Administrating Death: Role of Law, Medicine and Development in (Re)defining Suicide in India

Meghana Rao
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By
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39. *Administrating Death: Role of Law, Medicine and Development in (Re)defining Suicide in India.*
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Meghana Rao

Abstract:
Suicide in contemporary India is being governed through a complex structure of medical, legal, developmental institutions, knowledge forms and practices. On one hand, suicide is criminalized in India under Section 309 of the Indian constitution, which allows the state to exercise its sovereignty over life as well as death. On the other hand, suicide has attracted a huge interest within transnational public health and developmental organizations such as the World Health Organization, which interprets suicide as a serious mental health problem. While the earlier discussions on suicide law revolved around questions of sovereign rights over one’s own death, in recent years Indian law has appropriated the medical understanding of suicide to argue that suicide needs to be decriminalized since it is a mental health issue. Today, the medical conception of suicide is being increasingly instrumentalised by different actors to govern suicide incidents and suicide victims in India, while depoliticizing questions of sovereignty, politics and poverty, within which the act of suicide is embedded. In such a context, this paper studies the implications of medicalization and (de)criminalisation of suicide in India.

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INTRODUCTION
In July 2009, I was in Bangalore, India, conducting preliminary research for my PhD. The aim of my visit was to understand the recent interest in medical institutions to address the suicide problem in India. As a part of my interviews, I met with a psychologist who conducts free counselling sessions in a few medical organizations and non-governmental organizations (NGOs) in Bangalore. I was in one such venue, waiting in a long line of patients to meet the psychologist. The receptionist shouted out my name stating loudly for others to hear that I am from Canada and am there to study suicide. The receptionist’s call caused some murmur amongst the people waiting with me. Soon enough a women (name changed to Uma) and her husband walked up to me. Uma and her husband said in Kannada (one of the local languages of Bangalore) that she would like to speak to me about her son’s suicide, as she had overheard that I am studying suicide. She briefly explained how her second son, a happy 20-something man with a comfortable job, hanged himself. The psychologist, whom Uma had been visiting for a year, had reasoned to her that her son must have been depressed and so decided to end his life. Uma, who was herself on depression medication for a year, at the end of our short conversation asked me “what is depression? Why do people get it? How can it be detected?” I, much to her disappointment, had no answers to these questions and was there to understand the same thing. We spoke for a while about her family and my work, and after a while Uma thanked me and left. This brief conversation with Uma in many ways triggered my interest for this paper. Attempted suicide, along with being a mental health problem, is a criminal offence in India. Section 309 of the Indian Penal Code states, “Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to
one year or with fine, or with both.” Given the complex nature of the discussions around suicide, the interest in suicide has increased among legal and medical professions and local, national and international, developmental organizations. As per popular media discussions, there are multiple reasons for committing suicide in India: farmer suicides are grounded in questions of economy (Sainath, 1996), student suicides are said to be increasing due to high stress levels in education (Limaye, 2012), suicides by women (said to be on a rise) due to familial harassment and dowry demands (Ramanan, 2011). These are only a few examples, and several other kinds of suicides are constantly discussed. This paper focuses on understanding efforts in the present context to conceptualize suicide through a medical discourse, the nature of involvement of developmental actors and agencies, and lastly, the tension between criminalization and decriminalization of suicide. To do so, this paper tries to briefly trace three narratives:

1. The recent medicalization of suicide through the development discourse
2. Statistical language used by different disciplines and organizations to define suicide
3. The story of how the legal and medical understandings of suicide work or contradict each other to understand the tensions and the continuum between criminalization and decriminalization of suicide.

The data for this paper was collected from the publications by the World Health Organization (WHO), National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore, India, and Christian Medical College (CMC) in Vellore, India. I also used the large and rich literature that has emerged from public health experts in India and the English news media. A part of the research for the paper came from my visit to Bangalore during June-July 2009. My intention during the visit was to understand in some detail the approaches undertaken towards suicide prevention in Bangalore. During my time in Bangalore, I met three psychiatrists and two psychologists. Along with these medical professionals, I met two lawyers who had previously worked on the issues surrounding decriminalization of attempt to suicide. These conversations were designed to assist me in drafting my doctoral proposal and so I have not included their names and organizations. Since my field research is not substantial enough yet to make large claims, I have relied mostly on secondary data for this paper. My conversations with medical and legal professionals act as support for what I have found in published documents and news reports. In short, this paper is a work-in-progress.

