directly. Clearly the candidate should recognize the limitations of psychiatric diagnosis as compared with, for example, surgical diagnosis, should be able to relate individual patients to the various *syndromes* commonly described, and be able to argue cogently (and with humour?) for his particular choice of label. But that it is *diagnosis* that is under discussion need not be obscured by introducing other words, such as *formulation*.

The other problem, of differing models of mental illness, again needs nothing more than a proper understanding of the word *aetiology*. (In the *OED* this is: 'The assignment of a cause'; also, 'that part of medical science which investigates the cause of disease'.) A psychiatrist should be able to assess physical, social, cultural and family factors of causation, and include those relevant to a particular patient. Likewise, the dynamic and phenomenological models of basic psychopathology should be a routine part of his/her approach, integral with the physical and mental state examination. Again, there is nothing new about this: given that an ability to use varying viewpoints is an accepted part of our specialist training, we are the true 'aetiologists' of modern medicine. In fact, the sooner we can persuade our non-psychiatric colleagues to adopt a similar approach (and using jargon words will not help in this), the better it will be for the whole profession.

The words 'management' and 'prognosis' I will not discuss at length because the same argument applies. Perhaps the appropriate use of social agencies and other health workers is more widespread in psychiatry, and such involvement needs to be emphasized when discussing treatment options.

Given, then, that the formulation adds nothing to the accepted means of assessing patients, there remains the hazy idea of 'bringing the patient to life'. This is a difficult art (not a science) and requires skills accepted of a novelist or playwright, rather than a doctor. While several doctors have been outstanding writers (e.g. Chekhov, Somerset Maugham, Conan Doyle), there is little evidence that their medical training was essential to such descriptive powers. There is no doubt that a good mental state examination should be able to give a clear picture of an individual such that the examining consultants can imagine that patient as a person as well as a case. But the emphasis there is on the need for proper training in the mental state examination, not for any superadded formulatory skill.

A final important point is the continued need for psychiatrists to communicate with other medical specialties. By using a common language this may be enhanced; for the need to see the patient as a whole can be encompassed by the traditional terminology, and words such as 'formulation', with their faint overtone of alchemy and sub-Freudian mysteries, only serve to obscure. Many younger psychiatrists no longer feel any lack of confidence in their specialist abilities, until, that is, their doubts are renewed by the call for 'your formulation, doctor'.

I would ask, therefore, that recent and prospective candidates and examiners be consulted on this issue without delay. The beautifully clear outline of Drs Greenberg, Szmukler and Tantam would go very well as a written question, and itself uses traditional words for the six major headings. As they admit, it is a 'summing up' (i.e. a summary)—so let us call it that and end the present débâcle.

TREVOR H. TURNER

St Bartholomew's Hospital
London

DEAR SIRS

I entirely agree with Maurice Greenberg and his colleagues (*Bulletin*, September 1982, **6**, 160-2) that there is an outstanding need to assist postgraduate trainees in the construction of a formulation which is both useful clinically and agreed by the examiners of the College. I have found that trainees have difficulty in absorbing and remembering detailed instructions concerning formulation and I have invented an *aide-mémoire* which may be of interest to readers of the *Bulletin*. Although the order of items differs somewhat from the guidelines at St Bartholomew's Hospital, all the essential details are included.

Facts of life. This is a brief summary or picture of the patient as a person with any outstanding facts concerning social background, personal history and prominent personality characteristics.

Onset of illness or illnesses. This is essentially the presenting problem and includes the history of illness and recurrences over the patient's lifetime.

Recent mental illness. This is a description of the illness under consideration with its mode of onset, duration, course and any social repercussions.

Mental state. This is the familiar description of the mental state at the time of examination but only positive features should be described in the formulation unless there is some very good reason for stating negative findings; for example, absence of intellectual deficit need only be mentioned if the patient is very elderly.

Umpteen diagnoses! My *aide-mémoire* nearly came to grief because I could think of no synonym for differential diagnosis. This is a light-hearted reminder for the trainee to consider the differential diagnosis in the terms of the St Bartholomew's format.

Lack of information. This includes any difficulties in obtaining information from the patient and any omissions from the history and sources of further information such as physical and psychological investigations.

Aetiology. This refers to pathogenesis and psychodynamics in the case of neurosis or personality disorder and the evaluation of life events and stress factors.

Treatment. This is self-explanatory.

