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MEDICAL PRACTICE

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- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
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Section 47 of National Assistance Act: a time for change?

SIR,—Compulsory admission of the elderly to hospital or residential care is necessary occasionally under section 47 of the National Assistance Act. The Acheson report concludes that community physicians should not be concerned in its implementation.[1] We have examined the use of section 47 (1948 and 1951 acts) in Leeds between January 1982 and December 1987.

Of 113 visits, 17 resulted in compulsory admission. People visited were generally over 80, widowed or single, and living alone, and 77% were women. Fourteen women (one twice) and two men were admitted (median age 83, range 73-94), 12 to a geriatric hospital bed and the remainder to local authority residential homes. The average annual rate was 20·8 per million people aged 65 plus, which is similar to that seen in a previous study.[2] A pronounced seasonal variation occurred in requests for visits, with only 19% taking place from May to September.

The present act has serious shortcomings. Its wording is ambiguous, there is no independent review after implementation, and there is no immediate right of appeal.

Is a section 47 order still appropriate today? Removal of elderly people from their familiar surroundings can lead to increased mortality.[3] A section 47 request often follows a breakdown of social support, and our experience suggests that general practitioners may resort to it out of a sense of frustration at not being able to organise care for a "difficult" patient. Many of those admitted to hospital in our study had not been assessed at home by a hospital consultant beforehand, and support services had often not been requested. It is surely inappropriate that a section 47 admission should be used in a crisis to produce the needed multidisciplinary collaboration. Section 47 does not permit compulsory treatment, yet over half the patients admitted under this section in our series required it.

A review of the act is now timely and we make the following suggestions. Firstly, the circumstances covered by the act should be more clearly defined. Secondly, all professionals concerned in the care of the elderly should be consulted before implementation of a section 47 admission, coordination being most appropriately organised by the general practitioner. Finally, there should be an easily understood mechanism of appeal and an independent advocate to represent the interests of the patient.

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1 Committee of Enquiry into the Future Development of the Public Health Function. *Public health in England*. London: HMSO, 1988. (Cmnd 289.) (Acheson report.)
2 Forster DP, Tiplady P. Doctors and compulsory procedures: section 47 of the National Assistance Act 1948. *Br Med J* 1980;**280**:739-40.
3 Batier AA. For debate: slow euthanasia—or "She will be better off in hospital." *Br Med J* 1976;ii:571-2.

Self referral to consultants

SIR,—Dr Gerald Michael and his colleagues (27 February, p 640) are deluding themselves in thinking that paediatric self referral is a middle class phenomenon. At the other end of the social scale any paediatric senior house officer from their five neighbouring district hospitals will tell them that he or she spends much time, especially at nights and weekends, seeing self referred children in the accident and emergency department.

Rather than expressing their chagrin at this desertion from general practice Dr Michael and his colleagues should be asking why it happens. Until they do neither their justifiable concern nor the unwillingness of consultants such as myself to see self referred patients, nor even the wishes of the General Medical Council, are going to prevent patients from voting with their feet.

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SIR,—Though Dr Gerald Michael and his colleagues deplore self referral to consultants there is nothing new about it, and this tendency could increase with patients' higher expectations of specialists' skill.

Most consultants are reluctant to see a patient unless he or she has a referral letter. The history, current medication, and past investigations may be essential when seeing a patient for the first time. There are, however, a number of reasons for self referral and the acceptance of the patient by the consultant. Some patients deny being registered with any medical practitioner. This may apply especially in London and the south east because of a person's change of location or employment. There are others, many from overseas, who prefer the American system of seeing a specialist direct, and a few who have been refused referral to a specialist.

In paediatrics, obstetrics, ENT surgery, and dermatology—the specialists listed by your correspondent—it is unlikely that the patient will make an incorrect choice of specialist. In general medicine and surgery the background knowledge possessed by the general practitioner may be all important.

Consultants depend on the good will of their general medical practitioner colleagues and are reluctant to accept patients without referral. A small minority of patients will be seen direct. This is not unethical, for the reasons already listed, nor