MH 1536B (6/74)
REF: SEC. 5260 W&I CODE

My name is _____

I am a (Peace Officer, etc.) with (Name of Agency).

You are not under criminal arrest, but I am taking you for examination by mental health professionals at (Name of Facility).

You will be told your rights by the mental health staff.

If taken into custody at his or her residence, the person shall also be told the following information in substantially the following form:

You may bring a few personal items with you which I will have to approve. You can make a phone call and/or leave a note to tell your friends and/or family where you have been taken.

To _____
Evaluation Facility

Application is hereby made for the admission of _____
Name

residing at _____, California, for

72- hour treatment and evaluation pursuant to Section 5150, et seq., of the Welfare and Institutions Code.

****

The circumstances under which said person's condition was called to my attention are as follows:

Based upon the above information it appears that there is probable cause to believe that said person is, as a result of mental disorder:

☐ A danger to himself. ☐ A danger to others. ☐ Gravely disabled.

Signature and title of peace officer, member of attending staff of evaluation facility or person designated by county.	Date / Time	Phone
Address of Law Enforcement Agency or Facility		

The People of the State of California Concerning

_____
Respondent

NO. _____

NOTICE OF CERTIFICATION FOR ADDITIONAL 14 DAYS INTENSIVE TREATMENT

The authorized agency providing 14-day intensive treatment, County of _____,

has custody of: _____

Name _____ Date of birth _____ Sex _____

Address _____

Marital status _____ Religious affiliation _____

The undersigned allege that the above-named person presents an imminent threat of taking his own life.

This allegation is based upon the following facts:

_____

_____

Bureaucratic routine with suicide attempters. These are some sections of the forms used (in California) to put suicidal people in psychiatric hold. Police officers or (occasionally in some areas) psychiatrists fill them out for the local courts or mental health agencies. They are based on what a psychiatrist has gleaned by interviewing the patient. In most states the three justifications for holding a person involuntarily are that a psychiatrist feels the person is a danger to himself, a danger to others, or gravely disabled ("unable to provide for his basic personal needs for food, clothing and shelter").

attempts will be treated as not able to be responsible for their own safety."

Howard Blackstone, the clinical director of the Marin County mental health crisis unit, told me some of the things that happen in the initial psychiatric interview. "We're trying to find out what happened. Was it well thought out or was it impulsive? What kinds of problems led up to that point? What state were they in when they tried to do it? How likely are they to try it again? Oftentimes someone will come in upset, but after a day or two hold they will look back and say 'Why the hell did I do that?' If we believe that someone is still perturbed and still ruminating about how to kill themselves, we are required to hold on to them. We evaluate reasons less than states of mind. The purpose of what we're doing is to help someone out of a state of mind where they may do something not in their best interest."

Beyond that, I can't generalize about the psychiatric consequences of suicide. There are too many possibilities, they differ too much from place to place, and the patient has too little control over where he or she ends up. In many psychiatric institutions (and other social welfare institutions, like nursing homes) suicide is a sensitive issue, because a funding agency may investigate an institution if a suicide happens within its walls, Or a psychiatrist may be held responsible for a suicide if it can be proved he knew about it beforehand and didn't act reasonably to prevent it. Here as everywhere else, the main priority is keeping the person alive.

That may be changing. "There are a growing number of people in the psychiatric community," David Gruder said, "who feel privately that their patients, regardless of the law, have the right to decide whether or not to take their own life. Under certain circumstances, there are psychiatrists who won't prevent some of their patients from killing themselves. But you can't talk about this out loud too often, because it's illegal and

could also be grounds for disbarment." He said an influential book for therapists on this subject is **Back to One** by Sheldon Kopp (1977; $7.95 postpaid from Science and Behavior Books, P.O. Box 11457, Palo Alto, CA 94306).

IF YOU BELIEVE, as I did starting this article, that each of us has a right to commit suicide and potentially valid reasons for doing so which should be respected, you might think there's something gruesome about a system which automatically acts to preserve life, whether the person wants it preserved or not. There's an apocryphal story told in every emergency room: someone comes in for the thirtieth or fortieth time on a suicide attempt and a doctor finally explodes and says, "Look, why don't you try it this way," and the patient does next time and dies. Every professional I talked to – doctor, paramedic, suicide prevention counselor, therapist, pharmacologist, nurse – said there have been people who made them think, 'you're right. You have nothing to live for.' But the attempt to save the person's life is always made. As Dr. Richard Fein, who directs outpatient services at San Francisco General Hospital, said, to decide whether someone's life is worth living in an emergency is gross arrogance.

