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The Tightrope Walked by Psychiatric Nursing Staff Caring for People with Suicidal Thoughts Between 1920 and 1970

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Abstract

Nurses working in psychiatric care in the 20th century faced an ethical dilemma between monitoring and caring for suicidal patients. On the one hand, they had to comply with strict instructions to prevent suicides, but on the other hand, they were not supposed to restrict patients unnecessarily and should still allow them a certain amount of freedom. It was a tightrope walk between control and trust. Combating and preventing suicides was therefore considered to be a very challenging task within psychiatric nursing. An analysis of historical sources, such as textbooks, annual hospital reports, medical records, minutes of the supervisory committee, and interviews with former nurses, gives a broad insight into how the issue was dealt with in the 20th century. Suicide attempts and suicides could be interpreted as actions by patients to free themselves from a life situation that they no longer found bearable. Psychiatric doctrine assumed that suicides could not be prevented altogether. They did not happen very often. Nurses were rarely sanctioned for suicides, but nevertheless felt bad and had feelings of guilt even decades after such serious incidents. The risk of suicide can be minimised if nurses are well qualified and have sufficient resources available for everyday care duties.

Keywords: psychiatric nursing, suicide, twentieth century, Switzerland

1 Introduction

The ethical dilemma of psychiatry is inherent in the dual nature of its mission.[1] On the one hand, it has a function as a therapeutic institution and, on the other, is a force for social order. Psychiatric nursing is also characterised by contradictory demands and expectations. Nurses are integrated into the hierarchy of a psychiatric institution, where they are responsible for the care of inmates around the clock and, at the same time, responsible for the observance of house rules and regulations. They observe and monitor the sick, but are themselves subject to rigorous control and discipline. This is exacerbated by the harsh working conditions, especially if they are living on site, as was mandatory in many places in the first half of the 20th century. So they had to follow numerous regulations not only during duty hours, but also in their free time. This dual mission of psychiatry, and therefore of psychiatric nursing, shaped everyday psychiatric care.

Suicidal intentions or suicidal behaviour on the part of patients posed a particular challenge.[2] Even though suicides were rare, nurses were confronted with the implicit danger of sick people taking their own lives in the hospital. How did they deal with it when patients escaped from the institution and/or tried to end their lives? How did they endure the

1 The article is based on my PhD thesis: Braunschweig 2013.

2 On the history of suicide: Hintermayr 2021; Hoffmann 2009; Bowman 2009; Baumann 2001. Suicide means “intentional suicide”. For a discussion of the German terms “Selbstmord” and “Freitod” cf. Sauter et al. 2004, p. 940.

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dichotomy between the duty of control and caring for the sick? What did it mean for them if they could not prevent a suicide attempt or suicide? Did the nurses who were responsible for supervision on the ward have to fear sanctions? How are ethical conflicts at the crossroads between coercion and self-determination of the sick discussed and judged in psychiatric care today? Has the assessment changed over the course of the last few decades? I examine these and other questions on the basis of various sources from the Friedmatt psychiatric hospital in Basel, which opened in 1886.

Because suicides were a special but rare occurrence in the institution's everyday life, they were a recurring topic of discussion. In the early decades of the institution's existence, they were explained in detail in the annual reports. I show what function and role was assigned to the nursing staff. With the unionisation of the staff and the establishment of the trade union journal in the 1920s, the topic of suicides and suicide attempts was also discussed in articles. Escapes were feared because of the threat of suicide, as shown in a survey, which I supplement with case studies from the Friedmatt hospital. A tragic suicide at the Friedmatt resulted in a court case that produced a large number of files. This shows the considerations that led to the widow being denied compensation for loss of the breadwinner's income. In another section, I show how comprehensively the author of the Swiss textbook on psychiatric nursing, which first appeared in 1930, dealt with the subject of suicide and suicide prevention. Retired nurses who had worked at Psychiatric University Hospital Friedmatt between 1930 and 1960 told me in interviews in the 1990s how they had been affected by suicides, and how the subject still bothered them years later. Nurses had some leeway in their day-to-day care decisions. But finding the balance between duty of control and duty of care was a major challenge, as I discuss in section 8. Finally, I take a look at the textbook in use today and the current research on the care of suicidal patients in psychiatry. As a conclusion, it can be said that senior staff in psychiatric hospitals never assumed that suicides could be avoided altogether. But containing the risk was, and is, a fundamental task.

As a university hospital with 250 to 300 beds, the Friedmatt was one of the largest psychiatric institutions in Switzerland. It was built according to the pavilion system: the patients were accommodated in separate pavilions for “quiet, semi-quiet and restless patients”, according to their behavioural problems. The service buildings along the longitudinal axis separated the men's and women's sides of the hospital. In the early days, the nursing staff were also divided according to gender. It was not until the 1910s that female nurses were assigned to “quiet men's wards” because they were easier to recruit, were paid lower wages and exerted a positive influence on sick men.

