

Correspondence

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Domestic violence: we need changes in the ICD and at the start of training

In order to enhance rates of disclosure of domestic violence by service users, Rose *et al*¹ argue for additional specialist training for mental health professionals. I would argue that this is the wrong level at which to pitch training. I would also suggest that to precipitate any real shift in health workers' attitudes, and therefore practice, we need to see changes in ICD-11.

With ICD-11 still in development, Rose *et al*'s excellent paper should be mandatory reading for the Revision Steering Group. If, as the World Health Organization maintains, the ICD-11 aims to serve 'not only . . . as a classification system but also as a building block for health' (www.who.int/classifications/icd/ICDRevision.pdf), the Revision Steering Group would do well to reflect on the comments captured within this research. Medicine's ambivalence about accepting domestic violence as a key determinant of health is amply highlighted by the absence in our current ICD of any code for domestic violence. Whereas abuse of children can be recorded with a range of different Z codes, the abuse of adults remains non-existent in terms of axis V coding. This position surely validates both those in this study who do not see domestic violence as their business, but also goes some way towards promulgating the idea that this is a condition beyond the realms of ordinary practitioners' experience and therefore competence.

Training regarding domestic violence needs to happen at university level. Domestic violence is not just something that affects mental health service users, and it is something that medical students can be trained to ask about, think about and feel comfortable enough to approach. I base my comments on training I co-deliver with a service user to 5th-year medical students. The training takes place in the context of practising interviewing skills.

During the course of providing the history, the service user mentions 'being in a very violent relationship'. Medical students often freeze at this point, or say something such as 'I am very sorry', before moving swiftly on to another topic. At the end of the interview slot, the service user talks with the student group about how important it is to be able to ask about and listen to this kind of material, and how the student's desire to move away from the topic leaves her feeling this is something bad/dirty/unmentionable. She tells them how liberating it has been for her to be able to talk about this experience with others, and we both remind them of how common domestic violence is in our society, regardless of class or race or religion. Our work has not been evaluated in terms of whether the students who pass through our module go on to be better at facilitating discussion about

domestic violence, but this would perhaps be a useful area of study for medical schools or other professional training centres.

- 1 Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *Br J Psychiatry* 2011; **198**: 189–94.

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Assisted suicide: two sides to the debate

Editorials are surely meant to provide balanced, dispassionately presented information. The editorial by Hotopf *et al*,¹ while implying by its title that it is impartial on the issue of assisted suicide, is, in fact, highly tendentious in its approach and selective in the information it provides.

The authors first fail to draw an important distinction between 'assisted dying' and 'assisted suicide'. The former term is now widely used to describe the situation that pertains in Oregon, where terminally ill, mentally competent patients who are suffering intolerably despite the best available palliative care, have the right to ask their physicians to provide them with the wherewithal to end their lives. The term 'assisted suicide' tends to be used where patients are given the means to end their lives, although they are not terminally ill. They might, for example, be paraplegic or in the early or intermediate stages of a chronic degenerative neurological disorder. Dignity in Dying, of which I am a Board member, supports assisted dying but not assisted suicide.

The authors present a number of arguments that have been used by opponents of any legislative change in this area. They quote the 'slippery slope' view that suggests that if legislation allowing assisted dying were passed, it would not be long before assistance would be permitted with less stringent criteria in place. They do not present any contrary views or data. For example, in Oregon, where legislation has been in place to allow assisted dying since 1997, no attempt has been made to broaden the criteria. Nor have the numbers of patients asking to be given assistance to die increased to any significant degree. Deaths as a result of assisted dying have remained at or under 0.2% of all deaths per year in Oregon since 1997.² The editorial makes the wild suggestion that legislation might even be broadened to include the chronic mentally ill, a proposal not, I think, put forward since the infamous Nazi policies implemented in the 1930s and 1940s.

The editorial further suggests that, if psychiatrists were involved in assessing mental capacity, as they inevitably would in a limited number of cases, this task would present intolerable difficulty. Unless the clinical skills involved in distinguishing between the normal lowering of mood shown by people with life-threatening illness and those with clinically significant depression have been lost since I was in practice, this clinical task seems to me in no way insuperable though, of course, I agree that in a small number of cases it is indeed highly problematic.

Finally, the authors object to legislation on the grounds that physically fit people with depressive disorders who make suicidal attempts often change their minds about whether they want to die. They compare such patients with people in the terminal stages of physical illness who are suffering intolerably and reckon their quality of life does not make continued survival anything but horrendous. This comparison is surely quite inappropriate.

Although this is not stated in the editorial, the first author was a member of a working group of the Royal College of Psychiatrists

that, in 2006, produced a most unsatisfactory document strongly arguing against any legislation in this area.³ I very much hope that the College will withdraw this statement and take the only position that is appropriate in circumstances when, as is the case here, opinion is sharply divided, namely one of neutrality.

