# the columns

# correspondence

## Discharging psychiatric patients from hospital

Sir: In their editorial on the high-risk period after discharge from in-patient care, Walker and Eagles (*Psychiatric Bulletin*, July 2002, **26**, 241–242) quote one finding from the Wessex Recent Inpatient Suicide Study (WRISS): key personnel on leave/leaving occurred more often for patients who commit suicide than for controls (5% *v.* 1%). They state 'given the average consultant is on leave some 15% of the time, this strongly suggests incomplete or selective recording'.

Closer reading of our paper (King *et al*, 2001) may have prevented some erroneous assumptions and enhanced their review about factors during this period.

1. The WRISS is a retrospective case–control study, using data collected from case notes with manualised operationally-defined criteria and is not, as implied, a psychological autopsy study.
2. They presume that 'key personnel' are always the consultant psychiatrists. We know this is often not the case, distinguish between key personnel (including community psychiatric nurse, keyworker or out-patient doctor) and consultant, and acknowledge this finding is probably artefactual.
3. More relevant findings, not mentioned by Walker and Eagles, were differences between cases and controls in frequency of unplanned discharge (OR 2.73, 95% CI 1.77–4.22), and the protective factor of supported accommodation.
4. The WRISS highlights the high-risk period immediately after discharge, concurring with other findings of 34% dying within the first month. The National Confidential Inquiries report that 80% of patients died before their first out-patient appointment and recommend early follow-up, but our case–controlled results show no difference between groups in the percentage of people who were seen between discharge and death, or the equivalent follow-up period.

KING, E. A., BALDWIN, D. S., SINCLAIR, J. M. A., *et al* (2001) The Wessex Recent Inpatient Suicide Study, 1: Case–control study of 234 recently discharged psychiatric patient suicides. *British Journal of Psychiatry*, **178**, 531–536.

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## The suicide bomber – is it a psychiatric phenomenon?

Sir: Dr Gordon's paper (*Psychiatric Bulletin*, August 2002, **26**, 285–287) on the suicide bomber is a cogent reminder that psychiatrists are sometimes guilty of trying to explain all disagreeable and unusual behaviour in terms of disorder. This tendency to medicalise behaviour was challenged last century by Émile Durkheim, who refuted the prevailing view that suicide was always associated with mental illness and the assertion that people who kill or damage themselves do so because of the temporary disturbance of mind, and raises philosophical as well as psychiatric issues.

In contemporary psychiatry, the notion that suicide must be 'due to illness' is reinforced by classification systems such as ICD–10 (World Health Organization, 1992) and by 'rating scales' implying severity of disorder. Durkheim identified several social dynamics that could lead to suicide and it is the category of altruistic suicide that neatly describes suicide bombers. Altruistic suicide refers to self-inflicted death owing to powerful beliefs, resulting in individuals losing their sense of autonomy. When a central belief that life is but a temporary prelude to everlasting utopian existence is one of these regulatory norms, the definition of suicide itself becomes ambiguous and the role of psychiatry as a valid therapeutic intervention is also questionable.

DURKHEIM, E. 1952 *Suicide. A Study in Sociology* (trans. J. A. Spaulding & G. Simpson). London: Routledge and Kegan Paul.

WORLD HEALTH ORGANIZATION (1992) *International Classification of Diseases, 10th Revision* (ICD–10). Geneva: WHO.

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## Medico-legal implications of drug treatment in dementia

Sir: We read with interest the paper by Lawrence *et al* (*Psychiatric Bulletin*, June 2002, **26**, 230–232), which was both informative and timely.

However, in discussing the difficulties encountered in obtaining consent in dementia, they state that the alternatives to valid consent 'such as assent or vicarious approval by a carer, are unlikely to satisfy legal or moral requirements'. We disagree because these are not the only alternatives.

If an adult patient cannot give valid consent, because he or she lacks capacity, doctors must act in the person's 'best interests'. Of course, this does not simply mean best medical interests. As the Lord Chancellor has reminded us, 'best interests' are determined by broad and careful discussion and negotiation (Hughes, 2000). Decisions arising from such a process of open collaboration and mutual engagement will have both a legal footing and ethical basis.

HUGHES, J. C. (2000) Ethics and the anti-dementia drugs. *International Journal of Geriatric Psychiatry*, **15**, 538–543.

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