(a) The setting or context in which the assessment occurs and this includes the contribution of the assessor.
(b) Cultural factors and differences, which have to include the diversity of influences as well as the assumed norms.
(c) The child, whose own individual character and temperament may be such that he or she tests parenting ability and limits of safety beyond imagining.

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Choosing the best consultants – "the questions you dare not ask"

DEAR SIRS

Over the last 15 years, I have attended Appointments Advisory Committees and been a College assessor on 15 occasions. There are obvious differences in the way one should interview a candidate for a senior registrar post and below, and the way one interviews for the post of consultant.

One should not ask questions on medical knowledge, but confine oneself to assess their suitability for the appointment. In other words, to avoid questions such as, "How will you treat . . .", and rather to ask, "How will you organise services for . . ." Nevertheless, I have encountered instances when candidates for consultant posts were asked, "How will you treat epilepsy?" or "How will you distinguish between depression and Alzheimer's disease?"

It is my concern that some questions asked by consultants on Committees are not appropriate. This might indicate a need for these people to be given basic training in the performance of their functions in these Committees. Whether the College itself can take on the task, or could suggest some alternatives, remains a question which I would like to pose.

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DEAR SIRS

Thank you for inviting me to respond to Dr Azuonye's letter (*Psychiatric Bulletin*, March 1991, **15**, 168) commenting on the first piece in my recent series on Wisdom, 'Beginning'. I think he is right to point out that I misused the word *paradox*; and he will perhaps have noted that, for the sake of consistency, I have repeated the error in the final piece, 'Ending'.

On the one hand, on reflection, I could have wished to have used the word *riddle*, or perhaps *conundrum*. On the other hand, to have done so would have been to deprive myself and *Bulletin* readers of Ikechukwu's helpful disquisition on paradox.

I do not know the best way to teach; but the best way to learn clearly is to make such mistakes in public.

I am grateful for the generous opening remarks in Dr Azuonye's letter, and I would also like to take this opportunity to thank the many who have approached me privately to express their approval of the series.

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Sharing of casenotes with patients

DEAR SIRS

When the Access to Health Records Act 1990 comes into force later this year, patients will have a statutory right to see the contents of their casenotes. This may pose particular problems for psychiatrists who will often be recording not only straightforward factual information as related by the patient, but also much wider professional observations. Current training seems to encourage the recording of such observations, including comments on physical appearance and conduct during the interview.

The sharing of casenotes with patients may be beneficial in that it will discourage the writing down of derogatory or hastily made opinions, it may enhance the accuracy of information recorded and, most importantly, it should help to reduce suspicion or hostility engendered by what many patients see as a secret file full of intimate details. If the case file is to evolve to suit this new circumstance, should this not be reflected in training so that the emphasis is on recording factual information. It is usually facts rather than opinions that are most useful when casenotes are read at a later date, since it is these that are most readily forgotten, while the diagnosis, formulation, and general observations about the patient are much more easily remembered.

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