like the Social Psychiatry Unit, needs to be supported and preserved.

DOUGLAS BENNETT, *5 Mill Lane, Iffley, Oxford OX4 4EJ*

Section 17 (leave) of the Mental Health Act

Sir: I have recently run into problems with the use of section 17 (leave) of the Mental Health Act. The local Residential and Nursing Homes Inspection and Registration Unit has indicated that homes which are not registered under the Mental Health Act should not take patients on section 17 leave. There seems to be concern that such patients are "liable to be detained" under the Mental Health Act and therefore should only be in registered homes under the terms of the registration of homes legislation.

It seems that people can be sent to their own home, bed & breakfast accommodation and hostels but not residential or nursing homes if they are liable to recall to hospital. I have endeavoured to explain that they are only "liable to be detained" if they are recalled to hospital and are of course not detainable in the home.

I wonder if there have been similar experiences in other parts of the country and whether the College could help clarify this issue.

ADAM MOLIVER, *Delancey Hospital, Charlton Lane, Cheltenham GL53 9DU*

The problem orientated psychiatric discharge summary

Sir: Psychiatric discharge summaries generally follow a standard format but vary considerably in their content and presentation. We report an investigation into general practitioners' attitudes to a problem orientated psychiatric discharge summary, which includes information shown to be relevant to their needs diagnosis, management, medication, information given to patient, follow-up plans and prognosis (Orrell & Greenberg, 1986).

A questionnaire accompanied by three versions of a psychiatric discharge summary was sent to 100 GPs in Camden and Islington, London. *Summary 1* covered two sides of A4 paper, conformed to the traditional structure and contained detailed information under 11 headings recommended by the Institute of Psychiatry's guidelines. *Summary 2* was also on two sides of A4 paper, had a problem orientated list on the front-sheet, and contained brief relevant details under the same headings. *Summary 3* was on one side of A4 paper and contained the same problem orientated list as in summary 2, followed by a single paragraph describing the patient's presentation and management. The questionnaire asked for the summaries to be placed in order of preference and left additional space for comments.

Responses were obtained from 71 of the GPs. Telephone follow-up established that 16 had retired, moved, practised or deceased. The sample size was therefore reduced to 84 and the response rate was 85%. Summary 1 was the first choice of two, second choice of 19 and third choice of 44. Summary 2 was the first choice of 38, second choice of 20 and third choice of nine. Summary 3 was the first choice of 31, second choice of 25 and third choice of 11.

Eight general practitioners included only a first choice. Sixty-nine out of 71 (97%) preferred the discharge summaries which contained a problem list. Of these 38 (54%) preferred the summary that included the traditional headings and 31 (44%) preferred the one with a single paragraph outlining presentation and management. Ten general practitioners commented that greater detail would be preferred following an initial admission and the briefer summary for subsequent admissions.

Of a representative sample of inner city GPs, the overwhelming majority therefore preferred the summaries which contained the problem orientated list. Concise and prompt communication with primary care is essential to patient management, and this need has been sharpened by the introduction of contractual arrangements between purchasers and providers. A problem orientated list also allows easier transfer of important information onto computerised records. We believe that the requirements of both psychiatric services and general practitioners can be accommodated by incorporating problem orientated lists into discharge summaries, and suggest that, although it is appropriate to include more detailed information following a first admission, subsequent summaries could be even briefer.

ORRELL, M.W. & GREENBERG, M. (1986) What makes psychiatric summaries useful to general practitioners? *Bulletin of the Royal College of Psychiatrists*, **10**, 107–109.

SUKHI S. SHERGILL and MAURICE GREENBERG, *Jules Thorn Day Hospital, St Pancras Hospital, 4 St Pancras Way, London NW1 0PE*

Misuse of the word 'audit'

Sir: I find your publication informative and stimulating. The articles are concise and well-written, and I am pleased to see an increasing number relating to audit. However, as a medical audit officer, it does frustrate me to see the term 'audit' used in the wrong context, particularly in the correspondence columns.

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It is often used to describe the simple exercise of collecting figures, e.g. the number of DSH admissions or the percentage of GPs who prefer their patients having depots given at a hospital clinic. These are, however, examples of surveys. My computer thesaurus informs me of other words which could be exchanged for audit: study, investigation, poll, examination, assessment, analysis.

Unless the information collected results in standards being set, guidelines being produced or some sort of structured change implemented, it cannot be called audit. Research is often used synonymously with audit, but the same rules apply. A further important difference between research and audit is the condition of carrying out a re-audit, in order to determine whether practice has improved.

I, and my audit colleagues, would be grateful if you could encourage the proper use of the word.

PAUL KIRBY, *Medical Audit Officer, General Psychiatry, St James's University Hospital, Leeds LS9 7TF*

(*Point noted—Ed.*)

Abuse of human rights in Rwanda

Sir: No-one will fail to have been appalled by the news coming from Rwanda in the last three months. Shock and a sense of impotence to stem this wave of genocide prevails.

Drs Peter Hall and Andrew Carney, representing Physicians for Human Rights UK (PHR UK), were interviewed on BBC News on 15 July while investigating abuses in the remains of a Kigali psychiatric hospital. Worse than any Bedlam, those patients surviving a military attack were witnessed to be at the mercy of the ignorance and fear of the non-medical refugees seeking some asylum there.

Everyone working in mental health services will have an understanding of the prejudices about psychiatric ill health, but few I am sure would have suspected how depraved some people's behaviour could have become towards those most vulnerable. This is, however, only one example of an horrific catalogue of atrocities committed *en masse*. Perhaps the only hope we can have that this does not recur is to attempt to understand some of the driving forces in initiating and condoning these murders, as well as the psychological effects on survivors, witnesses and perpetrators. This is one of the aims for the members of the PHR team currently in Rwanda.

MORAG L. ROBERTSON, *Worcester Royal Infirmary NHS Trust, Newtown Branch, Newtown Road, Worcester WR5 1JG*

An open letter to the Secretary of State for Health

The Mental Health Act of 1983 arose out of the anti-psychiatry movement which was prevalent before that date. This involved the specific denigration of psychiatrists, particularly consultant psychiatrists.

This I think was reflected within the Mental Health Act 1983 from which came the Code of Practice. On page 3 of the Code of Practice, the initial letters of Approved Social Worker are in upper case, but when doctors are mentioned, even though they are specifically mentioned within the terms of the Mental Health Act, their name does not start in upper case. This may be a mistake, but on pages 24 and 25 the Second Doctor is not in upper case although ASW is and Managers are in upper case. On page 25, regarding the Responsible Medical Officer, an extremely significant person within the terms of the Mental Health Act, neither the full name starts in upper case nor does the abbreviation rmo. In the same sentence Managers start in upper case and the patient's rmo is in lower case.

It is quite clear that this is not a mistake but is deliberately intended and is a symbolic devaluation of the role and person of the Responsible Medical Officer in particular and doctors in general.

I would be grateful for your comments and even more grateful if the next edition of this Code of Practice could be suitably amended so that due respect is paid to the professionals mentioned.

DAVID MARJOT, *85 The Avenue, Sunbury on Thames, TW16 5HZ*

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