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WARD ROUNDS

DEAR SIR,

Two recent accounts (1), (2), of the harrowing experience of being interviewed at a psychiatric ward round, together with Post's claim 'there is really no need nowadays to ask the patient's permission to appear at a ward conference' (3), have prompted me to respond to Dr Baxter's request for descriptions of alternatives (4).

Not having space for a general analysis of ward round functions, real and symbolic, I list only those activities which might appear to demand patients' attendance:

(a) Eliciting further details of life histories and current crises.
(b) Observation of behaviour.
(c) Listening to the patients' descriptions of their experience of their situation.
(d) The demonstration of interviewing skills (I will not consider this further, as these surely are more realistically taught to the student allowed to sit in on private interviews).
(e) Learning patients' opinions of their present treatment and wishes concerning future help.
(f) Informing patients of the treatment team's opinions and decisions.

Street is both an acute admission ward and an active member of the Association of Therapeutic Communities. A daily Community Meeting is attended by all residents and staff present, followed, of course, by a staff review. Such a regular gathering, unlike a weekly ward round, soon becomes a familiar and reasonably comfortable event for most participants, so allowing feelings of trust to develop (cf. (1) and (2)). Like a case conference, it allows all the members of the treatment team to observe identical samples of behaviour, but in a richer context of interpersonal life. To an experienced observer a Community Meeting is an extraordinarily rich source of relevant clinical information.

Once a week there is the combined ward round attended by all staff, but not by patients. The latter, however, will be familiar to most of the team through individual, group and community encounters. Activities a, b and c, therefore, do not need to take place within the ward round. The round can be devoted to consideration of psychiatric, social and other 'histories' against an existing knowledge of the patient, and to decision making.

We try to cover items (e) and (f) with two additional meetings. The first is attended by residents and some staff, one of the latter acting as 'chairman'. This meeting is used to discuss such matters as patients' opinions of treatment so far and readiness for discharge. The Chairman will record these views for the following day's ward round, and relay the team's advice back to the residents afterwards.

I am aware that our attempts to restore people's right to have a say in their own fate without '. . . adding to the discomfiture of a person who is probably distressed already' (1) are far from perfect. However, like the nurses treating 'An Ex-Patient', I would not like to be cross-examined at a ward round, and I can see no significant loss in our so sparing those who come to us for help.

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(2) 'PROFESSIONAL WOMAN' (1978) Personal view. *British Medical Journal*, *ii*, 50.
(3) POST, F. (1978) Then and now. *British Journal of Psychiatry*, **133**, 83–6.
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ALCOHOL WITHDRAWAL

DEAR SIR,

I would like to draw attention to some of the problems inherent in the recent hypothesis on 'Kindling as a model for alcohol withdrawal syndromes' by J. C. Ballenger and R. M. Post (*Journal*, July 1978, **133**, 1–14).

A positive correlation was shown between severity of withdrawal symptoms and duration of alcohol abuse, and the authors went on to suggest an underlying change in neuronal excitability to account for this. Their findings are only in partial agreement with evidence from other investigators, since, as they indicated, recent studies have found the severity of withdrawal symptoms to correlate with the 'seriousness' of drinking and with pre-admission drinking patterns, rather than with duration of abuse (Mello, 1972; Whitwell, 1975).

Variables, such as pre-withdrawal drinking pattern, must be carefully controlled in any study aiming to detect changes in the severity of alcohol withdrawal

symptoms as a function of duration of abuse. An increase in alcohol consumption or a deterioration in health or both may account for the increasingly severe withdrawal symptoms found in the study by Ballenger and Post.

The Kindling model makes the prediction that withdrawal symptoms in alcoholics should become progressively more severe with continuing abuse. However, many chronic alcoholics experience surprisingly few symptoms during alcohol withdrawal. Whitfield *et al* (1978) have recently reported a very low incidence of withdrawal symptoms, with only 1 case of delirium tremens, in 1024 chronic alcoholics.

Our experience with skid-row alcoholics is essentially similar. Most of our patients have been abusing alcohol for many years and give a history of previous episodes of delirium tremens often 10–20 years before admission, with continuing abuse since. During their non-drug detoxification we have yet to see a case of delirium tremens, and we have a similarly low incidence of other alcohol withdrawal symptoms.

These findings in a population who, because of economic circumstances, have been repeatedly experiencing acute alcohol withdrawal over many years, are in direct contradiction to the predictions of the kindling hypothesis and cast doubt upon its validity in alcoholism.

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CORRECTION: IMMUNOGLOBULINS AND RACE

Dear Sir,

In our article on immunoglobulins and viral antibodies in psychiatric patients (*Journal*, April 1978, **132**, 342–8), we reported four schizophrenic patients with apparently elevated CSF IgG/TP per cent. Three of the four patients were black, which we noted was curious in that only 16 per cent of the patient sample were black. At the time there was only one study of race and normal CSF IgG levels, and it had reported no difference between races (Nerenberg and Prasad, 1975).

We have recently completed analysis of data on a following-up study which included eleven normal black controls. The mean CSF IgG/TP per cent of the normal black controls was 9 9 per cent (range 6.7 to 18 3), which is considerably higher than the 6.4 (2.9 to 9.1) we reported for ten normal white controls or the 6 1 (2 8 to 10 6) reported for 30 white controls in another study (Link and Muller, 1971). Consequently, it is likely that two black schizophrenics (one first admission, one multiple admission) whom we previously reported as having elevated CSF IgG/TP per cent were really within a normal range for blacks, and that our corrected conclusion should now read: '. . . five of seventeen multiple admission schizophrenic patients had definite elevations of IgG or measles antibody . . .'. It is suggested that all future studies of CSF IgG in psychiatric patients should include race-matched controls.

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