two control groups differed radically in their use of diuretics, and given that their model using control per case showed a significant odds ratio >100 associated with the use of diuretics, it may be important to determine potential synergies for risk mediated by hypokalaemia directly, as well as including the use of diuretics in regression analyses.

As several of the new, atypical antipsychotics recently have been shown to block the HERG K^+ channel, the clinical implications are that without a more complete understanding of the mechanism of risk, further studies examining this association for new atypical antipsychotic agents will require, where possible, prospective studies that can be used to determine the synergistic action of other known risk factors to be measured directly. Although mortality, even a low risk of mortality, is an unacceptable effect for a drug used to treat a non-fatal condition, the successful use of drugs such as thioridazine militates against the wholesale elimination of these drugs without due consideration for individual cases.

Choy, A. M., Lang, C. C., Chomsky, D. M., *et al* (1997) Normalization of acquired QT prolongation in humans by intravenous potassium. *Circulation*, **96**, 2149–2154.

Davies, S. J., Cooke, L. B., Moore, A. G., *et al* (2002) Discontinuation of thioridazine in patients with learning disabilities: balancing cardiovascular atoxicity with adverse consequences of changing drugs. *BMJ*, **324**, 1519–1521.

Hancox, J. C. & Witchel, H. J. (2000) Psychotropic drugs, HERG, and the heart (letter). *Lancet*, **356**, 428.

Keating, M. T. & Sanguinetti, M. C. (2001) Molecular and cellular mechanisms of cardiac arrhythmias. *Cell*, **104**, 569–580.

Lindquist, M. & Edwards, I. R. (1997) Risks of non-sedating antihistamines (letter). *Lancet*, **349**, 1322.

Reilly, J. G., Ayis, S. A., Ferrier, I. N., *et al* (2002) Thioridazine and sudden unexplained death in psychiatric in-patients. *British Journal of Psychiatry*, **180**, 515–522.

Roden, D. M. (1998) Taking the 'idio' out of 'idiosyncratic': predicting torsades de pointes. *Pacing and Clinical Electrophysiology*, **21**, 1029–1034.

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Decision-making and euthanasia

In a recent editorial Kelly & McLoughlin (2002) highlight the fact that the uncertain prognosis of most psychiatric diseases means that the objective accuracy of decisions on 'physician-assisted suicide' and euthanasia in this category of patients cannot be certified.

One important psychological issue, which parallels these views but applies to all cases of physician-assisted suicide and active euthanasia, is that decisions on these issues may be influenced by unintentional and even unconscious biases. One example of this phenomenon was presented in a recent study in which Swedish jurors were presented with a case description of a severely brain-damaged patient who was taken out of a respirator in the presence of muscle-relaxing drugs. The jurors were, most likely out of concern for the patient, generally supportive of euthanasia. However, since we varied the gender of the patient, as presented in the case description, we were also able to see that both male and female jurors tended to be most supportive of this kind of euthanasia when it was administered to a patient who belonged to the opposite gender (Sjöberg & Lindholm, 2003). Swedish jurors thus tended to be more impressed by the futility of the life of patients who were in important respects dissimilar to themselves.

Not only psychiatric, but almost all clinical decision-making is to a certain extent tentative and subject to the corrective forces of expectation and further empirical observations – but decisions that lead to the active and intentional termination of the life of a patient are not. We believe that this fact, which was also indirectly addressed by Kelly & McLoughlin, is important not only to the discussion of whether physician-assisted suicide should be administered to psychiatric patients but also to the discussion of whether physicians should engage in euthanasia and physician-assisted suicide and whether psychiatrists should take the risk of sanctioning such activities by assessing the mental status of potential subjects of such interventions.

Kelly, B. D. & McLoughlin, D. M. (2002) Euthanasia, assisted suicide and psychiatry: a Pandora's box. *British Journal of Psychiatry*, **181**, 278–279.

Sjöberg, R. L. & Lindholm, T. (2003) Gender biases in decisions on euthanasia among Swedish jurors. *Nordic Journal of Psychiatry*, in press.

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More to social capital than Putnam

I would like to comment on the editorial by McKenzie *et al* (2002) regarding social capital and mental health.

Putnam's conceptualisation of social capital is the one that has caught the interest of policy-makers in recent years but it is pre-dated, by at least a decade, by Bourdieu's (1980, 1985) theory of capital which, I would argue, has more relevance for the study of social and health inequalities. Portes (1998, 2000) gives an accessible account of this dynamic view of social capital.

One of Bourdieu's main insights is that people consciously participate to build their various forms of capital and then *use* them to their advantage. In this way, social capital is a property of the individual, acquired though it may be through group membership. More importantly, social capital (along with all the other forms of capital) is then implicated in the production and reproduction of the very inequalities it is generally thought to mediate against. This dialectic poses some very real questions for the study of health inequalities over the life course, especially with regard to the possibility of disentangling any direct effects of social capital on health from the indirect effects of social capital through increased social mobility and access to economic capital.

