and a third where there is no obvious injury but the accident has been so bad that the drivers are sent to hospital for observation and tests.

Another ambition that David Nancekievill has had for years —now, he says, unlikely to be realised—is to be medical officer on an offshore lifeboat. He has, however, been drawn into rescuing casualties in power-boat accidents. Like the motor racing, this happened accidentally: he bought a power boat for water skiing and was told that his best chance of being accepted as a member of the Chase Water Power Boat Club was to volunteer as medical officer. This he did, and now much enjoys this aspect of his leisure. The club has adopted a marvellous British invention—the first of its kind in the world—in the shape of a 17 ft Dell Quay Dory boat, which is unsinkable, and has a dropdown front (like a tank-landing craft) which enables the boat to be flooded to a depth of 6 inches or 1 foot so that casualties may be floated on board without having to be dragged over the side. When the flap is raised the water is automatically pumped out. The injuries are much the same as those in motor racing, with the added hazard of water, and the crew of the boat consists of one doctor (expert in resuscitation), two divers, and the driver.

David Nancekievill's alternative occupation is something of a busman's holiday, and not exactly what he set out to do in the first place, but it provides him with excitement and a chance to watch motor and power-boat racing, and he obviously very much enjoys the challenge of on-site medicine. He has found this work helpful in his everyday work—and his work in intensive care has helped him in his rescue work—and particularly so when he was senior anaesthetist at the Moorgate tube-train disaster a few years ago. He was in the train in the tunnel most of the day, and found his on-site medical experience invaluable. No one who has met him can doubt that his drive and enthusiasm have had much to do with the present excellent rescue services available in Britain —and he has lured many other doctors away from their gardens to help out. The drivers have much to thank him for.

Letter from . . . Chicago

Psychiatrists in restraints

GEORGE DUNEA

British Medical Journal, 1979, **2**, 1128-1129

This year, as a result of a rare unanimity of purpose among Jacobin and Girondin legislators, Illinois received a new mental health code, widely acclaimed by enthusiasts as the best thing that ever happened to psychiatry since Philippe Pinel freed the inmates of the Salpêtrière of their chains. Based on the premise that extreme illnesses require desperate remedies, the code represents the work of a host of liberals, lawyers, and legislators, who laboured for three years at a cost of half a million dollars to write down in ponderous legal jargon an attorney's perception of when and how a doctor may be allowed to treat a mentally ill patient.

In this enlightened and progressive code there are no doctors but only providers; no patients but only recipients of services; no hospitals but only facilities. Also, nothing can be done to a patient unless there is a presumption of potentially serious harm in the immediate future; and then only with written approval, written warnings, written notifications and reviews, and a whole rigmarole of legal mumbo-jumbo—giving rise to fears that untreated mentally ill patients will roam the streets in droves, rejected by the private sector and unable to be cared for by an already overburdened state system, using their newly found freedom to refuse treatment, to commit suicide, or to kill their neighbours in response to messages from Mars, because the lawyers had failed to see a difference between imprisonment in a prison and involuntary admission to a mental hospital.

The code heavily emphasises the rights of mentally ill patients, who must not be discriminated against and must not be deprived of their legal rights to marry, vote, manage their affairs, use their property, spend their money as they please, and work for wages. They cannot be presumed incompetent unless so determined by a court in a judicial proceeding separate from that determining the need for commitment. They shall receive adequate and humane treatment in the least restrictive environment; and shall be allowed unlimited opportunities to write letters, receive visitors, use the telephone, and avail themselves of forms of treatment relying exclusively on prayer. They may refuse drugs, electroconvulsive therapy, or other treatments (unless to prevent immediate serious harm to themselves or others); and no treatment may be initiated without prior written consent, formally witnessed and extensively documented.

Restraints and seclusion

The code addresses itself in great detail to the use of restraints and also of seclusion and isolation. Physical restraints are to be used in a humane and therapeutic manner, only on the written prescription of a doctor and only if there is a likelihood of the patient causing physical harm to himself or others. Restraints must not be put on too tightly, and they must be taken off when the patient wants to eat or use the bathroom unless, again, such "freedom of action may result in physical harm to the recipient or others." All orders must be written and documented, and no order shall be valid for more than 12 hours, when the doctor must again examine the patient (apparently even at 4 am) and renew the order in writing, as well as notify the facility director of his decision. The facility

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director must review daily the reasons for using restraints; and once restraints have been used for 24 hours they may not be used for the next two days without prior written authorisation of the director. For seclusion, which is to be used only as a therapeutic measure, similar detailed procedures are prescribed; and the patient's relatives, guardians, attorneys, and advocates are to be notified immediately if *any* of the patient's rights are being restricted.

In its later sections the code defines the procedures for admission to mental institutions, which may be informal, voluntary, or involuntary, and which must be preceeded by a complete exposition of all the patient's legal and constitutional rights. Most patients are expected to be admitted on an informal basis, on their own request, and without formal application—and on admission they shall be informed both verbally and in writing that they may leave the hospital any time they wish. Voluntary admission takes place on filing an application by the patient or any interested person, but the facility director must state in writing why informal admission was not appropriate. Patients voluntarily admitted must be informed of this right by means of a bold-face type statement in simple non-technical terms. They must not be threatened that they will be committed if they refuse voluntary admission, and the director must review the need for continuing stay in hospital within 20 days and then again at two-monthly intervals, again each time informing the patient of his right to leave the institution.

