moderate degree of accuracy. This sentence is dangerously misleading and fundamentally untrue. The clear inference to be drawn from the editorial is that the Supreme Court in the 'X' case was wrong in concluding that a real and substantial risk existed that Ms 'X' might commit suicide. This conclusion is derived from actuarial and epidemiological type evidence based on surveys of large populations of patients extrapolated to suicide many years later. This is like reviewing the characteristics of the 20,000 two year old race horses presently in training in these islands and attempting to predict those 15 or 20 or so who may eventually qualify for the Derby and may win the race.

The position of the court in the case of Ms 'X' was rather different. Here was a 14 year old raped girl who had been seen several times by an experienced clinical psychologist and who remained adamant in her expressed desire to commit suicide rather than continue with her pregnancy. Such a situation is comparable to the one the punters face when they attend Ascot and place their bets on one of the handful of race horses competing in the Derby.

Consider the situation of the clinical cardiologist. The prediction of imminent death from myocardial infarction may be extremely powerful when made in the context of the Intensive Care Unit but weakens progressively throughout patient departments to general practice. Yet nobody has yet suggested that cardiologists cannot predict heart attacks. Nor would it be advisable that an aged patient with marked ECG changes and three previous heart attacks to engage in marathon running. The fundamental flaw in D. Kelleher's thinking is to extrapolate the prediction of a rare event (suicide) from patient population surveys on the one hand, to prediction by psychiatrists dealing with actively suicidal patients in the context of intensive psychiatric inpatient care.

In the present political atmosphere, Dr Kelleher's conclusions are almost certain to be taken up and quoted by those whose sincerely held beliefs are strongly opposed to the introduction of liberal legislation on the matter. This writer firmly believes that practising psychiatrists are in fact remarkably efficient in the prediction of suicide, amongst high risk cases. There is a remarkable paucity of reliable research to support this view it must be admitted, but such research is at present being initiated at Galway.

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Reference
1. MJ Kelleher. The prediction of suicide and the law on abortion. Ir J Psychol Med 1994; 2: 55-6.

Author's reply

Sir – As a clinician, I welcome Prof Fahy's determination to identify factors, which if universally applied will predict the event of suicide. If he is successful, then he will have achieved something which, to date medicine and clinical psychology has been unable to do.[1,2,3]

Prof Fahy also confuses the difference between a court judgment and a medical opinion. The court's decision is, in law, true and, therefore, neither he nor I can refer to it as being wrong.

The point of the editorial was simple. At this moment in time, we do not have the ability to predict suicide with a modicum of certainty. Therefore, if the law, on termination of pregnancy within the Republic of Ireland, is to be changed, then, estimation of risk of suicide by clinicians would be an unreliable criterion for allowing such termination.

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1. Pokorny AD. Prediction of suicide in psychiatric patients: report of a prospective study. Arch Gen Psychiatry 1983; 40: 249-57.
2. Pokorny AD. Suicide prediction revisited: suicide and life threatening behaviour. 1983; 23: 1-10.
3. Maris R. The prediction of suicide. In: Divergent perspectives on suicidal behaviour. Edited: Kelleher MJ. 1994; 28-41

Erratum

The paper entitled *A descriptive study of adjustment disorder diagnoses in general hospital (Ir J Psychol Med 1994; 11: 153-7),* by Paul Foster and Thomas Oxman contained two errors.

1. The first sentence of the final paragraph on page 155 should read: "With respect to the outcome of the condition, follow up treatment was recommended for 40% of these patients". The figure given in this sentence was erroneously printed as 4%.

2. In table 2 on page 154 the DSM subtype of adjustment disorder for anxious mood should read as 309.24 and not 309.9 as was printed.

Our apologies to the authors.

https://doi.org/10.1017/S0790966700002093 Published online by Cambridge University Press