whether they had received teaching of any kind on the use of the Section 5(2), the majority said they had not. Training is essential but usually lacking. It should be done as part of the induction programme, and should include discussions of its use in different clinical situations.

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What happens after the 'Ashworth Inquiry'?

DEAR SIRS

It is now some eight months since the report of the Committee of Inquiry into complaints about Ashworth Hospital, a document which will, no doubt, eventually assume its position in the annals of forensic psychiatry. I am surprised that there has been no mention of it in the *Psychiatric Bulletin*. Having worked, albeit many years ago in a special hospital, I thought it might be of interest to comment.

The inquiry revealed what nearly everyone who has worked in a special hospital must know; that there is, and has been for decades, an unhealthy 'psychopathic' element in special hospital staff culture, prone to bully and victimise patients and staff who cross its path. This is not to say that there are not many well motivated professionals working within these hospitals or that reputable assessment and treatment processes are not practised.

The inquiry was initiated by the Government due to media pressure, occasioned by Channel 4's documentary 'Cutting Edge'. Following a legal struggle with the Prison Officer's Association, it was successful in penetrating the circle of silence and intimidation, within which patient abuse can flourish. However the mandate of the inquiry was to inquire and expose, not rectify. What happens next?

Undoubtedly the inquiry dealt a severe blow to the morale of professionals working within the special hospitals. Demolition, without reconstruction, is not necessarily helpful. With their long history of problems, are the special hospitals going to be able to recruit professionals of the right calibre to struggle with what may be a thankless task? I think there is reason for doubt. Should this be so, the future for the special hospitals after the Ashworth Inquiry may be bleak not hopeful. The opinion of colleagues would be of interest.

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'Psychiatric opinion audiotaped'

DEAR SIRS

We would like to report on giving patients audiotaped recordings of their psychiatric opinions after first consultations. This form of communication has been found to be beneficial when used in surgical out-patient clinics for women being told about their breast cancers (Hogbin & Fellowfield, *British Journal of Hospital Medicine*, April 1989, 330–333).

The study was carried out in North Herefordshire with a population of around 40,000. All new out-patient referrals were considered for entry. The patients were divided into immediate and delayed groups. The immediate groups constituted patients who would at completion of their consultation take the audiotapes home with them. The delayed groups consisted of patients who would have the audiotape recording made but would take their audiotapes four weeks later. The psychiatrist was blind as to which group the patient was in. Towards the end of each consultation an audiotaped recording was made of the psychiatric opinion and of any questions the patient asked. This recording would eventually be the property of the patient.

The patients completed assessment questionnaires at four and eight week intervals. The first questionnaire was a self rating questionnaire and scored eight items. Four items related to recall of initial consultation, two to compliance and report of side effects and the last two to satisfaction about the information given. The second questionnaire, rated at eight week intervals, was also a self rating questionnaire. It had six questions relating to the use of audiotape.

In all, 22 patients entered the study, 12 in the immediate group and ten in the delayed group. There was no significant difference in either two groups in terms of the recall of diagnosis, aetiology, suggested treatment and explanation of side effects, compliance with medication, or incidence of side effects. No patient felt that the information given was inadequate. Over 90% of the patients rated the information given as good or very good; 88% had listened to the tape since the first consultation. Of those who had listened, 73% listened to the tape with another person, usually the husband or partner. Most patients (88%) rated the recording as useful or very useful; 83% did not find the recording disturbing.

Our initial view that, because of the patients' anxiety at the first consultation, they may not remember what was being said to them about their illness did not hold. The results show that there is no value in routinely audio-taping initial psychiatric consultations to improve patients' understanding of their illness. This would underline the fact that good personal communication skills between doctors and

https://doi.org/10.1192/pb.17.4.243-a Published online by Cambridge University Press

patients remain the most powerful tool for achieving greater patient satisfaction.

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Are psychiatric case-notes offensive?

DEAR SIRS

The inclusion of truly offensive material in the case-notes of any patient has always been clearly unacceptable, regardless of whether or not patients are entitled in law to see their records. In the methods section of their study of case-notes from Charing Cross Hospital, Crichton *et al* (*Psychiatric Bulletin*, 1992), **16**, 675–677) give a defining example of what they would rate as "extremely offensive". This was the comment: "a most unpleasant man". No doubt this could be taken as offensive, even extremely so by some readers, and such comments appeared in 62% of the case-notes reviewed. A most disturbing finding? We think not. On examining the appendix which contains examples of comments considered extremely offensive by all four raters, the degree of offensiveness of none of them struck us as coming up to that of "a most unpleasant man". To test this, we presented the comments in the appendix to an intelligent layperson (Margaret, our Section secretary) and asked her to rate them for offensiveness. She regarded comments (4) ("My greatest fear is that A. was unwell when she decided to marry this individual") and (9) ("He is a pitiful and lonely man") as "offensive", but thought none of them qualified for an "extremely offensive". The study authors have a valid point when they urge those writing in case-notes to avoid unfortunate and insensitive value-laden comments and gratuitous rudeness. Contrary to the conclusions of this study, most psychiatrists do not write offensive comments in case-notes. We believe that the authors have misled themselves through the downright silliness of what they appear to have deemed as offensive. Perhaps the greatest offence we can occasion our patients is to patronise them with robotic, politically correct language when we speak to them and write in their case-notes.

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DEAR SIRS

I read with Crichton *et al's* audit of psychiatric case-notes (*Psychiatric Bulletin*, 1992, **16**, 657–677). Their raters universally found such terms as 'a schizophrenic' and 'a depressive' extremely offensive because they claim these terms are stigmatising. Turning to the same month's edition of your sister journal (*British Journal of Psychiatry*) I noticed it too carried references to 'schizophrenics', 'bulimics' and 'heroin addicts'. By these criteria both the editors and contributors to the yellow journal are 'extremely offensive'.

The more serious point Crichton *et al's* paper raised is that whereas this usage is stigmatising in mental illnesses, it is considered neutral in physical illnesses; thus labelling someone 'a diabetic' is inoffensive. It seems clear that in an attempt to sound politically correct psychiatrists run the risk of colluding with the prejudice suffered by their patients elsewhere.

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DEAR SIRS

It is hardly surprising that psychiatric case-notes contain material which patients find offensive. It is in the nature of mental illness to be seen as stigmatising, so merely being a "case" inevitably causes offence to some people. This is particularly likely to be the case with psychiatric case-notes as our observations tend to be of a far more personal nature than those found in medical case-notes.

I would not disagree with advice on the need to be cautious in making entries into notes. However, I think we need to be more discriminating than the authors of this article suggest. There is an important distinction between those remarks which are gratuitously offensive, and those that offend but which are nevertheless true and may be important. We must guard against the trend for case-notes to be become increasingly bland and convey no useful information whatsoever. This does necessitate making entries which will cause offence, for example comments on somebody's dress, hygiene and appearance. It would cause offence to many people to read a comment that they smelt or looked peculiar, but these observations may be as important as noting the presence of hallucinations. It may be of crucial importance to know that somebody has a "tendency to become seriously disturbed" even if that person does not like to see it in his or her notes.

I believe the simplest rule is that no relevant fact should be omitted, however offensive it may seem, but that personal opinion should be limited to that which is clinically justifiable.

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https://doi.org/10.1192/pb.17.4.243-a Published online by Cambridge University Press