

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.

Philip Graham, Emeritus Professor of Child Psychiatry, Institute of Child Health, London. Email: grapjraham1@aol.com

doi: 10.1192/bjp.198.6.492a

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.

- Curtice MJ. Assisted suicide: merely theoretical and illusory rights (eLetter). *Br J Psychiatry* 2011; 9 February.
- David AS, Hotopf M, Moran P, Owen G, Szmukler G, Richardson G. Mentally disordered or lacking capacity? Lessons for management of serious deliberate self harm. *BMJ* 2010; **341**: c4489.
- Rayner L, Lee W, Price A, Monroe B, Sykes N, Hansford P, et al. The clinical epidemiology of depression in palliative care and the predictive value of somatic symptoms: cross-sectional survey with four-week follow-up. *Palliat Med* 2011; Jan 12. Epub ahead of print.
- Lawlor PG, Gagnon B, Mancini IL, Pereira JL, Hanson J, Suarez-Almazor ME, et al. Occurrence, causes, and outcome of delirium in patients with advanced cancer. *Arch Intern Med* 2000; **160**: 786–94.

Matthew Hotopf, Psychiatrist, Institute of Psychiatry, King's College London. Email: matthew.hotopf@kcl.ac.uk; **Annabel Price**, Lecturer, **William Lee**, MRC Clinical Training Fellow, Institute of Psychiatry, King's College London

doi: 10.1192/bjp.198.6.493

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