Key messages

- Urinary incontinence in women is a common, distressing, and costly health problem
- General practitioners can treat urinary incontinence fairly simply
- Treatment options in this study were pelvic floor exercises, electrostimulation, oestrogen, anticholinergic drugs, bladder training, and protective pads
- After 12 months' follow up most of the women were cured or much better

women should be given six to 12 months' treatment in general practice before referral.

The use of light weight pads or of sanitary towels significantly decreased after treatment, but there seems to be a shift from use of sanitary towels to light weight pads during the first three months, as the number of pad users increased in this period. This supports previous findings that many women with persisting incontinence do not use optimal aids for protection^{3,18,19} and that doctors prescribe pads at the first consultation.⁴

Women with urge incontinence did not seem to benefit from treatment to the same degree as others. This group was not given instructions for pelvic floor exercises. But pelvic floor exercises have been shown to be effective also in urge incontinence.²⁰ As patients with urge incontinence are in the minority (10% in our study), perhaps instructions for pelvic floor exercises should be given to all incontinent women treated in general practice.

Women with urinary incontinence still represent a great challenge to general practitioners, and general practitioners should play an active part in treatment. Simple treatment works, and most women will be satisfied.

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Knowledge of emergency compulsory detention procedures among general practitioners in Edinburgh: sample survey

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There is increasing concern about doctors' knowledge of statutory provision for care of the mentally disordered, particularly in relation to compulsory measures.¹ In Scotland any fully registered medical practitioner may detain a patient in hospital for 72 hours given certain specific urgent circumstances, and with consent only where practicable. More than 3000 such admissions are recorded annually, not uncommonly initiated by a family doctor. We interviewed a sample of general practitioners working in Edinburgh to determine their understanding of this provision.

Subjects, methods, and results

A 1 in 4 random sample of Edinburgh general practitioners (n = 70) was selected. Eight declined to take

part and we could not contact 12 others. The 50 who were interviewed represented a wide range of age and seniority. Nineteen had had some experience in psychiatry. Questions were asked only about matters considered essential to lawful emergency detention.

Table 1 gives the results. Forty two believed that the emergency order was intended to be the mainstay of compulsory care. Although most were aware that standard documentation was not necessary, none was able to describe all the statutory requirements for emergency detention. Asked if any conditions were specifically precluded from being sole grounds for detention 10 said intellectual impairment, eight psychopathic or antisocial personality, and 13 intoxication with drugs or alcohol.

Comment

We interviewed 18.3% of general practitioners in the area, from practices responsible for more than 300 000 patients. Those with a particular interest in mental illness were equally likely to have been included in the sample, and it is unlikely that the non-participants represented a group with particular knowledge of the law; indeed our initial approach may have discouraged those with more limited understanding from taking part. Of concern is the possibility that others might have been sufficiently indifferent to decline interview.²

Table 1—Numbers of general practitioners giving correct answers to questions about legal provision for compulsory detention of mentally ill people

Question	No giving correct answer (n = 50)
What is the title and year of the current act ?	2
Which section should be mainstay of formal detention ?	8
May a patient be detained without the approved form A ?	32
Conditions for emergency detention ?	
Mental disorder	3
Urgently necessary	5
Health or safety (of patient) or protection of other persons	0
No alternative to hospital	0
Where practicable, with the consent of a relative or mental health officer	26
How is mental disorder defined in the act ?	1
Are any conditions specifically precluded from being sole grounds for detention ?	26
What period of detention does the emergency order allow ?	30
Does emergency detention include the power to enforce treatment ?	30
May one emergency order follow straight on from another ?	7

We asked about the law, rather than actual procedure in an emergency. Some doctors did state that before using compulsory powers they would always seek specialist advice, but in practice, given urgent circumstances, there may be less time for thought than during our interviews.

The results were disquieting. Our interviewees were uncertain about terminology and generally unable to define basic statutory requirements. Many doctors believed incorrectly that the presence of certain disorders precluded detention and that treatment could be enforced under the emergency provision.

These are not isolated findings, though previous studies have concerned the knowledge of psychiatrists.³

Medical practitioners base decisions about compulsory hospitalisation on a "needs" rather than a "rights" orientated approach, acting in the patients' best interest and often within the confines of the law.⁴ Nevertheless, lack of knowledge about statutory provision may lead to loss of the right to treatment for some or infringement of civil liberties for others in an area of the law where these are least well protected.

Most of the doctors interviewed estimated that they used the emergency powers of detention about once a year and then only after exhaustive attempts to do otherwise. Nevertheless, a fifth had detained three or more patients in the previous 12 months, and general practitioners initiated 86 urgent compulsory admissions to hospital in Edinburgh during the 10 month study period.

It is difficult to identify how this sample might differ from doctors working in other parts of Scotland or further afield. Some priority should be given to the issue of mental health law in continuing professional development for all those who might use compulsory measures, particularly in a jurisdiction where the initial decision to deprive an individual of his or her liberty may be in the hands of a single practitioner. Other findings suggest that there are no grounds for complacency elsewhere.⁵

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Survey of HIV patients' views on confidentiality and non-discrimination policies in general practice

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In Kensington, Chelsea, and Westminster in 1993-4, general practices knew of 761 HIV positive patients but 1186 HIV positive residents consulted HIV services. This discrepancy hinders the establishment of a therapeutic relationship and prevents primary health care teams gaining experience.

Patients may not believe that general practice is secure for confidential information. Therefore as part of a larger questionnaire we asked patients positive for HIV whether in general they were willing to disclose their diagnosis to practice staff, and then if they would be willing for all staff to know their diagnosis if there was a confidentiality or non-discrimination policy displayed at the practice.

Patients, methods, and results

All 1058 surviving HIV patients who attended out-patients departments between October 1992 and March 1994 were approached. We contacted 847 (80%); 170 patients were lost to follow up and 41 were physically unable to respond. There was no difference in

risk behaviour between those who could be contacted and those who could not. The questionnaire was completed by 593 men and 69 women (78% of contactable patients, 63% of attenders). Gay men were more likely to respond than other groups ($\chi^2=38.1$, $df=1$, $P<0.0001$); 85% (563) of responders were white, 7% (46) Black African, 3% (20) Afro-Caribbean, and 2% (13) Asian. Most respondents (519/656 79%) were registered with a general practitioner, 378 of these (76% of responders, 58% of sample) with a general practitioner who knew their diagnosis.

All patients were asked if they objected to practice receptionists, managers, counsellors, or nurses and a different doctor to their usual general practitioner knowing their diagnosis. Most patients (454/625; 73%) would not want one or more staff groups to know; 159 (35%) objected to all five. There was a clear hierarchy of acceptability: 436 (70%) patients objected to receptionists knowing, 301 (48%) to practice managers, 251 (40%) to a different doctor, 231 (37%) to counsellors, and 222 (36%) to practice nurses. A total of 257 out of 373 patients (69%) whose general practitioner knew their diagnosis still objected to some staff knowing.

Patients who objected were asked if they would be happy for all staff to know whether there was "a clearly displayed policy of staff confidentiality" or one of "non-discrimination against patients who are black, gay, drug users, or HIV positive" in the surgery; 415/454 (91%) of patients responded. The non-discrimination policy was more effective: 141 patients (34%, 95% confidence interval 29% to 39%) answering yes to the

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