There are people who think suicide can be a method of natural selection in an overcrowded world. Suicides in prisons are often not saved, I was told by several people; the same is true sometimes in some cities, for the indigent suicide, the alcoholic suicide, the aged or non-white suicide. Nobody else wants them; they finally succumb to the obvious. Aren't there people who ought to be killing themselves but are not?

Brr. I'm on the side of saving lives automatically. I liked what Stuart Bair, who counsels many of the desperate and penniless suicide attempters at San Francisco General Hospital, said: "I believe in miracles. I think there's always a reason to hope someone's life will improve." And I like what psychiatrist Michael Simpson said about the terminally ill that groups like Exit and Hemlock are trying to reach: "Those who work with terminal patients, like people in hospices, say there are very few requests for suicide. People want to be relieved of pain, which we could do for nearly everyone if we were given good hospice and palliative care. We need to be sure we've guaranteed mercy living before we get around to mercy killing."

Anyway, I suspect suicidal people are automatically rescued not for their own sakes, but for the rest of us. A suicide death, unless it is rationally prepared for, devastates. The message of a suicide attempt is often: Death is better than the pain you've caused me. And the message doesn't have to come from someone you know. David Gruder,

Single female, age 31

My boss, Kenneth J., seduced me and made me pregnant. He refuses to help me. I had not had intercourse in two years. He says that I will have to suffer through it by myself.

Several people know about this -- my doctor, Dr. James R., and Pete M. who works at Williams. Pete and I never had a love affair, although Kenneth would like to drag Pete into it. Also Dr. Arnold W. knows about it.

I have always been such a good girl.

Daddy dear --

As much as it hurts me, I cannot make it this Friday. I may be in very serious trouble. I have always been a very good person, but it looks like I really got in a mess, through no real fault of my own.

I must have been born to suffer.

Love - Elizabeth

P.S. Call me if you can. When will Sally be back? I may need her desperately.

Married male, age 52

Dear Joan,

For 23 years we lived happy together. Our married life was ideal, until two years ago when I witnessed Kristy die in the hospital something snapped in me. You remember when I returned from the hospital I broke down. That was the beginning of my illness. Since then my condition was getting progressively worse, I could neither work or think logically. You have been thru "Hell" with me since then. Only you and I know how much you have lived thru. I feel that I will not improve and can't keep on causing you and the children so much misery. I loved you and was proud of you. I loved the children dearly and could not see them suffer so much on account of me.

Dear Children:

Please forgive me.

Love, Frank

Divorced female, age 37

To No-one and Everyone:

Because of a growing conviction that a hereditary insanity is manifesting itself beyond my control, I am taking this way out -- before mere nuisance attacks and rages against others assume a more dangerous form.

Because I am an agnostic and believe funeral fanfare to be nonsense -- I ask that it be forgotten. Instead, knowing there to be a marked shortage of cadavers for the medical profession, for which I have endless respect, I hereby bequeath 1) my body to medics for dissection; also 2) To Mark B. all personal effects -- to be divided as whim decrees -- with Dr. Lois J., L.A. and to each -- a deep fondness and love. 3) To Joe A. the greatest devotion -- the kind that "passeth all understanding." 3a) And my life.

Anita R.

4) To my father, Vincent N., the sum of one dollar ($1)

who directed crisis hotlines, told me about a woman who called up and raved: "I've had it. I'm pissed off. I'm killing myself and damned if I'm not going to take someone else with me and you, you bastard, are coming. BANG!" She shot herself. And, as it happened, it was the hotline worker's first call. She went right into a nervous breakdown.

But I believe the main reason a suicide attempt devastates and fascinates us is it reminds us how fragile our own hold on life is. "Here I am struggling along with my problems," Michael Simpson said, "and here's a guy who's given up. Is it possible I'm wrong in bothering so hard to try to live? Once you start discussing suicide you're asking what the grounds are for killing ourselves. The other side of that question is, 'What am I living for?' That's an ugly question for most of us because we don't usually know."

