'incorporated into future meta-analytical reviews'.[2] A co-author of Roberts *et al*'s letter to the editor (Cipriani) was also a co-author on this publication by Girlanda *et al*.

Ultimately, although we agree that the results of observational studies certainly support a role for lithium in suicide prevention, we feel that there is a clear need for more randomised trials evaluating its efficacy in preventing death by suicide. The substantial effect of a single trial highlights the tenuousness of findings regarding lithium in RCTs. Fortunately, a brief search of clinicaltrials.gov suggests that there is a large trial of lithium for suicide prevention underway (NCT01928446) and another trial that was recently completed (NCT01134731). Notably, a third trial was prematurely terminated (NCT00520026).

1 Riblet N, Shiner B, Young-Xu Y, Watts B. Strategies to prevent death by suicide: meta-analysis of randomised controlled trials. *Br J Psychiatry* 2017; **210**: 396–402.

2 Girlanda F, Cipriani A, Agrimi E, Appino M, Barichello A, Beneduce R, et al. Effectiveness of lithium in subjects with treatment-resistant depression and suicide risk: results and lessons of an underpowered randomised clinical trial. *BMC Research Notes* 2014; **7**: 1–8.

3 Avins AL, Cherkin DC, Sherman KJ, Goldberg H, Pressman A. Should we reconsider the routine use of placebo controls in clinical research? *Trials* 2012; **13**: 44.

Natalie B. V. Riblet, **Brian Shiner**, Veterans Affairs Medical Center, White River Junction, Vermont, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, and The Dartmouth Institute for Health Policy and Clinical Practice, Hanover, New Hampshire; **Bradley V. Watts**, Veterans Affairs Medical Center, White River Junction, Vermont, and Geisel School of Medicine at Dartmouth, Hanover, New Hampshire, USA. Email: Natalie.BV.Riblet@dartmouth.edu

doi: 10.1192/bjp.211.6.396a

Where is the argument for the conceptual slippery slope?

I do concur with the position laid down by Brendan Kelly[1] in commentary on the paper by Verhofstadt *et al*[2] and his conclusion that 'we should not kill our patients'. However, one argument he has surprisingly not used is that of a 'slippery slope'. In particular, Beauchamp & Childress[3] specify two versions of this argument. The psychological–sociological one is well-known and is often cited as an argument against euthanasia. However, the conceptual slippery slope is by far the more dangerous and is exemplified here so succinctly. In Verhofstadt *et al* we have 'unbearable suffering' as a concept leading almost effortlessly and uncritically to the euthanasia of psychiatric patients who have no terminal disease. What is so shocking is that this is no sterile philosophical debate: it is in action in a European country and has led to patient deaths. This subjugation demonstrates the biggest risk in the euthanasia debate and should be actively resisted.

1 Kelly B. Invited commentary on: When unbearable suffering incites psychiatric patients to request euthanasia. *Br J Psychiatry* 2017; **211**: 248–9.

2 Verhofstadt M, Thienpont L, Peters G-JY. When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study. *Br J Psychiatry* 2017; **211**: 238–45.

3 Beauchamp TL, Childress JF. *Principles of Biomedical Ethics (4th edn)*. Oxford University Press, 1984.

John M. Clifford, Consultant Psychiatrist, Betsi Cadwaladr University Health Board, North Wales. Email: jmc123@yahoo.com

doi: 10.1192/bjp.211.6.397

Author's reply: I am very grateful to Dr Clifford for his letter. He is entirely correct to highlight the slippery slope. There are several slippery slopes here. Will the practice of euthanasia on the basis of suffering resulting from mental illness alone expand to less severe forms of mental illness, to earlier mental illness and to people without mental illness themselves but who experience substantial suffering as a result of mental illness in someone else (e.g. a family member)? The reason why I did not present the slippery slope argument initially was because the argument can, ironically, become a slippery slope itself, as skilled rhetoricians invoke all kinds of unlikely speculative scenarios with substantial emotional power, but limited practical relevance. Nonetheless, Dr Clifford's point is clearly right and I am especially pleased that he agrees with the central point of my commentary: we should not kill our patients.

Brendan D. Kelly, Professor of Psychiatry, Trinity College Dublin, Trinity Centre for Health Sciences, Tallaght Hospital, Dublin, Ireland. Email: brendan.kelly@tcd.ie

doi: 10.1192/bjp.211.6.397a

Authors' reply: Given that a recent trend analysis[1] revealed an increase in instances of euthanasia of people with psychiatric disorders since the Belgian law on euthanasia came into effect in 2002 (despite unresolved matters of great concern), Dr Clifford's call not to ignore the potential risks of euthanasia legislation and practice is indeed essential. Since legalised euthanasia affects directly involved actors as well as healthcare systems and (inter)national societies, discussion of slippery slope arguments is necessary to stay alert and prevent ethically unacceptable acts from being accepted.

At the same time, it is important to safeguard against these discussions becoming purely philosophical, uncorroborated or even leading to a slippery slope fallacy, as might be the case if they are not based on scientific evidence. Hence, it is striking that 15 years after Belgium introduced its euthanasia law, euthanasia among psychiatric patients is still underexamined. Our own study[2,3] has concentrated on the reality of clinical euthanasia practice in Belgium and finding ways of improving its transparency and quality.

In an effort to outline this reality, we would like to react to Dr Clifford's assumption that unbearable suffering as a concept might 'lead almost effortlessly and uncritically to euthanasia'. As we stated in the introduction to our paper,[2] unbearable suffering is a necessary but not a sufficient condition for granting euthanasia requests in Belgium (other conditions being the competent patient repeatedly making a voluntary and well-considered request, and suffering being rooted in an incurable medical illness without prospect of improvement[4]). Furthermore, for patients who are not terminally ill, the Belgian euthanasia law stipulates the specific legal requirement of due care that two additional independent physicians, one of whom is specialised in the patient's disorder, must be involved in careful assessment and evaluation of all the legal requirements. Hence, in the context of psychiatric patients requesting euthanasia, consultations with at least one psychiatrist are mandatory.

Our study[2,3] focused on just one of the key criteria, unbearable suffering, as it represents the most subjective and indeterminate criterion in granting euthanasia requests in the absence of an overarching solid definition and psychiatric assessment tool. In order to contribute to vigilance regarding euthanasia practice, especially concerning psychiatric patients, who are a particularly vulnerable group, the assessment of key criteria such as unbearable suffering should be undertaken as comprehensively and accurately as possible.

It is precisely this scientific involvement that might inform both the slippery slope discussion and the questioning of euthanasia as an end-of-life option on grounds of these arguments. In light of