and one is at once recognised as a *new man*. I had a vivid reminder of this at a recent meeting of consultant psychotherapists called to discuss the impending changes; a colleague showed a transparency of a beleagured psychotherapy service being menaced by two resource-seeking crocodiles labelled 'social workers' and 'psychologists'. I believe it is our patients who are menaced when professional relationships are construed in such terms of "mutual hostility" cloaked under the name of "fair competition".

There is a particular irony in the use of the new language in 1990, the year in which the market has apparently been wholeheartedly embraced by Eastern Europe. In the name of supposedly libertarian market values, a system of management is being created for the National Health Service which will be instantly recognised by those from Eastern Europe: with minimal exposure to public influence or inspection and with a much reduced professional participation, a vertical command structure is being created in which personal advancement for those lower in the hierarchy can only depend upon pleasing those higher up.

The defence of our patients' interests and of our own profession demands exceptional vigilance and I believe the preservation of clear speech is crucial. In making our own proposals, in considering managements plans, and in auditing our own work we must never leave out of what is said and what is recorded the information relating to the point of our enterprise, namely the provision of health care to the people of this country. The quality of care available, the efficiency with which it reaches those in need, the costs in human terms of what is *not* provided and the conditions of work of the professionals providing care should all appear in every evaluation. We are in the business of providing a service, not of serving a business, and our concerns must be expressed in, and defended by, the language appropriate to our professional commitment to that service.

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Teaching descriptive psychopathology to medical students

DEAR SIRS

Making psychiatry interesting for medical students is one of our great priorities. It is the only way we can recruit more doctors into the specialty at a time when more and more medical personnel tend to see other areas of practice as more rewarding.

Students tend to find descriptive psychopathology difficult. This is quite understandable. The terminology of psychopathology is not very precise and there are several phenomena which are easily mistaken for something else. The clarification of the concepts of descriptive psychopathology is an on-going assignment for us all.

I have discovered that by asking medical students to "Make a list of the things we do with our minds", and "Against each entry put down your own ideas of the various ways in which the function concerned can become abnormal", a good foundation is laid for the understanding of psychopathology. By the time they have worked through this activity they have, in fact, come up with descriptions of most of the signs and symptoms of mental disorder, even if they do not use the proper terminology.

A couple of tutorials clarifies their thinking about these things, as well as providing or confirming the correct terms for the signs and symptoms they have already figured out and adding those they missed.

I have found that because this exercise challenges the students' initiative and sense of discovery, it is a much more interesting activity for them than lectures on the subject.

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Chaos in mind

DEAR SIRS

I would like to comment on the conference report, 'The Atom in Mind' (*Psychiatric Bulletin*, September 1990, **14**, 559).

With the growing interest in the behaviour of dynamic systems in medicine, the reductionalist approach may not be the way forward when addressing the mind-body problem. Pressing the techniques of the individual specialisms of psychology, neurophysiology, theology, physics and mathematics to their limits may result in further division. The study of systems and chaos, although having its origins in mathematics, tends to unify across disciplines.

The brain is a complex dynamic system, with feedback at multiple levels of organisation. It is, however, not isolated but exists in the context of many other systems: the body, the environment, the family, and society. It is within these systems that body image and self-esteem are defined. The mind may therefore exist as a product of multiple dynamic systems, interacting at different scales, creating one whole. There is, however, more than mere complexity of the holistic approach which would be beyond analysis. For example, consider the brain alone: it contains 10^{13}–10^{14} synapses each of which will display non-linear behaviour. Simple dynamic systems, however, containing few non-linear elements can have complex, seemingly stochastic and unpredictable behaviour even though traditionally one would expect deterministic and thus predictable properties. Such

behaviour is chaotic. One consequence is that even if one could measure all possible variables in such a system, errors being inevitable, the ultimate behaviour would be unpredictable (sensitive dependence on initial conditions); a far cry from the predictability and control of the reductionalists. One would expect the same if, as hypothetically suggested, every neuron was replaced by a silicon chip with exactly the same properties (although measuring error would limit "exactness" as well). But all hope is not lost. Chaotic processes in systems can produce long range "order". This new "order" produces beautiful patterning believed to be responsible for the rich and varied forms in nature. It would not seem unreasonable to extend this to the rich variety and creativity of mental life. Moreover at the transitions between order and chaos this long range "order" may be characterised by long wavelength oscillations akin to the cyclical behaviour of some mental illnesses.

By viewing the mind as a result of a dynamic system one no longer needs the mind-body dichotomy, since the brain is only a part of this system. This dichotomy has plagued the area of classification in psychiatry but without it one is free to formulate psychiatric illness as a disorder of dynamic systems. Such concepts have already been applied in other areas of medicine and since many such systems have similar properties, perhaps in the areas of "healthy mind" or illness they may be usefully applied in psychiatry.

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A list of references is available on request to the author.

Psychiatric disorders in mentally handicapped people

DEAR SIRS

In some of the College *Journal* and *Bulletin* articles, mentally handicapped people are referred to as having psychiatric and behaviour disorders. For example, the *Bulletin* (November 1986, **10**, 321–322) article on 'Psychiatric Services for Mentally Handicapped Adults and Young People' states:

> "All forms of psychiatric disorder are seen although the pattern differs somewhat from that in the general population and there is a high frequency of behaviour disorders."

This statement implies that behaviour disorders are not psychiatric disorders which, of course, is not correct. Conduct disorder, in both the ICD (9th revision) and DSM-III, covers behaviour disorder.

I think we should speak of psychiatric illness and behaviour disorders under the heading of psychiatric disorders. This would avoid confusion in the minds of other professionals and managers working with us.

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Medical interchange

DEAR SIRS

Medical Interchange has been recently set up to facilitate the exchange of practices between doctors, both general practitioners and specialists, for short periods of time between the United Kingdom, Ireland, Australia and New Zealand. For the last ten years, I have been working as a locum consultant surgeon for four to six weeks each year in a major Sussex county hospital and have found the experience of great value and have also found that colleagues in both the United Kingdom and Australia have envied my being in a position to do this and have expressed an interest in being able to exchange their practices with colleagues for longer periods of time.

I have found a great deal of interest in this idea from editors of medical journals and newsletters in the four countries concerned and feature articles on the enterprise are about to start appearing. I have also placed advertisements in appropriate journals in the countries involved.

I would like to ask that you bring this enterprise to the attention of your members as I believe this would be to the advantage not only of Medical Interchange but also of the individuals who may well be delighted with the opportunity of an exchange.

The registration and immigration requirements are quite complex and it is the intention of Medical Interchange to carry out whatever is possible to comply with the formalities but quite clearly there are some which must be attended to personally by the doctors concerned. All details will be provided concerning these requirements.

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P.S. I have recently received an enquiry from a psychiatrist in Manly, Sydney, New South Wales who has expressed an interest in exchanging his practice with that of a colleague in the United Kingdom for a period of some months.

DEAR SIRS

Enclosed with the September 1990 issue of the *Psychiatric Bulletin* was a notice about registration of psychiatrists with the General Medical Council as "trained". I am sure that other overseas members of the College would appreciate a *Bulletin* article explaining the purpose of the new register. Unless