This dynamic view of social capital also allows health research to go beyond examining health 'status' to investigate its role in the onset of and recovery from illness and poor health. Those with low stocks of capital are more likely to become ill and take longer to recover or are less likely to recover at all. Further, they are more likely to suffer adverse consequences of their illness in other fields, such as regaining employment, thus contributing to the widening of health inequalities.

Although I agree with most of the editorial on the potential of social capital as a heuristic device in studies of mental health, I was disappointed that it gave the impression of theoretical or conceptual consensus on the issue. I hope that my brief sketch will encourage researchers to go further than Putnam's ideas.

Bourdieu, P. (1980) Le capital social: notes provisoires. *Actes de la Recherche in Sciences Sociales*, **31**, 2–3.

— (1985) The forms of social capital. In *Handbook of Theory and Research for the Sociology of Education* (ed. J. G. Richardson), pp. 241–258. New York: Greenwood.

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McKenzie, K., Whitley, R. & Weich, S. (2002) Social capital and mental health. *British Journal of Psychiatry*, **181**, 280–283.

Portes, A. (1998) Social capital: its origins and applications in modern sociology. *Annual Review of Sociology*, **24**, 1–24.

__ (2000) The two meanings of social capital. *Sociological Forum*, **15**, 1–12.

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Retention in psychiatry

Seeking improved means of recruiting psychiatrists appears to be only part of the solution to the present shortfall of consultant psychiatrists. Another aspect of the problem, as mentioned in Storer's editorial (2002), is the inability of psychiatry to retain trainees.

One potential factor contributing to the haemorrhage of trainees is lack of success at the membership examinations. Is it possible that this situation could be reappraised? It seems unfortunate that trainees who have already committed themselves to a career in psychiatry should have their prospects brought to an abrupt halt. Perhaps I am not alone in having had the experience of working with competent and enthusiastic people who found themselves in this predicament.

One can anticipate that many will express concerns about 'a lowering of standards'. But surely, affording people extra time to reach the desired standard is not the equivalent of requesting a reduced pass mark. Furthermore, if trainees avail themselves of additional opportunities and are ultimately successful, would it not be the case that the very qualities displayed – patience, forbearance and persistence – would serve them well in a career in psychiatry?

Storer, D. (2002) Recruiting and retaining psychiatrists. *British Journal of Psychiatry*, **180**, 296–297.

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One hundred years ago

Crime in general paralysis

IN the *Journal of Mental Science* for January Dr. W. C. Sullivan, deputy medical officer of H.M. Prison, Pentonville, has published an article on the medico-legally important subject of crime in general paralysis. While crime has been extensively investigated in recent years in association with conditions of arrested or distorted cerebral and physical development (criminal anthropology), less attention has been given to a class of criminals in whom the morbid aptitude for criminal acts is connected with acquired cerebral degeneration or defect, such as might be caused by alcoholic intemperance or general paralysis. The examination of conduct in chronic alcoholism shows a remarkable frequency of suicidal and homicidal impulse as well as a tendency to sexual crimes, a subject to which attention has already been called in these columns.[1] In general paralysis, on the other hand, says Dr. Sullivan, the character of conduct was entirely different. A rough illustration of this might be given in statistical form. During nine years (1888 to 1896) among convicted prisoners certified as insane in the local prisons of England and Wales there were 274 cases (261 males and 13 females) in which the form of mental disease was considered to be general paralysis. Amongst these 261 male general paralytics homicide or homicidal attempts constituted the crime in nine cases, suicidal attempts were met with in eight cases, sexual offences in 13 cases, assaults in 21 cases, crimes of acquisitiveness in 144 cases, threats in eight cases, and other offences in 58 cases. Crimes of acquisitiveness were notoriously common in general paralysis, their most typical form being petty larceny, fraud, forgery, and embezzlement. Generally the circumstances and execution of the offence showed a characteristic silliness, though occasionally the general paralytic did commit robbery or fraud with an appearance of adequate motive and premeditation. The most important point to be noted was that this tendency existed in the exalted and optimistic variety of general paralysis and not in the depressed or melancholic form. Very often the impulses to theft or undue acquisitiveness preceded the grandiose delusions by a long period of time or were met with in the purely demented type of general paralysis without delusions. Besides this impulsive origin, paralytics who had lost money or blundered in their accounts might in a more lucid phase embezzle to make good the deficit – a point of practical importance in relation to the question of legal responsibility. Paralytics are also very amenable through their *naïveté* to criminal suggestion by others. Magnan quotes the case of a patient who was sent by his wife to steal in the Bon Marché, and Foville mentions two instances where paralytics were used as tools to utter forgeries. Acts of violence may be committed by paralytics when their grandiose tendencies are opposed, but the majority of grave acts of violence depend on a primary homicidal impulse generated by the more or less persistent state of emotional depression. Sexual offences in early paralysis – in the form of rape, defilement of children, and offences against public decency – are not uncommonly met with.

REFERENCE

Lancet, 25 January 1902, p. 246.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

[1] *THE LANCET*, April 14th, 1900: On Alcoholism and Suicide.

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