active verb “prevents” are often not an accurate description of the findings of clinical studies. A Medline search on 12 active verbs in titles showed that informative titles are becoming more common. There was a post hoc relation between occurrence of searched active verbs and year: the percentage is increasing with the square of the year, such that 4.5%

(95%CI: 3.8%-5.8%) of all titles of clinical reports published in the year 2010 will contain one. There may be arguments for reviews and editorials carrying informative titles, but they are too often wrong to have any place in the reporting of research. Journals should ask for indicative titles, or alter investigators' informative titles during sub-editing.

Informative titles in the BMJ

Richard Smith

I have failed to find any solid evidence on the readability of declarative titles including active verbs. But journalists, who know a thing or two about getting people to read what they write, believe strongly in the use of declarative titles and the inclusion of active verbs. “Freddie Starr ate my hamster” is one of the great titles of our time. “Freddie Starr and my hamster: a personal account” would have long been forgotten. (Thanks to Tim Albert, who runs courses on medical writing, for this example.)

We at the *BMJ* are poised, sometimes uncomfortably, between academia and journalism. As true popperians, we support Neville Goodman's doubts about declarative titles, and we avoid them in original studies. We aim, however, always to use a declarative title in what we call TWIBs (the paragraph at the front of the *BMJ* headed “This week in the *BMJ*”), and for many years our news stories have always had titles that include active verbs. It may not be coincidence that the

pages that use declarative titles with active verbs are better read than the pages that don't.

We try to cater for both practitioners and researchers. Practitioners, we know, have limited time and want “take home messages.” The *BMJ* is thus designed that most of the messages it contains can be extracted within 15 minutes—with subheadings in editorials, TWIBs, active verbs in news stories, boxes on what original studies add, summary boxes in review articles, and declarative titles in all letters.

For now, we do not plan to introduce declarative titles to original studies, but we might. The journal *Evidence Based Medicine* uses them, whereas its older sister, *ACP Journal Club*, does not. The trend is undoubtedly for journals to become more like newspapers and for newspapers to become more tabloid. It's about readability and trying to grab people's attention in an ever more crowded world.

BMJ
Richard Smith
editor

A memorable patient Not wanted anywhere

Mr A, a 37 year old man with learning disability, autism, epilepsy, diabetes mellitus, and manic depressive illness, was admitted from home to an acute admission unit for assessment and treatment when his mental state deteriorated. At the end of the episode of treatment it became clear that his elderly mother could no longer care for him at home. He was therefore discharged to an independent care home in the Black Country, though the health authority and the social services department of the district of his origin paid for his care package. His care was handed over to the psychiatrist and community learning disability team of the host district. As the staff of the nursing home could not meet his needs, he was admitted several times to the admissions unit of the host district. Each admission led to heated discussions between the health purchasers of the two districts about who should pay for Mr A's care. During an episode of depression, Mr A fell and sustained a fracture of his femur, resulting in his admission to the orthopaedic ward in the local district general hospital. When I visited Mr A, a delegation of patients and their relatives greeted me and demanded that he should be taken away at once as he was “mental,” “disturbing the other patients,” and had “no right to be here.”

His placement in the care home was clearly untenable, but the owners were reluctant to admit this for fear of losing funding. Meanwhile, he could not return to his mother's home, as she could not look after him. While he was in his orthopaedic bed she had a difficult journey every day to see him. Under these circumstances I felt compelled to transfer him to the admission unit to “have his mental state stabilised” again.

I thought that I was being told that I was stigmatising Mr A by “medicalising” his needs and should have let his general practitioner look after him. Members of the public were not really welcoming and wanted him taken away from the general hospital. While the two purchasers argued about who was responsible for him, I had no option but to take him back into the admissions unit. The new NHS—“modern and dependable”—is supposed to provide Mr A with a seamless service. As a learning disability psychiatrist, I could manage his epilepsy, manic depressive illness, and autism. I also had to act as his advocate with other medical professionals so that he would be treated as a human being. However, certain professionals do not welcome my involvement in this. Our general adult psychiatric colleagues believe that more public funds are spent on people with learning disabilities than the general population with mental illnesses. I wholeheartedly support increased spending on health so that everyone's health needs are better met. But this should not be at the expense of a vulnerable group of people who cannot act for themselves.

Meera Roy *learning disability psychiatrist, West Midlands*

We welcome articles of up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to.