would not make patients' notes ready, they would not call the patients or show them the way to the clinic and they would not make any appointments. When all these manoeuvres failed the attendance register 'disappeared' after three months of running the clinic. Needless to say, this attitude had a negative effect on the patients who felt despised for taking an overdose. Another difficulty I faced was inappropriate referrals by the psychiatric trainees. The clinic was overwhelmed by referrals of drinking problems, marital difficulties and social and housing problems. This problem was solved by allocating two induction sessions for the newcomers to psychiatry to explain the function of the clinic.

Role of the clinic

It helps patients to avoid the social stigma of being labelled as a psychiatric case. It reduces the workload on the psychiatric out-patients and shortens the waiting lists. It reduces human suffering, both physically and psychologically, on a personal level and within the family. It shows A & E staff that this group of patients is 'treatable' and not merely a bunch of inadequate, immature and attention-seeking psychopaths.

I feel that it helps if the senior registrar has had training in various psychotherapeutic skills like counselling, problem solving techniques or crisis intervention. On the other hand, the clinic should not be used by the trainees as an expedient to avoid making an on the spot decision since many of them will be faced with this responsibility sooner or later.

The clinic has been providing a useful service for A & E patients for the last three years in spite of the usual disruption in the service due to shortage of medical staff.

I found that setting up and running this clinic has given me insight into the power struggle within the NHS hospitals and made me aware of such forces when planning any future service.

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Assessment of drunk patients

DEAR SIRS

Further to contributions in the *Bulletin* (March and November 1988) from Dr Healy and Dr Connolly, I wish to challenge certain widespread assumptions concerning the assessment of inebriated patients. Policy, either implicit or possibly enshrined in some document, is generally to exclude patients who attend for assessment whilst drunk. Often in condescending terms, they are asked to remove themselves (or be removed) and are invited in an equally condescending fashion to re-present when sober.

This clearly is both economic and safe since so many alcohol dependent patients cannot summon the courage to seek help during intervals of sobriety. Alcoholics Anonymous recognises this problem and welcomes the moderately inebriated so long as their behaviour is tolerable. Similarly, so long as I do not consider that the patient's behaviour is unreasonable, I find it often valuable to conduct the interview in the state in which the patient has been able to present him/herself. (I do not permit smoking.)

Contrary to accepted wisdom, caring interventions by the clinician are generally remembered by the mildly inebriated patient, and these greatly increase the likelihood of reattendance when sober. The disinhibition afforded by alcohol may render an otherwise prickly patient capable of providing an honest account of every aspect of his life, not least a more accurate drinking history.

I do take a certain risk, and sensible precautions are vital: I do not wish to be assaulted, my consulting room smashed up, or have my carpet vomited upon. However, *In vino veritas*, and surely *veritas* is the *sine qua non* of any assessment.

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Psychiatrists' use of investigations

DEAR SIRS

I read with interest Dr Anthony White's paper on psychiatrist's use of investigations (*Psychiatric Bulletin*, October 1988, **12**, 430–433). Dr White's comments on his findings fail to mention some rather obvious possible explanations for the results and make some assumptions that should be challenged. There appears to be an assumption that fewer investigations equate with better practice, and that the practices followed by consultants are inevitably better than those of their junior colleagues. I would like to challenge those assumptions by proposing that the reason the number of investigations thought appropriate for a particular case reaches a peak at registrar level, and thereafter declines to consultant level, is that registrars have their heads crammed full of facts and figures in preparation for their examinations, and that this mass of knowledge eventually decays to consultant level. It is with the decay of this knowledge that the unusual or rare case stands out more

noticeably, and the availability heuristic comes to influence the process of making a diagnosis. I would propose that far from producing more investigations striving to make predictions come true, this heuristic produces fewer investigations which might refute the prediction. Survey any group of juniors and they will tell you all too readily of how frustrated they become when faced with the operation of the anchoring and adjustment heuristic which prevents their consultant relinquishing a diagnosis based on the availability heuristic, despite the refutatory evidence produced (perhaps from further investigations).

Even for the best clinician, who makes judgements free of heuristics and bias, the nature of a consultant's work is so different from that of a junior that one might expect differences in practice. A consultant can usually work with the assumption that simple, routine, or screening investigations have been done by the juniors (if not, why not?). It is in the nature of a consultant's work to be concerned with the few incisive investigations while leaving the commonplace in the hands of their juniors. I would have been interested to have seen a breakdown of Dr White's results by type of investigation.

Although I do not doubt the therapeutic effect of investigations for the investigator, this does not automatically negate their diagnostic value, or mean that their use is a problem. In order to make economic savings one would have to reduce considerably the numbers of a particular investigation ordered. Almost certainly that would result in an increase in the cost per investigation. Many investigations are carried out in bulk, and are a necessary and appropriate part of the care of patients in other specialities. The cost per item is thus quite low, and is unlikely to be affected by a small reduction in work for psychiatry. What price should we put on the detection of those cases of "Wilson's disease or parasagittal meningioma that the textbooks and lectures would have us believe languishes on every back ward"?

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Dr White replies

DEAR SIR

The hard results in my paper demonstrate some outcome research. The process which led to this outcome was the decision-making behaviour of clinician psychiatrists. This process cannot be demonstrated by any method presently available to us and will always be open to conjecture. I am delighted to engender discussion, either through the *Psychiatric Bulletin* or in person, about the nature of the process.

The phenomena that Dr Adams and I have both addressed are in the realm of judgement and decision-making (JDM) theory, the understanding of the processes of judgement and choice. Approaches to understanding decision behaviour originated two centuries ago with Bernoulli's (1713) ideas in economics and Bayes' (1763) theorem for games theory. Further contribution came from utilitarian philosophy. The early part of the 20th century saw attempts to produce normative models of JDM theory. Numerous disciplines, statistics, economics, management, philosophy, social policies and law, as well as psychology, have found value in these models of JDM theory for understanding and improving the accuracy of their work. Medicine has been strangely absent from that list.

The evidence, from innumerable other sources as well as myself, has shown that man is clearly not the rational being he would like to believe (Polya, 1941; Kahnemann, Slovic & Tversky, 1982). As a result, recent years have seen a change in emphasis from normative theories of perfect JDM towards descriptive theories that attempt to understand the anomalies and aberrations found in decision behaviour wherever it takes place (Kahnemann, Slovic & Tversky, 1982; Kahnemann & Tversky, 1979; Slovic, Fischhoff & Lichenstein, 1977). Heuristics have proved one of the most prominent and successful contributions. The challenge facing this intriguing field is to bridge the gap between the theoretical core of JDM and the various practical applications.

The way that Dr Adams and I can attribute such simple differences in outcome to such wide differences in process suggests that the time is ripe for application of decision theory in medicine.

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A full list of references is available on request from the author.

The strip-searching of women prisoners

DEAR SIRS

The strip-searching of prisoners, both on remand and convicted in British prisons, started some years ago. It was introduced for "security reasons". Concern has been expressed about the use of strip-searching, particularly when used on women