IF SOMEONE YOU KNOW is thinking of suicide, or you think they are, and you don't want them to die, tell them. "Please call me or call suicide prevention before you try anything because I care about you and I don't want you to die." Don't argue with them about why life is worth living, because you can't win that one in rational argument. Tell them how you and other people will feel when they're gone. If there are mental health services you trust in your neighborhood, you may want to suggest them.

If you are scared you may commit suicide, and sometimes you don't want to, there may be more options than you realize. A good guide to whatever mental health services are around and how to find them is **You Are Not Alone (NWEC, p. 327).** It's worth looking around to see if there's a friend, family member, or neighbor that you can talk to about it. Even if, like me, you distrust mental health services, it's probably worth calling suicide prevention. They're listed under that name in the phone book white pages, or call the American Association of Suicidology at (303) 692-0985 for the phone number of one near you.

If you want to make someone pay attention to you through a suicide attempt, you might consider leaving a note for that person and checking into an emergency room and telling them you're suicidal. You'll go through the same psychiatric hold, but without the damage to your body. Choose your emergency room carefully. Some, like Herrick Hospital in Berkeley, often have eight- or ten-hour waits for non-critical patients, in dismal surroundings that will probably make you feel worse.

Or, have you considered changing your life? ■

Trina, a college student, 21 years old

Fall quarter I called Suicide Prevention. I'd called them before and the people were nice, but this time the woman acted a little indignant. "Why the hell do you want to do something like that?" she asked. We talked until she said she had other phone calls. But she made me promise I wouldn't try without calling back first. I had a bottle of Coricidin from a wisdom tooth operation. I'd been thinking about it for a month off and on. Much later that night I took ten Coricidin and went to bed. I woke up in the morning feeling really rotten – weepy, groggy. I could hardly move. I thought I was going to die any minute. My roommate came home and got a friend to drive me to the school infirmary, where they gave me something that made me sick to my stomach. The doctor who gave it to me calmed me down. She said it happens to a lot of people, the pills wouldn't hurt me. I felt tingly, like I might pass out any minute.

I was immediately taken in a wheelchair to the psychiatrist's office. I talked to him about five minutes. He kept yelling at me about why did I take the pills, why didn't I do this or that. I remember thinking, boy this man is a real jerk. I told him I didn't want to see him any more. He said, "That's fine," and put me in a locked room with bars on the windows. I couldn't make phone calls. I felt humiliated, which made me angry. I'm not crazy. I'm not weird. I don't want people to look at me like I'm nuts. I'm not some nutty kid who tried to knock herself off. I was most angry at being stuck in that room. I expected to be put in a straitjacket any minute. I complained until they moved me to a pretty room and let me make phone calls.

I was there about two weeks. My psychiatrist kept harping at me about school – was I going to stay in or drop out? I saw him ten minutes a day. The other patients and one orderly helped me a lot more than he did. I just wanted to find a place where I could be alone and think about things. I left feeling like not much had been accomplished, except letting me know that I didn't want to attempt it again. No – I feel like I've become a lot more sensitive to people. I don't look at their problems as trivial any more. I almost like it when my friends come to me with problems. I feel like I can help now. I still haven't told the two people I was most angry at – my father and my boyfriend – why I was in the hospital. ■

Sandra, a clerk, 27 years old

A year ago March, while I was living in Michigan, I took an overdose of Elavil. I was seeing a psychiatrist and I was just getting off the medication. But the bottle was still in my apartment. I'd gone out and had drinks, came home and that's when I did it – about ten in the evening or so. I called my boyfriend Jonathan in California and my social worker. I told them I had taken the pills. The social worker told me to drive to the emergency room. I'd have been lucky to make it to the front door. Jonathan called a friend of mine, who came to the apartment and broke down the door. I was in a coma for five days. I guess I was lucky because the doctors told everybody I wasn't going to make it. Then they said I'd have permanent brain damage. When it didn't happen they said it was the miracle of the floor. I was out of the hospital in about three weeks; a week of that was in the psychiatric ward, which was a real drag.

