These findings need to be interpreted with caution in view of the questionnaire used. The authors failed to ascertain whether the issue of doctors' dress was important to patients, prior to a specific choice of attire being made. Often, what doctors wear is not as big an issue for patients as we may believe and patients are reported to be less discriminating in their attitude towards physician appearance than physicians themselves (Dunn *et al*, 1987). Between 30 and 70% of patients in various studies are reported to have no preference regarding doctors' attire (Neinstein *et al*, 1985; Dunn *et al*, 1987; Friis & Tilles, 1988; Del Rey & Paul, 1995).

Patients should have first been asked whether their doctor's attire was of relevance to them, and those who felt it was could have gone on to choose one of the specified forms of dress. This study design would have provided a clearer picture of whether the issue of psychiatrists' dress was of significant concern to patients. If the majority felt that it was important, then the findings would have more relevance to clinical practice. To use an extreme example, consumers entering a fast food store may indicate a preference for one type of uniform over another when given two choices, but the majority may not really care as long as they get good service. While there are obvious differences between this situation and the issue of doctors' attire, the principle may well be the same.

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Diagnostic criteria and functional psychosis

Sir: The correspondence between Ryan (1997) and Van Os *et al* (1997*b*) made interesting reading. Van Os *et al* make an important claim that 'pure' affective and schizophrenic states become rarer with time. Strangely enough, their claim is not borne out by the results of a previous study they published (Van Os *et al*, 1996). In that study, the same sample when diagnosed with DSM–III–R diagnostic criteria led to a diagnosis of only 12 cases of schizoaffective psychosis, with schizophrenia being more or less stable, and 43 cases of affective psychosis, compared with 17 in their present study (Van Os *et al*, 1997*a*).

This raises the following questions. First, are the research diagnostic criteria (RDC) unreliable at distinguishing 'pure' forms of affective and schizophrenic psychosis? Second, is it only affective disorder that presents with schizophrenic symptoms over a lifetime (theoretically, the lack of pure forms should affect both diagnoses)? Third, if this were true of the RDC, should they be avoided in favour of DSM–III–R or any other reliable criteria used to diagnose schizophrenia and affective disorder?

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Authors' reply: What Dr Kirby notes, but may not realise, is that given a mixture of affective and psychotic symptoms, it is a lot more difficult to get a diagnosis of schizoaffective disorder using DSM criteria than it is using the RDC. The DSM requirement that there must have been delusions or hallucinations for at least two weeks in the absence of prominent mood symptoms is simply more restrictive. We recently examined 706 patients with functional psychosis and found the same relative diagnostic shift between the RDC and DSM systems, with ICD–10 being somewhere in between. Thus, more patients with affective and psychotic symptoms will be labelled as suffering with affective psychosis according to DSM and with schizoaffective psychosis according to RDC.

We fail to see what this relative shift has to do with our statement that patients with psychosis accumulate a variety of affective and non-affective psychopathologies as time progresses, which will affect the diagnostic distribution within a given diagnostic system accordingly. The only way to examine this *longitudinal* issue is to compare baseline with follow-up diagnoses within the *same* diagnostic system.

The choice of diagnostic system (and the ensuing diagnostic distribution) is arbitrary because there is no evidence that any system is more valid than the other. Thus, our response to Dr Kirby's first question ("are the RDC unreliable at distinguishing 'pure' forms of affective and schizophrenic psychosis?") is that, for the time being, all diagnostic systems remain equally (un)reliable. In our 1997 paper (Van Os *et al*, 1997) we chose the RDC to diagnose the patients because of its compatibility with the family history research diagnostic criteria method used to diagnose the relatives. In our earlier paper (Van Os *et al*, 1996) we examined a clinical issue and therefore used both DSM and ICD criteria, because these are most often used in clinical practice. The question following from Dr Kirby's observation is: if there is no agreement between diagnostic systems as to where to draw the line between basic categories in the functional psychosis, should we not, instead, concentrate more on overlapping psychopathological dimensions within the continuum of psychosis?

Van Os, J., Fahy, T. A., Jones, P., *et al* (1996) Psychopathological syndromes and the functional psychoses: associations with course and outcome. *Psychological Medicine*, **26**, 161–176.

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Family involvement in the care of people with psychoses

Sir: Should communication between psychiatrist and non-professional carers be permitted without the patient's agreement? Szmukler & Bloch (1997) have confirmed my impression that the profession is at sea over this question. Community care of people with psychoses

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demands fundamental changes in our attitudes to medical ethics as they apply to the rights and liberties of such people. These ethical questions cannot be resolved by laying down rigid rules. Psychiatrists should take personal responsibility for judgements that may sometimes appear to conflict with traditional ethics. Whenever there is doubt about the patient's frankness or ability to communicate, then surely it is incumbent upon the clinician to seek extra information from family or other informants, even without the patient's permission.

The duty of care towards the carers, discussed by Szmukler & Bloch, cannot be considered as a separate issue. The interests of patient and carer are closely linked. A short domiciliary visit may show a patient who appears to be cared for and living a relatively normal life when, under the surface, things are very different. Only carers who know them well and see them frequently know the full extent of patients' day-to-day inadequacies. The professional visitor may see nothing of the effort being made by the carers who may themselves be highly stressed, either singly or collectively. If one or more of them should crack, disaster may ensue before the professionals have any inkling of what is going on. So it is not only a duty of care towards carers that is involved. To neglect communication with them is to neglect the duty of care towards the patient as well, and should be regarded as serious negligence. The profession should recognise that there should be no rigid requirement to get the patient's consent for such communication. If it does not, there will be more disasters of the kind that are already disturbing public confidence in psychiatry, and many less dramatic disasters in which the lives of patients and carers are undermined unnecessarily.

Szmukler, G. I. & Bloch, S. (1997) Family involvement in the care of people with psychoses. An ethical argument. *British Journal of Psychiatry*, **171**, 401–405.

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One hundred years ago

The certifying of lunatics

Dr. Lovell Drage, the Hatfield coroner, recently held an inquest upon the body of a man, aged eighty-one years, which was found in a pond at Leverstock Green. Medical evidence was given by Dr. Hutchinson, of Hemel Hempstead, that there were no marks of violence on the body. The deceased's grand-daughter said that he had been quite childish for the last four years and that last year he had been certified as insane by a medical man, but a magistrate had refused to sign the order for his detention. The jury returned as their verdict: "Deceased walked into the Blackwater Pond, Leverstock Green, and was found drowned on March 9th, 1898, and he was of unsound mind at the time of his death." They added as a rider, "That it is unfortunate that the magistrate did not sign the order for the detention of the deceased in a lunatic asylum at the time of his examination in 1897." We quite agree with the jury. It used to be only too easy to get into an asylum, for during the first forty years of the century a lunacy order was a kind of *lettre de cachet* and the unfortunate victim was hurried off and imprisoned without either explanation or redress. Nowadays, however, it is by no means easy to get a lunacy certificate signed, but we may certainly take it that no medical man will sign a detention order without having very good reasons for so doing. This being so, it is intolerable that a non-professional person should be able to render a diagnosis and directions for treatment of no avail. In the case under consideration the life lost was perhaps one not very valuable to its owner, although such a death is a sad ending to a long life, but in similar cases which have occurred where homicidal tendencies were present many and more valuable lives might well have been sacrificed.

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