This process soon shows a registrar how to read critically and, to some extent, how to plan research. It is also encouraging to see that suitability for publication does not depend on genius, a statistics degree, a research grant, or a professor as co-author. But it does depend on a clear aim and a useful message that might make readers examine their own practice. Those readers want reliable information. For example, they can confidently believe what they read of a psychiatric study if validated questionnaires and rating scales were used to examine a statistically sensible number of patients. It is fairly easy to spot which authors have planned ahead – by performing a literature search to see where their hypotheses fit in and by seeking statistical advice at the start.

Selection is the first part of the editorial task. Once papers are acceptable on grounds of content, most need revision to arrive at a suitable form. Rewriting is usually left to the authors but occasionally the *BMJ* offers to help – and may pass it on to the registrar. Rewriting someone else's work is immensely good practice for writing up your own.

Lastly, the registrar must learn the principles of technical editing. In a medical journal this art, also known as copyediting or subediting, involves considerable science. Manuscripts must be licked into a consistent shape that makes scientific sense and will be understood by readers worldwide. The man from Patagonia (the *BMJ* equivalent of the man on the Clapham omnibus) may not know what LSD stands for and, even if he is reading a Christmas article about cycling across the Himalayas, he will probably find kilometres much easier to appreciate than miles. And will he know what Part III accommodation means? (Please note that these examples do not come from the same article.)

So much for scientific editing, in its various guises. What else does a brief training in medical journalism offer registrars? It certainly offers variety. During the year's post the *BMJ*'s registrar learns about each aspect of editorial work including leading articles, correspondence, book and media reviews – and the wider world of publishing and printing. It may also offer a unique chance to produce original work – researching and writing a series of articles on a topical subject.

And, finally, what does this experience offer in the long term? I found that it broadened my mind and helped me to see medicine in its wider scientific, social, and – inevitably – political context. In the long run this post offers the chance to keep in touch with the journal – perhaps as a referee or a writer (for news, reviews, and leading articles as appropriate). More frivolous advantages include openings for freelance work and, of course, civilised hours.

There are two main disadvantages in taking a full time post for a year. Firstly, there is no contact with patients – the job needs medical skills and qualifications but it is still only medicine by proxy (cynics may suggest that this is an advantage). Secondly, a year's gap on a curriculum vitae can create problems – will the appointments committee for that senior registrar rotation take it as evidence of inadequate career commitment? Perhaps that is the committee's problem, not the registrar's.

There is one other disadvantage, of course. The chance to try a new career that demands medical expertise and provides intellectual stimulation may prove addictive.

Reviews

Better Out Than In – report from the Fifth Annual Conference of the Team for the Assessment of Psychiatric Services – July 1990.
London: North East Thames Regional Health Authority. Pp. 125. £9 payable to TAPS. Available from Mrs R. Kendal, TAPS Research Unit, Friern Hospital, Friern Barnet Road, London N11 3BP

The team for the assessment of psychiatric services (TAPS) has been following up patients discharged from Friern and Claybury Hospitals since 1985. This report reveals the condition one year after discharge of the first three groups of leavers. It also assesses how patients fare two years after leaving hospital and monitors how local services keep in contact with discharged patients. The report measures costs, and outlines the use of rating scales.

The team is now scrutinising new long-stay patients and psychogeriatric patients. New studies on the transfer of psychogeriatric patients from hospital and the relocation of acute services are outlined.

Findings show that 14% of patients leaving both hospitals since 1985 were readmitted in their first year of follow-up, 80% of the costs of community care go on accommodation and the social contacts of long-stay patients remain non-verbal. After discharge there were no significant changes in social behaviour, clinical symptoms, social networks or domestic skills. Figures for deaths, imprisonment, violent incidents and vagrancy are recorded. Younger chronic (new long-stay) patients are accumulating in hospital at a rate of about six per hundred thousand of the population per year. Many patients over 70 at Claybury Hospital who were functionally ill also have severe cognitive disability. The research confirms that treatment in psychogeriatric wards is determined by severe behaviour problems.

In the second year after discharge patients showed some improvement in symptoms, fewer readmissions, a slight improvement in social behaviour but a decrease in activity. Two-thirds want to stay in their new accommodation.

A small group of patients (6%) cannot be accommodated in locally based facilities.

The financial conclusions are prefaced by the statement that it is not known whether cost differences between hospital and dispersed settings are explicable in terms of *efficiency* or *neglect*.

The social network schedule is an intriguing attempt to quantify patients' social contacts systematically but the schedule could only be completed on 489 out of 775 patients.

Whether patients with long-term mental illness can become *socially* integrated into a community remains problematic.

The TAPS reports, conferences and investigations are vital. The data clarify some of the problems associated with mental hospital closure and alternative provision for psychiatric morbidity. The research process is both a safeguard and in some cases therapeutic. The possibility remains that figures about satisfactory outcome may depend on researchers' attentions.

The importance of different social interactions, the hint at increased inactivity, and the clarification of the accumulation of new long-stay patients each indicate that alternative provision remains an extremely complex undertaking.

The principles underpinning the NHS and Community Care Act are consistent with the least restrictive alternative for individuals disabled by mental illness. In practice the funding, and responsibility for services may still militate against psychiatric expertise keeping in touch with psychiatric morbidity. The TAPS study helps greatly to inform the debate.

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Whose Service is it Anyway? Users' views on co-ordinating community care.
Edited by M. Beeforth, E. Conlan, V. Field, B. Hoser and L. Sayce. 1990. Pp. 40. £4.50 plus 50p postage & packing. Obtainable from RDP, 134–138 Borough High Street, London SE1 1LB

Over the past few years a reasonably sized and significant literature has built up on users' views and users' involvement in planning, developing and running psychiatric services. This booklet specifically addressed community care.

Whose Service is it Anyway is the product of listening to users describing what they want and expect. For example, the Brighton Users' Charter is described and this was purely the product of users of a local psychiatric service in Brighton. Topics covered include quality of life, users' involvement and empowerment, organisation and management, information, education and training, joint planning, and a final section entitled 'Conclusion' with a sub-heading of 'towards a redesigned mental health service'. A reasonable bibliography is provided and there is also an appendix on users' organisation.

I doubt if many people would disagree with most of the things that are said, though many would disagree with some. Unfortunately, the type face used is such that it is extremely difficult to read the document. I found it unpleasant, as did two of my colleagues, though we all managed to read it from cover to cover. The general layout is excellent and it is sad that nobody thought that the type-face used was not the best for communication and certainly not the best for communication with us older citizens!

Many professionals have expressed similar views to the consumer contributors to this publication and it is reassuring to find that what some of us thought was right is also what the customers want. The sad irony of it all is that in the present Health Service, with its emphasis on the magic of management and the need for managers to manage, there seems little place for the views of anyone, be they professionals, other employees or customers. For example, professionals have been repeatedly told by senior management, when there has been criticism of the reorganisation of the Health Service, that it is too complex for us to understand and hence our criticism cannot be taken seriously. They are doing to us what they accuse us of doing to patients!

Health Service newspeak consists of talking of choice and meaning 'no choice', emphasising user involvement and meaning 'no involvement'.

In summary, *Whose Service is it Anyway* spells out beautifully the why and how of user involvement in providing a proper, effective service but, to me, has