

Correspondence

Edited by Kiriakos Xenitidis and
Colin Campbell

Contents

- Domestic violence: we need changes in the ICD and at the start of training
- Assisted suicide: two sides to the debate
- Lithium concentrations in drinking water
- Suicide as protest against social suffering in Arab world

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.

Virginia A. Davies, Child and Adolescent Psychiatrist, Hammersmith & Fulham Child and Adolescent Family Service. Email: virginia.davies@wlmht.nhs.uk

doi: 10.1192/bjp.198.6.492

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