reports of new insights at home and abroad, particularly if they may affect practice. We want to reflect all aspects of the psychiatric life, particularly as it is experienced in Britain. We want to encourage authors who work under difficulties, those who manage to do research in provincial mental hospitals away from academic centres, or who work in countries of Africa and the East where psychiatry is not yet well developed. At the same time we try to adhere to certain standards.

The most important is the scientific attitude. We expect hypotheses to be based on observations, and to lead to further observations which can test their theoretical correctness. We want to know in sufficient depth how the observations were made, so that others can attempt to repeat them. We are not very interested in any ideas, however brilliant and appealing in themselves, which are not provided with some kind of factual base.

We are against an author producing many papers —presumably chiefly for personal professional reasons—where one would do. It is harder for readers to follow, bad for the subject and wasteful of space if a research is reported in a series of tiny dribbles instead of in one big paper; worse still if the author releases at three-monthly intervals a succession of papers reanalysing the data of the same experiment. Fragmentation is an unnecessary evil.

An editor lays down rules and guidelines, yet a part of his success lies in knowing when to ignore them. He must be flexible, open to new suggestions, and yet maintain a character. In sum, to increase your paper's chance of acceptance you need to make clear to yourself what your subject really is. You must choose an appropriate length and keep within it, and you must develop your account according to some logical scheme which the reader can grasp, and avoid irrelevance of data or ideas. Don't repeat the Introduction in the Discussion, and don't write a long Introduction if you can refer to a textbook or review article which says it all. Don't put all your data in, just what is necessary to make your points. Try your draft on a friend, not necessarily knowledgeable but candid, who will tell you about confusion and muddle, omissions and non-sequiturs. It is only too easy for the author who knows the material too well to forget to mention vital points or to become blind to what his script actually says.

Strive always for straightforwardness and clarity. The paper by Jane Smith on 'What does the subeditor do?' in the *British Medical Journal* (1978) **i**, 222 (28 January) is worth reading in this connection.

J. L. CRAMMER

THE SCRIBE'S COLUMN

Patient Found Missing

Among the severe shortages currently afflicting psychiatric hospitals there is one which is particularly worrying and which, if not remedied, will bring the psychiatric services of this country to a full stop. The purpose of this communication is to suggest certain measures which may prove helpful.

The particular shortage in question is, of course, the rapidly dwindling numbers of acceptable in-patients. Different psychiatric units have different in-patient needs, and it is, for example, extremely difficult to find patients who will fit the requirements of certain acute psychiatric units in District General Hospitals, especially where these are associated with Professorial Units—but the problem is much more extensive than even this.

An example of the desperate straits which some psychiatric units have reached is provided by the increasing number of urban (and rural) guerrilla bands nowadays dispatched to search the cities and countryside for much-wanted patients. These small, often partially trained, teams of men and women carry nothing more lethal than syringes and long-acting phenothiazines (a technique developed from the tranquillizing darts used in game reserves). Known as psychiatric community nurses, they have had quite spectacular successes in trapping and recovering patients at large in the community, either at home or even including those who have strayed too far from a local authority hostel. These dedicated groups act as undercover agents. Abandoning their nurses' uniforms, they dress in a wide variety of highly personalized mufti which, with appropriate hair styles, have enabled them to pass themselves off as harmless vagrants or research workers.

The work has not been without its dangers. Some groups of patients have organized themselves into

their own defensive militia or multidisciplinary team; and in a particularly brutal act of reprisal on one occasion masqueraded as an HAS team. In this guise they gained admission to and completely disorganized and demoralized the work of one unsuspecting mental hospital. (All hospitals have now been asked urgently to verify the credentials of groups of people claiming to be HAS teams. If in doubt, fire.)

One suggested remedy for this growing shortage of suitable patients (e.g. young, attractive, intelligent, co-operative *and* grateful) would be to husband our existing resources. It should be possible to classify all known reserves of 'clinical material' into special groups—distinguished by their varying prognostic potential and short- or long-term outlooks. This information being then fed into a central computer would enable different psychiatric facilities to program in their own particular patient requirements—they could, as it were, attend the computer patient supermarket with their own especial shopping list.

Now obviously certain classes of patients would be in much less demand than others. The elderly confused, rejected already by the geriatricians, form one such group. An answer to this problem would be to let a market economy operate. Those wishing supplies of easily curable patients would have to make a *per capita* contribution. Those willing to care for more intransigent problems would receive a down payment of money derived, of course, from, the first group—a simple example of resource allocation (and quite as neat as some of RAWP's proposals).

A second possibility would be to rehabilitate and retrain former patients so that they might hopefully acquire the skills demanded of them in our newer psychiatric facilities. Given suitable selection and training (and our colleagues the clinical psychologists have invaluable expertise in this)—given Behaviour Therapy, Operant Conditioning *et al*—first on a day hospital basis, then on a night hospital one—successful graduation to full-time in-patient status could be realizable. Such a fully trained patient would then be able to meet the demands of Group Therapy, Crisis Intervention, and finally even interrogation by Multidisciplinary Teams. (1)

A third possible answer to our problems—and really a sophisticated development of the concept of the retrained patient—would be the creation of a fully computerized all-purpose patient. Research into this possible development should now be undertaken by the DHSS and an appropriate University Psychiatric Department because even the most careful husbanding of our patient resources will not, like natural fuels, safeguard our needs for ever; we must, therefore, be thinking in terms of a sort of fast-breeder reactor psychiatric patient.

It would be essential for a University Department of Psychiatry to be involved in a pilot study, as the computerized patient could then be programmed to reflect that Department's idiosyncratic ethos and orientation. This would, of course, be of much value in demonstrating to students the validity of that Department's approach; and the same could be done by patients differently programed for other Departments with different ideas. The orientations of different Departments of Psychiatry are as specific as the fingerprints of the Heads of such Departments (and for the same reason).

In this context, we already have the experience of Stanford University, who in 1966 examined the possibilities of computer methods of psychotherapy (2). On 7 October of the same year, *The Times* reported the experience of Dr Louis West of the University of Oklahoma. There they had fashioned an experimental robot psychiatrist programmed in such detail as to utter such phrases as, for example, 'please speak up' and 'there is no need to shout at me, you know, I'm only a machine'.

What is now wanted is a development of those pioneer ideas—but as an experimental robot psychiatric *patient*.

It is high time for PLANNING NOW. One would hope that the Royal College of Psychiatrists and the Department of Health and Social Security might well establish a Joint Working Party. Clearly this is an occasion on which the membership of the College as a whole might well make useful oral or written suggestions. These should in the first instance be sent to Ezra the Scribe at 17 Belgrave Square, together with the usual crossed £5 PO, marking the envelope PATIENTS' WELFARE.

EZRA THE SCRIBE

References

1. An Ex-Patient (1978) An Open Letter on Ward Rounds *British Journal of Psychiatry*, **132**, 111–12.
2. A Computer Method of Psychotherapy: Preliminary Communication—Kenneth Mark Colby, M.D. (Dept. of Computer Sci., Stanford Univ., Stanford, Cal.), James B. Watt and John P. Gilbert, Ph.D. *J. Nerv. Ment. Dis.*, **132**, 148–52, Feb. 1966.