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TABLE I

Platelet 5-HT uptake kinetics in normals and patients before and after lithium treatment

Group	Km* (μ M)	Vmax* (pmoles/10 ⁸ platelets/min)
Normals	0.50 ± 0.12	116 ± 14.2
Bipolar depressed Placebo	$\left. \begin{array}{c} 0.53 \pm 0.16 \\ 0.44 \pm 0.19 \end{array} \right\} P = ns$	$ \left. \begin{array}{l} 88.9 \pm 26.2^{1} \\ 65.7 \pm 18.2 \end{array} \right\} P < 0.05^{2} $
Lithium treatment	0.44 ± 0.19 $\int \mathbf{r} = \mathbf{n} \mathbf{s}$	$65.7 \pm 18.2 \int $

^{*} Mean + SD.

MOURNERS WITHOUT A DEATH

DEAR SIR,

May I express my appreciation of the paper on Anticipatory Grief by Fulton and Gottesman (Journal, July 1980, 137, 45-54) and my hope that it will be added speedily to the College's recommended-reading list. It is a very welcome change to come across a paper that (a) is couched in readable English, and (b) points out the futility of the currently-prevalent blinding by statistics, and does so in two important respects:

- (i) the uselessness of trying to compare surveys which have not only taken widely differing groups but have studied those groups in non-comparable ways; and
- (ii) even more important, in which the authors point out that it is the covert quality of a relationship which really counts in bereavement and not the overt formal ties. A pet may be a much more significant figure—and its loss far more traumatic—than a parent (or any other human being) with whom relationships are, almost by definition, ambivalent.

One very important area that has not, to my knowledge, been dealt with by any medical group is the effect on survivors, whom for the purpose of my theme I would like to term the NOBs (not-officially-bereaved), of blocked anticipatory grief. This must be an increasingly common phenomenon nowadays in view of the progress in resuscitatory techniques and of, often heroic, treatments of conditions which could reasonably be expected to prove fatal. Leaving aside the fact that these treatments often leave the patient a mutilated caricature of their previous whole person, with the adjustments in life-style and attitudes

which this demands from the NOBs, I feel that there is a need for study of the effects on the NOB of having-sometimes repeatedly-to go through the processes of anticipatory grief, practical and legal as well as emotional, only to have to pick up again the cast-off threads and with the knowledge that the whole grisly process will have to be gone through again x times. The medical profession carries, but as a whole does not recognize, the greatest responsibility for inflicting this burden. It seems an egregious lacuna in medical education at both post- and undergraduate level that the issue is not a subject for continuous discussion and re-assessment. Instead we are actually taught to put prolongation of existence above quality of life and particularly the quality of life of the group of which the patient is a part, under the pseudo-scientific cloak of eschewing valuejudgements—a term which now seems to be applied almost exclusively in a pejorative sense. In reality this is a totally unscientific nonsense involving the wilful refusal to take into account all known facts. A very large part of the life of higher mammals, human beings in particular, consists of making value-judgements (is it more pleasurable to curl up by the fire with a bowl of milk or to go out hunting?; is my over-riding loyalty to my country or my friend?). Surely an essential part of training should be to help people to make the most valid valuejudgements possible in each circumstance rather than to encourage them to take the primrose-path of abrogating a common moral duty, cloaked in a blanket code of practice.

We are each entitled to take decisions that entail suffering for ourselves. What worries me is that

¹ Lower than normals (student t-test) P < 0.005.

^a Paired t-test.

professionals are increasingly taking decisions and actions which entail often prolonged sufferings by others, frequently without full consideration of the logical consequences, or disregarding them, and without the preparedness to give help in mitigation as and when it is needed. That we conceal even from ourselves the true nature of our actions with the blindfolds of 'absolute duty to preserve life', 'community-care', 'being non-directive, non-judgemental, non-paternalistic', simply adds the extra sin of wilful ignorance.

Lastly, what help, if any, is offered to the NOB who may have to contend with their own feelings of total revulsion from mutilations, e.g. amputations, and therefore with guilt-feelings as well? Particularly if a relationship is ambivalent anyway, these may well outweigh their sympathy or pity—but of course it is not acceptable to admit this.

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UP-TO-DATE RECORDS OF LONG-STAY PATIENTS

DEAR SIR,

We refer to correspondence on this topic (Journal, February, 1980, 136, 203-4; May 1980, 136, 523) and suggest that the main reason for the inadequacy of the case notes of chronic patients is not that useful information is inaccessible but that case notes often omit altogether data which we now regard as essential. This is not surprising since case notes were designed for case-management by doctors, who are mainly interested in the biological aspects of a case. (Witness the poverty of entries in a chronic patient's case file, apart from those recording injury or intercurrent illness). Nurses, too, write notes primarily for their own use and in most hospitals now use a separate Kardex system. We feel that a comprehensive assessment of both assets and disability giving weight to social as well as to biological factors, and the need to plan and monitor chronic patients' care and rehabilitation, require a recording system of a radically different kind in addition to traditional records.

The best system for this purpose is a matter for debate. Assuming that a chronic patient's case is managed strategically, as it were, by a staff group meeting monthly (and considering each patient on the ward at say six-monthly intervals) we agree that the record should contain all the data the group needs for its job, including statements of previous conclusions and recommendations; such data as have been mentioned by Dr Henryk-Gutt and Dr Roger

Morgan. However, there is something to be said for using printed forms on which data are recorded in clearly set out sections. This helps to ensure that important areas are not missed, facilitates the identification of areas which need attention, and if the sections are covered methodically can impart a regular structure to the review meeting itself.

Over the last three years at this hospital five forms have been developed, together with a guide. One form (blue) is for recording basic current information; three rating scales are used for rating deviant and general ward behaviour (pink), work performance (yellow) and OT performance (white); the fifth form (green) is a summary sheet for recording rating scores, the patient's attitude to discharge and work outside the hospital, and the conclusions of the assessment meeting (under the headings: greatest current problems; general goals; actions to be taken). The rating scales are filled in by the staff best placed to observe the patient's behaviour and include clearly written instructions. It is intended that assessment meetings should include an interview with each patient to discuss proposed changes with him and to rate his attitude to discharge and to outside work. At the end of each meeting the forms are returned to the local case-register centre, which sends back to the ward the basic current information and summary sheets as well as an updated print-out of the rating scores from the four latest assessments. These are filed in a prominent place in the notes, permitting staff to check on the actions to be taken.

The system works well on a number of wards and at the Day Hospital. Although there were some problems in implementing the system on a few wards, these have been largely overcome through monthly meetings between staff on long-stay wards and members of the Rehabilitation Committee. Apart from this, we believe that the recording system itself is a useful educational aid for staff working in the field of rehabilitation and social care.

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HLA-ANTIGENS, SCHIZOPHRENIA AND BRAIN ATROPHY

Dear Sir,

Luchins et al (Journal, March 1980, 136, 243-48) reported a possible association between HLA-A2, schizophrenia and brain atrophy: this antigen was increased in their black schizophrenic patients' group, and remained increased in a sub-group of patients without evidence of brain atrophy, while