In-patient management. Nursing, occupational and rehabilitative plans are discussed with other care options such as out-patient clinic, day hospital, day

centre and community support.

Outcome. I have simply divided this into short-term, long-term and the evaluation of possible modifying factors such as compliance with medication, effect of environmental change and the availability of community care.

New attacks of illness. This is to remind trainees to comment on the possibility of prevention and might include the use of depot preparations or lithium, community nursing and the education of the patient and relatives concerning the nature of the illness.

I am not unaware of the apparent naivety of the above approach, but I hope it may be helpful to those who have been glad of the Finn and German on the famous Olympus Towering Tops.

ROGER W. WHITELEY

Central Hospital
Warwick

Clinical credibility of the Special Hospitals

DEAR SIRS

I am tempted to rise to the bait offered by Dr Chiswick in his challenging article (*Bulletin*, August 1982, **6**, 130-2). I would take issue with him on factual matters and on the opinions he expresses, but shall restrict myself at present to informing members of the College that a Special Committee of the College's Council has been examining in detail the role and function of the Special Hospitals and is currently finalizing its report which will be submitted to Council in the new year.

JOHN HAMILTON

Special Committee on the Special Hospitals
Broadmoor Hospital
Crowthorne, Berks

DEAR SIRS

Dr Derek Chiswick's recent article (*Bulletin*, August 1982, **6**, 130-2) contains several propositions which are likely to be the subject of some dispute amongst his colleagues within forensic psychiatry in general, and within the Special Hospitals in particular. Not all, for example, will be able to accept his assertions concerning the 'arbitrariness of admissions to such institutions', or that the prediction of dangerousness is not a 'legitimate medical task'.

However, it is to two of Dr Chiswick's other assertions, which seem to me to be related, that I should like to draw attention. First, he states that psychiatrists are 'medical underwriters of preventive detention'. Secondly, in recommending the establishment of a specially constituted health authority to administer the Special Hospitals, thus ending their regulation by the Department of Health, he states 'its first task must be the redefining of a function in a form that is clinically realistic'.

His first point is beyond dispute, but it is not only forensic psychiatrists who preventively detain. All general psychiatrists will have experience of the use of orders for the compulsory admission for observation or treatment of the mentally disordered. Indeed, the Mental Health Act (1959) specifically provides for the involuntary hospitalization of those with mental disorder who are considered to be a risk to themselves or to others. For some patients, such as those whose potentially dangerous behaviour arises in response to abnormal psychopathology (such as delusions or hallucinations), the appropriateness for compulsory detention on a short-term basis is, at least for most psychiatrists, an issue that compels little debate. The critics of contemporary psychiatry would seem to have at least some of their concerns adequately represented in the proposals of the Mental Health (Amendment) Bill, which will reduce the maximum duration of certain compulsory admissions, and increase patients' access to Mental Health Review Tribunals, even for patients detained under Section 25. (The practicability of this latter proposal is not under consideration here.)

But compulsory detention of mentally disordered individuals poses greater problems in the Special Hospitals. In terms of their source and broad diagnostic category (in Mental Health Act, 1959 terms) most new patients to, say, Broadmoor Hospital come from the courts and suffer from mental illness. By the time transfer or discharge recommendations are made for such patients they will frequently have spent longer in hospitals than had they served straight prison sentences. This is not of itself unduly surprising. For the Special Hospital psychiatrist, however, transfer or discharge of patients with mental illness will not concern so much consideration of legal or penal factors as clinical progress and some estimate of the reduction in dangerousness. While an overall improvement in mental state can be fairly readily assessed by a clinician, the difficulties of predicting subsequent behaviour, especially while the patient is in hospital, can be considerable. 'Preventive detention', then, in the absence of substantial grounds for appropriate optimism, becomes an unfortunate necessity.

The situation is less clear and even less satisfactory in the case of the 'psychopath'. The logical and nosological pitfalls of the term are all too familiar to psychiatrists (Gunn and Robertson, 1976) and others (DHSS and Home Office, 1975), and yet this designation of putative mental disorder strides through successive generations of English mental health legislation. The current Mental Health (Amendment) Bill changes little in this respect. The new idea of a 'treatability' clause is unlikely to differ in practice from the implications of the tag 'and requires or is susceptible to treatment', appended to the definition of 'psychopathic' disorder in Section 4 of the Mental Health Act, 1959. Admittedly, at various stages during the compulsory detention of such an individual indication of continued treatability will need to be