will prevent situations where trainers ask Part 1 candidates what essays they wrote in the examination!

MINDHAM, R. H. S. (1995) Arrangements for MRCPsych examinations. *Psychiatric Bulletin*, **19**, 448–449

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HoNOS, CPA CPGs & Co

Sir: I attended the meeting of the Royal College of Psychiatrists in Torquay and took part in one afternoon session looking at Health of the Nation Outcome Scales (HoNOS), Clinical Practice Guidelines (CPGs), and the Care Programme Approach (CPA).

Individually, each of these developments is difficult to fault, as will no doubt be those that follow. HoNOS perhaps has the potential for national audit and the examination of the effectiveness of treatment, CPGs may allow the standardisation of treatments/procedures which are generally felt to be the most beneficial, and the CPA presumably has the advantage of ensuring people are not forgotten or ignored. In spite of this I have reservations on all three.

The subjective element of HoNOS is open to considerable abuse if used nationally to sort out the best from the worst services (it is surely inevitable it will be used for this purpose). CPGs invite the unrealistic expectation of 'perfect' treatment at all times with the likelihood of legal repercussions in some cases. It would also seem likely a few patients will miss out on the benefit of a treatment that is felt by their doctor to be right but which isn't prescribed because it doesn't follow the particular CPG.

During the presentation on the CPA it was explained how a psychiatrist, assessing a person in an out-patient clinic, making a referral to a specialist counsellor, following up the patient at a subsequent clinic, and calling themselves the keyworker, could then document that they had followed the CPA for this particular individual and by implication be satisfied with their thorough approach. Since this would have been normal practice in any case, the exercise in this case seems pointless while creating additional paperwork.

Individually, none of these approaches is bad; however, each is something more to remember or consider, and I can't help wondering if they will be the last 'innovations'. They also seem to require the unrealistic expectation that doctors will be perfect at all times, i.e. perform at the standard of the best available (a similar argument might suppose we should all be able to run 100 metres in 10 seconds, since this is the standard for optimum human achievement).

Perhaps the worst aspect is that in applying HoNOS, recalling all relevant CPGs, and successfully documenting CPAs, along with audit activity, business information and the rest that is currently demanded, there may be insufficient time to look at the clinical picture presented to us and consider properly how best to offer help.

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Schizophrenics, the unnameable?

Sir: Two fundamental problems in finding an acceptable way of describing 'an individual with schizophrenia' are the status of schizophrenia as an illness and the context in which the description is used. Haghighat & Littlewood (*Psychiatric Bulletin*, July 1995, **19**, 407–410) offer a valuable analysis of language, but are writing expressly in the medical model. The proviso, "if... people avoid certain linguistic forms... even when they accept that they have developed the corresponding illness..." avoids the issue. Whether one accepts the arguments against schizophrenia as a discrete entity or not, the 'safest' (least stigmatising? Most acceptable?) description may be, 'an individual with the diagnosis of schizophrenia'. This both allows for the medical model but begs the question of the existence of schizophrenia. The use of the word 'sufferer' is not without problems, not least the theological imperatives implied in the word (Atkinson, 1993), and that it seems to suggest the person's whole life is one of suffering.

Current labels/descriptions used by 'patients' focus on behaviour/experience, such as 'voice hearer' favoured by those in the Hearing Voices Network, or 'status', such as 'survivors' (of the system or of the illness) as in the group Survivors Speak Out. 'User' is common and often used as the best of a bad lot. In her last editorial (1995) in *Openmind*, Helen Imam confesses "that I never did like the term 'user' (nor 'carer' come to think of it!)" and the incoming editor offers a prize for "the best argued case for a better word than 'user'" (Daley, 1995). 'User' can be seen to imply choice, which many 'users' would deny they had.

Different situations call for different degrees of precision. 'People with mental health problems' fits some situations, but some argue that it diminishes the seriousness of their problem. The problems and stigma surrounding descriptive/diagnostic terms are not special to psychiatry. The disability rights movement eschews medical labels, seeing these as a major hindrance to overcoming barriers to their integration into society.

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