Medicalization is one of the core concepts in this paper. I will not go into the rich literature on medicalization here, but I will briefly describe what I mean by using the term. There has been no single agreed upon definition regarding “medicalization.” The term has evolved greatly from the 1970s to the present day. Medicalization today is increasingly understood as a process whereby medical and health precepts have been embodied in individuals who accept certain prescribed medical values. Foucault wrote several essays in the mid-1970s that addressed the issue of medicalization. In his 1974 lecture “The Birth of Social Medicine,” he spoke of the “medical intervention” into “biohistory” that first occurred in the eighteenth century. He introduced the term “medicalization” here, stating that “starting in the eighteenth century human existence, human behavior, and the human body were brought into an increasingly dense and important network of medicalization that allowed fewer and fewer things to escape” (2000a,134). He wrote of “state medicine” developing first in the German lands as an aspect of economic and political underdevelopment; its aim was to enhance the collective power of the state by the administration of a medical police well before the appearance of the scientific medicine of Morgagni and Bichat. In urbanizing France, Foucault identified a different development; there the experiences of plague and quarantine provided the “politico-medical ideal” of sanitary organization, individualizing and observing sick individuals and regulating the physical elements—water and air—that carried disease. Finally, in Britain he indicated the nineteenth century origins of “labor force medicine,” a kind of class project designed to ensure both a healthy workforce and the political security of the bourgeoisie (2000a, 151). These three distinct changes developed into modern social medicine.

By the late 1970s, Foucault had incorporated the notion of “governmentality” into his concept of how the modern state ruled the “social body.” In his important 1978 lecture on the arts of government, Foucault
abandoned the notion of an essentialized and willful state in favour of a conception of governance that was not based on a juridical notion of sovereignty acting on citizens, but on a set of practices that operated on bodies of the population. Medical practitioners were no longer, in his thinking, enforcers or servants of the state but experts in the service of a discourse that, as Foucault put it, was already “in some sense immanent in the population.” The aim of governance was thus “the welfare of the population, the improvement of its condition, the increase of its wealth. longevity, health, etc.,” (1991, 141). In the same year, in another essay, “About the Concept of the Dangerous Individual,” Foucault argued that the security of the whole and the health of the social body were also advanced by the development in nineteenth-century psychiatry and legal medicine of the concept of the “dangerous individual,” whose civil rights could be abridged in the name of a higher collective principle and with a medical judgment (2000b, 196-197). In this paper I use Foucault’s analysis of medicalization and governmentality to provide the necessary framework to understand the changes occurring on the topic of suicide in India. I return to Foucault’s work at the later part of this paper when analyzing the impact of medical/psychiatric reading of suicide in contemporary India.

DEVELOPMENT DISCOURSE AND THE MAKING OF MEDICAL SUICIDE

International developmental organizations such as WHO and the International Association for Suicide Prevention, France (IASP) have conducted extensive research on the “problem” of suicide globally and in India specifically. In 1999, WHO launched a worldwide initiative for Suicide Prevention (SUPRE). On the SUPRE’s website, it is stated that suicide is one of the leading causes of death in the world; each year almost one million people die due to suicide—a global mortality rate of 16 per 100,000, or one death every 40 seconds. According to SUPRE reports, suicide rates have increased by 60% worldwide in the last 45 years; it is one of the three leading causes of death among 15–44-year-olds and the second leading cause of death in the 10–24-years age group (WHO Suicide Prevention, 2003). With an intention to address this cause of death, SUPRE has developed a twofold mandate:

1. To design strategies for restricting access to common methods and tools of committing suicide, such as firearms or toxic substances like pesticides

2. To address the problem of depression and substance abuse this in turn will reduce suicide rate

SUPRE explains that these strategies have proved to be effective in reducing suicide rates and there is compelling evidence indicating that adequate prevention and treatment of depression and alcohol and substance abuse can reduce suicide rates.1 One of the leading mental health institutes in India, the National Institute of Mental Health and Neurosciences (NIMHANS), collaborated with WHO in 2002 to set up the WHO Collaborative Centre for Injury Prevention and Safety Promotion in Bangalore. As part of its work on suicide prevention, NIMHANS is interested in collecting in-depth data on suicide.2 Although the National Crime Records Bureau (NCRB), India, currently collects this data annually for the entire country, NIMHANS doctors believe that this data is unreliable and not detailed enough to direct any real interventions. So their primary focus has been to collect reliable data on the rates of suicide. Since this information is in the process of being collected, researchers at NIMHANS have been relying on the suicide statistics collected by the NCRB. Along with conducting this research, the WHO Centre for Injury Prevention and Safety Promotion has also designed capacity building programs for the police, media professionals, NGO workers, and volunteers to respond sensitively to the issue of suicide. These programs are said to be important for three reasons: firstly, the police are the first respondents in most suicide cases and, since suicide is a criminal offence, they need to conduct a criminal investigation; second, there is a consensus that the media often sensationalizes suicide news, which might encourage other suicides; and thirdly, the NGO workers and other volunteers work with individuals who are suicidal. These capacity building programs are aimed towards sensitizing all these groups of people to respond appropriately.

