either in a multidisciplinary (MDT) team or otherwise, together with the ability to employ counsellors within a practice, is a serious contractual flaw in the provider–purchaser system, to the detriment of service provision, organisational structure and the consumer.

First, the creation of a split in the referral pattern to uni-professionals would make the present multidisciplinary service seem unco-ordinated, lacking co-operation, with institutional (provider) inertia. Secondly, counsellors and psychotherapists who can now be directly employed by GP fundholders need not necessarily have acceptable qualifications or accreditation (EL(92)48). There are at present no universal training standards or quality controls for counsellors. Lack of standardisation may mean poor quality in primary care (Puetz, 1993). Until information about expected outcomes, probable benefits and estimated costs of such a practice is obtained, there will be unavoidable saturation of uncertainty in service provision.

Organisations have re-structured and adapted themselves to changes in psychiatric health care delivery in the last few years. The strategic thrust has been a move from hospital base to community, informal uni-disciplinary assessments to formal network of joint communication with statutory and voluntary bodies, and integration of rival professional autonomous disciplines with no formal inter-hierarchy to coordinated multidisciplinary teams with a formalised line of command. This restructuring is not just a process of reorganisation and formal allocation; it is simultaneously a readjustment of people's careers, tasks, responsibilities and a realignment of power and status.

The new patterns of psychiatric health care should be given a fair trial before disorganised market forces borne out of a contractual flaw between providers and purchasers prove that they are ineffective. GPs should have a contractual agreement that signs to an organisational model rather than functional arrangements with providers. If the government's strategic objective (*Health of the Nation*, 1992) is to be met, then fundholding GP's have a moral and legal obligation to help create an organisational climate which fosters co-operation and exchange of information. This interdependency with other parts of the 'whole' health organisation means the full autonomy as suggested by the NHS reforms seems impracticable. Neglecting to put new monitoring and co-ordinating mechanisms in place would ultimately mean that the consumer has yet again not benefited by another NHS reform. The organisational structure of the NHS needs to become more network like, rather than the continuance of the tripartite arms (primary practice, hospital, community) which GP fundholding schemes will propagate.

Patients' organisations and advocacy groups should monitor the needs of the patients and their carers. A major objective of the 1989 NHS reforms was seen to be an increase in consumer choice. However, extending the choice of purchaser (GP fundholder) for selective referral pattern gives consumers less access to a holistic care in psychological health. What price: a provider charter and or another NHS review? (Ham, 1993).

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## *Insight and psychosis*

DEAR SIRS

Drs Perkins and Moodley (*Psychiatric Bulletin*, April 1993, **17**, 233–234) take offence at the notion of insight and my discussion of it (David, 1990). I have much respect for the dedication they bring to their clinical work, including the "Eurocentric" treatment of patients against their will under the Mental Health Act which I have observed first-hand. In print however, they seem to balk at the necessity to provide assertive case management of psychotic patients for fear of imposing attitudes "defined within a psychiatric framework". This is an abnegation of responsibility, in short, a cop-out. Perhaps they should seek a less disturbed client group to work with. Certainly a patient who describes their experiences in terms of "karma or bodily imbalance or disharmony" as described in their article, is in great need of help since they clearly believe they are still living in the 1960s.

My review, long-winded and inconclusive though it was, has generated controversy ever since its publication with no less than two *Lancet* editorials devoted to criticism of it (1990 and 1993), the first intemperate and anonymous, plus much correspondence in that and other journals. The article should have considered cultural aspects of illness. Despite this important weakness, authors from the USA (Amador, 1991), Spain (Peralta & Cuesta, submitted), India (Kulhara *et al*, 1992), Japan (Takai *et al*, 1992), Singapore (Tan, 1993) and Australia (Roisin Kemp, personal communication) have found my elaboration of the concept moderately useful, with some provisos.

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