LETTERS TO THE EDITOR

Marital status and suicide: some common methodological problems

EDITOR,—In a recent paper published in this journal, Kposowa 1 reported that divorced and separated men had a higher risk of suicide than married men. Men and women of other unmarried status reportedly did not suffer any excess risk of suicide in comparison with their married counterparts. We have some reservation about the findings, and wish to point out two methodological problems that may have affected many studies in this area.

In this study marital status was enumerated at the beginning of the study period. Marital transitions between the baseline survey and death or end of follow up were unknown to the researcher. The author did mention this issue at the end of the discussion section, but seemed to suggest that the problem would not have seriously affected the findings. The failure to capture marital changes would lead to a misclassification of marital status during the follow up period and at death. The follow up period is from 1979 to 1989. Marital status would have changed during the 11 year period. For example, among the elderly, the married person would become widowed; the never married person would become single on suicide. The purpose here is to consider this problem.

As discussed in my article, marital status was measured at baseline. The study was not designed to estimate the effect of marital transitions, but the impact of being in a given marital status at baseline. Marital status is a time varying covariate. While such a variable may change over time, Yip and Cheung exaggerate the impact of this change on mortality.

Author's reply: Marital status and suicide: some possible misunderstandings

Yip and Cheung express reservations in their letter about results in a previous report 4 that failed to find significant effects of widowhood and being single on suicide. The purpose here is to consider these issues.

As discussed in my article, marital status was measured at baseline. The study was not designed to estimate the effect of marital transitions, but the impact of being in a given marital status at baseline. Marital status is a time varying covariate. While such a variable may change over time, Yip and Cheung exaggerate the impact of this change on mortality.

Table 1 Effect of marital status on suicide by selected years of follow up

Correlate | RR | 95% CI | RR | 95% CI | RR | 95% CI
--- | --- | --- | --- | --- | --- | ---
Marital status | | | | | | |
Married | 1.00 (Reference) | 1.00 (Reference) | 1.00 (Reference) | 1.00 (Reference) | 1.00 (Reference) | 1.00 (Reference) |
Single | 1.16 | 0.39, 3.47 | 1.18 | 0.73, 1.90 | 1.22 | 0.84, 1.79 |
Divorced | 2.82** | 1.15, 6.92 | 2.81** | 1.12, 2.81 | 2.79** | 1.83, 2.79 |
Widowed | 1.22 | 0.32, 4.65 | 1.25 | 0.57, 2.05 | 1.23 | 0.57, 2.39 |
Unknown | — | — | 0.61 | 0.07, 5.02 | 0.68 | 0.08, 5.47 |
LRS | 53.11** | 304.44** | 471.85** |
degrees of freedom | 12 | 12 | 12 |
Number of subjects | 170 | 170 | 170 |
Number of observations | 328 | 328 | 328 |

*Adjusted for age, race, sex, education, income, and region. For the last year of follow up, see Kposowa. 1 LRS = likelihood ratio statistic; **significant at p<0.01.

Y B CHEUNG
PAUL S F YIP
Department of Statistics and Actuarial Science, University of Hong Kong, Pokfulam, Hong Kong
Correspondence to: Dr Yip (dypip@hkuce.hku.hk)


Neonatal mortality by place of delivery in São Paulo, Brazil

EDITOR,—In São Paulo, Brazil, 0.6% of all births do not occur in a hospital. Although neonatal mortality in home deliveries in the UK is higher than that in hospital deliveries, it is accepted that home births consist of two different groups: those who planned to deliver at home with higher average birth weight and lower neonatal mortality, and those who either booked a hospital delivery or did not book, with lower birth weight and extremely high neonatal mortality. 1 In São Paulo, home deliveries are not encouraged and there is no policy of booking in the state sector.

As part of a study of neonatal mortality in the city of São Paulo, a case-control study is being undertaken to investigate maternal and hospital risk factors. For the first six months of 1995, birth certificates were identified and linked to all neonatal deaths and a 10% sample of children who survived up to 28 days. Children with birth weight under 500 g were excluded.

The study included 9583 births with known place of birth, of which 64 did not occur in a hospital. In our data, children who were born at home were teenagers (<20 years) and had not completed primary education (eight years). There were no statistically significant differences according to the proportion of low birth weight, prematurity, and whether a father was named in the birth certificate, but the study may not have had enough power (table 1).

The risk associated with delivery not in a hospital was restricted to mothers of lower social sector.