1. I will touch upon the issue of evidence in the form of statistics and its implications at a later part of the paper.
2. Suicide is not the only concern for the doctors at NIMHANS. They are also involved in advocacy and research in areas such as road traffic injury and violence against children and women.
There have been several NGOs that have emerged in Bangalore and across India that address the problem of suicide. As of 2009 there were several suicide prevention NGOs working in Bangalore. NGOs such as SNEHA (translates as Friendship) and MAITRI (also Friendship) in Bangalore, offer 24-hour suicide helplines and free counselling sessions for suicidal people, and organize self-help groups for families of people who are suicidal. These organizations, along with NIMHANS, offer suicide awareness programs through psychology students who volunteer to spread awareness about dealing with suicidal tendencies. They organize workshops with high school students, university students, and nursing students to bring about awareness on stress and suicide prevention. The NGOs, similar to NIMHANS's efforts, organize workshops for police and teachers with an aim to sensitize them regarding issues affecting people with suicidal tendencies. This complex architecture of the developmental organizations emerges as the infrastructure along which a particular discourse, i.e., the medicalization of suicide, travels in India.

Suicide in India, as mentioned at the outset has various causes. It can be political as in the case of suicide bombings, it can be economic as in the case of increase number of farmer suicides in States of Maharashtra and Karnataka due to excessive debt among farmers, or it can be gendered as in suicides due to harassment of women for dowry (which is currently a criminal offence). The multiple reasons for suicides are acknowledged in all the documents published by WHO and other medical/psychiatric organizations in India, but what is most interesting is that the various agencies’ approach to the problem assumes a largely medical/psychiatric dimension.

I will explain the implications of this by taking the example of pesticide control for the reduction of suicides in rural areas.

WHO’s Department of Mental Health and Substance Abuse, SUPRE, and IASP, in many of their publications, discuss effective interventions for suicide prevention. These documents are published and distributed to nations that have high rates of suicide. Although these publications are universal, in that they address suicide problem for countries across the globe, they suggest that each country should adapt the interventions to match local socio-cultural conditions. One of the major causes for suicide identified by a 2006 SUPRE report is suicide through pesticide consumption. As per this report, 60% of suicides in the world are due to pesticide consumption, especially in rural areas of China and South-East Asia. The report also states that “in many low and middle-income nations pesticides are the most readily available and frequently used method of self-poisoning.” (WHO and IASP, 2006) In accordance with its twofold mandate for suicide prevention, SUPRE recommends the following community interventions:

1. Designing safer storage facilities to regulate access to pesticides, educating farmers and rural populations regarding harmful effects of pesticide consumption
2. Designing psycho-social interventions for local community level doctors who attend to people who have attempted suicide by consuming pesticides
3. Formulating pesticide regulatory policies for its production, sales and pesticide substitution.
(WHO and IASP, 2006)

In India, where the rate of farmer suicides are very high, NIMHANS following WHO, prescribes two specific recommendations: (1) promoting manufacturing of less harmful pesticides, and (2) banning all lethal pesticides from routine availability. The striking aspect of these recommendations, both on the global and Indian scale, is the absence of discussions around farmers’ social, political, and economic contexts and their relation to suicide attempts amongst farmers. When these recommendations are studied, SUPRE’s focus seems to be more to regulate the methods and tools of suicide and less on addressing the political/economic reasons which might be driving people to commit suicide. Regulation of access is not limited merely to substances and tools. In a 2003 workshop with the Bangalore police, NIMHANS doctors and other expert

3. The number of farmers who have committed suicide in India between 1997 and 2007 now stands at a staggering 182,936. Close to two-thirds of these suicides have occurred in five states (India has 28 states and seven union territories). Maharashtra, Karnataka, Andhra Pradesh, Madhya Pradesh and Chattisgarh account for just about a third of the country's population but two-thirds of farmers' suicides (Sainath 1996, 2009).
participants, such as suicide prevention activists drew out recommendations and guidelines for the police. These recommendations were to regulate high-risk places such as high-rise buildings, public parks, and ponds to control people from attempting suicide. Similarly, hotels and lodges were also identified as spaces that need policing since couples (who often elope) rent hotels and lodges to commit suicide (Gururaj and Issac 2003).