Since the opening of the Friedmatt, the annual reports have been available in printed form. In the medical reports, the clinic director recorded changes in personnel and described special incidents in the everyday life of the institution. A statistical section provided information about diagnoses, admissions and discharges, and also deaths. Suicides were listed under the heading “violent deaths”. A review of the annual reports shows that suicides only occurred every few years. Because they were not common, they were specifically highlighted in the annual reports.

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2 Disruptions in Everyday Life in the Psychiatric Institution

Until the beginning of the 20th century, nurses in Swiss psychiatric hospitals learned their work through experience, learning by doing. They received some knowledge from colleagues and superiors. Only occasionally were there lectures on psychiatric topics. With the introduction of somatic cures (fever, sleeping, insulin and electric shock therapies) in the 1920s, psychiatrists became increasingly dependent on competent support from nursing staff. Experiential knowledge was no longer sufficient. In order to recruit suitable staff, systematic training for psychiatric nursing staff became indispensable. From 1925 onwards, courses started to be organised in some clinics. In 1930, the first textbook became available in Switzerland. It went through seven editions and was in use until the 1960s.[3]

Due to the different and unpredictable ways that mental illness expresses itself, everyday life was marked by incidents that disturbed the order of the institution. The severe incidents included outbreaks of violence, phenomena with a sexual element, escapes, suicide attempts and suicides. They can be interpreted as actions by which patients attempted to free themselves from a life situation that they no longer found bearable. For the nursing staff, on the other hand, they were a disruptive factor in the routine of everyday life.

According to Carlo Ginzburg and Carlo Poni, these incidents could be described as the "exceptionally normal" (l'exceptionnel normal, das außergewöhnlich Normale).[4] The "normal", the everyday, which is not narrated or commented on, is revealed indirectly in connection with extraordinary events and thus allows conclusions to be drawn about everyday life and daily routine. These incidents were a challenge for the nurses, who had to learn to deal with them.

Suicides were unavoidable if one did not want to secure the area like a prison and lock up patients who were a risk to themselves. This was a basic conviction in psychiatry. In the annual report of 1891, the director of the Friedmatt hospital, Ludwig Wille (1834–1912), stated that the clinic was "principally and systematically designed for the task of granting the sick the greatest possible degree of free movement". He was referring to escapes which, according to his experience, would very rarely lead to suicide. It would be irresponsible to make the other patients "suffer unnecessary restrictions" because of a few patients. Wille was an advocate of the no-restraint system. The aim of the no-restraint system was to use as few restraining measures as possible against agitated patients.[5] It was partly down to Wille that the professional association of Swiss psychiatrists, the Swiss Society of Psychiatry, agreed on the introduction of the no-restraint system at its annual meeting in 1868. This reform meant not only eliminating means of coercion, such as straitjackets, but treating the sick differently, examining them carefully and individually. The idea was that nurses would continuously observe and supervise the patients in order to recognise incipient moods and agitation in good time and intervene to defuse them. But without training, without professional expertise and without knowledge about the psychiatric illnesses of the sick, it was difficult for nurses to meet the medical requirements and demands. Psychiatrists were reluctant to provide information because they considered the nurses – most of whom came

3 Morgenthaler 1930–1962.

4 Ginzburg/Poni 1985, p. 51.

5 Cf. on the no-restraint system Sammet 2004; Aan de Stegge 2005.

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from the lower classes – to have little formal education and did not want to forfeit their own authority. Instead, they complained about the unsuitable nurses and the high staff turnover.

The directors of psychiatric clinics were aware that more liberal institutional treatment also had a downside and could lead to serious incidents. The cases listed in the Friedmatt annual reports prove that it was almost impossible to avoid suicides. A "melancholic patient" ran away from a nurse on a walk and threw himself under a passing express train. 1889 Wille wrote in the annual report:

> Anyone who can judge such situations objectively and according to experience will not blame such a nurse too much, if he has otherwise proven himself to be dutiful and reliable, even if, after the event and taking all circumstances into account, one might think that it could most probably have been prevented [...].[6]

He made a similar judgement about the following case: an elderly patient diagnosed with "severe hypochondriacal melancholia with manifold obsessions" was given round-the-clock care because of his anxiety. However, he chose to hang himself at the precise moment when the nurse went out to get him a cup of coffee. Since the patient had been sleeping well and talking to him, the nurse assumed he could leave him alone for a few minutes.[7] In 1890, a 58-year-old patient with "depressive paranoia" was able to hang himself from his bed frame by means of his handkerchief in the immediate vicinity of the nurse in the dormitory, without the nurse or any of the other patients noticing anything. Because the patient's previous behaviour had never indicated such an intention, the suicide had come as a surprise to everyone.[8]

In the annual reports, the director made an effort to exonerate the nursing staff, because these accountability reports were intended for authorities and donors. Assigning blame would have reflected badly on him. He could have been criticised for employing unsuitable staff.