For involuntary admission, emergency commitment may take place on the basis of a petition, which may be prepared by any person, stating the reason for commitment, describing the nature of any acts of threats witnessed, explaining his own relationship to the patient, and giving names of witnesses. The petition shall be accompanied by a certificate issued by a doctor, qualified examiner, or clinical psychologist who has examined the patient and confirmed the need for admission. After admission treatment may be begun, but the patient must be informed of his right to refuse such treatment. Within 24 hours a *second* psychiatrist must conduct an examination or the patient must be immediately released. Again, a variety of documents must be sent to lawyers, guardians, and facility directors, and the examining psychiatrist must formally warn the patient that he does not have to talk to the examiner, and that any statement he makes may be used in evidence against him at a court hearing. Patients may also be involuntarily admitted by court order, again on the completion of a petition and certificate, a court hearing, and examination by another psychiatrist, and again with suitable warnings, appeals, periodic reviews, and ample documentation. There are also sections in the code outlining rules for guardianship, confidentiality of records (a 12-year-old patient may deny record access to his parents), fitness to stand trial, and procedures for the admission of minors. The code provides for a legal advocacy service on behalf of mentally ill patients; and it sets up a human rights authority, consisting of "interested professionals and consumers," to investigate, on its own initiative or in response to complaints, alleged abuses against mentally ill patients.

Mixed feelings and considerable controversy

As might be expected, the code, was received with mixed feelings and generated considerable controversy. Many people hailed it as a landmark of legislation, and some psychiatrists also expressed approval, saying that it was good psychiatry and that they had always done it this way. Others thought that patients' rights had to be protected, that communities should fund ambulatory treatment facilities for mentally ill patients rather than put them into institutions, and that at any rate the new code merely reinterpreted the courts' earlier rulings that no man may be deprived of his freedom without valid reason. Yet others thought that the doctors had over-reacted, interpreting the code as yet another plot against the profession and objecting to the inclusion of paramedical people into the diagnostic process. It was also said that the code would work out well if given a chance, unless the local courts interpret it so rigidly as to make it unworkable.

Many psychiatrists, however, expressed a sense of outrage, calling the code an affront to the medical profession and paradoxically discriminatory against patients, since many would now be denied treatment. They argued that the legislators had constantly ignored the realities of clinical practice; that treatment of patients and recruitment of personnel would become more difficult; that the paperwork would be horrendous; and that the section on restraints was an insult to the intelligence of the medical and nursing professions. They feared that the code would transform the therapeutic process into a endless series of legal confrontations, creating an adversarial climate and destroying the doctor-patient relationship, so that many people would be treated too late or not at all because of the elaborate rituals required. It was also said that the great difficulties of legal commitment would land many more mentally ill people in prison, a phenomenon already observed in the other 14 States that have adopted similar codes, especially in California.

Even supporters of the code admitted that many provisions were unrealistic, that patients did not want their attorneys and relatives notified in the middle of the night because their radio had been turned off or because their smoking privileges had been suspended, nor did their relatives necessarily want to know about this. Already the insistence on confidentiality of records had made it difficult to arrange for clinical information to be transmitted to outpatient clinics; the 20-day affirmation rule had induced patients to leave hospital prematurely; and the regulations about restraints and seclusion were clearly unworkable—though the defenders of the code pointed out that this was an all-inclusive code designed to also protect the mentally retarded from the kind of abuse that may be prevalent in some State schools and hospitals.

Yet many people felt that the legislators had erred too far in the direction of protecting the patients' rights at the cost of interfering with treatment. Did it really make sense to prohibit suspending visiting rights; to allow a manic patient to spend all the family's money; to let the guilt-ridden depressive remain untreated; to tell the paranoid schizophrenic that he does not have to accept treatment, that he has the right to remain silent, that everything he says may be used in evidence against him, and that he has right to legal counsel? Will patients henceforth be allowed to have the radio blare in the middle of the night and play the guitar at four o'clock in the morning, unless there is a likelihood of causing serious harm to himself or others? How long must one wait, it was asked, before a suicidal or homicidal threat becomes "serious" enough to satisfy a judge or jury, and how dangerous indeed must a paranoid schizophrenic be before a psychiatrist would feel reasonably confident to prescribe restraints or recommend commitment? And particularly galling to many psychiatrists was the increasing assumption by legislators and bureaucrats that professionals must be constantly monitored and watched; that the best way to prevent abuses is to pass more regulations; and that the most effective way to help the mentally ill is to put the psychiatrist in restraints.

A patient with ulcerative colitis has developed severe rosacea. The rosacea has responded to tetracycline but this aggravated his colitis, normally well controlled with sodium cromoglycate and an occasional prednisolone enema. What treatment is advised for the rosacea?

Oral tetracycline is the most effective treatment for rosacea, but if it is certain that the small doses (often as little as 250 mg daily) required to control the disorder will exacerbate the colitis it is worth trying metronidazole (Flagyl).[1]

[1] Pye, R J, and Burton, J, *Lancet*, 1976, **1**, 1211.