competence. Their responsibility indicates that it is not professional medical bodies that lack commitment in requiring doctors to acquire detailed knowledge of mental health law. The Royal College of Psychiatrists is currently exploring, with colleagues at the Department of Health, ways of providing such training in mental health law both for trainees and as part of continuing professional development for established consultant psychiatrists and general practitioners.

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- 1 Eastman N. Mental health law: civil liberties and the principle of reciprocity. *BMJ* 1994;308:43-5. (1 January.)

Public must be protected from violence

EDITOR,—We were horrified to read in the summary to Nigel Eastman's article on mental health law that "protection of society from nuisance or even violence is insufficient reason for detention."¹ We disagree profoundly with this assertion and wonder if there is any way in which the opinions of other *BMJ* readers may be polled. We contend that this is a minority view.

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Voluntary patients have rights too

EDITOR,—Nigel Eastman outlines principles for a new, broadly based mental health act, such as self determination, protection from exploitation, and the safeguarding of human rights.¹ The current statute is most narrowly focused in regulating compulsory detention of psychiatric patients while largely ignoring the great majority, who are resident without legal formality. Unlike those detained, these "informal" patients have no right to information or to the protection of the Mental Health Act Commission. As voluntary patients, however, they have rights of autonomy under common law, which can be summarised as follows: to refuse some or all of their treatment and to leave hospital if they wish. The code of practice for the Mental Health Act confirms that informal patients should be made aware of these rights (see paragraphs 14.1, 15.8, 15.14), but it does not directly impose a legal duty.²

In our study of two teaching hospitals just 63% of informal psychiatric patients thought that they had the right by law to leave hospital and only 55% believed that they had the right to refuse treatment.³ A substantial number thought that they would be instructed, pressurised, or restrained if they tried to refuse treatment or leave, and some mentioned possible detention under the Mental Health Act. Psychiatric patients were less likely than medical and surgical patients to perceive a need for treatment in hospital and more inclined to refuse it. Similarly, patients surveyed by the mental health charity MIND (of whom 80% had been admitted informally at some time) expressed much dissatisfaction, and 80% considered that they had not received enough information about their treatment generally in the past.⁴

We propose that regulation of the rights of informal psychiatric patients should be included in new legislation. A minimum requirement is a right to written and oral information, equivalent to the right of compulsorily detained patients.⁵ Leaflets

for informal patients, in both English and minority languages, have already been designed. These outline, in simple language, current legal rights and statutory complaints procedures. An information pack is available from Carol Dowell at Reaside Clinic (021 453 6161).

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- 1 Eastman N. Mental health law: civil liberties and the principle of reciprocity. *BMJ* 1994;308:43-5. (1 January.)
- 2 Department of Health and Welsh Office. *Code of practice. Mental Health Act 1983*. 2nd ed. London: HMSO, 1993.
- 3 Sugarman PA, Moss J. The rights of voluntary patients in hospital. *Psychiatric Bulletin* (in press).
- 4 Rogers A, Pilgrim D, Lacey R. *Experiencing psychiatry. Users' view of services*. London: Macmillan, 1993.
- 5 Sugarman PA, Long A. Informing voluntary patients of their rights. *Psychiatric Bulletin* 1992;16:549.

National Schizophrenic Fellowship supports supervised discharge

EDITOR,—The National Schizophrenia Fellowship has been in touch with all professors of psychiatry and regional health authorities in England and Wales about the knowledge of the Mental Health Act 1983 of doctors approved under section 12(2) of the act. We are encouraged that a special training package is being developed for them and that the Royal College of Psychiatrists has suggested to the Department of Health that doctors should not be approved unless they have received such training. We hope that this will deal with some of Nigel Eastman's criticisms¹ and some of ours.

The National Schizophrenia Fellowship was one of the organisations that, for a variety of reasons, did not support the royal college's proposal of a community supervision order,^{2,3} but we do support the Department of Health's proposal for supervised discharge. Though both proposals attempt to help some particularly vulnerable patients, there are appreciable differences in approach, hence our different reactions. This may also apply to other organisations since Virginia Bottomley has said there is a wide measure of support for this new legal power.

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- 1 Eastman N. Mental health law: civil liberties and the principle of reciprocity. *BMJ* 1994;308:43-5. (1 January.)
- 2 Burns T, Goddard K, Bale R. Care of mentally ill people in the community. *BMJ* 1994;308:62. (1 January.)
- 3 Thornicroft G. Community supervision orders. *BMJ* 1993;307:1213. (6 November.)

Police surgeons familiar with the law

EDITOR,—I am interested in the lack of attention paid to mental health law by the Royal College of Psychiatrists in its examination and by regional health authorities with regard to their appointment of doctors approved under section 12 of the Mental Health Act.¹ As a police surgeon who runs training courses in clinical forensic medicine and examines on behalf of the Society of Apothecaries in the diploma in medical jurisprudence, I place great importance on mental health law. It is a mandatory part of the syllabus for the diploma, and any police surgeon who obtains this qualification will have studied not only the current law but the ethics and pitfalls of its application. This is one example in which the standards of police surgeons exceed those set by more august bodies.