But in one case he criticised the "negligence" of the nursing staff in the annual report, when a patient managed to escape from the clinic during the daytime in 1901. The nurses searched for him in vain. Hopes that he had returned to his family were dashed when he was found dead in a river eight days later. "With correct conduct" the death could have been prevented, Wille said.[9] But without training, nursing staff at that time were not sufficiently aware of what "correct conduct" meant. It was difficult for everyone in psychiatry to correctly assess such unpredictable actions. Although suicides could not be avoided, they caused dismay among the medical and nursing staff.

3 Escapes With Consequences

In connection with their demand for nursing training, psychiatric nurses began to organise themselves in a trade union at the beginning of the 20th century and to promote professionalisation. The nursing journal *Kranken- und Irrenpflege* was a joint project of the trade union

[6] Wille 1889, p. 4.
[7] Wille 1892, p. 5.
[8] Wille 1890, p. 5.
[9] Wille 1901, p. 3.

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and the psychiatric association and published articles by both psychiatry and nursing professionals from 1922 onwards.

In 1924, a large survey was conducted among psychiatric nursing staff in Swiss institutions, the results of which were published in the journal. The focus was on escapes, which were a big worry, especially where suicidal patients were concerned.[10] In addition to developing a typology of the patients who were likely to escape, the survey looked at the reasons for escape, the types of escape and the instruments used, and addressed questions concerning the prevention of escapes.

As long as patients were admitted against their will, the question of escape was part of everyday life in the institution. It was always possible to escape from the institution, for example to run away on walks, not to return from the city or to make off while working in the fields. Even on closed wards, it was not impossible to break out with cunning, luck, good preparation or outside help. A few incidents from the nurses and patient files of the Friedmatt hospital illustrate this.

A young male nurse had only been employed on a permanent contract for a few weeks, following a one-year probationary period. He was on supervision duty in the garden on a Sunday in August 1922 when a patient managed to escape from the area. When the nurse noticed he was missing, he immediately went in search of him. The incident ended well, the patient was apprehended and brought back in a cab. The nurse was ordered to pay the transport costs or have them deducted from his wages. The union appealed against this order, arguing that the lack of a clear view over the whole garden had prevented him from tracking down the patient in time; this had also been confirmed by colleagues. The punishment was said to be too harsh because the nurse had never previously been admonished or fined.[11] The supervisory committee looked at the garden, but rejected the appeal. It wrote that the nurse would have had sufficient visibility from his position to observe the patient, and warned that special attention must be paid to the few "patients at risk of absconding".[12] According to the penal regulations, the director could even have fined him up to five days' wages for neglecting his duties or violating the house rules.[13]

A few years later, when patient escapes became more frequent, the principle of fining the nurses responsible for them was discussed by the supervisory committee. The key factor was a specific case in which a nurse had failed to prevent the escape of a patient who had already attempted suicide. After a lengthy discussion, he was fined thirty francs as well as the cost of transporting him back.[14]

According to her medical records, a 66-year-old female patient, who had stayed at the Friedmatt five times since 1912 for shorter and longer periods, managed to escape spectacularly

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[10] N.N.: Ueber Entweichungen 1924.

[11] Letter from the trade union to the supervisory committee dated 21 August 1922. In: Staatsarchiv Basel-Stadt (StABS): Staff file, SD-Reg 2a 991.

[12] Minutes of the supervisory committee meeting of 30 August 1922, and letter from the supervisory committee meeting of 31 August 1922. In: StABS: Staff file, SD-Reg 2a 991.

[13] Dienstordnung für das Wartpersonal der Irrenanstalt of 1886, § 13, 2. fines up to 5 francs [equivalent to about 5 days' wages]. In: StABS: San-Akten T 2a.

[14] Minutes of the supervisory committee meeting of 11 June 1925. In: StABS: San-Akten T 2a.

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in 1947. Because she "pestered" doctors and nurses about her discharge, she was locked in the toilet one morning. She was to be transferred to another ward later. But in the toilet she climbed over the wall and left through a watch room window at an unguarded moment and fled over the wooden fence. That was how she had discharged herself, as her medical records laconically put it.[15]

In another case, a 36-year-old patient diagnosed with "defective hebephrenia", a severe mental illness with an unfavourable prognosis, failed in his first attempt to escape in 1935, but shortly afterwards managed to escape over the garden fence. Two weeks later, relatives from Nancy, France, called to say that they had seen him and given him money, but could not convince him to stay with them. A nurse was assigned to bring the patient back, which was apparently possible without any problems. According to his medical records, the patient did not resist being returned to the Friedmatt.[16]

