Usefulness of routine blood tests in dementia work-up

Recent government reports and strategies have placed the diagnosis and treatment of dementia as a major priority within the NHS. Guidelines issued from the Royal College of Psychiatrists and the National Institute for Health and Clinical Excellence on the assessment of suspected dementia suggested that all patients being referred to an old age service should receive blood tests. These include a full blood count (FBC), renal profile, liver profile, calcium, erythrocyte sedimentation rate (ESR), C-reactive protein, thyroid function tests, folate and vitamin B12. In contrast, the Scottish Intercollegiate Guidance Network suggested that blood tests should be ordered on clinical grounds. An audit by our old age psychiatry service reviewed the laboratory and radiological results of 120 consecutively referred individuals with suspected dementia, all of whom received the blood tests suggested by the Royal College of Psychiatrists guidelines. None had reversible dementias or conditions diagnosed on computed tomography. 8.5% had low haemoglobin, 5.7% had a raised ESR, 19% had urea and electrolyte abnormalities and 14% had abnormal liver function tests. Just one patient had thyroid abnormalities and they were already on treatment for this; two had vitamin B12 and folate deficiencies and both individuals had nutritional problems due to advanced dementia.

Previous meta-analyses have shown that less than 0.6% of so-called potential reversible dementias were reversible. Our results suggest that laboratory investigations in dementia work-up are useful in the identification of medical problems that may worsen the patient's overall health or effect suitability to potential treatments. A third way should be taken between the guidelines incorporating their most useful recommendations. Simple tests like FBC, ESR, renal and liver function tests are useful in dementia work-up and should be routinely checked in all individuals with dementia. Less routine tests such as vitamin B12 and folate and thyroid function should only be completed based on clinical grounds.

Postmodernism and psychiatry

We have found that ‘post-psychiatry’ tends to challenge our patience more than it does our ontological security. We agree with Bracken & Thomas in that an increasing number of psychiatrists are seeking to work with different frameworks and to engage positively with the diversity of the user movement. However, we doubt that post-psychiatry has much to contribute to this effort. Holloway’s commentary is generous with regard to the philosophical basis of the article. We believe that the application of the confused and confusing ideas that are known as postmodernism to psychiatric practice is deeply misguided and counter-productive. The key concept in Bracken & Thomas’s article is that organised psychiatry’s recent attempts to form an alliance with service users and carers are inauthentic. A true alliance, according to them, requires that we abandon the biomedical perspective in general and descriptive psychopathology in particular in order to allow us to preferentially engage with radicals within the service user movement.

They briefly mention more conventionally minded service users and carers, but effectively dismiss their point of view. This apparent lack of respect for the diversity of opinion within the service user movement is entirely consistent with the postmodernist convention that everything, including ‘facts’ and ‘truth’, is relative. Where all perspectives are equally valid, the postmodernist is free to reject objectivity as an illusion, and to confine dialogue to the like-minded. For those of us who cling on to older humanistic ideas, the challenge in getting alongside patients is to take service users’ experiences and views seriously whether or not they coincide with our own. Choosing to align ourselves with one particular perspective is patronising and simply repeats the mistakes of the past.

There is an inappropriate modishness (not to mention a lack of self-awareness) in Bracken & Thomas’s free use of the term ‘madness’. The word remains offensive to many service users, despite the fact that a minority choose to reclaim it. It is one thing for service users to define themselves as ‘mad’. It is quite another matter for mental health professionals to use such terminology. There is a parallel here with the reclamation of racist words by some Black people. There is no degree of alignment with anti-racism that makes it OK for White people to use these terms. Similarly, it is hard to see how the interests of people with mental illness are furthered by urging psychiatrists to embrace the language of bigotry.

Bracken & Thomas sustain their argument by caricaturing the biological-mechanistic approach and suggesting that it is the primary conceptual framework of psychiatry. They make assumptions as to how the profession might respond to the challenges of the more radical parts of the service user movement, but they do not reference these responses, presumably because no one has made them. Although this type of argument is common in postmodernist writing (the discourse is implicit, so the lack of explicit reference to it is irrelevant), it is hardly likely to be persuasive to anyone with a reasonable level of independent mindedness.

In a fine piece of postmodern doublethink, post-psychiatry seems to want to be both part of psychiatry and separate from it. Bracken & Thomas deny being anti-psychiatry, anti-medical or anti-scientific but they reject the existence of any objectivity that transcends a particular paradigm and they regard descriptive psychopathology as oppressive. The logical corollary of their rhetoric is that when we are helpful to patients, it is despite the fact that we are psychiatrists, not because of it. If this is the case, why involve doctors in the care of people with mental illness at all? It is simply implausible and logically inconsistent to suggest that a Royal College of Post-Psychiatrists would somehow shrug off the encultured baggage of the doctor–patient relationship to lead us to a better place where the biomedical is replaced by something which is unspecified, but nicer.

A significant part of mainstream British psychiatry has long been working to develop a more humanistic, relevant form of practice that seeks to help people to solve problems in their lives rather than
simply fixing problems in their minds or their brains. Biological research and treat-
m ents in psychiatry are necessary in this
deavour, although it would be foolish
to deny that there is a problem when they
dominate. Indeed, it was the then
president of the American Psychiatric
Association (not himself a post-
psychiatrist, we believe) who complained
that too much psychiatry followed a
“bio-bio-bio model”.

Post-psychiatry is a tendency within the
Critical Psychiatry Network, a small group
of psychiatrists united mainly by their
dissatisfaction with the status quo. We
accept that there is a great deal wrong
with the status quo, but we choose to put
our faith in ordinary mental health
professionals and service users who have
worked steadily to change attitudes and
to try to develop better, more user-
friendly psychiatric services. This seems
more fruitful to us than self-righteous
separatism.

