Mrs Joyce McDougall referred to psychic change being intimately involved with the patient's ability to regress, in which each step allows for a new "surprise", a new discovery. She also emphasised that there are pre-verbal gestures and body expressions that affect both patient and analyst. "All analysts are also psychological survivors; the patients help to promote psychic changes in the analyst too, which in turn promotes psychoanalysis itself."

Of the many workshops, the one about training concerned a topic that affects us all. How much evaluation of standards takes place? How much are trainees allowed to participate in their educational systems? Why not allow different theories to be taught if the students required it? Fear of chaos if pluralism was to be permitted might stifle creativity in the trainees. A new model of training more tolerant of change and variety, without infantilising the trainees, is required. There was a feeling that there should be more sharing of educational and scientific activities between a training analysis and candidates. An increase in research and an academic university-type atmosphere is also to be encouraged in analytic institutions.

Dr Etchegoyen, in his closing address, gave a thorough historical perspective of thought and psychic change. He also expressed his preference for clinical presentations at conferences, rather than high level academic discussions. He emphasised that the *fundamental* issue is to get in touch with the patient's feelings.

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Psychiatric Bulletin (1992), **16**, 170–179

# Correspondence

## *Are your case-notes perfect?*

DEAR SIRS

Dr Cunningham has stated that the "perfect case-notes" should serve four main functions – informative, legal, communicative and storage of information. (*Psychiatric Bulletin*, 1991, **15**, 672–674.)

As part of our regular medical audit we looked at the accuracy of documenting important symptoms of depression in the notes of 20 patients admitted to our hospital with an ICD diagnosis of manic depression – depressed type (296.1). We identified 13 symptoms commonly used to make such a diagnosis. The figures in brackets indicate the percentage of notes in which the symptom is clearly stated as being present or absent. These symptoms included: depressed mood (100%), anhedonia (64%), appetite disturbance (75%), weight change (55%), sleep disturbance (84%), lack of energy (30%), psychomotor agitation/retardation (40%), suicidal ideation (75%), poor concentration (75%), ideas of guilt (40%), diurnal variation in mood (50%), hallucinations (90%) and delusions (85%).

Also, previous episodes of hypomania/mania were documented only in 15% of the notes. Level of nursing observation on admission was clearly stated in only 65% of the notes and severity of depression was stated in only 26%. Our small study has important implications. Firstly, from a medico-legal point it is important that the notes clearly state the admitting doctors' initial assessment of suicide risk and also the level of nursing observation appropriate.

The draft copy of ICD-10 (WHO, 1990) requires for a diagnosis of a depressive episode there has to be the presence of three cardinal symptoms – depressed mood, anhedonia and lack of energy. In the 20 notes we were unable to give them ICD-10 diagnoses as basic information in the notes was lacking. We are sure that the junior doctors elicit this information but it appears that this is not always put into writing.

During our meeting we discussed the feasibility of the admitting doctors filling in a depression checklist. We concluded that this would impede the clinical interview. The results of the audit have been circulated to the junior doctors and we will do a follow-up audit in due course.

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WORLD HEALTH ORGANIZATION (1990) ICD-10 1990 draft of Chapter V, *Mental and Behavioural Disorders*. F00-F99. Geneva: WHO.

DEAR SIRS

Dr Cunningham's article on the audit of case-notes identified several areas which necessitate improvement and suggested a strategy to reinforce the findings. The use of Care Plans (Holman, 1989) would provide an objective focus and means of updating the notes and recording management decisions. The recent change in the law which provides patients, at their request, with access to records written manually

after 1 November 1991 means doctors must be aware of the type of information recorded. An additional category to the "perfect case-note" should be a check that the records would be appropriate for a patient to see.

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## *The family of professions*

DEAR SIRS

Some differences between family psychiatry and family therapy – or at least between John Howells and me – may be discernible from our letters (*Psychiatric Bulletin*, 1991, **15**, 707–708). But I would like to make things clearer, beginning with what we agree on.

We agree that families are important in psychiatry. We must be aware of the effects of labelling in ordinary and professional circles. We believe that medicine and psychiatry should encompass the psychological along with the somatic, and that psychiatrists should concentrate on research and training in the "healing of psyches". The plea is well made in the letter from Jan Doyle (*ibid*, 709–710) describing her various experiences of psychiatric treatment for anorexia nervosa. I am also keen that all kinds of research method be applied in our field, including the rigorous discipline of medical science.

Where we differ is over what other disciplines have to offer. I had suggested we respect the important research and practice contributions to family therapy of other disciplines. Family therapy is a multidisciplinary field academically and clinically.

Many of us consider psychiatry itself multidisciplinary, so I am amazed at John Howells' wish to excommunicate other disciplines. I was referring to more general relationships than the multidisciplinary teams he introduced, but from what he says, I guess that some of his views are the result of traumatic experiences in them. However just as there are well-functioning families, there are well-functioning clinical and academic teams of various kinds (other than the surgical model he describes) where different professional and personal philosophies and skills are respected and used productively. Some of the most effective forms of team (multi- or uni-disciplinary) can be found where family therapy is practised.

John Howells clearly wishes family psychiatry to remain in exclusively medical hands. I would reverse his accusation and suggest that to *exclude* all other disciplines is much more to "indulge in cosy popularity" within a familiar realm, than is working things out with different disciplines in academic and clinical fields. We need go no further than the *Journal* to find Roland Littlewood ('Against pathology: the new psychiatry and its critics', **159**, 696–702) demonstrating how much more complex the notion of "pathology" is than John Howells' outmoded notion that "psychopathology" can be separated from "concepts that have no basis in reality".

Is it not part of the reality we all try to understand and deal with in relationships in work and family groups, that people deploy a variety of concepts and projections that "render the field more complex by able and ingenious speculation and invention"? Even if "healing psyches" was an exclusively medical and psychiatric affair (and that's a questionable concept about the reality of the matter if ever there was one!) we would still need to understand and work with, not nullify, that reality – that people deploy concepts that may not (at first) match the recipient's true nature. And, in psycho-social matters, by whose authority does who decide which reality is the true one? This is a complex area where it is easier to declare onself and one's own approach the exclusively true and scientific authority, rather than open up a more complex debate.

Jan Doyle's experience confirms how misplaced many of the standard psychiatric methods can be, despite being (or because of it?) so realistically conceptualised and researched with scientific rigour. Fiona Caldicott's letter in the same *Bulletin* (*ibid*, 699–710) officially confirms both how correct John Howells is to want the best training for psychiatrists in the healing of psyches, and also how wrong he is to be so proudly iatro-centric in his views about where the highest standards of practice are to be found.

I look forward to opening my mind to what family psychiatry has to offer, although I no longer expect as much similarity with family therapy. I invite him and all psychiatrists to be open to what a family-systems approach has to offer, and more generally to what other disciplines can positively contribute to academic and clinical psychiatry. An interest in how different individuals interact and combine together in families, I think goes naturally with an interest in how different disciplines combine together academically and clinically in the "family" of academic and helping professions. A systems approach entails a systematic application.

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