In his guide to practical psychiatric care, the head nurse at the Friedmatt, Franz Küpfer (1904–1967), distinguished between "harmless escapees", such as "senile, arteriosclerotic or even certain imbeciles", and "dangerous patients". The former would run away without a plan if they found the opportunity. One had to look for them immediately, because they could have an accident or freeze to death in winter. Among the "dangerously ill" he included "schizophrenics who are under the influence of commanding voices or delusions, patients who commit impulsive acts, epileptics in a twilight state, those suffering manic episodes", as well as "criminal psychopaths" and "remand prisoners entrusted for evaluation". In these cases, senior staff would have to be informed before the search. If the search was unsuccessful, the relatives were to be contacted so that they could notify the hospital when the sick person appeared. Finally, the police should be informed, with the exact details of the missing person. In the case of patients who were a danger to themselves or others, a police dog should be called in to pick up the trail.[17] Although such escapes usually took place without serious consequences, the nursing staff never knew exactly what would happen because of the unpredictable nature of the medical condition.

4 Suicide With Legal Repercussions

When Ernst Rüdin (1874–1952), director of the Friedmatt from 1925 to 1928, took office, he asked for some structural changes that he thought were necessary to reduce the risk of suicide, although in his opinion suicides could not be completely prevented even in the best-equipped psychiatric hospital.[18] A suicide occurred under his leadership that had legal consequences. Albert E. had been admitted with a diagnosis of depression at the beginning of May 1928, accompanied by his wife and father, after he had increasingly expressed suicidal ideas and had possibly already attempted suicide. After eight weeks in the watch room, the director prescribed occupational therapy. The nurse took him with three other patients to work in the fields. When they passed a building with a ladder for renovation work, E. broke away and climbed up the ladder. Although the orderly followed him immediately and caught him by

[15] Entry dated 7 September 1947. In: StABS: Universitäre Psychiatrische Kliniken (UPK): KG archives, KG 53 (1), Medical record 6215.
[16] Entries dated 28 March and 10 April 1935. In: StABS: UPK: KG 53 (1), Medical record 2912.
[17] Küpfer 1944.
[18] Minutes of the supervisory committee meeting of 23 October 1925. In: StABS: San-Akten T 2a.

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the foot, E. pushed him away and threw himself headfirst from the roof. He was killed instantly.

His wife was convinced that the hospital management was responsible for her husband's death. She therefore demanded compensation, as she lived in poor conditions with her two small sons and without an income from her husband, who worked as a painter. The doctor in charge wrote to her lawyer that the institution was not to blame "because the supervision had been carried out professionally". Only an unfortunate chain of circumstances could have caused the "accident". Even "with reliable and close supervision", suicides and self-inflicted injuries could "occasionally" occur. "Given the rapid, impulsive action of the patient and the proximity of the supervising nurse, no one can be blamed," he added.[19]

While the supervisory committee would have granted the widow compensation to avoid a court case, the Health Department was against any compensation payment because it did not want to set a precedent. For reasons of principle, it therefore had the case settled by the courts. The civil court ruled in favour of the hospital management and dismissed the claim for compensation. The patient had been adequately supervised on the way to occupational therapy. Whether he should have stayed longer in the watch room was a matter of discretion, for which there were several possible approaches in medicine. According to the doctor's colleagues, the director, who in the meantime no longer worked at the Friedmatt, had "perhaps been somewhat careless in the treatment of such cases, perhaps even consciously." It had been one of his therapeutic views.[20] At no time was the nurse held responsible for the suicide. It was emphasised that he immediately followed E., who, as a painter, was probably more experienced in climbing ladders, and even put himself in danger.

Not only because of the different doctrines on how to deal with suicidal patients, but also for reasons of power politics, the widow, a woman from the lower classes, had no chance of getting her claim accepted by the authorities, despite having the support of a lawyer. If she had succeeded, the Friedmatt would have had to clarify the question of compensation for every suicide in the future. The institution and the government did not want to take this financial risk under any circumstances.

5 Care of Suicidal Patients in Theory and Practice

Before 1930, when the first Swiss textbook on psychiatric nursing appeared, which would be authoritative for the following three decades, the doctors of the first training courses in German-speaking Switzerland used the textbook *Geisteskrankenpflege* by Valentin Faltlhauser and the manual *Der seelisch kranke Mensch und seine Pflege* by Karin Neuman-Rahn as teaching materials.[21] Both textbooks attributed self-endangerment above all to patients diagnosed with "melancholia" and "depression" respectively. The danger of suicide is particularly high at the beginning and when the illness subsides. Care requires extremely

[19] Letter from the doctor to the lawyer dated 7 December 1928. In: StABS: UPK, KG-Archiv, KG 53 (1), Medical record 10628.

[20] Letter from the supervisory committee to the Health Departement dated 19 June 1929. In: StABS: UPK, KG-Archiv, KG 53 (1), Medical record 10628.

[21] Faltlhauser 1923, p. 168; Neuman-Rahn 1925, p. 99.

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careful supervision because any unguarded moment is enough for the patient to take his or her own life. A nurse should never believe that the patient is healthy, even if he appears to be calm on the outside and is waiting to be discharged.

