mind that simpler machines have reduced memory requirements. I frequently use the Z88 with a modem (and an additional amateur radio 'packet' modem from the car) without undue trouble, although for heavy use a set of rechargeable pencil batteries has usefully added approximately 10 hours of operation.

When considering compatibility, remember that simple text can be transferred between any type of computer. IBM clone compatibility is measured in percentage terms, often scoring less than 100. The current explosion of faster computer processors gives the software writers a choice, either write programs that ignore the newer, expensive features, or cut out most of your potential customer market, and pass on the costs to those that have the faster machines.

If it is your hobby, buy computer potential. If it is for your work, you should buy only the computer power you need. It will all be archaic soon. A lesser machine that is demonstrated, has local service arrangements and some telephone support can still be a better deal overall.

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## *Cigarettes and psychiatric patients*

DEAR SIRS

I read with interest Dr Brown's paper on cigarette smoking among psychiatric out-patients (*Psychiatric Bulletin*, July 1991, **15**, 413–414) in which he reported a prevalence of "about one and a half times that of the general public" for both sexes. He states that their residency in the community at the time of the study rules out the effects of institutionalisation. How can we judge this for ourselves when he does not tell us if and for how long these people had been in-patients in the past. I found that 24% of psychiatric in-patients started their smoking careers as in-patients. In-patients also have very high consumption of tobacco (Masterson & O'Shea, 1984).

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*Reference*

MASTERSON, R. & O'SHEA, B. (1984) Smoking and malignancy in schizophrenia. *British Journal of Psychiatry*, **145**, 429–432.

DEAR SIRS

I accept Dr O'Shea's point that current residence in the community does not exclude previous institutional experience as an aetiological factor in cigarette smoking. A number of patients in the study had been in-patients in the past; however all were living independently in the community at the time of the study. None were from the group who have recently moved into the community as a result of the closure of long stay hospital beds, as these patients came under the care of a different service. I therefore feel that institutionalisation in a narrow sense cannot explain the high levels of smoking.

Dr O'Shea's figure of the number of patients who start smoking as in-patients is surely cause for embarrassment, at least. We have a degree of responsibility for the physical health of our patients, smokers and non-smokers alike, especially those involuntary patients who may be unable to leave a smoky environment. The risks of passive smoking are now recognised. Perhaps self-interest may prompt a re-examination of our attitudes to smoking.

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## *The meaning of 'psychosis'*

DEAR SIRS

The term 'psychosis' is in widespread use yet little is known about what it means to health workers. A study was performed among 96 members of various professional groups working within Exeter Health Authority (all 41 psychiatric medical staff, eight District General Hospital (DGH) consultants in acute specialities, 36 psychiatric nurses, five occupational therapists and six approved social workers). Each was sent an unstructured questionnaire asking them to write their understanding of the term psychosis. All replies were anonymous and varied in length from 300–500 words. From each it was possible to identify a definition, often with several items, which could be listed, as well as a variable length of commentary. Many definitions contained items expressed in so similar a fashion that they could be grouped together with "disturbance of contact with reality" the most frequent, appearing in 25 replies and "loss of insight" the next commonest feature (in 15 definitions). Thirteen respondents included "disorders of thinking, experience or perception". Half the respondents (26) had only one item in their definition and a further 19 had only two items.

Historically the term 'psychosis' is imprecise, from its appearance early in the 19th century distinguishing mental disorder from neurosis or a functional disease of nerves to the view of Gelder *et al* (1989) of psychosis as meaning broadly the more severe forms of mental illness. DSM–III–R regards psychotic as gross impairment in reality testing and a creation of a new reality while the ICD-9 definition contains three elements – gross interference with insight, with ability

to meet ordinary demands of life, or maintenance of adequate contact with reality.

In the light of this background, it was interesting how many respondents gave a simple, easily comprehensible statement of their understanding of the term. The most commonly cited item (disturbance of contact with reality) was distributed across all the professional groups except the DGH consultants and was considered sufficient to stand alone as a definition with no other items in almost half those who cited it. However, although the most common, it was in fact only cited by half the respondents. It constitutes one element of the ICD-9 definition and analysis for the inclusion of any of the ICD-9 elements revealed them in less than two-thirds of replies (31 of 51). Thus over a third of our respondents understood psychosis to mean something outside the ICD-9 definition, this group being proportionately distributed among the professions except among DGH consultants and social workers where two-thirds fell outside the ICD-9 classification.

This very limited study indicates that although there is some consensus about the meaning of psychosis within hospital psychiatry, this is not shared by workers outside psychiatry and the usefulness of the term should therefore be questioned. The discrepancy may be particularly important when psychiatrists are communicating with doctors in other areas of medicine or in discussion with approved social workers.

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GELDER, M., GATH, D. & MAYOU, R. (1989) *Oxford Textbook of Psychiatry* (second edition). Oxford: Oxford University Press.

## *Competitive psychiatry*

DEAR SIRS

Paul Foster (*Psychiatric Bulletin*, August 1991, **15**, 509–510) has discovered the awful truth! Not only is psychiatry, like any other branch of medicine, competitive but in the post White Paper NHS all of us are going to be competing with each other at every level and with our colleagues in the multidisciplinary team for patients, resources and the renewal of our time limited contracts. We hope he recovers from the loss of idealism, because when he obtains a consultant post he will have to divert his energies from clinical matters to survival at the coalface – **management!** . . . courses to gain managerial skills and expertise, endless hours of meetings, volumes of minutes and reports to be read and even written, not to mention the accountancy, marketing and planning . . . the emperor's new clothes!

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## *Voluntary treatment – funding implications*

DEAR SIRS

One consequence of the current development of purchaser/provider arrangement in psychiatry does not seem to have received much attention; that being a potentially marked increase of powers of detention and transfer of patients under 1983 Mental Health Act.

We recently encountered what must be a fairly common situation whereby a middle-aged man who had previously been treated at this hospital and who had since moved out of the health district, presented himself here requesting treatment. On examination, he was found to be suffering from a psychotic depressive illness and was at high risk of suicide, making hospital admission necessary. He was unwilling to be transferred to his catchment area hospital due to the mood congruent paranoid persecutory delusions which he held about that hospital. He was willing to stay in this hospital because he held no such delusions about us. We were then faced with a dilemma; should he be detained and transferred under Section to his catchment area hospital, or should he remain as a voluntary patient at this hospital despite the funding implications for his own health district? We decided that his right to voluntary treatment outweighed the funding implications and he received a satisfactory course of treatment and was discharged to follow up care from his catchment area hospital, and they will shortly be receiving a bill from us. We would be interested to know if cases of this kind would be considered sympathetically by health-care purchasers across the country.

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