or alcohol, the statement may be accurate. However, the greatest overall harm to our nation comes from our "respectable" drugs.

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Department of Psychiatry
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[The author replies:]

Dr. McCormick has pointed out an important nuance, one with which I agree.

John Hoey, MD
Editor-in-Chief

A new approach to suicide

Doris Sommer-Rotenberg is to be congratulated on her campaign to establish a research chair in suicide studies at the University of Toronto, as described in her article "Suicide and language" (*CMAJ* 1998;159[3]:239-40). Her courage in speaking out against the stigma of suicide and mental illness is an example for all.

Sommer-Rotenberg asserts that the phrase "commit suicide" is part of the problem. It is. More damaging than the terminology, however, is the underlying implication: that suicide signifies a moral lapse by the patient or a failure by either physicians or relatives to prevent it.

The clinical reality is that up to 60% of people with schizophrenia will experience suicidal thoughts, and 10% will die as a direct result of the illness. The rates are similar for bipolar illness. In psychiatry we say that the patient committed suicide; in any other branch of medicine we say that the illness had a fatal outcome. Only when we stop seeing suicide as a moral lapse and recognize it as a possible outcome of a brain illness will we start to use standard medical means to address the problem.

In Victoria, deaths from suicide vastly outnumber those from motor vehicle crashes (Dianne Olson, Regional Coroner Victoria Region, BC Coroner's Service: personal communication, 1998). For example, last year 61 people died from suicide and 13 from motor vehicle mishaps. Those latter 13 people received extensive media coverage, but the 61 who died from suicide did not receive the same attention, nor will others who die the same way until more people like Sommer-Rotenberg are willing to stand up publicly and say, "My son had a psychiatric illness that was fatal, and something must be done."

Properly organized programs of care *can* make a difference. For example, a Swedish public health program in 1983/84 showed that primary care physicians, properly supported, can reduce the suicide rate.[1] Following an educational program concerning depression, given to all general practitioners, the suicide rate dropped significantly, especially among those with major depression. Admission to hospital for depression also decreased substantially. The prescription of antidepressants increased, whereas that of both tranquilizers and hypnotic agents declined. After the program was discontinued, however, the suicide rate reverted to the baseline level.

Mortality rates are reduced by establishing programs to deal with high-mortality illnesses. Some psychiatric illnesses fall into this category. We need to change our thinking about suicide so that we can change our approach to dealing with the problem.

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Reference

1. Conwell Y. Management of suicidal behaviour in the elderly. *Psychiatr Clin North Am* 1997;20:667-83.

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