The Bernese psychiatrist Walter Morgenthaler (1882–1965), author of the first Swiss textbook *Die Pflege der Gemüts- und Geisteskranken* (The Care of the Mentally Ill), also wrote that "combating and preventing suicides and caring correctly and properly for suicidal patients is one of the most important, but also one of the most difficult tasks of the institution and the nursing staff".[22] Morgenthaler devoted a chapter to "behaviour in depressed and suicidal individuals" and explained the risk of suicide for the various diagnoses, the stage of the patient's stay at the institution that was particularly delicate, the suicide methods used and the demands to be placed on nursing care.[23] Until the sixth edition of the textbook in 1954, he maintained that "extremely close supervision", which "should not let up for a second", was central. He meticulously pointed out the dangers for suicidal patients in every possible situation. In his opinion, they belonged in bed. He wrote, for example, that the bed should not be too close to the window, that it should be easily visible to the nurse, quickly accessible and sufficiently well lit at night. The sick person must "not crawl under the covers", must at most hold his hands above the covers, and must be accompanied to the toilet. In the bathtub, he must be bathed in the shallowest depth of water possible, potentially lying on a sheet. On walks, the accompanying nurse must exercise utmost caution near water, railways and cars, as well as when crossing bridges and in unclear terrain.

Morgenthaler explained in detail the possible dangers when handing out medication and food. Patients who were a danger to themselves or others were only given spoons to eat with. In the Friedmatt, knives had to be counted after the meal to be sure that none had been stolen. When twelve knives went missing from a men's ward after breakfast one day in July 1946, it caused a great commotion.[24] The night before, the orderly had only reported to the night watch that knives were missing. He had assumed that they had been mistakenly stored in another drawer. He defended his omission by saying that if only one knife had been missing, there would have been a risk that it had been taken "with dangerous intent", but not with this large number. And he added that, in any case, the "kitchen attendant" was responsible for checking. Later, the head nurse found the knives in a patient's room "under a folded piece of fabric on the floor". During a conversation, the male nurse confessed to having allowed patients to leave the dining room and go into the garden before the knives had been counted. This was often done in order not to keep the patients at the table until the cutlery had been washed and counted. He received a written reprimand for this mistake and for not reporting it to his superiors.[25]

This incident shows that in the everyday life of an institution, nursing staff had to weigh up whether they followed all the rules to the letter or whether they confidently gave the

[22] Morgenthaler 1930, p. 180.
[23] Morgenthaler 1930, pp. 179–186, the same wording until the 6th edition, 1954.
[24] Report on missing knives on ME 1 on 21/22 July 1946, dated 22 July 1946. In: StABS: Personaldossier: SD-REG 2b 2-2-3 (1) 47.
[25] Interlocution of 26 July 1946 and reference of 30 July 1946. In: StABS: Personaldossier: SD-REG 2b 2-2-3 (1) 47.

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patients a certain amount of freedom, in this case not making them wait at the table after eating.

Even trained and qualified nursing staff were not always able to prevent a suicide or a suicide attempt. In the case of the patient Berta Z., there seemed to be nothing to indicate that she was suicidal, as the nurse reported after finding her hanging in the summerhouse one afternoon in 1943.[26] She had been unobserved for ten to twenty minutes. Immediate attempts to resuscitate her with an emergency respirator, initiated by the nurse, were unsuccessful. Although the patient was described in the medical record as depressed and distressed about her child, who was in a home, neither the nurses nor the attending physicians had recognised the danger. Like any extraordinary incident, this unexpected suicide required a detailed explanation. All the nurses involved in the patient's care had to write a report. A patient who had got on well with the deceased was also questioned. It turned out that the night supervisor had told a nurse a few weeks ago that Ms. Z. had said that "she would like to die". Evidently, the nurses had not taken this remark seriously enough to report it, since an entry in the report book would have triggered strict supervision.

In the report to the highest authority, the Health Department, which had to be notified of such incidents, the doctor stated that it was only known that the patient had attempted suicide five years earlier in connection with marital conflicts, but that there had been no further attempts since then. There had been no reason to consider the patient as explicitly suicidal or to monitor her particularly; they had believed that they could justify "somewhat freer treatment", namely unaccompanied walks in the garden. It was "one of those abrupt and unpredictable actions of schizophrenics that can occur most often at the beginning of the illness, but more rarely later on," the doctor explained, describing the dilemma:

> If one wanted to take precautions against every such incident through much stricter supervision, the personalised treatment, psychotherapeutic consideration of the character and special wishes of a sick person would be called into question and many chances of improvement would become impossible.[27]

He hoped to make the authority understand that not every risk could be covered.

