

In conclusion, I would agree with Professor Casey that defensive medicine and kneejerk practice is no substitute for sound clinical judgement. Based on the scientific facts which are now available to the medical profession, I do question the objective basis of what she considers to be sound clinical judgement.

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Dysmnestic MCQs

Sir - An experienced neurologist reported great difficulty in finding the correct answers to neurological MCQ questions when these were requested by the first author whilst he was preparing for the College exams. Experienced psychiatrists often have the same experience when attempting to answer psychiatric MCQ questions for their trainees. The basic problem was illustrated when the second author sought guidance with this question¹ - Q(28). "Following a head injury, the following is true: - Anterograde amnesia may persist for longer than post-traumatic amnesia." The answer, "true".

The correct answer is that it is controversial and misleading. The question was derived from Kopelman² - "post-traumatic amnesia (PTA) refers to memory loss for events following a lesion. Anterograde amnesia (AA) refers to an impairment in learning new material. AA, may persist long after the termination of PTA." These definitions are uncomfortably alike for clinical purposes, as Kopelman agrees when he writes: "AA is commonly used synonymously with PTA."²

Varying definitions abound, eg. one source defines PTA in terms of memory and AA in terms of conscious level. The problem would be solved if we had only the following terms;

post-traumatic disturbance of consciousness (PTDC) and PTA, each meaning what they said. Unless terminology reflects what is being observed it is dangerously misleading. How many trainees can remember the difference between hypnagogic and hypnopompic hallucinations before they see the go (-ing to sleep) in hypnagogic?

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Psychiatric inpatient suicide

Sir - Coakley *et al* in their thoughtful study of inpatient suicides¹ recommend two types of investigation following an inpatient suicide; a formal inquiry and a confidential informal review of the event. I have worked in a system where such a practice has been in place for many years and I support their recommendations in this regard.

When a suicide occurs in either the inpatient or outpatient setting a procedure known as a "Psychological Autopsy" is activated. Administrative and clinical staff who have been involved in any way with the patient, as well as care givers from the community are invited to review the deceased patient's contact with our services, the treatment strategies that were used, and make recommendations to prevent a similar tragedy. A record which is kept confidential within the department is kept of the recommendations. This procedure serves as a healing ritual for staff and helps protect staff morale. It helps to deal with the feelings of loss and grief that many staff experience when the tragedy of a suicide occurs.

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