I had a lot of problems with my memory for a while. Even now I can't remember some things. Starting a week before the overdose I don't remember anything at all. All I know about it is what Jonathan says I told him over the phone. Everybody asks "Why did you do it?" and I don't know. It sounds real stupid.

Everybody in the hospital was real nice. I was afraid that they would get down on me but they didn't. It was a Catholic hospital, and I had my own room. Friends were there 24 hours a day. It made me realize how many friends I had. On the psychiatric ward they give you tests for brain damage. They ask you a lot of silly questions. They test your reflexes, your memory. They give you EKG tests. It took a while to get back my coordination. I couldn't write or do other things with my hands. Most of the time I stayed by myself. There were programs for the other patients but they didn't put me in any because they didn't know how long I would be staying.

I'd tried twice, but those times weren't serious. I was just trying to get some attention. The first time I was 14, and I slashed my wrists. It was basic adolescent scare tactics. As a result I ended up in an inpatient clinic for teenagers for about five months. Almost everybody there was there because they ran away or they were doing a lot of drugs. The second time was a couple of years ago. I did a Valium overdose. It wasn't very serious – I just had to have my stomach pumped.

This time it shocked me to realize what could have happened to me. I realized how much I had hurt my friends and family, which I didn't think about before. I started wondering if people could trust me. It upset my life a lot – it threw everything backwards. Jonathan flew in from California. He said the scariest part was worrying about having to decide what to do if my body kept living but I had no brain response. When I first woke up I didn't think there would be anything wrong with me. And then it hit me that I couldn't move. I was embarrassed that people had to see me like that.

Once you're out of the hospital a lot of institutions won't hire you. You can't get health insurance. You have to lie on your job applications. People look at you like you're dangerous. It's real scary for some of my friends – they think they're responsible. Trying to convince people that I was OK was the hardest thing. That they didn't have to watch over me, that I wasn't going to try it again. ■

Thomas, a hairdresser, 21 years old:

I tried it five years ago. I was at a neighbor's house and fired a gun at my head. Nothing happened; it seemed empty. I fired it at a wall and put a bullet in it. So a minute later I found some Seconals in a medicine cabinet. I remember watching cartoons and taking the pills one by one. A neighbor lady found me and couldn't wake me up. I couldn't open my eyes or move, but I heard everything. I remember the lady shaking me and saying, "Oh, my God." I remember the ambulance people taking off my clothes and making me throw up. There wasn't any pain. I don't remember having my stomach pumped.

When I woke up it was five days later. A big black lady kept tickling me. " 'Bout time you woke up," she said. "I've been tickling you for three days." I thought I was in heaven – it looked like some place in heaven for the misfits. Turned out I was in the basement of a free clinic, a long room with rows of beds with all kinds of teenagers, pregnant girls, suicides, drug addicts. We walked around in gowns, smoking cigarettes and watching TV. The reason I tried was I was angry at my mother, but when she came in she just said, "Why'd you do this – to try to get attention?"

Am I glad I was rescued? Oh yeah. I was so glad I didn't die. It made me realize how much I appreciated myself, because I had a glimpse of what I might have lost. I had some friends and I would've missed them. I didn't have to go home after that. They put me in a foster home. The State made me go to a psychiatrist. I never liked the man. I thought he had more problems than I did. I felt drugged and slow for a couple of years. Every now and then I'd take speed to feel normal. Downers still make me feel speedy. If I had a suicidal friend now I'd ask them, "Why don't you have any alternatives? Could it really be so awful?" That's what I say to myself now. ■

How to Die with Dignity

Let Me Die Before I Wake

All the preceding words still don't address people facing a lingering, painful terminal illness or encroaching oblivion who want to die because they cannot seek other options (like hospice care or pain relief centers). These books tell specifically how to die, by relatively peaceful, relatively painless methods.

