that with patients whose mother-tongue was not English, translated versions of standardized English questionnaires could be given by computer and remain accurate and valid.

The use of microcomputers is of special interest in psychiatry, as a large part of diagnosis depends on explicit answers to questions. There is a growing interest in structured interview techniques (for example, the Present State Examination of Wing *et al*). In the United States many workers have shown that even disturbed psychiatric patients are amenable to computer interview (for example, Williams, 1975).

At the present time, we are engaged in a number of studies looking at applications of the computer in different psychiatric populations:

The assessment and treatment of phobic disorders;
The assessment of severity of depression;
The assessment of suicidal ideation;
Designing a program for general history taking;
The assessment of elderly patients;
The assessment of the deaf psychiatric patient;
The assessment of intelligence.

We would be interested to hear from other workers engaged in similar work.

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PSYCHIATRIC ILLNESS AND HYPERCALCAEMIA

Dear Sir,

Dr Weizman and his colleagues in their paper on Hypercalcaemia-Induced Psychopathology in Malignant Diseases (*Journal*, October 1979, **135**, 363–6) have missed what appears to me to be the most important conclusion from their data, namely, that the psychiatric disturbances in patients with hypercalcaemia are in most cases organic brain syndromes (confusional states).

In the first place I note that they describe Case 1 in their table as "anxiety, depression" but report that he had mild symptoms and that in the admission examination he showed memory disturbance. Although there sometimes may be an apparent disturbance of memory in *severe* affective disorders this is not the case here and the diagnosis is clearly an organic brain syndrome. Secondly, although it seems that the descriptions of Cases 2 and 3 may have been interchanged in the table in error, even so *each of* these patients had an organic brain syndrome, and the paranoid symptoms in Case 3 are to be regarded as part of this and of no diagnostic importance per se. Thus at least 5 of their patients with psychiatric disturbance suffered from organic brain syndromes. (Might one not, perhaps, be excused for suspecting that Cases 4 and 6 described in the table as "depression" and "severe depression" respectively might also have been suffering from organic syndromes?).

Finally I note that they state that "patient no. 1 was suspected to suffer from a psychogenic anxiety depressive syndrome reactive to malignancy until hypercalcaemia was found". The diagnosis of an anxiety state on the one hand or a confusional state on the other does not depend upon the level of calcium but upon a correct evaluation of the clinical features. I find it difficult to see how anyone could ascribe "cognitive dysfunction . . . to emotional reactions to the basic disease". From the information given it seems to me that if the clinical features had been correctly evaluated then "potentially harmful treatment with . . . drugs" could have been prevented long before the diagnosis of hypercalcaemia.

A sound clinical basis is essential for proper research in psychiatry.

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UP-TO-DATE RECORDS OF LONG-STAY PATIENTS

Dear Sir,

Assessment of long-stay psychiatric patients is often made difficult because the past records are inadequate. It may be impossible for staff having no previous knowledge of the patients to extract an adequate account of the clinical course and treatment from unorganized handwritten notes.

I would like to suggest a cumulative type of record making; in essence, a brief typewritten statement of