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- 1 Eastman N. Mental health law: civil liberties and the principle of reciprocity. *BMJ* 1994;308:43-5. (1 January.)

Clinical freedom and drug dependence

EDITOR,—It is a pity that Andrew Johns did not acquaint himself with the facts of the case before making unsubstantiated criticisms.¹ My practice follows that of Dr John Owens in Birmingham and Dr Jim Willis in London. Section 7 of the Misuse of Drugs Act 1971 provides for the lawful management of addiction, including the long term prescription of cocaine, thus codifying the practice dating from the report of the Rolleston committee in 1926. It is difficult to see how practice can be enshrined in the law and yet be unethical.

Johns also refers to the "orange guidelines" (more appropriately called the "orange misguidelines"²), the new edition of which has all the failings of the old.³ Why is it undesirable to prescribe substitute stimulants? How can Johns assert that there is no accepted rationale for prescribing cocaine when consultants such as myself and John Strang are licensed to do so?

Where is the evidence that prescribing cocaine had disastrous results? Strang was a coauthor of *Drug Scenes*, published in 1990 by the Royal College of Psychiatrists, which states (p 213) that "the Prohibition was a fantastic misreading of the realities." If prohibition of cocaine is thus mistaken how do Strang and others propose that cocaine be made available if they condemn its only lawful source? The chief inspector whom Johns quotes encourages a "return to Rolleston."

Health gain by patients receiving such prescriptions is an ethical imperative. Results suggest that my prescribing practice reduces mortality among drug takers to zero,⁴ reduces acquisitive crime by 96%,⁵ and, most remarkably, has reduced the incidence of addiction by 92%.⁶ By contrast, practice such as that prevalent in London yields a 15% mortality over 10 years.

Finally, Johns clutches at the straw of ill informed press reports as a yardstick of what happens in Merseyside. He may confirm with my health authority, the Home Office, or the local police that a straightforward but rigorous policy of accepting only written referrals from general practitioners for the substitute prescribing programme (which also confirm longstanding domicile) ensures that no "honeypot effect" occurs. I repeat my invitation to him to refute or replicate my findings.

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- 1 Johns A. Clinical freedom and drug dependence. *BMJ* 1993;307:1565. (11 December.)
- 2 Marks JA. The orange misguidelines. *Health Trends* 1991;22:180.
- 3 Spear HB. Management of drug addicts. *Lancet* 1987;i:1322.
- 4 Marks JA. The north wind and the sun. *Proceedings of the Royal College of Physicians of Edinburgh* 1991;21:319-27.
- 5 Lofts M. Policing the Merseyside drug treatment program. In: Bammer G, Gerrard G, eds. *New alternatives in heroin treatment*. Canberra: National Centre for Epidemiology and Population Health, 1991:97-108.
- 6 Marks JA. The paradox of prohibition. In: Brewer C, ed. *Treatment options in addiction*. London: Gaskell, 1993:77-85.

Trapped fingers

EDITOR,—D A Esberger¹ and Steve Crowder and Samit Mitra² report briefly on children who got their fingers stuck in plugholes. Such cases are a problem for receiving surgeons, especially in paediatric accident and emergency departments.

A 2½ year old girl presented to this hospital's accident and emergency department with two fingers stuck in a plughole; a plumber had had to dismantle the sink. The condition of both fingers was critical, and she was taken straight to theatre: there was no time to search for the ward camera, so no pictures were taken, but the appearance of the

fingers was captured by a sculpture (fig 1). A useless armamentarium of crude instruments was presented in theatre (fig 2). Her fingers were freed when my variable speed Hobbydrill was used with its cutting attachment; the blade of tissue forceps was interposed to protect the tissues. This equipment helped save the child's fingers. She was allowed home the next day, and there was no sign of the injury at follow up six weeks later.

FIG 1—Sculpture of fingers caught in plughole

FIG 2—Useless instruments in theatre

The drill was in the hospital only because I intended to engrave the neonatal stethoscopes. It is an adaptable, controllable, and precision piece of equipment and would be a worthwhile investment (of about £40) for hospitals until manufacturers change the design of their waste outlets.

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- 1 Esberger DA. Photo finish. *BMJ* 1993;307:1634. (18-25 December.)
- 2 Crowder S, Mitra S. Photo finish. *BMJ* 1993;307:1634. (18-25 December.)

Access to cardiac catheterisation

Influenced by deprivation, not sex

EDITOR,—F Kee and colleagues have added to the continuing controversy regarding fair access to cardiological services.¹ They found that the rate of cardiac catheterisation was significantly lower in women than men and noted no influence of social background. This is in contrast to our findings.² We have updated our results and continue to find a strong influence of social deprivation on the uptake of both cardiac catheterisation and coronary bypass surgery, particularly in women (submitted for publication), but no significant sex bias in cardiac catheterisation based on patients discharged from hospital with coronary heart disease.

