CORRESPONDENCE

pamphlet published in June 1991 by the Committee of Vice-Chancellors and Principals which states that universities face an insidious decline in the standards of teaching and research. He said that universities should take their case to the voters and only by doing so will they "prevent the decline of the university system". In addition, the science lobby in the UK should take advantage of cuts in military expenditure in the UK. This has already happened in the US. In the current fiscal year, the budget for civilian research and development (R & D) has increased by 10.7% (or 6% after inflation) while defence-related R & D has taken a cut for the second year in a row.

Third, the MRC should broaden its collaboration to include the charities and other research bodies in the development of a comprehensive medical research strategy (Advisory Board for the Research Councils, 1986; British Medical Association, 1990).


MICHAEL MORRIS
Department of Medical and Molecular Genetics
Indiana University Medical Centre
975 West Walnut Street
Indianapolis
Indiana 46202—5251

Pathological jealousy defined

SIR: Mullen's account of jealousy (Journal, May 1991, 158, 593—601) demonstrates the perils of travel through the soul. Without a careful eye on ambivalence one gets lost. The answer to a question he poses can be simply stated: desire for rivalry is the hallmark of pathological jealousy, separating it from zealous engagement in and solicitous guarding of a relationship (normal jealousy). The Concise Oxford Dictionary definition is "jealous — fiercely protective (of rights etc.); afraid, suspicious or resentful of rivalry in love or affection".

Mullen refers to Freud (1955) but misunderstands — projection and reaction formation are not burdens for jealousy as he laments — they are fuels propelling zeal into the realm of disease. Within pathological jealousy lies concealed the wish for a rival to enter or challenge the relationship. Within non-pathological jealousy lies the wish to preserve the relationship. Both forms usually coexist.

How can anyone wish for a rival? Generally these desires fall into three groups (Freud, 1955a,b):

(a) Oedipal, where rivalry enhances the parent-like qualities of the spouse
(b) Homosexual, where rivalry or unfaithfulness permit a less distressing form of awareness of one's own fondness for someone of the same sex
(c) Narcissistic, where one's own self-representation is enhanced by rival's attention to spouse.

These are some ways. There are others. Pathology is proportional to the amount of one's self ones sees in the jealousy-provoking situation. What about envy? Looking carefully at individual cases we see it does not occur without self-investment (projection). Sadness and grief do. By understanding the psychodynamics of a given case with an eye on the above and other ambivalent contents, one can separate pathological jealousy from relationship-affirming solicitousness. Once the central discriminant is established, subsidiary questions like "how much zeal is ok?", answer themselves.


RICHARD KAST
Medical Center of Hospital of Vermont
Burlington
Vermont, USA

Access to health records

SIR: Gaitonde (Journal, July 1991, 159, 164) is right to draw our attention to the likely impact of the Access to Health Records Act, 1990, but his pessimistic conclusion that record keeping may be inhibited to the detriment of patient care is disappointing. His prediction of a defensive response from the profession may well come true and was documented in response to the UK Data Protection Act (1987) by Jones et al (1988). These authors audited the censoring of information disclosed to patients by doctors in computerised records in a diabetic clinic and found that 69% of the problems which had been censored out could, on
closer scrutiny, be reinstated and disclosed. Such a
defensive response to patients having access to
records is not inevitable and there are well docu-
mented examples from general practice (e.g. Baldry,
1986) and psychiatry (Essex et al, 1990) where actively
couraging patients to share the medical record has
been a positive experience for both doctors and
patients. Such sharing was entirely compatible with
responsible medical practice and supplementary
‘confidential’ records were unnecessary.

