it is clear that the patient's behaviour shows his intention to appear irresponsible. In the 'Gaslight Phenomenon', on the other hand, 'mental illness' exists only in the reports of a party interested in getting rid of a person whose presence at home has become undesirable, under the false pretence that this person is mentally ill. Labelling the 'Gaslight Phenomenon' a modification of the Ganser Syndrome is apt to confuse the issue rather than clarifying it.

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THE PROBLEM-ORIENTED MEDICAL RECORD AND PSYCHIATRY

DEAR SIR,

The necessity for psychiatrists to become acquainted and comfortable with the problem-oriented approach to medical records is likely to become important in the near future as the advantages of this approach are recognized and it comes into widespread use. It is, therefore, unfortunate that Hayes-Roth *et al.* (*Journal*, July 1972) have published an article that is likely to convince psychiatrists that this approach has only a limited application to psychiatry.

First of all, the article is confusing to a psychiatrist who wants to apply this system in a practical straightforward manner. It initially describes a way of dividing problems into psychiatric, social and organic subgroups and numbering the problems of these subgroupings separately. Then the article does an about face, admits that such a system of organization 'results in tremendous duplication' and goes on to describe an alternative approach which 'is more efficient' and requires that a series of 'necessary questions' (the data base) be asked of each patient and that the responsibility for asking each of these questions be relegated to various members of the psychiatric team. The answers to these questions are evaluated at a planning conference in order to define the patient's problems, and out of this planning conference a single problem list is developed.

Besides being extremely cumbersome, the systems as described are useless to the private practitioner, the psychiatrist based in a general clinc, and even to a psychiatrist in a psychiatric hospital where a fast turnover of patients makes extensive psychiatric conferences on each patient impracticable. Such psychiatrists are likely to read Hayes-Roth's article with the thought that problem-oriented records might be useful for intensive psychiatric-hospital-based practice but have no value for them.

Because their article fosters such an attitude, it subverts the intent and purpose of the problem-oriented medical record, which is a means of organizing data for all medical personnel in a clear and comprehensive manner, with all the benefits that accrue from such a systematic organization (ability to audit medical care, the necessity for the physician to organize his thoughts more clearly, ultimate computerization, etc.). The article illustrates that psychiatry has strayed so far from the medical model that it has difficulty in formulating problems simply and clearly; that is, difficulty in achieving diagnostic consistency and reliability, although there are systems where clear objective means of making psychiatric diagnoses based on the medical model do exist (for example, see Feighner *et al.*).

Utilizing such a consistent system of diagnoses would allow the psychiatrist to take advantage of the problem-oriented approach to medical records in a comprehensive manner, comprehensible to him and his medical and paramedical colleagues, no matter whether he worked in a psychiatric hospital, general clinic or private practice. He could easily gain the essentials of the problem-oriented method by reading such basic source material as Weed's *Medical Records, Medical Education and Patient Care* or Bjorn and Cross's *Problem-Oriented Practice* rather than having to resort to such special systems as those offered by Hayes-Roth. If more idiosyncratic notes are thought necessary (relating to intrapsychic processes, for example), they could and should be kept separate from the main body of medical records. As long as the psychiatrist keeps in mind that the ultimate goal of the problem-oriented medical records is the integration of a patient's various medical, emotional and social problems in a way that is comprehensible to all those who must deal with the patient, he will not feel himself forced into a mould by the problem-oriented record, but will regard himself as a necessary part of a system working to provide the patient with comprehensive, complete and intelligent medical care. To operate otherwise would be to isolate psychiatry further from medicine to the ultimate detriment of medicine, psychiatry and the patient.

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References

Hayes-Roth, F., Langabaugh, R. and Ryback, R. (1972). 'The problem-oriented medical record and psychiatry.' *British Journal of Psychiatry*, **121**, 27-34.

Feighner *et al.* (1972). 'Diagnostic criteria for use in psychiatric research.' *Archives of General Psychiatry*, **26**, 57-63.

Weed, Lawrence L. (1969). *Medical Records, Medical Education and Patient Care*. Cleveland, Ohio. Press of Case Western Reserve University.

Bjorn, J. C., and Cross, H. D. (1970). *The Problem-Oriented Private Practice of Medicine*. McGraw-Hill.

SERUM CREATINE PHOSPHOKINASE ACTIVITY IN ACUTE PSYCHOSIS

Dear Sir,

In a recent paper (*Journal*, October 1972, pp. 351–5) Gosling *et al.* confirmed my previous reports of increased serum CPK activity in acutely psychotic patients and its lack of an increase in non-psychotic patients. They inaccurately stated that I and colleagues had studied only admission serum CPK levels in non-psychotic patients. We have previously published the lack of an increase in serum CPK activity in samples obtained Mon.–Fri. throughout hospitalization from two sizeable groups of severely disturbed, hospitalized non-psychotic psychiatric patients (Meltzer, 1969; Meltzer and Moline, 1970).

Gosling *et al.* also claimed that there was a trend towards a higher percentage of psychotic patients with increased serum CPK activity who were diagnosed manic-depressive, manic phase, or paranoid schizophrenic, as opposed to psychotic depressive or non-paranoid schizophrenic. In our previous studies (Meltzer, 1969; Meltzer, Elkun and Moline, 1969), we have indicated that the incidence of increased serum CPK activity is not significantly different in non-paranoid schizophrenics, paranoid schizophrenics, or manic-depressives, manic phase. We reported on too few psychotic depressions, bipolar or unipolar, of recent onset to know if the enzymes are elevated in depressed patients with equal frequency (Meltzer, 1969; Meltzer, Elkun and Moline, 1969). In our current studies, looking only at patients admitted within one week of the onset of psychotic symptoms, but whose serum CPK activity was studied Monday to Friday throughout hospitalization, I have found increased serum CPK activity in 41 of 53 (78 per cent) acute schizophrenics of non-paranoid types, 29 of 32 (91 per cent) acute schizophrenics, paranoid type, 6 of 7 patients with paranoid states, 9 of 12 patients with manic-depressive psychosis, manic-phase and 3 of 3 psychotic depressives. There are no statistically significant differences between the incidence of elevations in these groups. In approximately one-third of these patients, the increases in serum CPK activity did not occur until after discharge from hospital. I suggest that the data of Gosling *et al.* are best explained by a greater delay in admitting non-paranoid schizophrenics and psychotically depressed patients to the hospital in comparison with paranoid psychotic patients and manic-depressives, manic phase patients.

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References

Meltzer, H. Y. (1969). 'Muscle enzyme release in the acute psychoses.' *Arch. gen. Psychiat.*, **21**, 102–12.

Meltzer, H., Elkun, L., and Moline, R. (1969). 'Serum enzyme changes in newly admitted psychiatric patients.' *Arch. gen. Psychiat.*, **21**, 731–8.

—— and Moline, R. (1970). 'Muscle abnormalities in acute psychoses.' *Arch. gen. Psychiat.*, **23**, 481–91.

UK 3557 IN DEPRESSION

Dear Sir,

Dr. Wheatley's conclusion that UK 3557 'has a similar antidepressant effect to the control drug, amitriptyline, but that there are no therapeutic differences between them' (*Journal*, December 1972, p. 622) is unwarranted. The results of his trial show that amitriptyline was consistently superior to UK 3557 at all periods of assessment, although this did not reach significance. In the absence of a placebo control group no inferences can be drawn about the antidepressant effects of UK 3557, as the improvement shown during the trial could be entirely due to non-specific factors.

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Dear Sir,

In the interpretation of clinical trial results, it is always necessary to strike a balance between that which is statistically significant (or non-significant)