unremitting psychoses. The criteria for the Sandoz trial were not met by two of these patients who had experienced grand mal convulsions and a third who failed to meet the DSM–III–R criteria for schizophrenia. A further patient refused to have regular blood tests required for the monitoring procedures.

We have since identified 12 patients with intractable schizophrenia, nine men and three women, with an age range of 21 to 62, who might benefit from clozapine. Of these, five patients, four men and one woman, declined to have the regular blood tests which are mandatory for the continuation of treatment due to the risk of neutropenia. Other reasons for patients unsuitability for clozapine are as follows:

(a) A 62-year-old man was undergoing investigation for deteriorating gait and upper limb incoordination.

(b) A 40-year-old man refused on the advice of his sister who suggested he wait until "an analogue" without the haematological side effects had been developed.

(c) A 55-year-old woman coincidentally suffering from bullous pemphigoid, which was felt to be a contraindication in view of the potential effects of the drug on the immune system.

(d) A 26-year-old male patient developed a tooth abscess within days of starting medication but had normal neutrophilic response. The drug was discontinued but we intend to reinstate this once the dental problems have resolved.

(e) A 21-year-old male patient was commenced on the drug while in a locked ward and initially made a good response. When returned to the open ward his mental state deteriorated and his delusional beliefs that part of his body were being stolen extended to the blood being taken for monitoring. He refused further testing and the drug had to be stopped.

(f) A 26-year-old man dislikes the blood testing and, currently at the third week of treatment, is reluctant to continue

(g) A 23-year-old woman developed malaise, tremor and hypersalivation within three days of starting the medication (75 mg a day) and experienced a grand mal seizure on 100 mg of clozapine on day 4. The drug was discontinued.

Four of the patients were detained under Section 3, including (e), (f) and (g), together with a woman who refused regular blood tests. She had given delusional reasons for not taking her conventional medication and was incapable of giving informed consent to taking clozapine.

Clozapine is novel in its requirement for weekly blood tests for monitoring side effects. Lithium is the only commonly used psychiatric medication which comes close in this respect. The giving of clozapine without informed consent, even if the patient agrees to the blood test, remains an issue to be clarified. We would have been prepared to ask the Mental Health Act Commission for a second opinion prior to the introduction of clozapine to the treatment regime of the patient unable to give informed consent. We did not feel justified in restraining the patient for weekly blood tests when she refused to have these.

The current limited use of clozapine and its reputation for dangerous side effects is perhaps to deny its advantages for many suitable subjects. Colleagues in Germany (Gabel & Gallhoffer, personal communication) report the extensive use of clozapine in a wide variety of patients with great success. The lack of extrapyramidal side effects make it more acceptable to patients, and tardive dyskinesia does not seem to be a long term sequelae (Casey, 1989).

Gabel & Gallhoffer identify well motivated and compliant patients as being ideal for treatment with clozapine and will use it as a first line treatment.

Our experience is at odds with that of Launer (1991) since we have had great difficulty in starting and maintaining our most seriously disturbed patients on this drug at a time when the issue of consent is far from clear. Nevertheless we look forward to the wider use of clozapine with its many potential benefits.

CHRISTOPHER J. BALL
United Medical and Dental Schools
Guy's Campus

MAURICE LIPSEDGE
Guy's Hospital
St Thomas Street
London SE1 9RT

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Assessment of parenting

DEAR SIRS

Reder & Lucey provide a timely consideration of some key ideas in an interactional framework for the assessment of parenting (*Psychiatric Bulletin*, June 1991, **15**, 347–348) and with the rapid incorporation of some of the Children's Act provisions into our practice, the era of impressionism as regards assessment of parenting ability must needs pass.

In addition to the logical progression expounded by Reder & Lucey, three further headings ought to be borne in mind, even if as child psychiatrists we honestly say we do not know their full import.

(a) The setting or context in which the assessment occurs and this includes the contribution of the assessor.
(b) Cultural factors and differences, which have to include the diversity of influences as well as the assumed norms.
(c) The child, whose own individual character and temperament may be such that he or she tests parenting ability and limits of safety beyond imagining.

LAWRENCE MCGIBBEN
TOM HUGHES

Gulson Hospital
Coventry CV1 2HR

Choosing the best consultants – "the questions you dare not ask"

DEAR SIRS

Over the last 15 years, I have attended Appointments Advisory Committees and been a College assessor on 15 occasions. There are obvious differences in the way one should interview a candidate for a senior registrar post and below, and the way one interviews for the post of consultant.

One should not ask questions on medical knowledge, but confine oneself to assess their suitability for the appointment. In other words, to avoid questions such as, "How will you treat . . .", and rather to ask, "How will you organise services for . . ." Nevertheless, I have encountered instances when candidates for consultant posts were asked, "How will you treat epilepsy?" or "How will you distinguish between depression and Alzheimer's disease?"

It is my concern that some questions asked by consultants on Committees are not appropriate. This might indicate a need for these people to be given basic training in the performance of their functions in these Committees. Whether the College itself can take on the task, or could suggest some alternatives, remains a question which I would like to pose.

R. P. ARYA

Greaves Hall Hospital
Banks, near Southport
PR9 8BL

DEAR SIRS

Thank you for inviting me to respond to Dr Azuonye's letter (*Psychiatric Bulletin*, March 1991, **15**, 168) commenting on the first piece in my recent series on Wisdom, 'Beginning'. I think he is right to point out that I misused the word *paradox*; and he will perhaps have noted that, for the sake of consistency, I have repeated the error in the final piece, 'Ending'.

On the one hand, on reflection, I could have wished to have used the word *riddle*, or perhaps *conundrum*. On the other hand, to have done so would have been to deprive myself and *Bulletin* readers of Ikechukwu's helpful disquisition on paradox.

I do not know the best way to teach; but the best way to learn clearly is to make such mistakes in public.

I am grateful for the generous opening remarks in Dr Azuonye's letter, and I would also like to take this opportunity to thank the many who have approached me privately to express their approval of the series.

LARRY CULLIFORD

Aldrington House
Hove Community Mental Health Centre
35 New Church Road
Hove BN3 4AG

Sharing of casenotes with patients

DEAR SIRS

When the Access to Health Records Act 1990 comes into force later this year, patients will have a statutory right to see the contents of their casenotes. This may pose particular problems for psychiatrists who will often be recording not only straightforward factual information as related by the patient, but also much wider professional observations. Current training seems to encourage the recording of such observations, including comments on physical appearance and conduct during the interview.

The sharing of casenotes with patients may be beneficial in that it will discourage the writing down of derogatory or hastily made opinions, it may enhance the accuracy of information recorded and, most importantly, it should help to reduce suspicion or hostility engendered by what many patients see as a secret file full of intimate details. If the case file is to evolve to suit this new circumstance, should this not be reflected in training so that the emphasis is on recording factual information. It is usually facts rather than opinions that are most useful when casenotes are read at a later date, since it is these that are most readily forgotten, while the diagnosis, formulation, and general observations about the patient are much more easily remembered.

D. H. THOMAS

Hensol Hospital
Pontyclun
Mid Glamorgan CF7 8YS

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