Lipsitt (1980) discussed patient and doctor
responses to the introduction of Chapter 214 of the
Massachusetts Acts of 1979 which guaranteed
patients in the USA access to their records. He
noted that few patients sought access to their records
despite having the right to do so, and suggested that
the traditional doctor–patient relationship, modelled
on the parent–child interaction, carries subtle cues
which define who will control and who will be con-
trolled. Many doctors found the idea of patients hav-
ing access to their records threatening to the balance
of this relationship and label those who break the
taboo and ask to see their records as deviant. Lipsitt
warned that attitudes and traditions in medical care
are more likely to be modified by an awareness of
patients and their feelings than by an incantation of
laws.

Gaitonde underplays the potential benefits to
patients of the new legislation. Ellis (1979) showed
that giving medical patients written information
about their conditions significantly improved under-
standing and recall. An efficient way of providing
such information is in the form of a patient-held
record which the doctor writes in and the patient
keeps. Essex et al (1990) have reported the use of such
a record with psychiatric patients receiving care
shared between general practice and out-patients.
They found that the record was enthusiastically
accepted by patients who valued being consulted and
thought they were in a better position to challenge
their doctor. The record also improved communi-
cation between staff. Despite the obvious benefits of
the system, these authors also reported a negative
response by most psychiatrists and nurse managers
consulted.

Patients today expect more information and a
more collaborative working arrangement with their
doctor. This trend is reflected in the current legis-
lation and is likely to grow in the future. The pro-
fession can react to this trend either defensively to
maintain the traditional paternalistic approach to
patients, or by viewing it as a way of forging a closer
relationship with the patient and adding it to their
therapeutic armoury. If the latter is to apply, doctors
will have to learn how to write records in a manner
which patients will understand, and record informa-
tion which is useful to the patient as well as to
professionals. Rather than inhibiting record keeping
this would result in an enriched record and improved
patient care. Teaching doctors how to write such
records should become an important element in
undergraduate and postgraduate education and
offers a particular challenge to psychiatry. It is a
challenge which should be taken up sooner rather
than later.

Baldry, M., Cheal, C., Fisher, B. et al (1986) Giving patients their
own records in general practice: experience of patients and staff.
trolled trial of supplementary, written information for patients.
British Medical Journal, Feb 17, 456.
for people with mental illnesses. British Medical Journal, 300,
1442–1446.
patient-held records by doctors. Journal of the Royal College of
General Practitioners, 38, 117–118.
Journal of Medicine, Jan 17, 168–169.

Paul McLaren
Department of Psychiatry
Guy’s Hospital
London SE1 9RT

Anorexia nervosa in Asian children
Sir: Bryant-Waugh & Lask (Journal, February 1991, 158, 229–233) have reported cases of anorexia nervosa
(AN) in Asian children which, although interesting,
are not the first, as Badrinath (Journal, April 1990,
156, 565–568) and Neki et al (1977) have also reported
similar cases.

The earlier report by Badrinath has generated a
lively discussion to which we would like to add some
of our own experiences with AN in India.

At our general hospital psychiatry department, we
have encountered five new cases of AN in the last
four years. With the average annual intake of about
2500 new patients, the frequency of presentation is
quite similar to that reported by Buhrich (1981) in
Malaysia. All were unmarried females aged between
13 and 25 years. Contrary to the experience of
Khandelwal & Saxena (Journal, November 1990,
157, 784), three of our patients did have body image
disturbance while none had associated hysterical
symptoms.
Access to health records.
P McLaren
Access the most recent version at DOI: 10.1192/bjp.159.4.590b

References
This article cites 0 articles, 0 of which you can access for free at:
http://bjp.rcpsych.org/content/159/4/590.2.citation#BIBL

Reprints/permissions
To obtain reprints or permission to reproduce material from this paper, please write to permissions@rcpsych.ac.uk

You can respond to this article at
/letters/submit/bjprcpsych;159/4/590b

Downloaded from
http://bjp.rcpsych.org/ on June 10, 2017
Published by The Royal College of Psychiatrists

To subscribe to The British Journal of Psychiatry go to:
http://bjp.rcpsych.org/site/subscriptions/