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Authors' reply: Dr Cantor seems to have misconstrued the intended scope and content of our editorial. We did not set out to comment upon national suicide prevention strategies but, as the title suggested, we sought to discuss the role of psychiatrists specifically in attempting to prevent suicide among the patients we treat. We agree wholeheartedly that any strategy that focused exclusively on psychiatrists as the agents of suicide prevention would be absurd. Indeed, this was one of the main points we were trying to make.

Dr Cantor thinks that our ignorance of the epidemiological data makes us state that "all of our patients are at increased risk of suicide". This is in fact an epidemiological statement, which he interprets concretely. The fact that the lifetime risk of suicide among people with recurrent depression has been adjusted downwards actually renders statistical prediction of a rare event even more difficult. Largely for this reason we cannot predict which of our patients will commit suicide or when they might do so, and thus we must regard the entire cohort of patients we see as collectively at increased risk of dying by suicide and view their clinical management accordingly.

We take issue that it is "self-indulgent" to suggest that psychiatrists find the suicide of their patients to be traumatic. We know this to be the case from our survey in Scotland (Alexander *et al*, 2000) and from other, more qualitative accounts (Hendin *et al*, 2000). While valid comparisons among professional groups are difficult to make accurately, we in Aberdeen are more than a little interested in the impact of 'critical incidents' on colleagues in the caring and emergency services (e.g. Alexander, 1993; Alexander & Klein, 2001). One crucial difference between psychiatrists on the one hand and other doctors and other professionals on the other is the issue of blame. While, as we try to point out, it is often illogical for psychiatrists to take responsibility for the suicide of our patients, we frequently do, and this distinguishes it from the deaths that other professionals encounter. Finally, presumably we would wish our patients (and their families) to feel cared for and understood. Surely, as professionals in psychiatric services, we should accord the same opportunities to each other.

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Psychiatric training in developing countries

Jacob (2001) successfully highlights the problems of community care of people with mental disorders in developing countries. Both he and the *Journal* are to be commended for addressing the mental health issues of the vast populations of such countries, a topic generally overlooked in the literature. The author is right to point out that most programmes have failed to deliver and that the success of local model projects has not been repeated at a national level. From personal experience as both a trainee and a trainer and from discussion with colleagues in a similar situation, I believe the most important reason for this is the inappropriate training of psychiatrists in developing countries.

The suitability of the training in developed countries for psychiatrists who will ultimately work in developing countries is increasingly being questioned (Mubbashar & Humayun, 1999), but questions have rarely been asked about the training in their own countries. Unfortunately, the training in most developing countries is still based on models of psychiatric services and theories derived from developed nations. An obvious example is the concept of community psychiatry. This concept and its enactment, derived from the history of modern Western psychiatry, cannot be applied in developing countries (Farooq & Minhas, 2001). Young psychiatrists from developing nations who trained in this model of community psychiatry will find the realities of psychiatric services in their own countries totally different from what they have learnt in training.

Moreover, the training in many developing countries remains narrowly focused on acquiring clinical skills. This is despite the fact that a World Health Organization expert committee recommended long ago that trained mental health professionals should devote "only part of their working hours" to the clinical care of patients (World Health Organization, 1975). As Jacob points out, the realities of mental health care in the community in developing countries demand that training is broad-based and equips the psychiatrist to work effectively with other disciplines, particularly primary care. This, however, is rarely the case in many developing countries.

The training of psychiatrists in developing countries needs a total paradigm shift to address the problems raised by Jacob. Both the mental health professionals and the policy makers need to address this as a priority. If they do not, most of the mental health initiatives in these countries will fail.

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Vascular risk factors for stroke and depression

Stewart *et al* (2001) present an important study of the association between the vascular risk factors for stroke and depression. Although the non-participation rates and levels of physical morbidity were high in the sample, they did not find any association between risk factors for vascular disease and level of depression in the older

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