Correspondence

Don't forget the patient

Day *et al*'s study of thiamine prescribing[1] was interesting and valuable. The results given in the abstract report only the small positive change in the post-intervention group, rather than reflecting the mixed picture of positive and negative change in the appropriateness of prescribing which are outlined more fully in the body of the paper. It is concerning and disappointing that such a clear and ostensibly easy-to-use flowchart did not produce the degree of change in practice that one might reasonably have hoped for, and still left the significant majority of patients apparently receiving suboptimal treatment.

The authors highlight the role of clinician-dependent factors, such as incomplete history taking on admission, lack of knowledge and disproportionate concern with rare adverse reactions. I would argue that the relative failure of an information-giving intervention to produce real improvements in clinical practice should encourage us to look more deeply at the patient-related factors which may act as barriers to the delivery of 'optimal' treatment.

From my own clinical experience, I would suggest that factors such as patient concordance, cooperativeness and capacity are major determinants of the feasibility of delivering what, on paper, would be best practice. Patients with chronic alcohol misuse not uncommonly have comorbid psychiatric conditions or personality styles which affect their adherence to the relatively unpleasant treatments of cannulation and intramuscular injection. Acute confusion, noted in around a third of the sample in Day *et al*'s study,[1] would often impair the capacity to consent to treatment. The risks, to staff and the patient alike, of attempting to administer thiamine parenterally to an uncooperative individual are considerable, and must be evaluated in any best-interests decision-making process. Such patient-related factors may explain the preference among treating professionals to take the route of oral medication despite advice to the contrary, particularly in less clearly defined cases.

I look forward to seeing further exploration of factors that bear influence on the delivery of treatment in future studies.

1 Day E, Callaghan R, Kuruvilla T, George S, Webb K, Bentham P. Pharmacy-based intervention in Wernicke's encephalopathy. *Psychiatrist* 2010; **34**: 234–8.

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Care pathways mislabel and mislead

Care pathways originated in the North East, Yorkshire and Humber regions and I understand why the current 21 clusters have been developed. There is a need to measure what psychiatric services do and develop objective ways of assessing outcome rather than process.[1] The problem is that this newly imposed system does not achieve these objectives. Its main measure of outcome, the Health of the Nation Outcome Scales (HoNOS), was developed in the 1990s at a time when the focus was on psychotic illnesses. At the time there were concerns about the instrument's sensitivity to change and ability to measure outcome.[2,3] In 2010, the focus has broadened to include statistically more significant health challenges such as stress disorders, substance misuse, somatoform disorders, personality disorder, anxiety and depression. HoNOS remains a helpful tool in rehabilitation services and forensic settings, but its applicability to general and community psychiatry is limited. Using it on a day-to-day basis, as I have been instructed to, it smacks of a system that is out of date and that simply does not address the heart of the matter.

For example, if somebody has psychotic experiences as a result of drinking alcohol, the computerised system will allocate that individual to a psychotic pathway even though it is clear that alcohol had a causal role. There is only one care pathway for substance misuse despite the variations in substances, legality and levels of addiction and yet there are eight pathways for psychosis. There is no appropriate care pathway for eating disorders, nor is there any specific enquiry at any point about whether a person is losing weight.

It does not surprise me that anecdotal findings suggest that many people referred to general psychiatry are categorised into the common and mild pathways, 1 and 2. This is a problem with the unbalanced nature of the assessment tool rather than the referral process. It alarms me when I hear commissioners and senior mental health trust managers suggesting that psychiatric services should not see such patients. This may lead the local communities that we serve to perceive us as increasingly irrelevant.

Care pathways are a bureaucratic procedure. It is labour intensive and competes with other documentation processes for time spent in direct face-to-face contact with patients. In my view, the process has the ability to mislead clinicians, managers and the general public. It also has the power to offend some service users by labelling their distressing conditions as, for example, 'common mental health problems (low severity)'. As a professional body, I think we should ask the question, is this a good enough measure to underpin payment by results?

1 Department of Health. *Practical Guide to Preparing for Mental Health Payment by Results*. Department of Health, 2009.

2 Trauer T, Callaly T, Hantz P, Little J, Shields R, Smith J. Health of the Nation Outcome Scales. Results of the Victorian field trial. *Br J Psychiatry* 1999; **174**: 380–8.

3 Bebbington P, Brugha T, Hill T, Marsden L, Window S. Validation of the Health of the Nation Outcome Scales. *Br J Psychiatry* 1999; **174**: 389–94.

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A 'meaning-centred approach' to patient consultation is the same as spirituality and psychiatry

I commend Paul Wallang's excellent piece,[1] which is as brilliant as it is relevant. I cannot agree more with the contents of his

narrative reflected in his write up although, like everybody else, I have my own.

