the percentage of appeals could be much higher than that found in Oxfordshire.

The methodology in Bradley and colleagues' study is well thought through and easy to follow. Interestingly, however, they interviewed their patients on day 13 of the section. If these subjects had been interviewed at an earlier stage of their admission the results might have been different as the subjects' mental state would have been different and would have affected their concentration, initiative, and response rate. Also, the sample was skewed as 40% of the initial sample was excluded.

The authors' conclusions may not be fully justified. This is especially so as only four of the 28 subjects whom they interviewed subsequently appealed against their section. Recently, Blumental and Wesley found that the cost of mental health tribunals had risen considerably; they claimed that about £12m is spent annually in tribunals.² Despite these costs it is important to protect the civil liberties of patients. One way forward would be to carry out further audits in other districts and analyse ways of improving the rates of appeal. The Mental Health Commission could take a leading role in coordinating this.

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- 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 Blumental S, Wesley S. The cost of mental health tribunals. *Psychiatric Bulletin* 1994;18:274-6.

Managers should review patients who do not appeal

EDITOR,—If authors comment on the law they should cite it correctly. Section 2 (2)(b) of the Mental Health Act 1983 and section 72 (1)(a)(ii), as used by tribunals, both state "health or safety, or . . . etc" and not, as Caroline Bradley and colleagues say,¹ "health and safety, or . . . etc"; this is a considerable difference. The first reason given by the authors for the low rates of appeal against detention is that patients are content to remain in hospital. If that is so, it is said, they should not be detained. Are the authors content to give electroconvulsive therapy to an informal patient in depressive stupor who not unwillingly resides in hospital but who cannot consent? A second explanation given is that patients are deterred from exercising their rights. Could not a third be that the patients are too sick or confused?

No mention is made of patients' responses to explanations given under section 132 (1)(b) of the Mental Health Act 1983, which obliges managers to take such steps as are practicable, soon after detention, to ensure that patients understand their "rights of applying to a mental health review tribunal." These steps "shall include giving the requisite information both orally and in writing." The code of practice advises that a record should be kept of the advice given to each patient; the fact that the information has been properly given; the member of staff designated to monitor the procedures; and, in the case notes, the information given, the patient's reactions, and an assessment of his or her comprehension.

For the patients described, were section 132 procedures not implemented, ineffective, or not recorded? The researchers state, "patients must . . . in the absence of independent help . . . rely on . . . the booklet." Were those who did not appeal given oral explanations under section 132? Did patients who had difficulty in writing an application receive help from members of the multidisciplinary team? It is not uncommon for

members of tribunals to see typed or handwritten letters of appeal, or forms, that have only been signed in the patient's own hand.

If more appeals are contemplated do we need the present duality of appeals to tribunals and hospital managers? Patients who appeal to both are often heard twice within days. Was this so for the patients studied, and with what degree of concordance or discordance? Tribunals are costly. Running a parallel system is even more expensive. Should not hospital managers be more concerned about screening those patients who do not appeal to tribunals and refer them on to tribunals if they feel concern? Effectively implementing section 132 should also concern managers.

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- 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 The mental health act 1983. London: HMSO, 1983.
- 3 The code of practice, mental health act 1983. London: HMSO, 1990.

Intellectually elite are more likely to appeal

EDITOR,—Caroline Bradley and colleagues' conclusions concerning appeals against detention under section 2 of the Mental Health Act are limited since no comment is made about the inclusion of patients with learning disability and mental illness, which could appreciably alter the data.¹ The finding that those educated to A level standard are more likely to appeal is interesting but not surprising and may reflect a bias in favour of the intellectually elite. Patients who do not understand the process of appeal because of mental illness or intellectual handicap, or both, cannot be expected to appeal. We agree with the authors' conclusion that the current procedure does not protect the civil liberties of all patients.

Clearly, the system of appeal against detention needs to be reviewed. The rate of discharge as a result of appeals is low; the current system is expensive to operate; and, as Bradley and colleagues' paper suggests, the process inadvertently discriminates against those it is intended to help. Perhaps a fairer system should be implemented, in which all those detained under the Mental Health Act are automatically reviewed by a local independent body with psychiatric input.

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- 2 O'Dwyer J, Neville P. Appeals against section 2 of the mental health act 1983. *Psychiatric Bulletin* 1991;15:225-6.

Low appeal rate may reflect trust in doctors' judgment

EDITOR,—Caroline Bradley and colleagues conclude that too few patients appeal against detention under section 2 of the Mental Health Act and that this would be improved if patients were fully informed of their rights.¹ Our experience in

Springfield Hospital does not confirm this. An advice and legal representation project has existed at the hospital since 1982.² As the table shows, the rate of appeal against detention under section 2 (15%) is lower than that reported in Oxford. Understanding why most patients do not contest their section may require more than attributing it to lack of either knowledge or time.

It is an error to assume that because patients agree that they need to be in hospital then compulsory detention was, or is, a mistake. The relationship between doctors and patients is complex and can simultaneously include a whole range of conflicting and ambivalent attitudes. Patients can disagree with their doctors' decision to detain them yet retain trust in their judgment and often a remarkable willingness to cooperate with both detention and treatment. Most are nursed in open wards. The Royal College of Psychiatrists' unsuccessful proposal for a community supervision order regularly met with a simplistic characterisation of the relationship between psychiatrist and detained patient which acknowledged only the element of compulsion. Viewed thus, the community supervision order was judged unworkable despite the extensive evidence of its clinical workability before 1986 in England and Wales and its continuing use in Scotland.³

Bradley and colleagues' figures may reflect the fact that a sizeable majority of patients detained under section 2 (and perhaps many on section 3 (table)) "agree to disagree" with their psychiatrists yet derive a sense of security and containment from being obliged to be in hospital at a time of personal turmoil. This interpretation fits more closely the clinical experience of very little coercion (other than that afforded by the legal sanction of the Mental Health Act) being required for most detained patients.

The Mental Health Act 1983 contains extensive safeguards for patients' civil liberties. Before an increase in the rate of appeals (which inevitably take time and resources from clinical care) is advocated a greater understanding of the reasons for not appealing is required. Bradley and colleagues have made a start on this process.

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- 2 King's Fund. The advice and legal representation project at Springfield Hospital 1982-1985. An evaluation. London: King's Fund, 1986. (King's Fund project paper No 59.)
- 3 House of Commons Select Committee on Health. Community supervision orders. Vols 1 and 2. London: HMSO, 1993.

New Zealand's system has much to offer

EDITOR,—Caroline Bradley and colleagues' audit of section 2 of the Mental Health Act suggests that the current appeals procedure is "not a satisfactory way of protecting the civil liberties of patients."¹ Much more equitable (although more costly) would be a routine appeals procedure, based on a combination of the managers' hearing and the review tribunal. A regular weekly session devoted to reviewing people detained under the Mental Health Act, particularly in the inner London areas where up to 90% of patients are so detained, would

Appeals to mental health review tribunals, Springfield Hospital, 1993

	Patients detained	Consulted law centre	Appealed (%)	Discharged under section 23*	Withdrew	Other
Section 2	188	49	29 (15)	8	2	4
Section 3	224	159	47 (21)	10	1	5

*Consultant discharged patient from section under section 23 of Mental Health Act 1983.

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?

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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.

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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.

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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

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- 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.
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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.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."

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- 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.)
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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