In his seminal work on the development industry in Lesotho, James Ferguson argues that development discourses have the capacity to ‘depoliticize’ certain integral aspects in society. He states, “(although) poverty, hunger, and unemployment are fundamentally political issues, the routine discourses and practices of ‘development’ machine render them apparently susceptible to technical solutions…. The ‘development’ machine thereby depoliticizes these fundamental issues” (1990, 270). Writing on Indonesia, Tania Li in her recent work The Will to Improve (2007) argues that, by identifying a problem through a particular framework, the development apparatus immediately links it to the availability of a solution, a practice she terms “rendering technical.” This way of approaching issues confirms expertise and constitutes a boundary between those who are positioned as trustees to define the problem and those who are subject to their expert direction. These experts, she argues, are trained to frame problems in technical terms, which then allow them to address the problem through technical means. Questions that are rendered technical get simultaneously rendered non-political.

Through their efforts to prevent suicide, the development organizations and professionals simultaneously de-signify suicide from all its other contexts and meanings (political, economic, social, etc.) and re-signify it as a development issue that needs a specific kind of attention. By studying suicide as a health problem and addressing it through control of substances and spaces, the development apparatus frames suicide as being outside political, economic, and social spheres and within the realm of health and medicine. Suicide thus gets depoliticized and subsequently becomes susceptible to technical solutions such as pesticide control. By using the term “depoliticize,” I do not intend to indicate that suicide is non-political nor do I not want to suggest that political or economic situation is dire, causes suicide. I merely want to show the way in which the development rhetoric frames suicide, removes other aspects to the act of suicide and makes it into a medical/psychiatric problem.

WHO and NIMHANS state in all their documents that suicide is to be addressed through a multi-faceted approach by taking into consideration the political, economic, religious, and other factors affecting suicide. In spite of these recommendations, their documents, prescriptions, recommendations, and reports repeatedly state that suicide is to be addressed as a mental health problem. In the Suicide Prevention documents designed by NIMHANS for media professionals, health professionals, police, NGOs, and educational institutions, there is a mention of the various factors that play a role in suicide prevention. This is explained through what is termed an “intersectoral approach” (Figure 1). In this approach, the various sectors/factors are identified, such as Education, Agriculture, Industry, Drug industries, Economics and finance, Traditional systems of medicine, Local governments, NGOs, Media, Police, Law, and Social welfare—and holding the rein is Health. The document states that the health sector must take control and coordinate the other areas; thus we see that, when agencies such as NIMHANS designs interventions, these various areas are not emphasized, whereas pesticides are identified as the problem. The fact that sectors such as Agriculture, Police, and Economics are not the focus explains the way in which psychiatry chooses to address the suicide problem in rural areas: not through the market politics or agriculture-related pressures, but rather by controlling and regulating pesticide use.

At the centre of such a depoliticization of suicide are the experts: the mental health professionals who design interventions and dictate the direction and meaning “suicide” takes. For example, in India, although suicide might be stemming from economic problems (as in the case of farmers), it continues to get identified as a mental health problem by large international health organizations. This problem is then addressed through a technical lens by controlling access to pesticides, hotel and rental spaces, high-rise towers, etc. Li in her work argues that it is often that experts who are handed the task of improvement exclude political-economic relations from their diagnoses and prescriptions (Li, 2007).
The psychologists and psychiatrists I met in Bangalore all stated either that “suicide is a mental health problem and people do not understand this” or “they are ignorant about the effects of depression” and so appropriate programs must be designed to spread the knowledge regarding suicide through health care workers, NGOs, and other experts such as the police. Among the psychiatrists and psychologists, non-medical experts such as the NGO workers and the police are also thought to be ignorant about the “appropriate” response to suicide. They too, similar to everyone else, have to be trained to (re)understand suicide in medical terms. The assumption here is that there is no prior knowledge through which people can or should make sense of suicide. Anthropologist Stacy Pigg’s work on Nepal has shown the way in which development programs that aim to train Traditional Medical Practitioners and Traditional Birth Attendants accept a specific reading of “local perspectives,” based on which the whole program gets designed. She explains that the design reflects a specific set of development desires—a desire not only for a certain kind of development practice, but also for a certain kind of “traditional” person to be first the object and then the product of development efforts (Pigg, 1997). Similarly, the approach by the NIMHANS and other medical interventions go with the assumption that the “local” has no existing ways to deal with suicide and, more importantly, that this “local culture” is static and fixed and has not altered for a long time.