Table 1 Distribution of birth weight, gestational age, schooling and age of mother and whether father is named on birth certificate in cases and controls by place of birth. São Paulo, 1995

<table>
<thead>
<tr>
<th>Variable</th>
<th>In hospital</th>
<th>Hospital</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n %</td>
<td>n %</td>
<td></td>
</tr>
<tr>
<td>Birth weight &lt;2500 g</td>
<td>11 (78.6)</td>
<td>6 (12.0)</td>
<td>1.55</td>
</tr>
<tr>
<td>Gestational age ≥37 weeks</td>
<td>8 (57.1)</td>
<td>4 (8.0)</td>
<td>1.37</td>
</tr>
<tr>
<td>Mother’s age ≥20 years</td>
<td>6 (57.1)</td>
<td>12 (14.0)</td>
<td>1.07</td>
</tr>
<tr>
<td>Mother’s schooling &lt;8 years</td>
<td>10 (71.4)</td>
<td>20 (40.0)</td>
<td>2.93</td>
</tr>
<tr>
<td>Name of father absent</td>
<td>5 (57.1)</td>
<td>15 (30.0)</td>
<td>1.65</td>
</tr>
</tbody>
</table>

Not in hospital

<table>
<thead>
<tr>
<th>Variable</th>
<th>n %</th>
<th>n %</th>
<th>OR 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>p Value</td>
</tr>
<tr>
<td>Birth weight &lt;2500 g</td>
<td>11 (78.6)</td>
<td>6 (12.0)</td>
<td>0.53, 4.71</td>
</tr>
<tr>
<td>Gestational age ≥37 weeks</td>
<td>8 (57.1)</td>
<td>4 (8.0)</td>
<td>0.37, 5.42</td>
</tr>
<tr>
<td>Mother’s age ≥20 years</td>
<td>6 (57.1)</td>
<td>12 (14.0)</td>
<td>1.07, 12.12</td>
</tr>
<tr>
<td>Mother’s schooling &lt;8 years</td>
<td>10 (71.4)</td>
<td>20 (40.0)</td>
<td>1.27, 6.63</td>
</tr>
<tr>
<td>Name of father absent</td>
<td>5 (57.1)</td>
<td>15 (30.0)</td>
<td>0.52, 4.86</td>
</tr>
</tbody>
</table>


**Family doctor advice and pneumococcal vaccine uptake**

EDITOR,—Kyaw et al 3 highlight the importance of advice from general practitioners in the immunisation of patients with pneumococcal vaccine. However, greater knowledge regarding pneumococcal immunisation is required among GPs and doctors in general before patients in the target groups are likely to be vaccinated. I performed a postal questionnaire survey of the awareness of the indications for, and practice of pneumococcal immunisation among GPs in one inner London borough. Questions explored knowledge of the guidelines for pneumococcal immunisation with six real and six fictitious indications for GPs’ immunisation practice. One hundred and fifty six GPs were mailed the questionnaire. The response rate was 56 of 156. The responses are summarised in table 1.

Respondents may represent those GPs interested in immunisation. However, few GPs seem to have a clear understanding of the Department of Health guidelines and some seem to confuse indications with those for influenza and meningococcal vaccines. On the other hand some GPs are aware of the indications but do not immunise accordingly, possibly because of the workload implications, lack of remuneration for the service or because of doubt regarding the vaccine’s efficacy. 2

Kyaw et al have previously suggested a pattern similar to ours in the UK is higher than that in hospital deliveries, and there is no policy of booking in the state sector. Further prospective randomised controlled trials are needed before we can be certain that many GPs may be uncertain about the indications for pneumococcal vaccine. Indeed, earlier work we performed demonstrated the exist-
ence of similar uncertainty in the early 1990s, regarding the indications for influenza vaccine. With regard to pneumococcal vaccine, the situation is probably worsened by the fact that the evidence in support of effectiveness in high risk elderly persons is restricted to the prevention of invasive disease (bacteraemia). We also agree that GPs face many issues around appropriate workload and remuneration. Nevertheless, we cannot accept that pneumococcal vaccination is too difficult to incorporate into routine practice. The indications for influenza and pneumococcal vaccines overlap considerably. The UK Department of Health recommends that patients recalled annually for influenza vaccination, are offered pneumococcal vaccine simultaneously (on a “once only” basis and at a different injection site), thereby delivering two preventive measures for the same consultation and administrative costs. We agree that the availability of new conjugate vaccines, which offer the hope of reducing nasopharyngeal carriage, may bring about the need to review policy.

The contradictory role played by mental health services in society has been progressively described by commentators and different interest groups since the beginning of the 1960s when mental health practice moved from an institutional to an increasingly larger community-based system of care. However, the complexity of the issues related to the acknowledgement and application of civil rights to mental patients on the one hand, and on the other hand, the disparate power and demands of involved parties—that is, relatives, users, professionals and agencies—have often hindered an objective joint outlook. In this sense, the Perkins and Repper book provides a valuable contribution because it entails a comprehensive up to date well documented overview of most of the underlying problems brought to surface by the application of the Community Mental Health Practice. Aimed at the defence of the full citizenship rights of the people with serious mental problems and anchored in this respect, it represents a meeting point for scientific literature, professional expertise and user experience where classically crucial and unresolved issues as the cure concept, the limits between madness and human condition, the interference of professional roles in mental health teams, the duty of patient protection, the treatment priorities, compliance and compulsory detention, or the different view of mental health difficulties in users, relatives and professionals, are thoroughly analysed and further discussed by means of the dilemma of choice or control. Reading this book will surely be of help to any professional in the community mental health field interested in deepening the understanding of the serious demands of mental patients to increase the quality of their service.

EMMA PASCUAL GÓMEZ
The Rehabilitation Unit, Dr Esquerdo Centre, Ramón de Campoamor 25, Sta Faz, Alicante, Spain

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Y B CHEUNG and PAUL S F YIP

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