# From the Editor's desk

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## USEFUL DIAGNOSES

Some of us spend a great deal of time grumbling about the diagnostic labels that we are forced to use in our clinical life even when we have no confidence in their ability to help our practice. The aim of a good diagnosis is to satisfy, clarify and edify, and occasionally we find some which do just that. Two are described in this month's issue: bulimia nervosa (Palmer, pp. 447–448) and acute and transient psychotic disorders (Singh *et al*, 452–459). Bulimia nervosa was first described by Gerald Russell 25 years ago, but is now so well known that it is difficult for many to contemplate how we could have functioned without it. Palmer explains part of the reason for this in his editorial; lifestyle and psychosocial changes in the past quarter century have left fertile ground for the diagnosis to grow and thrive.

Acute and transient psychotic disorders, on the other hand, are normally left in the diagnostic undergrowth and it is good to see them exposed. My first psychiatric post was with the evangelical promoter of physical treatments in psychiatry, William Sargant. But although he promoted heavily the advantages of drugs in the treatment of schizophrenia he was well aware of the 'stickiness' of the diagnostic label and that it unfairly tagged some people with the impression of chronicity. So with some of the transient forms of the condition he encouraged us to describe it to the patients as 'Bleuler illness' (after the inventor of the diagnosis), on the grounds that when the patient got better (as Singh and his colleagues found among women in particular) the label of schizophrenia would not hold them back. I did not think at the time that this was more than a teaching ploy, but some years later I saw a patient, a young man as Singh *et al* would have predicted, who came into the clinic with a relapse of his psychotic illness. I saw his mother separately. She seemed to know all about his problem. 'I knew it was a mistake for him to go back to work too early [he worked on a merchant ship]. He spent all his time in the engine room and got that boiler illness that Dr Sargant said he had three years ago'.

## DOGGEREL OF THE MONTH: RISK

Risk assessment, management, avoidance are now everywhere in psychiatry and yet our efforts to reduce it do not seem to be too effective. I note that in this year's two volumes we have published 12 papers (vol. 184: 41–47, 258–262, 263–267, 352–356, 432–438, 534–535; vol. 185: 63–69, 70–75, 127–133, 245–250, 306–311, 394–398) which highlight, directly or indirectly, the extremely risky business that psychiatrists and other mental health workers happen to find themselves in. This deserves wider awareness; I thank The Gondoliers of W. S. Gilbert and A. Sullivan for giving me the framework to record an average risky day:

*Risking* early in the morning
We proceed to stoke the fire
Of fateful actions without warning
Leading us into the mire.
We embark without delay
On the dangers of the day.
First we polish off some batches
Of our section forms in snatches
And interesting details circumvent.
But user response is heavy
With an advocacy levy
With threats of retribution imminent.
Then we'll probably see them all in groups
When we'll be prancing through the hoops
just like dupes.
Surmising our behaviour inchoate
May in some way protect our mental state.

After that we generally
Visit in a grubby alley
All the people who won't see us 'cos they
do not want to know,
While the consultant who's on duty
Goes *to find* his junior tutee
And warns *her* of the *risks* of stepping
on a drunkard's toe.

Oh, philosophers may sing
Of the troubles of a King;
But psychiatrists have many and their
just rewards are none.
With zero toleration
And their work short of ovation
It's a hard and risky business and their
tasks are never done.

Well, it has some attractions and might merit another verse later. Happy Christmas to all our readers!



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