Both Scottish Exit (publishers of **How to Die with Dignity***) and Hemlock (publishers of* **Let Me Die Before I Wake***) require you to join their group and fill out an application form before they send their publication. Scottish Exit members sign a statement that they will not copy the book or show it to anyone and that they will destroy it before they do the deed. Hemlock members are advised to be cautious. Recipients are expected to observe the honor system. Both organizations state they have a waiting period of three months before they send the books, but Scottish Exit sent ours within a couple of weeks.*

How to Die with Dignity *is short (31 pages plus a 13-page supplement). Much of it consists of reasons why to rationally commit suicide, methods to avoid and fine points of Scottish law. A chart gives lethal doses of different brands of sedative drugs, and there are matter-of-fact descriptions of six specific methods in detail (involving drugs plus: electrocution; drowning; freezing; auto exhaust; suffocation). They're gruesome, not because they're sensationally horrible, but because they make you realize that dying is a hard, complex, mundane process. (A description of normal hospital treatment for the dying would be equally gruesome.) A few people I know who had idly considered suicide gave up the thought for good after looking at this book.*

Let Me Die Before I Wake *is longer, more journalistic, not nearly as direct. It contains seven true case histories, written in high melodramatic style, of terminally ill people who sought death or people who performed mercy killings. Author Derek Humphry weaves the specific dosage information into each story, an effect that seems meant to be casual but actually jars. The stories themselves are usually very moving. A more comprehensive chapter on methods follows, and another follows that on preparing the people around you for your death. There is also a full history of the voluntary euthanasia movement, a history of attitudes toward terminal illness, and an appendix about legal risks.*

I've been asked why, after writing that attempted suicides should be automatically saved, I still wanted to review these books. I feel that a few people may need them directly (although it's absolutely worth checking out other options first). More important, reading about voluntary euthanasia makes suicide seem closer to what it should be: not a romantic escape (that leads often instead to the emergency room), but a tedious act that makes you realize why life is valuable. —*Art Kleiner*

How To Die with Dignity
George B. Mair, M.D.
1980; 41 pp.
(including supplement)

£20 postpaid (about $50; includes membership) plus three-month waiting period
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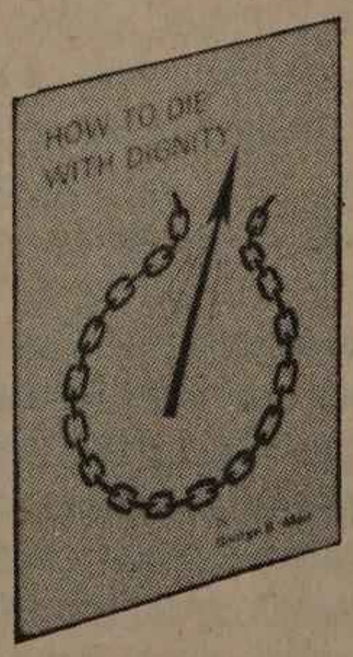
Polmont, Stirlingshire
FK2 0XZ Scotland



Let Me Die Before I Wake
(Hemlock's Book of Self-deliverance for the Dying)
Derek Humphry
1981; 102 pp.

$25 postpaid (includes membership) plus three-month waiting period

Membership alone (includes quarterly newsletter)
$15 /year
both from:
Hemlock
Suite 101
2803 Ocean Park Blvd.
Santa Monica, CA 90405

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Arrange 'timing' so that at least 16 hours of total privacy can be ensured.

It may be possible to use a hotel room. If so request Reception not to transfer telephone calls to your room and give as explanation that you are tired and do not wish to be disturbed.

When in the room hang the DO NOT DISTURB notice outside the door. If using a hotel try to be in bed by 1600 hours (04.00 p.m. since staff can become active before 0800 hours (08.00 a.m.)

If using a hotel it is suggested that a short letter is left to thank the manager and apologise for abusing hospitality. This should be left by the bedside together with 'reminder letters' to family doctor, solicitor and friend(s) recalling earlier documents signed perhaps years earlier.

Finally, it is useful for the Police if a note is left stating what drug has been used — and why — and giving names of doctor, solicitor and family. This will minimise 'formalities.' —**How to Die with Dignity**

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Methods of Self-Deliverance Which Should Not Be Used

