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CURRENT CONTENTS

## LEADING ARTICLES

Erythropoietin: the developing story	P MARY COTES	805
Safety and the therapeutic protein products made by genetic engineering	D R BANGHAM	806
Lateral thinking in gynaecology	JAMES OWEN DRIFE	807
Second opinions	SIR RICHARD BAYLISS	808
Reactions to contrast media and steroid pretreatment	J F REIDY	809
Managing localised cancer of the prostate	A W S RITCHIE	810

## CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

Single dose versus daily intravenous aminohydroxypropylidene biphosphonate (APD) for the hypercalcaemia of malignancy	A R MORTON, J A CANTRILL, A E CRAIG, A HOWELL, M DAVIES, D C ANDERSON	811
Raised plasma intact parathyroid hormone concentrations in young people with mildly raised blood pressure	D E GROBBEE, W H L HACKENG, J C BIRKENHÄGER, A HOFMAN	814
Cardiac transplantation in severely ill patients requiring intensive support in hospital	DAVID MULCAHY, CHRISTINE WRIGHT, LORNA MOCKUS, MAGDI YACOB, KIM FOX	817
Malaria chemoprophylaxis in travellers to east Africa: a comparative prospective study of chloroquine plus proguanil with chloroquine plus sulfadoxine-pyrimethamine	S FOGH, A SCHAPIRA, I C BYGBJERG, S JEPSEN, C H MORDHORST, K KUIJLEN, P RAVN, A RØNN, P C GØTZSCHE	820
Early detection of visual defects in infancy	D M B HALL, SUSAN M HALL	823
Pregnancy after renal transplantation: severe intrauterine growth retardation during treatment with cyclosporin A	M D PICKRELL, R SAWERS, J MICHAEL	825
Clinical carpal scaphoid injuries	M R A YOUNG, J H LOWRY, N W McLEOD, R SCRONE	825
Body building and myoglobinuria: report of three cases	C DORIGUZZI, L PALMUCCI, T MONGINI, E ARNAUDO, L BET, N BRESOLIN	826
Blackwater fever caused by Plasmodium vivax infection in the acquired immune deficiency syndrome	EDWARD KATONGOLE-MBIDDE, CECIL BANURA, ALEXANDRIA KIZITO	827
Adult epiglottitis due to Vibrio vulnificus	SHAHEEN MEHTAR, LIETTA BANGHAM, DEBORAH KALMANOVITCH, MICHAEL WREN	827
Can patients with Refsum's disease safely eat green vegetables?	S W COPPACK, R EVANS, F B GIBBERD, M E CLEMENS, J D BILLIMORIA	828
Patients' assessment of out of hours care in general practice	MARY J BOLLAM, MARK MCCARTHY, MICHAEL MODELL	829

## MEDICAL PRACTICE

Public drunkenness: the failure of reform	ROY LIGHT	833
Everyday Aids and Appliances: Urinary catheters	P W BELFIELD	836
Are doctors born teachers?	GRAHAM A O'BYRNE	838
How informed is signed consent?	D J BYRNE, A NAPIER, A CUSCHIERI	839
ABC of Dermatology: The skin and systemic disease I	P K BUXTON	841
Research Policy: Wondering whether to join the brain drain	RICHARD SMITH	844
New Drugs: Adverse drug interactions	MARTIN J BRODIE, JOHN FEELY	845
USSR Letter: Infant mortality in the Soviet Union	MICHAEL RYAN	850
Modern medicine and war: Didn't we do well?	TONY DELAMOTHE	852
Retrial ordered in "medical negligence case of the decade"	CLARE DYER	855
Words	B J FREEDMAN	835
Any Questions?		837, 840, 849
Medicine and Books		856
Personal View	JOHN V SALINSKY	859

CORRESPONDENCE—List of Contents 860

OBITUARY 869

## NEWS AND NOTES

Views	866
Medical News	867
BMA Notices	868

## SUPPLEMENT

<b>The Week</b> .....	871
<b>Spring cleaning time</b> JOHN WARDEN .....	872
<b>Build on strength of NHS, says King's Fund</b> .....	873

# CORRESPONDENCE

<b>Section 47 of National Assistance Act: a time for change?</b> J D Fear, MB, and others ..... 860	<b>Pancreatic cancer</b> J P Neoptolemos, FRCS, and others ..... 862	<b>Chickenpox in pregnancy</b> R G White, MRCP ..... 864
<b>Self referral to consultants</b> S Herman, FRCP; P Hall-Smith, FRCP; G Williams, FRCS; M M Lieberman, FRCP; D M Bowker, MRCPsych; D Brooks, FRCP ..... 860	<b>Complications of erythema infectiosum in pregnancy</b> I A Greer, MRCP ..... 862	<b>How does smoking harm the duodenum?</b> R H Hunt, FRCP, and S G Chiverton, FRCS ..... 864
<b>Hypomagnesaemia and muscle function</b> C W H Havard, MRCP ..... 861	<b>Cough and angiotensin converting enzyme inhibitors</b> D M Coulter, MB, and I R Edwards, FRCP ..... 863	<b>Services for sickle cell disease</b> M L Tillyer, MB ..... 865
<b>Prevalence of microalbuminuria in patients with insulin dependent diabetes</b> Joan Metcalfe, BSC, and J L Day, FRCP ..... 861	<b>Skin reactions and fever with indapamide</b> B H Ch Stricker, MB, and C Biriell, MSC ..... 863	<b>Home visiting by consultants</b> Zoe Slattery, FRCPsych ..... 865
<b>Collars and corsets</b> Linda M Vasey, MRSP, and others; Rosaleen Little, MCSP; G J Huston, MRCP ..... 862	<b>HIV, hepatitis B, and sexual behaviour</b> A Mills, MRCP; A J France, MRCP, and others; B A Evans, FRCP, and S G M McCormack, MRCP; K Sivakumar, MRCP, and others ..... 863	<b>New staff grade and associate specialists</b> K P Reddi, MRCPsych ..... 865
		<b>A blot on the profession?</b> A W Asscher, FRCP ..... 865

- 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*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

## 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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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, co-ordination 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. (Cmd 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;iii: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