risks accepted for example by miners, mountain climbers and racing drivers; they take risks but recognize them and guard against them.

The word would label that behaviour in which an individual haphazardly took a number of tablets or physically injured himself without any real forethought concerning the implications of the act in terms of risk to life.

Thus treatment of the attempted suicide might well be psychiatric, but it is probable that the management of the propetic individual would be more likely to include social and environmental relief by various agencies, not excluding the family.

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DEAR SIR,

Thank you for asking me to write in reply to Dr Seager's letter. I ventured the term 'self-poisoning' as preferable to 'attempted suicide' because it allowed those first coming into contact with the people concerned to pursue a course of action without needing to consider the patient's intention which is often, at the time of first intervention, still obscure. There still seems merit in this. Norman Kreitman with 'parasuicide' and now Phil Seager with 'propetia' wish to reintroduce concepts of motivation into the nomenclature. This is unhelpful in the Accident and Emergency Department or the general hospital ward where the circumstances surrounding the tablet taking may not yet have been established. Moreover, the psychiatrist must pursue his own inquiries without having had the issue pre-judged by terminology.

The nice nuances of Dr Seager's 'pejorative' were not lost on me, but the implication of 'merely an "overdose" ' cannot be drawn from my writings; and as to the implication of self-poisoning not being 'an act of someone in distress' may I perhaps quote from a paragraph headed 'Distress' from my article which Dr Seager himself cites: 'Is there a unifying basis to self-poisoning? Is there some feature that informs them all? The answer has already been hinted at. Distress drives people to self-poisoning acts: distress and despair, unhappiness and desperation.'

You will see that I still believe we should use a term that is independent of conclusions concerning motivation. Of course within psychiatric circles we ever need to discuss each of the multiple motivations for self-poisoning. Will new vocabulary help? I doubt it.

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DEAR SIR,

Any honest parent entering his offspring for a baby show would have to admit that he brings a prejudiced eye to bear on the other competitors. It could well be that having proposed a term of our own to replace 'attempted suicide' my colleagues and I are biased against alternatives, but even with strenuous efforts to be impartial we have to conclude that Dr Seager's term 'propetia' will not do.

A distinction is proposed within the generality of self-poisoning and self-injury patients, but no definition is offered of the primary group to whom that differentiation is to apply. However, even if we allow this to pass, problems remain.

First, the distinction between the 'real' attempters and the rest is to be based on intention to die. The efforts of the last decade or so towards the use of criteria other than intent arose precisely because of the notorious difficulties of categorizing intentions with any degree of precision; those difficulties are no less now than formerly.

But it seems that to complicate things further, Dr Seager is also introducing an additional criterion based on notions such as recklessness, rashness, or impulsivity. This at once confounds the classification principle; what becomes of someone who resolves to die but makes up his mind briskly, or of the not-so-infrequent patient who plans quite carefully to take a non-lethal overdose?

Thirdly, while the characteristics to which Dr Seager points are certainly common, it can scarcely be claimed that they have been defined in his letter. What, for example, is the maximum time which a patient is allowed to take while thinking about his overdose and yet still be considered to be 'impulsive'? Just how 'reckless' must he be, and against what