predictive of mood fluctuations (particularly dysthymic swings) over time (Williams, 1981).

Our reference list (44 items) does contain recent reviews of conversion disorder and will be adequate for most readers of a publication of this nature. We stated on the first page of our text our reasons for considering globus to be different from disorders such as pseudoseizures.

It remains our opinion that globus might make a good model for conversion disorder. The results of our preliminary study have encouraged us to continue our study of psychological factors in globus. A report, in preparation, of a substantial number of patients, including an ENT control group, uses questionnaires designed to index psychoneurotic disorder and attempts to replicate our previous results on the personality traits of globus patients.

We agree with the workers from NHND that journal clubs can be educationally rewarding. Sometimes, however, the joint perusal of a document can lead to errors in understanding.

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Reference

Williams, D. G. (1981) Personality and mood: state – trait relationships. *Personality and Individual Differences*, **2**, 303–309.

Hospital suicides

Sir: During our psychiatric training, it has been our combined experience that when a patient commits suicide, the responsible team responds with a mixture of sorrow, guilt, embarrassment, and concern about possible litigation; there is little open discussion.

In our training, much attention is given to learning about known risk factors for suicide. However, despite an extensive literature, assessing suicide risk remains an imprecise art and virtually all psychiatrists recognise that despite their best efforts, some patients will successfully take their own lives.

It seems to us strange that emphasis is placed on learning about the theoretical aspects of assessment of suicidal risk, but that when a suicide does occur, the absence of ensuing discussion severely hampers the learning of practical lessons.

We believe that a completed suicide in a psychiatric patient is an extremely valuable opportunity from which lessons may be learnt for the benefit of future patients. It is our belief that formal discussion of such cases would have several benefits: firstly, and most importantly, it would help the responsible team and other staff to learn from the case: secondly, it would reduce unhelpful speculation; thirdly, if conducted sensitively, it would reduce, rather than increase, the anxieties of involved professionals; and fourthly, it could facilitate later discussion with bereaved relatives.

In medicine and surgery it is standard practice to hold post-mortem review of 'difficult' cases, with formal discussions of findings in the light of clinical presentation and interventions. We are not aware of this practice in psychiatry, but would be keen to learn of its existence and of the opinions of those who have experienced it.

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Sir: Goh *et al* (*Journal*, February 1989, **154**, 247–249) draw attention to the special features of suicide by psychiatric day and in-patients, and highlighted the importance of factors that related not only to the patient's illness but also to the immediate ward environment. Using the Edinburgh Suicide Case Register, I recently identified and reviewed the case notes of psychiatric in-patients who committed suicide in the Royal Edinburgh Hospital between 1977 and 1985. There were 29 such cases, and this population shared many of the characteristics of that described by Goh *et al*. However, in the Edinburgh survey there was an increased proportion of females, and the diagnoses of neurosis, personality disorder, and adjustment reaction were more common than in the Birmingham study. Also, over half had a past history of deliberate self-harm.

The notion of the high-risk patient can be described with reference to the characteristics of those who complete suicide, but it is more difficult to predict from patient characteristics which ones actually go on to commit suicide. Pokorny (1983) identified patient characteristics on admission in an attempt to predict which ones would later kill themselves, without success. Thus, it is particularly relevant to consider what local environmental factors influence suicide, as such factors may lend themselves more liable to change. Local ward layout is of obvious importance – such as the types of windows, window locks, and bathroom arrangements. In the Edinburgh study, means of suicide ranged from hanging by a bathrobe cord in the ward toilet area to jumping off the Forth Road Bridge.