Psychiatry is having something of an
identity crisis at present. Under rather
different circumstances, Gramsci\(^4\) wrote:
“The crisis consists precisely in the fact
that the old is dying and the new cannot
be born; in this interregnum a great
variety of morbid symptoms appears”.

Despite its good intentions, there is little
chance that post-psychiatry will achieve
much by suggesting that a set of
inconsistent and logically flawed ideas can
renew the profession. Like Sokal,\(^6\) we
believe that ‘truth’ and ‘facts’ are impor-
tant because they are one of the few
weapons that the weak have against the
strong. Post-psychiatry is a distracting
irrelevance. The real task is to shift the
intellectual centre of gravity of the
actually existing profession.

**Authors’ reply:** We would like to thank
Philip Cowen,\(^3\) and Rob Poole & Robert
Higgo (see letter above) for taking the
time to comment on our editorial.

Cowan rightly raises the question of
coercion and perhaps this should have
featured more centrally in the editorial. It
is certainly a major issue for service users
and their organisations – although many
will accept that some sort of control and/or
coercion is needed to deal with risky
behaviour, many complain that the domi-
nance of a psychopathological framework
means that few alternatives are presented
to people in times of crisis. Sometimes it
is the lack of alternatives that leads to
conflict, which in turn leads to coercion.

People who do not think of themselves as
having an illness (even when they are
‘well’) understandably resent the idea that
what they are offered in times of crisis is
simply hospital and medication. When
alternatives to hospital are available they
are often used positively by service users.
In their book, *Alternatives Beyond
Psychiatry*,\(^2\) Statnny & Lehmann bring
together descriptions of such alternatives
from many parts of the world. If coercion
does become necessary, we do not believe
that psychiatry possesses the sort of
predictive science that would justify its
being the lead agency. We agree fully with
Cowan that this is primarily a political
issue and only secondarily a medical one.

We also agree with Cowen that modern
psychiatry provides not only expla-
natory models, but also ‘some degree of
mastery over the natural world’. But the
practical utility of a scientific model does
not provide proof for the ‘truth’ of that
model. The Romans could build magnifi-
cent aqueducts but we would now regard
many of their ideas about the nature of the
natural world as mistaken. In addition,
‘mastery’ is not always positive. In many
ways, it is the idea that science could, or
should, be about providing us with
‘mastery’ over the world that has given
rise to contemporary (postmodern)
interrogations of the Enlightenment
project.

We do not believe that mental health-
care can, or should, be centred on a
primary discourse which is scientific-
technical in nature. However, this does
not mean that biomedical science has no
role to play in helping people who endure
episodes of madness or distress. The sort
of neuroscience we value is the sort
articulated by Steven Rose, Professor of
Biology and Director of the Brain and
Behaviour Research Group at the Open
University and one of Britain’s leading
scientists. Rose argues for a neuroscience
which is non-reductive, humble and able
to engage positively with philosophy and the
humanities.\(^5\) We are also not anti-
psychopharmacology but we want a
pharmacology that has freed itself from
the corruption of Big Pharma, and one
that moves away from the notion that we
can only understand the action of anti-
psychotic drugs in relation to outdated
concepts like schizophrenia.\(^4\)

Poole & Higgo are less generous in their
response to our paper. Indeed, we find it
hard to understand how they have reached
some of their conclusions. At no point
do we characterise recent moves on the
part of the Royal College of
Psychiatrists or other organisations to
engage with service users as ‘inauthentic’.
The kernel of our argument is that this
engagement can and should develop from
consultation into collaboration. We believe
that most psychiatrists actually welcome
this. Nor do we at any point dismiss the
ideas of those users and carers who
understand their problems in biomedical
terms. However, one does not have to be
a critical psychiatrist to know that a very
large percentage of service users and
their organisations are deeply unhappy
with what is offered to them by psychiatry
and, in particular, the way in
which psychiatry frames their difficulties.

The health editor of *The Independent*,
Jeremy Laurance, took time away from his
usual work to survey mental health a few
years ago. He travelled to different places
in England and spoke to many service
users on his way. He writes: “The biggest
challenge in the last decade has been the
growing protest from people with mental
health problems who use the services.
There is enormous dissatisfaction with the
treatment offered, with the emphasis on
risk reduction and containment and the
narrow focus on medication. They dislike
the heavy doses of anti-psychotic and
sedative drugs with their unpleasant side
effects, and a growing number reject the
biomedical approach which defines their
problems as illnesses to be medicated,
rather than social or psychological diffi-
culties to be resolved with other kinds of
help.”\(^5\)

It is nonsense to suggest that simply
acknowledging this dissatisfaction (while
at the same time accepting that a certain
number of service users are happy with
the status quo) amounts to a ‘lack of
respect for the diversity of opinion within
the service user movement’.

Poole & Higgo also object to our use of
the word ‘madness’ and indeed accuse us
of embracing “the language of bigotry’. We
would point out that there is no set of
words that will be acceptable to everyone
in the mental health field and we certainly
do not use the term ‘madness’ in order to
offend. The word has been used in many
different cultural and academic writings
as well as by organisations such as Mad Pride
and the Icarus Project. Do the makers of
the film *The Madness of King George* also
stand accused of bigotry? Are Richard
Bentall, Roy Porter, Jeremy Laurance, and
a host of others, guilty of ‘inappropriate
modishness’ for using ‘madness’ in the