Gururaj and Issac’s work in the WHO-sponsored NIMHANS publication on Capacity Building Strategies for Non-governmental Organizations clearly states, “It is generally agreed that there are misconceptions, lack of awareness, greater stigma and decreased response from the general public regarding suicide prevention.... Individuals in India have strong faith and affinity towards spirituality…. However, there are no programs to mitigate the same. Hence, NGOs should initiate and organize sensitization and design awareness programs on the nature, causes and prevention of suicide…. There is a need to involve spiritual organizations and their leaders in prevention of suicide by providing them with specific inputs” (2003, 35). In another statement, a consultant psychiatrist states, “We have observed that people in the north are more aggressive and this aggressiveness is directed towards others. Which is probably why while the south tops when it comes to suicides, more cases of rapes and murders are reported from the north” (Times of India, 2011). Such uniformity between attitudes towards aggression and suicide amongst all “south Indians” and “north Indians” become important for the development of generic forms of health development policies based on transnational expertise. Such broad generalizations on “faith” and “spirituality” among Indians illustrate the specific lens—medical—through which suicide is perceived by the health development sector, i.e., as a transnational epidemic. The object of intervention, according to NIMHANS, is to be constituted mostly through medicine (vs. political, social, and economical means) and thus the product to be achieved (the prevention of suicide as an epidemic) and the necessary interventions (regulation of substances and spaces leading to suicide) both get constituted along with it.

STATISTICS AND SUICIDE

Another science, besides medicine, that plays a role in constituting this object of study and intervention is statistics. Almost every news or crime report, television show, medical article, and legal debate on suicide begins with statistics. When reading any report on suicide, the dependence on numbers is evident (Sahoo et.al., 2010; Shetty et.al., 2009; Gururaj et.al. 2004). This section focuses on the meaning assigned to suicide through statistics and its implications.

The WHO, NCRB, and several public health institutions are few of the many organizations that collect statistical information on suicide in India. The data is collected and organized through categories of gender, age, location, occupation, income, reason or cause for suicide, and method of committing suicide. For example, the authors, three medical professionals, of Attempted Suicides in India: A Comprehensive Look (Saddichha and Prasad 2010) begin by quoting global suicide statistics collected by WHO before moving onto suicide statistics of India:

The number of suicides in the country (India) during the decade 1996–2006 has recorded an increase from 88,241 in 1996 to 118,112 in 2006. The official adjusted suicide rate in India, according to NCRB was estimated to be 10.5 per 100,000 population (NCRB 2007), although these are widely believed to be under-reported. India currently occupies the 45th
position globally and 2nd position in the South East Asian Region (SEAR) with respect to number of suicides committed (WHO 2003). The latest data reveals an alarming rise of suicides with 118,112 persons having committed suicide in 2006 (Law Commission of India, 2008, 9).

Similarly, the Indian Law Commission's Report states, “the overall male to female ratio of suicide victims for the year 2006 was 64:38; however, the proportion of boys: girls suicide victims (up to 14 years of age) was 48:52, i.e., almost equal number of young girls have committed suicide as their male counterparts. Youths (15–29 years) and lower middle-aged people (30–44 years) were the prime groups taking recourse to the path of suicides. Around 35.7 per cent were youths in the age group of 15–29 years and 34.5 per cent were middle-aged persons in the age group of 30–44 years of the total suicide victims. Senior citizens have accounted for 7.7 per cent of the total victims” (Law Commission of India, 2008, 9). These examples show that quoting numbers is not an unusual phenomenon while discussing suicide problem in India.

These examples indicate an urgent desire to display numbers while discussing the issue of suicide. Through this, the meaning of suicide is increasingly being read through numbers. While discussing statistical information in a different context, Adrina Petryna in Life Exposed speaks of her experience with statistics while researching Chernobyl blast victims: “every subsequent hospital administrator with whom I spoke told me the same thing: statistical information was off limits. The urgent desire to withhold statistics on the part of these administrators only highlights another point. Without statistics, the effects of the disaster had to be understood from other perspective. What I understand was that bureaucratic windows on the Chernobyl reality were open to a certain kind of reality, inviting me to see its brute physical effects and nothing more” (2002, 7). In direct contrast to this, I found that one constantly hears statistical data on suicides in India. Unlike what Petryna witnessed, in India, one is made to think of suicide repeatedly through numbers. We are made to read the issue of suicide through a statistical lens. I need to state clearly here that I am not opposed to statistical research to understand suicide, or any other health problem, but the focus on number in addition to an erosion of other forms of reading suicide leads to a very narrow understanding of the act of suicide itself.

Statistical data, unlike most other disciplinary specific medical and legal knowledge, has the ability to travel across disciplinary boundaries. In this study, statistical data collected by the National Crime Records Bureau is until today used by the World Health Organization, the National Institute of Mental Health and Neurosciences, and a host of other smaller NGOs. This illustrates that statistics allows for something that other discipline-specific knowledge production does not. It is at the realm of statistical information that law, medicine, and development come together and can work together. Statistics as a science and form of knowledge allows for a conversation between disciplines that others forms of disciplinary specific knowledge does not.

