be most effective. When in New Zealand, in 1990, I was most impressed by the fact that a judge was available in the hospital every Friday afternoon and reviewed all detentions as required. Is there any likelihood of such experienced legal minds being routinely available in Britain?

T H TURNER
Consultant psychiatrist

Division of Psychiatry,
Hackney Hospital,
London E9 6BE

1 Bradley C, Marshall M, Gath D. Why do so few patients appeal against detention under section 2 of the mental health act? *BMJ* 1995;310:364-7. (11 February.)

Possible problem with section 12

EDITOR,—Caroline Bradley and colleagues studied appeals against detention under section 2 of the Mental Health Act.¹ I recently came up against a problem with section 12 of the act, which gives psychiatrists the power to detain people under the act. I was involved in a case heard by the General Medical Council after I had failed to reapply for approval under section 12 (2) of the act when renewal was due. I had relied on the previous practice of Trent Regional Health Authority and the Department of Health's guidance on the process for approval of medical practitioners under section 12 (2) of the Mental Health Act 1983, which states at paragraph 4: "and subsequently they [the regional health authority] should remind him [the practitioner] that he should apply for renewal of approval if he so wishes."² The previous practice of Trent Regional Health Authority was to remind practitioners that their licence had expired, but it did not do so in this case.

All doctors in the Trent Regional Health Authority area should be warned that they cannot rely on the authority to follow the Department of Health's guidelines. For their own protection and to avoid entrapment, medical practitioners in other regions would be wise to discover whether those regions are following the department's guidelines. It is, of course, standard procedure to remind people when their motor licence, television licence, registration with the General Medical Council, or insurance policies are due.

JOHN HARDING PRICE
Press officer, Society of Clinical Psychiatrists

Lawn Medical Centre,
Lincoln LN2 5QT

1 Bradley C, Marshall M, Gath D. Why do so few patients appeal against detention under section 2 of the mental health act? *BMJ* 1995;310:364-7. (11 February.)

2 Department of Health. *Guidance on the process for approval of medical practitioners under section 12 (2) of MHA 1983*. London: DoH, 1990. (HC(90)21.)

Authors' reply

EDITOR,—Our reported rate of appeal against detention (27%) is much closer to the national rate (roughly 25%) than that of P C Naik and L Klenka. This is because our findings were based on data from nine hospitals.

Gordon Langley raises four questions: whether our citation of the Mental Health Act is accurate; whether patients are too confused to appeal; how far the code of practice is being applied; and whether the parallel system of appeals to tribunals and hospital managers is a good idea. We will deal with each in turn.

Langley is correct on the exact wording of the act. In our paper, however, we were not quoting the act but paraphrasing it. Our purpose was to indicate to general readers that the main considerations when deciding to detain a patient are the patient's health and safety and the protection of others. We do not dispute that the patient can be detained on grounds of health or safety.

With respect to the second question, there is

an important distinction to be made between being mentally ill and being too confused to make a rational decision to exercise one's rights. As reported in our study, six of the subjects approached were too unwell to be interviewed. The 40 subjects who were interviewed, however, were sufficiently coherent to give informed consent and to complete a reasonably demanding interview. It was startling to observe the surprise of some of these patients when they were informed of their right to appeal.

Langley's question on the code of practice is interesting. Answering this question was not one of the objectives of our study, but in the light of our findings it is an obvious direction for clinical audit.

With regard to the final question, in our retrospective study 75 of 104 patients who appealed did so to the mental health review tribunal only, 15 did so to the hospital managers only, and 14 did so to both the tribunal and managers. Of the 65 appeals that reached a hearing, six of 47 appeals to the tribunal, two of eight to the managers, and none of 10 double appeals resulted in discharge. We agree that the double appeal system is absurd.

MAX MARSHALL
Wellcome health services research fellow

CAROLINE BRADLEY
Wellcome research registrar

DENNIS GATH
Clinical reader

Department of Psychiatry,
Oxford University,
Warneford Hospital,
Oxford OX3 7JX

1 Department of Health. *Mental health review tribunals for England: annual report 1993*. London: HMSO, 1993.

APACHE scoring and prediction of survival in intensive care

EDITOR,—We are disappointed that Minerva has fallen into the same trap as others before her in misconstruing the role of the acute physiology and chronic health evaluation (APACHE) score in critically ill patients.¹ Although the APACHE systems can be used to provide information on the risks of death for a group of patients suffering from a specific disease category that may require admission to an intensive care unit, they cannot be used as predictors of the risk of death in individual patients and consequently should not be used to make decisions concerning withdrawal of treatment in seriously ill patients.