There is an old wine in a new bottle in all these discussions and narratives. The old wine is what prehistoric man and ancient civilisations perceived as 'spirit', as it is not difficult to imagine that a 'spirit' or anything 'spiritual' must reflect a story or narrative, the beginning of which must have a purpose (known or unknown) and the end a meaning that 'loops back' onto the purpose at the beginning. Everything about the human mind will be pointless, as some intellectuals say about the universe, unless it is centred on 'meaning.' There is no need to bring in Wittgenstein's legacy since we can figure this out ourselves from scratch. The ongoing recording or tape of our individual experiences (consciousness) is what forms our memory, which itself determines all future thinking and moment-by-moment definition of reality. The process of our minds determining or defining reality on a moment-by-moment basis is what we call (ordinary) perceptions. What is significant about this old wine, however, is that these recordings or narratives are intergenerational, ancestral and ultimately biological (DNA-based). Therefore even emotions and instincts represent forms of narratives, because they are the stories and instruction our ancestors continue to tell us that allow us to perceive without previous individual experience of what we 'just know' or feel. In response to Jeremy Holmes's letter, 'What about psychodynamics?',[2] I suppose it is now obvious that Freudian psychoanalysis and whatever psychodynamic psychotherapy and interpretations that we come up with can only represent the individual and/or culturally shared narrative. To the average Itsekiri (my fellow tribesman), psychoanalysis would be meaningless unless this Itsekiri person is tutored in Western culture and psycho-analytic narratives. For education and training purposes it is important, as stated in the adult psychiatry curriculum of the Royal College of Psychiatrists,[3] that trainees should be 'able to appreciate the "scientific unknowns" in the relevant field of psychiatric practice'. To be able to do this the trainee needs to be encouraged to see the movie (narrative or story) on the DVD and not the chemical constituents of the DVD, the mechanism of the DVD player or description of its casing. Here is the secret of the so-called 'mind–brain problem' resolved in part. Each new generation comes with a new narrative worth listening to as part of the clinical encounter. It is unlikely that the impersonal biological DVD player (the brain) and its mechanisms, like those of other animals, will physically change much over a generation, but the narratives (the movies or stories held on the DVD or tape) that give meaning to people's lives – their spirituality – will continue to change and evolve for as long as the species exists.

In our consensus approach to patient consultation, the word 'narrative' may be more acceptable than 'spirituality' as it has no direct association with religion (something that one should rightly be suspicious of), but if 'meaning' is what we aim to centre consultations on, then it is important to understand that underneath the various terms we use, a 'meaning-centred approach' must be the same as spirituality and psychiatry.

1 Wallang, P. Wittgenstein's legacy and narrative networks: incorporating a meaning-centred approach to patient consultation. *Psychiatrist* 2010; **34**: 157–61.

2 Holmes J. Meaning centred approaches: what about psychodynamics? *Psychiatrist* 2010; e-letter (http://pb.rcpsych.org/cgi/eletters/34/4/1579964).

3 Royal College of Psychiatrists. *A Competency Based Curriculum for Specialist Training in Psychiatry: Specialist Module in Adult (General and Community) Psychiatry*. Royal College of Psychiatrists, 2009 (http://www.rcpsych.ac.uk/PDF/Adult_(General_and_Community)_Feb09.pdf).

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Better definitions of concepts

> **If you talk to a man in a language he understands, that goes to his head. If you talk to him in his language, that goes to his heart.**
>
> Nelson Mandela

In their article on religion, spirituality and mental health, Dein *et al*[1] have made some very important points. As health professionals, we are encouraged to become competent in our understanding of the role of culture and religion in the mental illness phenomenon but at the same time our effort to reach such understanding could be perceived in a negative light.

We seem to restrict our definition of spirituality. In my search for better understanding I have found the following definition by Murray & Zentner[2] very helpful: 'in every human being there seems to be more a spiritual dimension, a quality that goes beyond religious affiliation that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in God. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes essentially into focus in times of emotional stress, physical (and mental) illness, loss, bereavement and death'. This has suggested several important implications for my clinical practice; especially, how I can incorporate this meaning in the patients' understanding of their mental illness in relation to their spirituality. The individual patient approach employed by Western-trained psychiatrists and other mental health workers may fall short of what the patient expects in some cases, as a result of our ignorance of this important aspect.

1 Dein S, Cook CCH, Powell A, Eagger S. Religion, spirituality and mental health. *Psychiatrist* 2010; **34**: 63–4.

2 Murray RB, Zentner JP. *Nursing Concepts for Health Promotion*. Prentice Hall, 1989: 259.

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It's belief systems that keep us healthy, not religion

Dein *et al*[1] appear to believe, on the basis of suggestive but by no means overwhelming evidence, that religious belief is associated with good mental health. Bruno Bettelheim, in his account of his concentration camp incarceration,[2] noted that those who survived best were those with firmly held beliefs and ideology. Devout Jews and committed Marxists (atheists all) survived longer than those without a belief system. It is not religion as such that saves, but – however derived – a sense of community and connection, and the capacity to put even