Within the development discourse statistics play an important role. Understandings of development are largely dependent on the standardized use of certain kind of aggregate statistics. Although no doubt valuable for some purposes, such statistics do not always reveal what the experience of everyday lives means for people in a particular “development regime.” With respect to addressing suicide in India, statistics allow for people's experiences to be categorized and classified within well-defined definitions. These characteristics of statistical information allow statistics to become the point at which law, medicine, and development knowledge come together and work together.


5. All the medical organization use the NCRB data with an acknowledgement that this is not the appropriate data set to understand suicide as a health problem. But the fact remains that these organizations have the ability to exchange this information in the form of statistical numbers.
But why are statistics so important for development, medical, and legal professionals? In his seminal work on governmentalism as the new science (rather than art) of governance, Foucault conceptualizes statistics as “a (instrumental) science of the state” through which population gets constituted as an object of governance (2007). By government rationality or governmentality, Foucault refers to the ensemble of institutions, procedures, and tactics that allow the exercise of a form of power whose object of regulation is the “population” (Burchell, Gordon, and Miller 1991). The emergence of such a model of government was aided, he argues, by the rise of statistics or the science of the state. Statistics provides a vision of the “the population” as a concrete and palpable reality in the form of a tabular representation. By the middle of the eighteenth century, the purpose of rule was not just the defence and expansion of a sovereign’s wealth and territory, but, rather, the provision of security. By security Foucault refers to an all-encompassing centripetal form of power which emerged alongside the othering or centrifugal disciplinary and sovereign forms of power. Governmentality, Sovereignty, and Discipline form a triad through which, Foucault argues, modern forms of power are exercised. This technique of governmentalism was instituted both inside and outside the state. Timothy Mitchell’s (2002) work on the formation of the economy as a recent form of knowledge and governmental rationality speaks of this intimate link between economy and statistics. In arguing that the economy as an object of study is a recent phenomenon, he shows how statistics get instituted by the state as a form of knowledge outside itself and the economy as such, although they function together as an ensemble. Reading the role of statistics through such a lens allows one to understand why there is such an emphasis on statistical data within NIMHANS, WHO, NCRB and other local NGOs concerned with controlling or regulating suicide acts and rates. Statistics, as a science of state and governance, allow for these various disciplines, irrespective of the boundaries, to come together to constitute a “population” and its correlation to factors, causes, or categories in order to regulate and control it. Thus statistics as a science of the state could and does form the basis for the different disciplines—law, medicine, social work, police, planning, economics—actors, and agencies to come together to intervene and address the issue of suicide.

**LAW AND MEDICINE: A TENSION OR A CONTINUUM**

When I began exploring the relationship between law, medicine, and suicide, I began with the hypothesis that law and medicine were contending to define and control suicide in India. I thought one of the reasons for suicide not getting decriminalized (in spite of experts debating it for a few decades now) was because law wanted to continue to hold control over it. As I continued my research, the story I found was quite different from what I had anticipated. Law as a discipline is not really opposed to medical interventions to control suicide. The two disciplines are rather merging at the point of statistics and together creating something that is unique. This section of the paper will briefly look at some of the legal debates in India regarding the decriminalization of suicide and then consider the ways in which law and medicine work together towards (re)defining suicide.

Indian Penal Code (IPC) states that, “Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both” (Indian Penal Code, Section 309) The first effort to decriminalize attempt to suicide was in 1971; in its 42nd report, the Law Commission of India recommended repealing Section 309 on the grounds that the section is “harsh and unjustified.” A bill seeking to amend this section lapsed later on because of different, political reasons. Twenty three years later in 1994, a two-judge bench (Sahai and Hansari) of the Supreme Court of India struck down Section 309 in order to “humanize our (Indian) penal laws” (Rathinam/ Nagbhushan Patnaik v. Union of India, 1994). This bench argued that Article 21 of the Indian constitution allows for the protection of “right to life” and also read into this Article the “right not to live a forced life,” thus concluding that Section 309 violates Article 21. However, this decision was overruled in a 1996 case (Gian Kaur v. State of Punjab, 1996) by a Constitution Bench of the

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6. In this paper I only briefly study the role of statistics and its relation to suicide. This is not to say that simply because statistics categorize the experience in a certain way, they are redefining the experience itself. Something more complex is occurring, which requires a comprehensive and more detailed research. I intend to take this topic up in the next stage of my research.
Supreme Court, on the grounds that Article 21 could not be construed to include the “right to die” as a part of the fundamental right guaranteed by the Indian constitution.