Nurses had to weigh up whether they wanted to follow all the rules precisely or whether they wanted to allow the patients a certain amount of freedom, i.e. not restrict them unnecessarily. Morgenthaler also addressed this balancing act in the textbook when he called for "scrupulously strict" supervision to prevent suicide, but said it should never "degenerate into thoughtless torture of the sick person". Nevertheless, he gave priority to strict supervision. It was not until the seventh edition of the textbook in 1962 that he revised his position and wrote that "too strict supervision is torture for the sick person". And he went even further, saying that tight control not only worried patients but could directly stimulate them to make further [suicide] attempts.[28] A "new liberal and relaxed treatment" had shown that the frequency of suicides did not increase, but actually decreased significantly. The

26 Report by L. K. dated 11 August 1943. In: StABS: UPK, KG 53 (1), Medical record 8626.

27 Friedmatt report to the health departement with copies to the members of the supervisory committee, 12 August 1943. In: StABS: UPK, KG 53 (1), Medical record 8626.

28 Morgenthaler 1962, p. 228.

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beginning of the 1960s heralded a new era in psychiatry, which slowly moved away from the hierarchical and authoritarian system.

6 Controversy Between Psychiatry and Nursing Concerning Information About Sick Patients

To what extent should nurses receive background information about the patients entrusted to them? Although head nurse Küpfer expressed the opinion in the above-mentioned guideline that staff should be made aware of "dangerous sick people", this was not the case in many institutions.

For years before 1950, there was a controversial discussion among psychiatrists and nurses about how much information nurses should receive about patients and whether they should be allowed to inspect medical records. The question was: who was "in charge of the record system"? Some psychiatrists denied the right of nurses to see medical records. A psychiatrist argued that the psychiatric medical history, which contains the "history, findings and course of the illness", reflects the doctor's opinion and is subject to medical professional secrecy. For this reason, nurses were only allowed to inspect it in exceptional cases. There are fashions in "medical jargon", scientific opinion changes, new questions arise, and as a result the doctor's personal opinion and interpretation can lose its value. He wanted to prevent nurses from learning about medical misjudgements and errors. The doctor could only do "responsible, conscientious psychiatric work" if he recorded observations and progress in a case history only "for himself and later generations".[29]

This opinion was contradicted by a psychiatrist colleague: "Misunderstandings between doctor and nurse" could be avoided if the nurse knew "the history of the individual case".[30] Informed staff could care for the sick in a more personalised and adequate manner.

A nurse who dealt with nursing responsibility also criticised the distrust of hospital administrators who did not tell the nurses anything about the background of sick individuals.[31] For forensic patients in particular, the nurses' duty of supervision is essential. They must therefore be informed about "patients with criminal tendencies" who are interned for assessment of their sanity, in order to be able to act appropriately; after all, they are "nurses" and not "jailers". "Silence and mistrust of the staff" only lead to "trouble and damage for both parties". It was a mistake of many hospital administrators to withhold medical histories from the nursing staff, treating it as "top secret". A good nurse is aware of the duty of confidentiality.

The conflict over access to medical records showed once again that there was a widespread fear among psychiatrists of losing authority over nursing staff, their auxiliary staff. This line of conflict was already evident when training was introduced in the 1920s. Precisely because psychiatric expertise was not yet well established in the first decades of the 20th century, psychiatrists feared that trained and informed nursing staff would challenge their supremacy and that they would lose their power in the day-to-day running of the

29 Pflugfelder 1958, pp. 225–229.
30 Straus 1937, p. 3.
31 E. E. 1928, pp. 149–152, and E. E. 1931, pp. 215–217.

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institution.[32] In the Friedmatt too, the nursing staff did not have access to patients' medical records, nor could they write in them themselves.

7 Suicides Remembered by Former Nurses

Suicide attempts and suicides affected all staff members. They searched for their own failures and mistakes. Even years and decades later, a suicide could still bother them, and they remembered every detail. I discovered this in interviews with long-time psychiatric nurses. None of my interviewees mentioned suicides or suicide attempts without emotion.

As late as the 1920s, patients in the Friedmatt were fastened to the bed with leather straps on one leg, said Rosa S., a retired psychiatric nurse, who had a key to loosen the restraints. "There were patients who would have done themselves harm," she explained.[33]

Retired psychiatric nurse Ida D. told me about a stressful memory. One patient had succeeded in taking his own life. She had accompanied him on a walk authorised by the doctor, but was restricted because of a hand injury: "This was an elderly gentleman, of course he already wanted to die, that was inside him, but he hadn't had the chance [before]."[34] The previous day, in fact, he had been outside with a nurse who had been able to restrain him. When he jumped into a stream outside the area, Ida D. could not pull him out because of her bandaged hand.

The nurse Fritz D. was once able to remove a patient who had "hanged himself" just in time: "He was still wriggling, so he got away,"[35] he said casually, trying to hide the fact that the incident had affected him, and that he was glad to have saved the patient. In the course of the interview, he returned to the subject: "I was lucky that nothing ever happened to me, outside, that nobody committed suicide when I was on duty, supervising in the watch room; nothing, one was glad."