Declaration of interest

P.G. is a member of Healthcare Professionals for Assisted Dying, www.hpad.org.uk

- Hotopf M, Lee W, Price A. Assisted suicide: why psychiatrists should engage in the debate. *Br J Psychiatry* 2011; **198**: 83–4.
- Oregon Public Health Division. *Oregon's Death with Dignity Act: Annual Report 2010*. Oregon Public Health Division.
- Royal College of Psychiatrists. Assisted Dying for the Terminally Ill Bill. Statement from the Royal College of Psychiatrists on Physician Assisted Suicide, 24 April 2006. Royal College of Psychiatrists, 2006.

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Authors' reply: With opinion sharply divided we wonder whether it is possible to address the issue of assisted suicide without a charge of bias, and for this reason we thought it was better to be explicit about our position in relation to a change in the law. No editorial limited to 1500 words will satisfy our correspondents' criticisms that other evidence was overlooked. Matthew Hotopf was indeed involved with the Royal College of Psychiatrist's response to Lord Joffe's Bill.

We agree with Professor Graham that terminology is important. However, we do not think the distinction between assisted suicide and assisted dying is clear. The use of 'assisted dying' is problematic, we suggest, as it may be confused with the work of palliative care, a system of care specifically designed to assist people at the end of their lives, to do all to maintain dignity in dying and not to 'strive officiously to keep alive'.

Any change in the law is likely to involve drawing a distinction where assisting suicide is lawful as opposed to one where it is not. If one sets aside the legitimate moral question as to whether a doctor should ever assist in suicide, the issue comes down to devising a set of safeguards. Most, we think, would agree that freedom from coercion is important, although there may be debate about how to define this. Psychiatry may have only a limited role to play in such an assessment. The other main safeguards which tend to be proposed relate to the presence of suffering, mental capacity and consistency of wishes, and are areas we think psychiatrists bring expertise and might be expected to be agents in a new legislation.

The proponents of a change in the law might argue that a specific group can be defined in whom a law could safely be applied, whose request is valid and whose suffering is authentic. In terms of suffering, in an era where the voices and views of patients with psychiatric disorder are, thankfully, increasingly given due weight, we do not think it is tenable to suggest that patients with psychiatric disorder can so readily be distinguished from the rest of the population. If one makes 'unbearable suffering' a condition of assistance, but does not think that people with chronic mental disorders should have access to such assistance, then we suggest one has to answer the 'why not?' question. The suffering of patients with chronic mental disorders may be quite as unbearable or more so than that of a patient with cancer. As Dr Curtice's letter points out,¹ this is a live issue.

The issues of mental capacity in relation to suicidal behaviour are complex, as the case of Kerry Woolterton (a woman with an

emotionally unstable personality disorder whose death by suicide was not prevented on the basis that she had mental capacity) indicates.² The complexity is added to by the high frequency of depression³ and cognitive impairments⁴ in patients with advanced disease. We suspect that mental capacity assessments in this context are unlikely to be value neutral.

Our clinical experience of working with patients with advanced disease suggests to us that there is considerable commonality between the patients we see in emergency departments who have harmed themselves and patients receiving palliative care who have persistent suicidal ideas. No matter how apparently understandable their desires, in our experience there is nearly always a high degree of ambivalence, and we have seen many patients whose strong suicidal ideas have reversed with support provided by palliative care services.

In Oregon, the Death with Dignity Act became law before psychiatrists had had an opportunity to fully consider the implications of their role in the process. In a time when assisted suicide is being discussed in depth but not practised we have this opportunity. We hoped our article would encourage psychiatrists to grapple with the complexity of the arguments and consider how they might respond personally and professionally to the patient who asks for assistance to end their life.

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Lithium concentrations in drinking water

Kapusta *et al* claim that they provide conclusive evidence that lithium concentrations in drinking water are inversely correlated with suicide rates. This claim is apparently based on the estimate of a negative association between the average level of lithium in drinking water and average district suicide mortality at a marginally significant level ($P=0.022$) of an ecological study, males and females combined, in 99 Austrian districts. However, this claim can be challenged as there are limitations of the ecological model used to analyse the study.

First, it is well known that suicide mortality is associated with social demographic factors such as gender, age, area poverty and economic issues.¹ Such factors are largely variable across regions and hence constitute major heterogeneity in health outcomes such as suicide rate. Failing to take into account those risk factors will most likely lead to biased results. The authors were aware of this deficiency, but could not properly compensate for it for two reasons: (a) an ecological regression model with only 99 data-points can only include a few covariates; and (b) their model was incapable of incorporating variables at levels lower than district.

Second, weighted least square (WLS) regression analysis was used in the study to examine the possible association between