neonatal nurse practitioners there should be no barrier to teaching neonatal resuscitation to all midwives. In the northern sector of the North Eastern and Yorkshire region a day of training in neonatal resuscitation has been run four times a year for many years.³ The initial impetus for this was the need to train new senior house officers, but midwives have always been welcome and several have attended each course. Recently we have been asked to run the course separately for 80 midwives a year.

The baby, however, is not the only potential patient. Maternal problems also occur, and obstetric flying squads have all but died out. In this region we are piloting a course in advanced life support in obstetrics, which is designed to cover these aspects. It is aimed mainly at midwives, general practitioners, obstetricians, and paramedics, but others may find it appropriate. At present we are seeking primary funding, but if this is achieved the first course should be run next year; it would then be self funding. Such courses will not provide emergency care in the community to the level of that expected in hospital but should narrow the present gap. We suggest that such an approach is more effective than maintaining a fully staffed flying squad sitting idle, awaiting the relatively few calls from the community.²

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Midwives can cope with home confinements

EDITOR,—Carol Sullivan and colleagues correctly highlight the delays inherent in calling a neonatal flying squad to assist in the management of emergencies outside hospital.¹ Nottingham City Hospital is probably not alone in taking a median of 45 minutes to mobilise such a flying squad, and whether these squads have any place in the management of such emergencies is doubtful.

The authors seriously underestimate the skills of midwives and paramedics in providing the necessary basic life support in such situations. All midwives are trained in neonatal resuscitation, and the skills of many who undertake home confinements extend to intubation. Under normal circumstances two midwives attend at each home confinement, preventing conflicts of interest between the mother and baby. A report on obstetric flying squads by the Royal College of Obstetricians and Gynaecologists recommended their replacement with specially trained paramedics.² Although not yet fully implemented in all parts of the country, the NHS Training Directorate's paramedic training course includes a module on the emergency care of newborn infants, written by experts.³ The module makes the valid point that drugs have a relatively small role in early neonatal resuscitation and emphasises basic resuscitation, rapid transport, and communication with specialist staff in the receiving hospital to arrange reception.

It is sad that doctors should continue actively to dissuade mothers from choosing a home confinement and to put pressure on midwives not to offer this choice because of the non-availability of high technology.

We are sure that the debate on the place of confinement will go on for many years, but as a couple we were sufficiently confident of the capabilities of our midwives to opt for our three children being born at home. We would not wish other medical parents to be put off by inadequate or misleading information.

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Depression and the desire to die

EDITOR,—Peter Madeley is right to point to the role of depressive disorders in people who express the desire to die.¹ However, he is wrong to suggest that people expressing such a desire necessarily merit psychiatric examination. Those of whom I wrote in my Personal View were positive about their lives and mainly fun to visit.² They expressed a sense of completion or fulfilment. They therefore did not want their lives to be extended by medical means. They did not, however, mention euthanasia. They wanted to be allowed to "die naturally." They would probably figure among the 88.5% of elderly patients admitted to hospital for medical reasons who do not exhibit depressive disorders.³

The nurse who called a chaplain rather than a psychiatrist in the first instance to see the patient expressing a wish to die may have been on the right track. Chaplains have a greater experience of the whole range of humanity as they give attention to all patients and are not confined as is a psychiatrist largely to those who are mentally sick. An experienced chaplain knows when to suggest referral to a psychiatrist.

Those who automatically assess an expressed wish to die as a symptom of depressive disorder leave us with a question. As all human beings have to die at some time, at what stage is it healthy to wish to do so? Or must we fight death to the end?

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Prevention of suicide

Depressed patients need more choices

EDITOR,—The prevention of suicide may be controversial, but does it really warrant the pessimism expressed recently? David Gunnell and Stephen Frankel provide a comprehensive review of the prevention of suicide, but their conclusions seem unduly negative.¹ Jennie McCarthy and Ian Davidson rightly see problems with the use of suicide as an indicator for the performance of mental health services.² However, "health of the nation outcome scales" to measure improvements

in the health and social functioning of mentally ill people should be available soon.

Suicide is an important cause of death (5542 suicides occurred in 1992, including death of undetermined cause) and is more common than deaths from road traffic accidents (3814 occurred in 1992) and from cervical cancer (1532), yet the attention paid to it is far less. Perhaps it is still viewed as a choice that should not be constrained. Yet most people who commit suicide are seriously depressed,³ believing that they have no or little choice other than to kill themselves.

The prevention of suicide thus aims at making choices available. Paradoxically, this means making suicide harder to commit through detection and the management of risk—just as the prevention of accidents aims at making it more difficult for accidents to happen. Community measures to reduce the availability of lethal substances—for example, carbon monoxide and paracetamol—can either directly prevent suicidal acts or allow time for interventions so that impulsive acts in response to anger or depression are not fatal.

The management of depression by trained staff can allow balanced choices to be made and reduce the likelihood of suicidal intent emerging in the first place. Not all suicides are preventable, and people may still choose to commit suicide—for example, in the course of a terminal illness—but at least they should be given the right, and access to the reasoning capacity, to consider all alternatives (including adequate pain relief when relevant).

Further research is being commissioned by the Department of Health and the Medical Research Council. Above all, though, we need a change in attitude by doctors and the general public to appreciate the importance of relieving the distress caused by and leading to suicide.

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Suicide may not be preventable

EDITOR,—Greg Wilkinson alludes to an important principle that needs to be highlighted—namely, that suicide is often not preventable.¹ The public, politicians, and some doctors seem to perceive that if a patient commits suicide there has been a failure of care. Few other specialties are constrained by this doctrine. When a patient dies of cancer or a heart attack the doctors involved are rarely blamed.

Why are doctors commonly regarded as culpable if a patient commits suicide? There may be a fundamental lack of understanding of the nature of the condition or, because suicide is self inflicted, a need to ascribe blame. It is now, thankfully, unacceptable to hold the patient responsible, and therefore the doctor is blamed instead. Another factor may be the pernicious culture of self blame that arises within the medical profession because expectations outstrip reality. H G Morgan perpetuates this ethos and diminishes the fact that mental illness is potentially fatal despite intervention.¹

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