Other interviewees expressed equal relief that they had not been personally affected by a suicide. Retired psychiatric nurse Helena F., for example, told of a young man who had obtained arsenic at home and died of it shortly before she started her shift, after having taken it at the institution.[36] From his medical record, it was possible to trace the incident in detail.[37] Max U., only 19 years old, was a patient at the Friedmatt in 1946. He had been diagnosed with "hebephrenia" and was considering questions of murder and suicide from the moment he arrived. His statements were written down, yet his death could not be prevented. Following his request for female care, he had been transferred to the private ward on the women's side. There, a fellow patient complained to the ward nurse that Max U. had spoken of his "homicidal desires" and of his intention over the following weekend, whereupon she herself became frightened and wanted to spend the night in another pavilion. A few days later, another patient reported to the head nurse that Max U. had made "strange remarks", that he wanted to see "what it was like on the other side". The fellow patient feared that he

32 Radkau 1997, p. 86.
33 Interview with Rosa S., 29 April 1989.
34 Interview with Ida D., 30 May 1989.
35 Interview with Fritz D., 25 May 1989.
36 Interview with Helena F., 11 May 1989.
37 Entries dated 28 July and 3 August 1946. In: StABS: UPK, KG 53 (1), Medical record 1858.

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"was planning to do something to himself". The doctor on duty on Sunday was then instructed to talk to him after his return to the clinic. According to the progress sheet, the patient returned accompanied by his father in a good mood and was asked about his "homicidal and suicidal thoughts". He claimed that he was confident about the future, that "everything had survived and was no longer relevant". However, a few hours later, the nurse telephoned the doctor that a patient had reported U.'s suicidal thoughts and a vial of poison. Although the ward nurse had not noticed anything about his behaviour – he was smoking a cigar in the lounge – the doctor instructed her to discreetly search his bedside table and the room and keep an eye on the patient. Barely half an hour later, she called back to say that he had probably felt sick from the cigar, that he was very pale and had vomited. A short time later, she phoned again to say that he was very poorly and had just confessed to having drunk a vial of cyanide three minutes ago. The patient was immediately transferred to the treatment room and treated with the available medical options such as mouth rinsing and stomach pumping, injections of the heart drug coramine and administration of oxygen for respiratory distress. However, early in the morning, the patient died as a result of the poisoning. According to the letter written by child and adolescent psychiatrist Carl Haffter (1909–1996) to the Health Department about the tragic incident, the suicide could only have been prevented if the young man, whose "prognosis was extremely unfavourable", "had been kept permanently on a completely closed ward and not allowed to go out."[38]

8 Scope of Action of the Nursing Staff

The ethical dilemma of whether to constantly monitor suicidal patients, possibly against their will, or to grant them some privacy, which entailed some risk, was inherent in psychiatric and nursing treatment.

Medical and nursing staff had to deal with this question and decide in each individual case. Morgenthaler described this individual discretion of the nursing staff in various articles. He demanded that although the doctor's orders had to be "scrupulously understood and kept in mind", they should "absolutely not be rigidly and slavishly carried out" on the sick.[39] Psychiatric nursing staff needed a great deal of "adaptability and versatility in the execution of the task and in the choice of means" – in other words, they needed a great deal of flexibility and creativity in individual care. In everyday psychiatric nursing, situations could arise at any time in which the doctor's "original orders could no longer be carried out pedantically". Therefore, the psychiatric nurse has to "change the orders, refrain from implementing them, or make completely new ones, while adapting as fully as possible to the changing situation as well as to the intentions and original orders of the doctor".[40] This gives the nursing staff "a much greater freedom of action". This requirement to weigh up at every moment whether to react in one way or another, i.e. to sound out the possibilities for action, to use their discretion, was virtually a condition of psychiatric nursing.

Morgenthaler did not discuss the dangers that existed for staff in everyday nursing as a result of this large scope for interpretation, for example if they decided and acted "wrongly"

[38] Letter from Carl Haffter to the Health Department dated 6 August 1946. In: StABS: UPK, KG 53 (1), Medical record 1858.

[39] Morgenthaler 1925, p. 433; Morgenthaler 1926.

[40] Morgenthaler 1925, p. 433.

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in the eyes of their superiors. He concealed the relationship of dependence between doctor and nurse and conveyed the impression that both acted as equal subjects. Due to the hierarchy of the institution and the doctor's powers, however, this did not correspond to reality. In her subordinate position, a nurse could never know and never be sure whether she had decided and acted in line with her superior's intentions.[41] The fear of having made a mistake and of being summoned before the director and punished was something the former psychiatric nurses brought up several times in the interviews.