The following may explain the differing findings. We restricted our analysis to patients

aged 35-64 since we thought that they were most likely to be affected by non-clinical variables: younger patients would almost certainly be investigated, irrespective of their social status, and older patients would be presented for investigation because of symptoms that could not reasonably be ignored on demographic grounds. The rates of cardiac catheterisation in our population were roughly four times higher than those in the population studied by Kee and colleagues. Our patients were allocated to eight groups according to their deprivation score; the groups were not equal in size but had comparable mixes of deprivation and affluence. In contrast, Kee and colleagues' patients were divided into fifths. The larger numbers of investigations and social groups in our study may have enhanced our ability to detect an influence of social deprivation. Furthermore, our higher rates of catheterisation may have allowed more liberal and subjective criteria to influence the decision to investigate.

These differences reinforce concerns about different patterns of investigation and treatment of patients with coronary heart disease.^{3,4}

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- 2 Findlay IN, Dargie HJ, Dyke T. Coronary angiography in Glasgow: relation to coronary heart disease and social class. *Br Heart J* 1991;66:70.
- 3 Findlay IN, Cunningham D, Dargie HJ. The effect of cardiac catheterisation facilities on the rate of coronary bypass grafting in Scotland. *Br Heart J* 1992;68:69.
- 4 Clinical Standards Advisory Group. *Access to and availability of coronary artery bypass grafting and coronary angioplasty*. London: HMSO, 1991.

Access to surgery linked to social class

EDITOR,—F Kee and colleagues report the variation in rates of cardiac catheterisation among electoral wards in Northern Ireland and suggest that social deprivation has little influence on the rate once a proxy measure of clinical need has been taken into account.¹ We examined the relation between social class and rates of coronary artery bypass grafting in 7735 men aged 40-59 at entry to the British regional heart study, a prospective investigation of cardiovascular disease in 24 towns in England, Wales, and Scotland. Information on social class was based on occupation at entry to the study in 1978-80. Details of coronary artery bypass operations and major ischaemic heart disease events were obtained by annual review of the patients' records supplemented by tagging for fatal events at the NHS central register.²

By 1992, 91 men in the original cohort were reported to have undergone coronary artery bypass grafting. Forty (1.31%) of the men with a non-manual occupation had undergone such grafting compared with 48 (1.08%) with a manual occupation (odds ratio (non-manual:manual) 1.21 (95% confidence interval 0.78 to 1.89)). The higher rate of coronary artery bypass grafting in the non-manual group contrasts with the lower proportion of men in this group who had either evidence of ischaemic heart disease at entry to the study (odds ratio 0.65 (0.57 to 0.75)) or a major fatal or non-fatal ischaemic heart disease event during follow up (odds ratio 0.74 (0.61 to 0.88)).

These results suggest that social class differences in rates of coronary artery bypass grafting may not reflect clinical need, at least in this study population. The extent to which the imbalance observed reflects differences in rates of cardiac catheterisation and social class differences in acceptance rates for operation, possibly influenced

by smoking³ and other clinical and social factors, requires further exploration.

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- 2 Walker M, Shaper AG. Follow-up of subjects for prospective studies in general practice. *J R Coll Gen Pract* 1984;34:365-70.
- 3 Underwood MJ, Bailey JS, Shiu M, Higgs R, Garfield J. Should smokers be offered coronary bypass surgery? *BMJ* 1993;306:1047-50.

Home visits by general practitioners

EDITOR,—Linda Beecham reports on the current state of negotiations about the reorganisation of out of hours emergency services by general practitioners.¹ The accompanying photograph of a young general practitioner visiting an elderly woman at home is ironic, because those who argue in favour of emergency centres overlook two important facts.

The first fact is that the overwhelming majority of home visits are made to patients over 65, who often have multiple diagnoses and are the least able to travel to emergency centres. I recently showed this in an audit of home visits in a semirural practice in Norfolk: 207 out of 265 visits were to patients over 65, in whom the three commonest diagnoses were respiratory tract infections, dizziness, and joint pain. These are clearly the patients who are least likely to be able to travel to an emergency centre.

The second fact often overlooked is that many general practitioners already try, whenever possible, to see patients out of hours on surgery premises, so that notes are available and treatment facilities are to hand.

As with many other aspects of the new health service, we are being encouraged to reinvent the wheel for a vehicle whose main problem is shortage of fuel. We should not sanction a change in our conditions of service that will ultimately reduce the standard of care that we offer to some of our most vulnerable patients.

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- 1 Beecham L. Home visits will fall with new GP scheme. *BMJ* 1993;307:1375. (27 November.)

Selective decontamination of the digestive tract

EDITOR,—M J M Bonten and colleagues agree with us that meta-analysis helps to clarify the methodological quality and clinical consistency of published research.¹ They also acknowledge the merits of our recent review of trials of selective decontamination of the digestive tract in making clear important differences in study design, population, and methods that may explain why results of different studies differ.² They criticise us, however, for using the "number to be treated" as a measure of the effect of treatment. They argue that only trials in which the incidence of pneumonia was high showed a positive effect of selective decontamination. Such a statement does not help in understanding the difference between statistical significance, clinical relevance, and cost-benefits. Everybody running an intensive care unit has to appraise the scientific evidence before deciding