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Psychiatry, post-modernism and politics

Sir: Allan Beveridge believes medicine, and psychiatry in particular, to be vulnerable to a post-modernist critique if it is founded upon the belief that there is a "single, objective, verifiable reality" (*Psychiatric Bulletin*, September 1998, **22**, 573–574). This may be the case, but the question that is perhaps more true to the origins and traditions of medicine, as opposed to many of the natural sciences, is less 'what is' than 'what works'. Employing a technique that ameliorates or abolishes the features that are troubling the patient, and being concerned with evidence that this is in fact the effect of the treatment, bypasses the critique. This argument is tacitly accepted when post-modern theorists become seriously ill; concerns about treatment effectiveness quickly take precedence over disagreements regarding the possibility of accurately representing reality.

Beveridge highlights the potential for a post-modern approach leading to a better understanding between the psychiatrist, who attributes disease to neurotransmitters, and the patient, who complains of poor housing and poverty. Such an approach might be expected to facilitate a widening of the scope of medical/psychiatric interest to include areas politicians might prefer remain unscrutinised, but this is not necessarily the case. Indeed, post-modernism has itself been accused of engendering political hopelessness and inertia, or of being a product of perceived political impotence (Chomsky, 1994). When there are so many equally valid ways of formulating a problem, how can a particular solution be implemented with conviction?

Reference

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Patients' knowledge of their lithium therapy

Sir: I was interested to note the results of knowledge of lithium treatment among patients attending a lithium clinic (Anderson & Sowerbutts, *Psychiatric Bulletin*, December 1998, **22**, 740–843). I conducted a similar study in 1995 on patients in an area without a lithium clinic (Oxford). I recruited recently discharged in-patients and day patients on lithium. I devised a questionnaire on knowledge of lithium and sent it to 28 people.

I received 16 replies. In my sample eight had received a lithium information leaflet, five reported having received no information, the remainder having been informed by their doctor. None of the patients correctly identified the signs of lithium toxicity, only one knew of any drug interactions and none knew what other factors could affect lithium levels, although two women recorded pregnancy as a reason to contact a doctor or community psychiatric nurse. The study had obvious limitations, but the 16 respondents clearly showed an inadequate knowledge of the most dangerous aspects of their treatment.

It has been suggested that the most appropriate setting for lithium surveillance is a specialised lithium clinic (Guscott & Taylor, 1994). However, this can be difficult to organise with the move towards sectorised clinical services. The resultant idiosyncrasies of lithium management could lead to inadequate knowledge among patients and poor compliance. I suggest the need for a national protocol of minimum standards of education on treatment for patients which involves multimedia educational techniques as well as regular re-checking of information retained.

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