

Neuropsychiatry (SCAN; World Health Organization, 1994) offers another view on this and related terms.

SCAN refers to "delusional perception or primary delusion", suggesting that these terms are synonymous. If this interpretation is correct it implies that delusional mood, delusional memory (as defined by some) and the autochthonous delusion are not different forms of primary delusion, but are altogether different entities according to SCAN.

SCAN defines delusional perception as "an intrusive, often sudden knowledge that a common perception has a radically transformed meaning . . ." but goes on to add ". . . a normal perception, image or memory takes on an entirely new significance." Thus this definition includes what some would term a delusional memory.

Delusional memory 'proper' is recognised and rated as a separate item in SCAN and is defined as "experiences of past events which clearly did not occur." This is consistent with Sims' view (1988) of a delusion retrojected in time, although not so with Gelder *et al*'s view (1989) that delusional memories are delusional interpretations of real memories.

Similarly delusional mood is not a form of primary delusion according to SCAN. Being both rare and difficult to distinguish from other psychotic and non-psychotic symptoms, delusional mood is only rated as present when other delusions are subsequently formed. Furthermore, no mention is made at all of the autochthonous delusion in SCAN.

SCAN is now an established research instrument which aims to improve interrater reliability in the recognition and assessment of a variety of psychiatric phenomena. This is achieved through the use of strict differential definitions of psychopathological symptoms and signs, as described in the SCAN glossary. While these do not fully concur with other authorities, adopting these definitions in clinical practice does at least provide the opportunity to improve reliability between clinicians and reduce the confusion which currently exists.

GELDER, M., GATH, D. & MAYOU, R. (1989) *Oxford Textbook of Psychiatry* (2nd edn). Oxford: Oxford University Press.

SIMS, A. (1988) *Symptoms in the Mind. An Introduction to Descriptive Psychopathology*. London: Baillière-Tindall.

WORLD HEALTH ORGANIZATION (1994) *Glossary: Schedules for Clinical Assessment in Neuropsychiatry* (version 2.0). Geneva: American Psychiatric Press.

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### Phlebotomists – not always a good thing

Sir: Like many others we have introduced phlebotomists onto our admission ward, as taking blood is now seen as a non-educational activity for junior doctors. However, our juniors themselves have noticed some unexpected drawbacks. If blood is taken at the end of the initial consultation, a patient may often speak a little more freely, believing that the formal interview is over, thereby revealing further important features of his/her mental state. Taking blood for liver function tests serves as a useful *aide-mémoire* to enquire about an alcohol history. All too often, the less demanding in-patients can easily be forgotten by the doctors. A blood sample can be a useful way to at least keep an eye on one or two. Finally, incoming general practice registrars can feel uncertain and lost at the start of a six-month psychiatry attachment. The task of taking blood can be a familiar landmark in an otherwise confusing experience, and can be the start of adjustment to and integration within the team.

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### Responsible medical officers and keyworkers: a conflict of roles

Sir: I have been involved in the teaching of a course for keyworkers for some time. A particular question has arisen with practically every one of these groups, namely: How do we resolve whether the responsible medical officer or the keyworker coordinates the care plan for each patient, given that both are given the same role under the Care Programme Approach?

This is a reasonable question. Paragraph 15.5 of the *Code of Practice* (Department of Health & the Welsh Office, 1993) states that "treatment plans are essential for both informal and detained patients. Consultants should coordinate the formulation of a treatment plan in consultation with their professional colleagues. The plan should be recorded in the patient's clinical notes". At the same time, Paragraph 3.2.18 of *Building Bridges – a Guide to Arrangements for Inter-Agency Working for the Care and Protection of Severely Mentally Ill People* (Department of Health, 1995) states: "As well as coordinating the Care Plan, keyworkers/care managers may also provide an element of the plan in their own right".

Insofar as Treatment Plans and Care Plans are one and the same, it is true that government

documents do assign the same role – the coordination of the Care Plan – to both the consultants/responsible medical officers (RMOs) and the keyworkers. This is, potentially, a recipe for conflict if not correctly interpreted. Fortunately, the answer to the question is contained in the government documents themselves, if one reads them carefully. My interpretation is that consultants/RMOs coordinate the *formulation* of the Care Plan and keyworkers coordinate the *delivery* of the Care Plan. These roles are complementary, and not identical.

As *Building Bridges* states in paragraph 6.1.12, “Keyworkers have a crucial role under the Care Programme Approach in ensuring that mentally ill people get the services they need in the community and that they do not lose contact with specialist services”.

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