The debate to decriminalize suicide has continued over three decades now but with little change. In 2008, the Law Commission of India presented a report on Humanizing and Decriminalization of Attempt to Suicide. The report states, “it is felt that attempt to suicide may be regarded more as a manifestation of a diseased condition of mind deserving treatment and care rather than an offence to be visited with punishment.” (Law Commission of India, 2008, 38) In a similar statement, Justice Jahagirdar in a paper titled Attempt at Suicide—A Crime or A Cry (2008) notes, “the attitude towards suicide and attempted suicide has changed in most civilized countries…. they have done away with the concept of attempted suicide as an offense” (Jahagirdar, 2008, 3). In the case of State v. Sanjay Kumar Bhatia, where a youth was booked under Section 309 IPC, the Delhi High Court stated, “Instead of sending the young boy to psychiatric clinic it gleefully sends him to mingle with criminals…medical clinics for such social misfits certainly but police and prisons never.” (Law Commission of India, 2008, 13) In a similar discussion, professors of forensic medicine argue in their paper on suicide, “Society owes responsibility towards those who scream out against life because of personal reasons... They need sympathy and psychiatric help rather than criminal prosecution” (Sharma 2009, 143-144). In my conversations with mental health professionals in Bangalore, suicide as a crime did not figure prominently. They all mentioned that it must be decriminalized so that the appropriate medical attention could be provided, but the focus was more on the efforts that could be put to steer the issue of suicide towards a medical model. What is striking in these statements is the resistance on the part of both medical and legal professionals to thinking of suicide as a crime. They all argue that suicide must be decriminalized in order to provide the appropriate medical and psychiatric attention. In spite of such strong support to decriminalize suicide, attempt to suicide continues to be a criminal offence. In the recent past, there have been several constitutional challenges posed and Public Interest Litigations (PIL) filed to decriminalize attempt to suicide. These efforts have been discussed repeatedly, but there continues to be resistance to decriminalization. That having been said, the 2008 Indian Law Commission’s report, while supporting decriminalization, simultaneously defends Section 309 IPC. The report states, “certain developments, such as the rise in narcotic drug-trafficking offences, terrorism in different parts of the country, the phenomenon of human bombs, etc. have led to a rethinking on the need to keep attempt to commit suicide an offence. For instance, a terrorist or drug trafficker who fails in his/her attempt to consume the cyanide pill and the human bomb who fails in the attempt to kill himself or herself along with the targets of attack, have to be charged under section 309 and investigations be carried out to prove the offence.” (Law Commission of India, 2008). But why is there continued resistance to decriminalize attempt to suicide, despite the growth in anti-terrorism laws on one hand and the all-pervasive medicalized understanding of suicide on the other? What is striking is most of the legal publications on suicide argue that psychiatry does provide the appropriate alternative. Psychiatric and development literature also accept that suicide is a mental health problem and criminal law has little to do with it. But nowhere in India, as far as I know, has there been a consistent and unified push towards decriminalizing suicide. As recently as May 2011, another PIL was filed in the Delhi High Court by an NGO Mental Health Foundation to repeal Section 309. This is currently being discussed and there is some push towards decriminalizing attempt to suicide, but nothing concrete has occurred yet.

To understand this contention over suicide it is worth taking a detour into Foucault’s seminal lectures on the Abnormal (2003), where he traces the emergence of a medico-juridical system in eighteenth- and nineteenth-century France. In early eighteenth century, he argues, the juridical system was opposed to interference from medical discipline, but by the end of nineteenth century, the judges themselves begin to demand the medicalization of their profession, functions, and decision-making procedures. Central to Foucault’s narrative is a shift wherein law, which had allowed no space for medical expertise, gradually begins to find medicine an important form of assistance within juridical processes. He writes, “Right at the start of the nineteenth century the problem of the doctor's power in the juridical apparatuses was essentially a problem of antagonism, in the sense that doctors demanded the right to exercise their knowledge within the juridical institutions…. [But] as crime becomes increasingly pathologized, the expert and judge [begin to] swap roles” (2003, 39). What do these medico-juridical approaches to suicide allow for in the Indian
context? “With expert medico-legal opinion,” Foucault suggests, “we have a practice concerned with abnormal individuals that introduces a certain power of normalization and which through its own strength and through the effects of the joining together of the medical and the judicial that it ensures, tends gradually to transform judicial power as well as psychiatric knowledge and to constitute itself as the authority responsible for the control of the abnormal individuals” (2007, 42). The expert medico-legal opinion thus, I submit, provides a form of power over the abnormal which neither law nor medicine can individually exert; law and medicine work in conjunction, through which emerges a new power of normalization.

Three things follow or begin to fall into place from this: firstly, an agreement amongst the medical and legal professionals on the rejection of all forms of prior understandings of suicide as backward or spiritual and its reconstitution as a “modern” medical or health problem that needs to be addressed through medicine and psychiatry; secondly, the emergence of a development apparatus that brings together legal and medical professionals alongside international, national, and local NGOs to regulate suicide; and thirdly, the formulation of new forms of interventions geared towards policing access to things such as toxic substances (pesticides) and dangerous spaces (hotels, building roof tops, bridges). But this only helps us understand a part of the relationship between law and medicine. Another part of the story lies in the question, why does the Indian justice system continue to maintain attempt to suicide as a criminal offence by justifying it through the cases of suicide bombers and drug traffickers.

