Most disappointing though is Perkins and Moodley's wholesale acceptance of post-Thatcherite market economy jargon at the expense of scientific psychiatry. Here the 'user' is King. "Martians invading your thoughts? Whatever you say Sir". "Bodily insides rotting? Quite so Madam". For in the market, the customer is *always* right.

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The arrogance of cultural relativism

DEAR SIRS

I want to endorse the multicultural perspectives advocated by Perkins and Moodley (*Psychiatric Bulletin*, April 1993, **17**, 233–234). Psychiatric diagnosis, and especially treatment and management, depend on cultural factors. This is evident in the major changes over the last five decades: the altered status of the mental hospital; the imposition of independence and empowerment of long-standing asylum inmates; the notion of the caring community (promoted by monetarist politicians); and the ascendancy of brain-oriented treatments over mind-oriented ones (due to the might of pharmaceutical budgets).

Such cultural changes sweep across our own profession. But a wholesale cultural relativism, such as Perkins and Moodley's pluralism, has problems too. It is very much a Western attitude; and anthropology, upon which they rely, is also an idiosyncratic Western development.

Cultural relativism leaves no opportunity for judging which ideas, from which cultures, are the most useful; except to say that those most widely held are the best (a 'survival of the fittest' argument). This is one reason for the hope invested in scientific psychiatry; it offers a position seemingly outside the melting-pot of culture, based on the working of the physical world, the brain. The psychiatrist becomes convinced he is in an objective world, uninfluenced by local cultural attitudes and can adjudicate from this 'neutral' base in the biochemistry of the synapse, etc. Unfortunately this spreads to the psychiatrist's belief in possessing 'objective' facts about the mind, as well as the brain. In fact both the minds of patients and of psychiatrists are formed and changed as creations of cultures.

As Perkins and Moodley rightly imply, the scientific arrogance of psychiatrists and the imperial arrogance of Western trade go hand in hand. With this imperial legacy it is easy for Western psychiatry to feel that we should be adjudicators for the world. We need to recognise the arrogance of believing we can stand outside culture, and adjudicate upon its creations. Our difficulty is to exist *within* our world of cultural attitudes (with our patients) while attempting to assess the distortions *of* it (*by* ourselves and our patients).

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Encouraging in-patients' access to their notes

DEAR SIRS

I read with interest Butler & Nicholls' paper on the Access to Records Act (*Psychiatric Bulletin*, April 1993, **17**, 204–206). They report that of staff completing a questionnaire concerning the Act, 60% of them had reservations about paranoid patients seeing their psychiatric records and 49% had similar reservations about access for psychotic patients. They did not ask whether any staff had already allowed patients access to their notes but this seems unlikely. I would like to suggest that had they done so, some anxieties may have been alleviated.

In one of my former posts, as a registrar, it was the consultant's policy to encourage in-patients to read their notes, and it was the registrar's duty to facilitate this by discussing with patients issues raised. My experience of this was overwhelmingly positive. It was noticeable that no patients actually requested to see their notes but few refused when offered the opportunity. Most had a diagnosis of psychotic illness and yet, contrary to expectations, it was possible to discuss recorded symptomatology, diagnosis and treatment calmly without provoking distress, anxiety or anger. This was true even with patients who had little, if any, insight. Most of the disagreements patients had were concerning factual information that was inaccurate, for example age of a parent or occupation of a sibling. They were keen to ensure an accurate history was recorded. In one patient, a woman in her 20s with severe schizophrenia, access to her records facilitated the most frank discussion about her diagnosis than had ever been possible. The impression of the written record seemed much

greater than any oral information previously received.

I found myself thinking more carefully before I wrote notes and allowing patients access enabled details to be corrected and a more accurate record to be made. It was still possible to record sensitive information if it was correct.

The Access to Health Records Act may make little difference in practice, as our experience was that patients themselves rarely asked to read their notes. However, perhaps we should take the more radical step of offering and encouraging access. The major drawback is that it takes time adequately to explain psychiatric jargon and answer questions raised, but it is certainly time well spent.

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The Public Records Act, 1958, and local archive services

DEAR SIRS

Psychiatrists who have a concern about the preservation of hospital documents and records will find the provisions of the Public Records Act, 1958, helpful. This Act places a duty on health authorities to preserve those classes of records deemed worthy of permanent preservation. Records less than 30 years old are the responsibility of the health authority and those over 30 years old of the Lord Chancellor's Department.

In practice, the Public Record Office asks a local record office to locate and care for the significant hospital records in its area. The records most at risk, for example at hospitals facing closure, are usually given priority for assessment and transfer. There is no change in the ownership of records deposited under the Act and if deposited records are needed by a hospital they are returned. There is no charge for the service although a free service may not exist for ever. Mental health seems to be an increasingly popular topic for students, but they are not permitted to see 'closed' medical records.

Psychiatrists seeking more information will no doubt find advice from their local archive service.

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Pre-interview questionnaires

DEAR SIRS

We read the audit article on pre-interview questionnaires (Eynon & Gladwell, *Psychiatric Bulletin*, March 1993, **17**, 149–151) with interest.

In a recent study we examined the use of pre-interview questionnaires by a child and family psychiatric unit. We found that the introduction of a pre-interview family questionnaire had significantly reduced the number of families who 'survive' the referral process and attend their first appointment. In parallel with Eynon & Gladwell we identified other functions provided by pre-interview questionnaires, apart from that of information gathering. The very act of getting families to answer questions about the nature of their problems might in itself be a catalyst for change, thus removing the need for any professional intervention. The type of questions asked may act to deter those families who would find it difficult to engage and use the type of service that we provide. The hurdle described by Eynon & Gladwell may indeed be too high for families in a state of chaos or crisis but who might otherwise have benefited from our type of service.

Proper evaluation of these latent functions – the therapeutic, the deterrent, and the hurdle – require studies of two types. Initially, recipients who fail to return their questionnaires will need to be contacted directly and an attempt made to find out why. Subsequently, pre-selection of patients in this way will need to be correlated with outcome criteria before we can justify deterring any sub-group of those individuals or families referred to us.

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Consumer audit of psychiatric training

DEAR SIRS

I read with interest Cunningham & Aquilina's paper on consumer audit of psychiatric training (*Psychiatric Bulletin*, February 1993, **17**, 93–94) but am surprised that they are unaware of previous attempts by trainees to assess the quality of their training. Fahy & Beats (1990) described a survey of junior psychiatrists' experiences at the Maudsley which seemed to address similar issues. They also discussed the long history of trainee assessment of psychiatric training quoting Jeffreys & Murray's study conducted in 1974!

The authors can be forgiven for being unaware of current trainee led audits of psychiatric training. On the Mid-Trent (Nottingham) rotation the Feedback on Jobs Committee, a sub-committee of the Junior Medical Staff Committee, has been engaged in a programme of regular audit for over six years. At six monthly intervals the trainees on the rotation (currently 17 SHOs, 25 registrars and four PM79/3