1. Jumping from other than an exceptionally high building carries no guarantee of certainty.
2. Use of a knife is both painful and uncertain.
3. Use of a rope, is distressing to victim and — more than most other methods — to family and friends.
4. It is exceptionally unwise to attempt to jump in front of trains, motor buses or other vehicles. Results are unpredictable.
5. Jumping into the sea from a ferry or other deep sea vessel is highly inconvenient for the ship's crew and passengers. It is also, curiously, often also uncertain in that 'rescue' may arrive from some unexpected quarter such as an un-noticed fishing smack.
6. Jumping on to the live rail of an electric rail system is not in any way dignified and is a great offence to witnesses.
7. Death using a gun is not always successful either and the author has seen cases of survival following bullet wounds which entered an eye and apparently left the back of the head. Nor is the method 'dignified.' Tradition will have it that death by a bullet is a death of a soldier. We are not all soldiers! Nor do soldiers — even with shocking and multiple wounds — all die.
8. Aspirin and paracetamol should not be used since results are unpredictable. Recovery is often associated with kidney and liver damage.
9. Attempt to crash a car even moving at a very high speed is extremely uncertain and should be avoided.

—**How to Die with Dignity**

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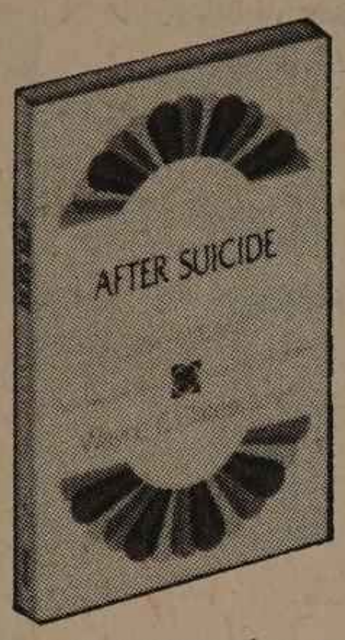
It's an obvious point — but one often overlooked for whatever reasons — that people who have decided to die alone because illness has made their life unbearable must decide to act before becoming absolutely dependent on others. It is necessary to decide in advance on the method and secure the means, and then act when there is no risk of interference. The means must therefore be fairly fast-acting and, as our stories have indicated, with drugs this is not always so. (Of course, if a person has decided to use a gun, these difficulties do not arise. But I have probably talked to more people intending voluntary euthanasia than most and have yet to meet one who plans their eventual death by shooting. A very few have decided on the car exhaust method.)

—**Let Me Die Before I Wake**

After Suicide

How to recover from the devastating fact that someone you love has committed a suicide at you. This book has what you wouldn't expect from a series called the **Christian Care Books**: *lots of insight, some solid taboo-busting, no rejection of non-Christians and hardly any preaching.*
—Art Kleiner

After Suicide
John H. Hewett
1980; 119 pp.
$6.55 postpaid from:
Westminster Press
P.O. Box 718
William Penn Annex
Philadelphia, PA 19105



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You are going to feel a constant temptation to take a short backward look. Take a long one instead. People have been purposely taking their lives for thousands of years. Suicide shows up in all kinds of societies and throughout every historical epoch. It is as ancient as humanity itself. It occurred among the ancient Hebrews. The Greeks and Romans also were plagued with the problem of self-destruction. They held a hard-line position opposing it, except for the Stoics and Epicureans, who adopted a softer approach. The early Christian church was forced to take stern measures to deal with the epidemic of suicides that took place. So many believers were eager to gain heavenly glory that martyrdoms became commonplace. Augustine, and later Thomas Aquinas, labeled suicide a mortal sin equivalent to murder. With a few exceptions, they gave the church's sanction to the civil laws against the act.

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A touchy issue must be discussed here. You will have to decide what to do with the suicide note, if one was left behind. This has the potential to be a major source of hurt and disappointment for you in the future. Talk about it with your family before you do anything, but face this question *soon*. Don't let this note rattle around your dresser drawer for ten years of indecision. If you think it will only bring you pain, then have a private, symbolic burning, and commit its contents to the memory of God.