Normalization as a modern form of power, I argue, can only govern what gets classified as “abnormal” (by the state). What is not abnormal cannot be normalized. Terrorists, suicide bombers and drug traffickers are recognised by the Indian state as a threat to its sovereign power, and thus are not understood as abnormal either by the state authorities or medical experts. To some extent, this line of analysis illustrates the reason why attempted suicide continues to be a crime in the Indian legal system. But simultaneously, it is also within the same social sphere that medicine and law make their push to decriminalize suicide. Medical and development interventions on suicide also allow for something more: they allow suicide to be addressed prior to the act, not after. The initiatives undertaken by psychiatric and development institutions mentioned earlier offer a different access into the lives of people and families. Medical access to the body is significantly different from the legal intervention. Psychiatry is a form of disciplinary power which can intervene beforehand, prior to the act of suicide or attempt to suicide. This allows for a certain form of supervision over the body and mind of the population. Law, on the other hand, can exert power over the individual after suicide has been attempted. Psychiatry has the ability to exert its presence earlier in the form of suicide help lines, clinics, and counselling, among other measures, to regulate access to substances, spaces, and the body itself.

The two disciplines (medicine and law) together address suicide as a mental health problem which needs to be individualized and normalized, but problems such as terrorism and drug trafficking get termed political and hence do not come under medical supervision. Psychiatry does not identify suicide bombing or drug trafficking as a symptom of stress caused either by a global economic or social crisis. It thus “depoliticises” suicide by situating it within the realm of medical and psychiatric science, controls it through regulating access to substances and space, and at the same time allows suicide to remain under the sovereign control of the Indian state. In her work on the implication of criminalizing the practice and glorification of sati in 1980s in India, Veena Das argues that, in all modern forms of governance, the state establishes an absolute right over the death of its citizens. She states, “Within modern state structures it is only through due process of law that a person maybe deprived of her life.... no death is legitimate unless certified by agencies of the state, and as far as heroic deaths are concerned it is the nation which has a monopoly over what constitutes sacrifice” (1999, 464). Decriminalization of attempt to suicide law would similarly remove this control over death by the state's legal structure and leave it in the hands of the people. Modern law cannot give this up, at least not yet.

**CONCLUSION**

In context of suicide in India, medicalization has allowed for regulation and surveillance over life rather than death through specific kinds of interventions that law is unable to access by itself. Law is no longer
interested in imprisoning suicidal people once they die; it increasingly attempts to regulate their actions while they are living. Law and medicine, necessarily, cannot be studied in separate analytical spheres to understand suicide in India. The legal, medical, and development institutions have to be studied within one framework and as part of one assemblage to trace the trajectory that suicide is taking in contemporary context. This shift that focuses more on providing medical attention has not necessarily challenged the sovereignty of the state over death that the act of suicide allows for, since the criminalization of suicide still persists under the Indian Penal Code.

Considering the discussions around the issue of suicide, there is no doubt that suicide in contemporary India lies at the intersection of structures of medicine, law, development discourse as well as a multitude of other actors, agencies, and their institutional practices. This paper touches only the tip of the issues surrounding suicide in India, my future research aim is to delve deeper into these questions and understand the ripple effects of these new institutional interactions. In this paper, I try to understand how different discourses of suicide get formulated in different spheres, particularly law and medicine, and try to highlight its relationship to the development world. In my future research I would like to further understand the roles of the actors involved, the forms of knowledge employed to understand suicide, and the institutional practices deployed in dealing with the issue of suicide in India? Lastly, what is also crucial to study is what gets left out in the medical and legal formulations of suicide and their subsequent practices? This last point is tied closely with my conversation with Uma, that I began the paper with. Uma's question, what is depression? and her inability to comprehend the relationship between suicide and medicine pose an important challenge and problematize the present hegemonic push of law and medicine to completely arrest all meanings of suicide. Depression as an explanation for her son's suicide did not provide a satisfactory answer for her and law did not figure anywhere in her narrative. She still could not define what depression meant and if it indeed did cause her son to commit suicide. The ambiguity arises, I think, because of the resistance to understanding concepts of life and death through a more poetic lens and the insistence on defining suicide in terms of law / crime or medicine / mental health. It is thus worth asking if law and medicine can completely define life and death for anyone or everyone like Uma, or are third or multiple third readings of suicide possible outside of law, psychiatry, and development?
References


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Court Cases

Figure 1