Morgenthaler said that with careful selection, sound theoretical training and, finally, with professional experience, the high expectations placed on the staff could be met – here was a call for autonomy in the professional field of psychiatric nursing that was only addressed by the staff themselves in a much later debate about professionalisation.[42]

9 Conclusion

Suicide attempts and suicides in psychiatry cannot be avoided, as documents from every era in the history of psychiatry have shown, wrote Asmus Finzen, deputy medical director of the Basel Psychiatric University Clinic in 1990.[43] The sources from the Basel Psychiatric Clinic and the case studies show not only that it had been impossible to prevent suicides since the clinic opened, but also that the clinic directors refused to run the clinic like a prison in order to avoid any risk. They were aware of this ethical dilemma between granting freedom and confinement. As a rule, they did not hold the nursing staff responsible if a patient took his or her own life. Only in a few cases did they criticise a nurse for having acted negligently or carelessly.

Since the introduction of recognised training for psychiatric nurses, the topic of suicide has been part of the curriculum. It is a subject that trainee psychiatric nurses have had to deal with. The textbook, first published in 1930, contained some concrete advice on how to deal with suicidal patients.

The current textbook of psychiatric nursing (*Lehrbuch Psychiatrische Pflege*) also deals with the topic in detail in the chapter “Suicidality” and states:

> Suicides are one of the biggest global health problems and a frequent cause of death among the mentally ill. Assessing suicide risk, caring for suicidal patients and coping with suicides are among the most difficult interpersonal and professional challenges in psychiatric work.[44]

Behind this lies the basic ethical conflict of self-determination and heteronomy, which psychiatrist Tilman Steinert deals with in his research on psychiatric treatment and care.[45] Ethical problems are characterised by the fact that it is not possible to identify either scientifically (medical/psychiatric) or legally unambiguous solutions to problems or

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41 Cf. on this “double-bind situation” Braunschweig 2008.
42 Raven 1995, pp. 347–355.
43 Finzen 1990, pp. 24–25. Finzen was deputy medical director of the Psychiatric University Clinic from 1987 to 2003.
44 Sauter et al. 2004 (4th ed. 2019), p. 940.
45 For the following cf. Steinert 2001, pp. 32–36.

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guidelines for action. The conflicts centre around the issue of personal freedom, for example when restricting or granting freedom in the case of suicidal tendencies, danger to others or questionable helplessness, and when administering treatment against the will of the person concerned. The basic question relevant to care is: "Do we have to respect the patient's personal freedom and his or her stated wishes, or do we have to override these wishes for his or her own good, in accordance with his or her presumed 'real' will?"[46]

Steinert places the answer between the two poles of liberalism and paternalism. A liberal therapeutic attitude is associated with a certain willingness to take risks and allows the patient a certain degree of self-determination and personal responsibility, while the basic paternalistic therapeutic attitude focuses on security. Which of these attitudes a nurse is more closely aligned to has an impact on decisions in the daily organisation of a psychiatric ward. The different attitudes also affect the care of suicidal patients. Ward teams are constantly challenged to be clear about their attitudes and values and to negotiate appropriate measures. However, one basic rule must be observed at all costs, writes Steinert: "We can avoid ethical conflicts in the area of tension between self-determination and coercion if we succeed in convincing the patient!"[47]

But sometimes, despite nursing commitment, the success of persuasion is limited, in which case nurses and treatment teams have to reflect on the extent of coercion and heteronomy that can be ethically justified. A central prerequisite if teams are to be able to function in such dilemmas is a high level of collegial solidarity and clear support from superiors. This is particularly important when problems arise in difficult situations or when a suicide has occurred.

Findings from scientific studies that either confirm or call into question the usual measures and behaviour of the nursing team up to that point are also helpful. In many psychiatric hospitals, for example, high-risk patients are placed on locked wards. Only if they are prevented from attempting suicide and escaping, so the reasoning goes, can they be adequately protected and receive appropriate therapy. But until now there had been no proof that closed wards prevent self-harming behaviour. Now, a large study by Basel University and the University Psychiatric Clinics Basel, which evaluated nearly 350,000 cases in 21 German clinics over 15 years, has shown that the risk of patients committing suicide or escaping from treatment is no higher in exclusively open psychiatric clinics than in clinics with closed wards.[48] "The effect of locked clinic doors is overestimated," said first author Christian Huber.

> Being locked in does not improve patient safety in our study and is sometimes even counterproductive to the prevention of suicide and escape. An atmosphere of control, restricted personal freedoms and coercive measures is more of a risk factor for successful therapy.[49]

According to this study result, an "open door policy" does not increase the risk of suicide. In other words, a liberal ethical stance does not exacerbate the risk of suicide.

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46 Steinert, p. 34.
47 Steinert, p. 26.
48 Huber et al. 2016, pp. 842–849.
49 Huber et al. 2016, p. 848.

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Psychiatrists had already recognised at the end of the 19th century that suicides cannot be prevented altogether. But the risk can be minimised if nurses are well qualified and have sufficient resources at their disposal while carrying out their care duties. Nevertheless, psychiatric nursing remains a tightrope walk between supervision and care.

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