For example, the APACHE score on admission for a patient with diabetic ketoacidosis may be high because of considerable physiological disturbance, but the mortality from this condition is low. On the other hand, a low score on admission may be obtained after resuscitation of a patient with a catastrophic intracranial haemorrhage, while the prognosis may remain extremely poor. Additionally, APACHE scores on admission may be altered considerably by the interventions performed before admission to the intensive care unit—the so called "lead time bias."²

Misconceptions surrounding the use of the APACHE scoring system are common. Despite the contribution that APACHE scoring has made in clarifying severity of illness and to the concept of standardised mortality ratios it was not intended to be a method of predicting outcome in individual patients. Thus curtailing costs by limiting admission or continuing treatment according to scoring is invalid.³ In addition, APACHE scores cannot be used to decide who is to be admitted to an intensive care unit and should not be used to decide on a patient's discharge from an intensive care unit to either a ward or a high dependency area, as frequently patients' scores are similar in each of these areas.⁴ Finally, recent evidence suggests

that the ability of the APACHE system to predict outcome may be no better than the clinical judgment of physicians and nurses.⁵

S N PILKINGTON
Senior registrar

Department of Intensive Care Medicine,
Queen Alexandra Hospital,
Cosham,
Portsmouth PO6 3LY

1 Minerva. *BMJ* 1995;310:70. (7 January.)

2 Dragsted L, Jorgensen J, Jensen N-H, Bonsing E, Jacobsen E, Knaus WA, et al. Interhospital comparisons of patient outcome from intensive care: importance of lead-time bias. *Crit Care Med* 1989;17:418-22.

3 Civetta J, Hudson-Civetta J, Nelson L. Evaluation of APACHE II for cost containment and quality assurance. *Ann Surg* 1990;212:266-75.

4 Franklin C, Rackow EC, Mamdani B, Burke G, Weil MH. Triage considerations in medical intensive care. *Arch Intern Med* 1990;150:1455-9.

5 Johnson M, Corbett M, Fitzgerald F. Evaluation of prognostic stratification in medical intensive care unit patients using clinical judgment compared with APACHE, a severity of disease classification. *Chest* 1985;88:31S.

Sexual health education interventions for young people

EDITOR,—Ann Oakley and colleagues' methodological review of the effectiveness of sex education programmes draws attention to how few well designed studies have been carried out in this important area.¹ Wellings's book review of *Sex in America* gives no indication that this self styled "definitive survey" even asked about sex education.² However, Wellings and colleagues' national survey of sexual attitudes and lifestyles did ask nearly 20 000 Britons about sex education in considerable detail (in questions 17 and 18 of the long questionnaire).³ This must have yielded the most comprehensive British data available on the effects of sex education on such matters as age at first coitus and use of contraception. It is therefore curious that these data are not discussed in either of the published reports of the survey.^{3,4} The official reason given for this serious omission was that there had been insufficient time to analyse the data. Yet, over a year later, these results are still not available for public scrutiny.

If the authors of the largest ever British sex survey have given such a low priority to publishing their findings on the effects of sex education it is little wonder that, as Oakley and colleagues rightly lament, we are "still knitting without a pattern."

TREVOR G STAMMERS
General practitioner

Church Lane Practice,
London SW19 3NY

1 Oakley A, Fullerton D, Holland J, Arnold S, France-Dawson M, Kelley P, et al. Sexual health education interventions for young people: a methodological review. *BMJ* 1995;310:155-62. (21 January.)

2 Wellings K. Sex in America: a definitive survey [book review]. *BMJ* 1995;310:540. (25 February.)

3 Wellings K, Field J, Johnson A, Wadsworth J. *Sexual behaviour in Britain*. London: Penguin, 1994:393-4.

4 Johnson A, Wadsworth J, Wellings K, Field J. *Sexual attitudes and lifestyles*. Oxford: Blackwell, 1994.

Peripheral vascular disease—a term to be eschewed

EDITOR,—What's in a name? Quite a lot, if it happens to be seriously misleading. The term peripheral vascular disease is widely used as synonymous with obliterative arterial disease of the limbs. This fosters a double misconception since vascular care is limited neither to arterial disease nor to the periphery.

Misconceptions such as these are not trivial, since they have far reaching and damaging effects on clinical attitudes, referral practices, the provision of resources, research funding, training, and