admission from patients with pure depressive disease (PDD). Van Valkenberg *et al* (4), in a study comparing the two groups found that DSD patients had a 26 per cent chance of being re-admitted after the index admission, compared to 44 per cent of patients with PDD ($P < 0{\cdot}025$). This reflected a 23 per cent rate of one or more relapses among the DSD patients, compared to 48·7 per cent relapse rate among PDD patients ($P < 0{\cdot}005$).

DSD patients might then be underrepresented in rates of hospital admission for psychiatric disorder as compared to other depressed patients. This would be particularly true if DSD patients suffered from less severe symptoms than the PDD patients. That there may be a differential severity in different types of depressions has already been shown, e.g. Weissman *et al* (5) demonstrated that secondary depressions have fewer symptoms than primary depressions.

A loosening of restrictions on alcohol should not strongly affect such rates, since DSD patients tend not to abuse it (6). Patients in whom alcoholism is a primary disease would need hospital admission for alcoholism; however, it is their non-drinking relatives (usually females) who typically need to enter psychiatric hospitals for depression. Whether the alcoholic male relations of depression spectrum patients would suffer depression if the source of alcohol were denied is currently unknown. It is certainly worth investigating. Failure to show an inverse relation in admission rates does not disprove a link between alcoholism and psychiatric disorder.

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THE RIGHT WAY TO TREAT SCHIZOPHRENIA?

DEAR SIR,

A schizophrenic patient in her thirties, after occasionally taking trifluperazine for two years and having four hospital admissions in that time, was put on to depot flupenthixol in 1973 and after eleven months developed fairly severe tardive dyskinesia with generalized chorea.

Her neuroleptic was replaced with pimozide 4 mg every morning, and in the course of the next five months her abnormal movements disappeared entirely. Shen then refused to take her tablets, but four months later appeared in out-patients again complaining of auditory hallucinations and ideas of reference. Shen then took her pimozide in a dose of 4 mg every morning for six months, when it was reduced to 2 mg, and for the next two years I thought that she had religiously taken this medication with complete control of her illness. In fact she now tells me that she takes the pimozide for two months, and then leaves it off until her voices return, which usually takes about twelve weeks, to re-start the antipsychotic for another two months.

She seems to have achieved the object that we should all be striving for, and that is to control psychosis with the smallest dose of neuroleptic. Would that all patients had such insight.

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AN OPEN LETTER ON WARD ROUNDS

DEAR SIR,

I have recently been a patient in a large psychiatric hospital. Each week there was a ward round or meeting, as it was called. I would like to question the therapeutic value of these.

I believe that it is current psychiatric practice to interview the patient in front of the whole psychiatric team; some of whom have nothing to do with that

particular patient. In my opinion this is wrong. How can a doctor get the best out of a patient if he interviews them in front of people they may not know or trust? To give an example, the majority of my treatment was physiotherapy, as I am disabled. The physiotherapist attended the meetings for every patient, even though I was the only person she treated. I was often asked by my fellow patients who the lady in the white uniform was. They were often confused as they did not come across her during their treatment.

Many patients came from the room crying. A typical example is that of a young married woman who went into the room and found that it was full of people she did not know. She was consumed with fear, dried up completely and burst into tears. She was so distressed that she worried her husband even more than he was already. I know that it is held by some people that tears are a good thing. However, surely it is bad to induce them in public, so adding to the discomfiture of a person who is probably distressed already?

There were few patients who were not affected in some way. I know that it always brought out the worst in me. One of the doctors once asked me if I thought ward meetings were like vivas. (I am a graduate in an allied medical profession and so I am used to vivas.) I told him that ward meetings are much worse than vivas. In vivas I could give the right answers, in meetings I never could. I quite appreciate the need for a regular team meeting. It is obviously necessary to coordinate treatment and review progress. However, I see no point in having the patient there. I asked the doctors the purpose of having such a meeting, and they seemed to have no concept that there is anything traumatic in it for the patient. It is not very pleasant for one woman to be asked about the regularity of her intercourse with her husband, in front of a whole lot of strangers. In fact one might call it degrading. Many of the nurses agreed with me that they would not like to go through a ward meeting themselves. I know I never told the consultant anything of significance during the meetings. Our encounters were often stormy, yet I would readily talk to him in private.

There is presumably some theory to support this type of meeting. I would be interested to know how they can be justified, as I cannot see any therapeutic value in making a patient more unhappy than he is already.

AN EX-PATIENT

(Name withheld by agreement)

A CORRECTION

In the article 'Non-accidental Injury in Children' by the late Peter Scott (*Journal*, October 1977 **131**, pp 366–80), Table I showed N.E. Wiltshire to have a population of 2 million rather than 200,000 (one-fifth of a million); furthermore, the rate of battering in the Leeds and Manchester Metropolitan Districts should have been 1·12 new cases per thousand children under 4 years old per year, not 12 new cases per 1,000.