The diagnosis debate: professional responsibility

I sympathise with Sam Thompson's wish to provide practical assistance to clinicians who involve the service users in their own care,[1] but I do not agree with his recommendations. I have studied more than a thousand homicides by patients or people with severe mental illness in the UK,[2] and it is clear to me that many of these cases might have had a very different outcome had the clinician not relied just on "what the service user tells them".[1] In many of these serious incidents, the patient's record is not fully studied and corroborating information is not sought from family and friends.[3] I would argue that Thompson's opinion, that "the job of the clinician is not to use their innately powerful position to impose a particular perspective",[1] is an abdication of professional responsibility and years of training. Although well meant, this strategy could leave seriously unwell service users in very vulnerable positions where they might harm themselves or others.

My own father was killed by a man with a psychotic mental illness. Just a few days earlier, the perpetrator had insisted he was perfectly well during a brief visit by mental health professionals following his mother's concerns about his rapidly deteriorating mental condition. The day he killed my father, he was acutely psychotic, insisting to the arresting police officers that not only was he well, but he was also the victim of a conspiracy by the US President and the Prince of Wales to clone his children and give them sex changes to make them look like Kylie Minogue. It is hard to see his rejection of the professionals' intervention as anything other than "a lack of insight or denial",[1] and the professionals' attempts "to enter the service user's world empathetically and sensitively"[1] rendered them ill informed, unprepared, and unable to prevent a catastrophe, for both his family and mine.

Results of a study[4] commissioned by the National Health Service (NHS) London of 40 patient homicide perpetrators showed that many perpetrators wished they had been more assertively treated when they were unwell. Of course, consideration of the service users' perspective is important, but I would argue that this perspective has to be balanced with corroborating information and the careful use of professional expertise and judgment, if we are to keep people with mental illnesses, their friends and families, and the general public safe from harm.

I am the director of HundredFamilies, a small national charity supporting families who have lost loved ones as a result of homicides by people with mental illness and working with local and NHS organisations to improve learning after such events and prevent further tragedies in future.

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Teaching global mental health at home and abroad

I support Andres Barkil-Oteo and colleagues'[1] statement that "international electives should be one part of a larger commitment of medical schools to sustain involvement in the host country". Their model, in which medical students participate in local community mental health placements in low-resource, primary-care settings, introduces a novel means of skill development that is valuable during overseas electives.

However, such approaches entail curriculum redesign and considerable administrative, organisational, and educational investment in order to be effective. In view of the current economic climate of austerity, in the UK at least, securing additional funding for such global mental health programmes might be an unrealistic prospect.

Curricular adaptations have to be supplemented with low-cost educational interventions that will teach medical students cross-cultural aspects of psychiatric disorders, management of mental health problems with limited resources, and the realities of health care in low-income countries. Furthermore, as the authors identify, "ensuring shared benefit between trainees and host countries is an important challenge in global health education". Indeed, such projects should be mutually beneficial to students in both low-income and high-income settings, whether in medicine, nursing, pharmacy, or any other health professions. Collaborations between hospitals or trusts in high-income and low-income countries to strengthen health care through exchange of knowledge and skills are common, but the integration of these collaborations at the level of medical school remains weak. The King's Tropical Health and Education Trust (THET) Somaliland Partnership (KTSP) developed a peer-to-peer global mental health e-learning programme for medical students at King's College London, University of Hargeisa, and Amoud University.[2-3] Medical students from each medical school are paired and meet for 1 hour online sessions to discuss global mental health topics. One result of this participation is the substantial improvement in the attitude towards psychiatry in students from Somaliland. Students from Somaliland valued the opportunity to enhance

For the **HundredFamilies charity** see http://hundredfamilies.org

For the **MedicineAfrica website** see http://medicineafrica.com

their factual knowledge, whereas students from the UK valued the cross-cultural learning.

One effective component of medical training in Somaliland is the MedicineAfrica website, a telemedicine portal with a social network structure that facilitates online case-based tutorials in real time[4] and is suitable for low bandwidth connections. The approach needs to be specifically adapted to the learning objectives, technological availability, and practical constraints of each local context, including access to internet, access to computers versus smartphones, and a shared language through which students can communicate. Although this model is still in its infancy and has yet to be trialled with large cohorts, it offers an additional, cost-neutral approach to global mental health education at home and abroad and has the potential to address many of the limitations of short-term overseas electives undertaken in isolation. Just as there can be no health without mental health[5], global health education for medical students is incomplete without concerted focus on global mental health. I welcome the authors' focus on this critically neglected area.

I am the co-founder of Aqoon, the peer-to-peer global mental health e-learning partnership between King's College London, University of Hargeisa, and Amoud Universities in Somaliland; I am the Mental Health co-Lead for the King's THET Somaliland Partnership. The King's THET Somaliland Partnership (KTSP) is funded by Tropical Health and Education Trust (THET) at King's College London. Aqoon receives no funding and is run on a voluntary basis.

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