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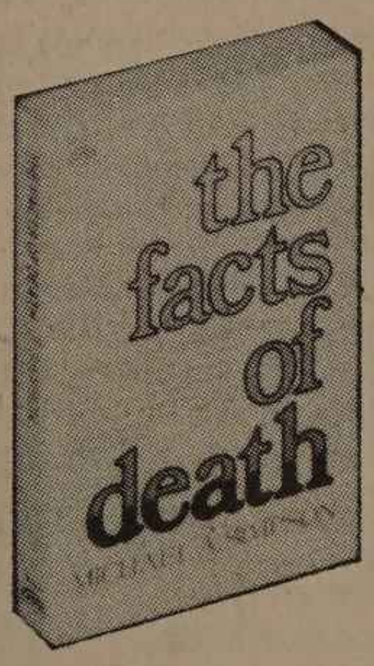
Those well-meaning souls who bustle up to your older children and exclaim, "Now, you've got to be brave and take care of your dear mother (or father)," do your children great harm. You have to ensure that this doesn't happen. *Don't make your children take care of you.* A fourteen- or fifteen-year-old boy is not prepared to be either the "man of the house" or your substitute husband. Also, be careful about forcing your surviving children to make up for the loss of a child who completes suicide. No one can replace a lost family member — no one. And no one should ever be the square peg forced into a round hole.

The Facts of Death

Unlike most authors who suggest their own books for review, Michael Simpson was right. If you're looking for a sympathetic, knowledgeable guide to dealing with the prospect of your own death or the death of someone close to you, look here. There's a lot of thought-provocation about the place of death in our culture; plus a very good annotated bibliography and an access guide to hospices, pain clinics, widow-to-widow projects, and death and dying groups. Best is the way he cuts at the manipulators who seek to make money off someone else's grief.
—Art Kleiner

The Facts of Death
(A Complete Guide
for Being Prepared)
Michael A. Simpson
1979; 276 pp.

$6.20 postpaid from:
Prentice-Hall
P.O. Box 500
Englewood Cliffs,
NJ 07632
or Whole Earth
Household Store



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A much more practical concept [than cryogenics], but one less likely to have general appeal, is the potential cultivation and harvesting of the dead. After brain death, the body could be maintained with persistent basic functions. One would have a cadaver, fully legally, personally, and spiritually dead, and with a dead nervous system — but warm, breathing, and with heart beating (with mechanical assistance), excreting, and requiring feeding, nursing, and haircuts. Dr. Willard Gaylin of the Institute of Society, Ethics, and the Life Sciences in Hastings-on-Hudson, New York, has explored the possibilities (1974). Such newly dead functioning cadavers, which he calls *neomorts*, could be maintained in body banks or what he calls *bioemporiums*. Medical students and young doctors could practice physical examinations, technical procedures, and operations on neomorts rather than on live patients. Experimental surgery techniques could be performed, and new drugs and vaccines tested very reliably and without risk to the living. Diseases could be induced to allow comparisons between different treatments. Organs would be available for transplant after careful testing of compatibilities. The neomorts could supply blood for transfusion ("like a saw-mill produces sawdust," in Gaylin's words), as well as several rarer blood constituents. Antitoxins and antibodies could also be produced by them.

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My closest approach to death, perhaps, was when I was attacked by a highly disturbed patient who tried to strangle me. He grabbed me efficiently from behind, and because I knew him to be a judo, jiu-jitsu, karate, and aikido enthusiast, I knew I had little chance of releasing myself by physical force. As he increased the pressure, my consciousness began to fade. There was a rushing noise in my ears, but I felt very alive, clearheaded, and alert. I seemed to be out of my own body, somewhere behind both of us, watching. I revolved between three mainstreams of thought. One, with a mixture of sadness, annoyance, and anger, was concerned with how much the patient would lose. His situation was desperate, but I had not yet begun working with him, and I was sure he could achieve a great deal. "But if he kills a doctor," I thought, "he's had it!" I conveniently overlooked the fact that I would also have "had it." The second line of thinking was a great swell of humor. Knowing how much I enjoy talking, it seemed a splendid irony that I should have to die speechless. "Damn it, Simpson!" I thought, "you'll get no famous last words!" The third stream of thought was a quiet mulling over of the question of whether there was, in fact, anything whatsoever I could do to save myself. It seemed very unlikely — he was strong, frenzied, and not thinking clearly. Any attempt at force on my part led him to grip harder still, and I had little consciousness left. I wanted to get through to him with something unexpected but nonthreatening, something that might just indicate that I meant him no harm. So, as I began to fade out, feeling as if I were falling headlong down a narrow grey tunnel, I stroked his arm very, very gently. (He said, afterward, that it puzzled him, and he let go to think about it. He was sure that a violent response from me would have let him finish the job promptly.) I recovered quite rapidly, and we later became firm friends.