The Act goes on to define "severe subnormality," "subnormality," and "psychopathic disorder." Severe subnormality means that a patient is incapable of leading an independent life or guarding himself against serious exploitation. A subnormal patient is one whose condition is less severe but who requires treatment or care. Psychopathic disorder in a patient means that he persistently displays abnormally aggressive or seriously irresponsible behaviour and requires medical treatment.

The Act makes it clear that promiscuity or other immoral conduct on their own are not grounds for compulsory detention. Though not mentioned in the Act, drug addiction is not if causing severe physical effects is not a reason for commitment.

THE EXTENT OF THE MENTAL DISORDER

Apart from the specific definitions given above mental illness is usually regarded as meaning psychosis. The effects of drugs including alcohol or certain physical disorders—for example, hypoglycaemia—may, however, temporarily produce a clinical picture similar to a psychosis, and it may be difficult to distinguish one from the other.

CONSENT FOR ADMISSION

If the patient voluntarily agrees to enter hospital then this is all that may be required. It may be known, however, that a particular patient discharges himself from hospital after being admitted voluntarily, and if this has occurred several times, then it may be assumed that the patient has no real wish to enter hospital as a voluntary patient. Under these circumstances compulsory admission may be the only option. Clearly where a patient is incapable of giving consent due to his mental condition, then hospital detention can only legally be effected through the Act.

THE PATIENT'S HEALTH OR SAFETY, AND OTHER PERSON'S PROTECTION

An actual or implied threat of suicide, attempted suicide, or self injury (including care neglect), or some action against another are the other circumstances in which compulsory admission can be argued. These must, however, arise from a mental disorder not criminal behaviour; the patient must be "mad not bad."

THE APPLICANT

There has to be an actual applicant who has seen the patient within the previous 14 days (the threshold for Section 29) in order to start the admission procedure. This means that doctors cannot act on their own by solely providing the medical opinions, unless the patient is already in hospital voluntarily. An applicant is defined in Section 27 of the Act as either the nearest relative of the patient or a mental welfare officer appointed for the purpose by a local authority. If the admission needs to be arranged urgently then any relative will do. Section 49 of the Act carefully defines who is a relative, what the nearest of that relationship has to be, and what modifying circumstances (such as the nearest relative being abroad) may apply.

It is clear that the mental welfare officer does not have to be a party to an admission. A relative, however, may not wish to be responsible for such an act. Also most general practitioners do not carry the appropriate forms without which admission cannot be authorised. Apart from providing the documents the mental welfare officer usually arranges the admission, and may even physically convey the patient to hospital as he is authorised to do under Section 31.

The mental welfare officer is not, however, an entirely free agent. If the nearest relative objects to the application being made, the mental welfare officer has to apply to a court for permission to continue with the procedure (Section 52). Furthermore, the mental welfare officer has to seek out and consult with the nearest relative before making an application unless this would result in undue delay or is not reasonably practicable.

At times the patient may have locked himself in his house making it impossible for the applicant or the doctor to assess him. Under these circumstances a mental welfare officer under oath to a justice of the peace can declare that he believes that the mentally disordered patient is neglected, ill treated, or unable to look after himself. The justice may then issue a warrant authorising a constable (accompanied by a mental welfare officer and a doctor, who may be the patient's general practitioner) to enter the patient's house and move him to a safe place. He can then be committed if it is thought appropriate (Section 135).

MEDICAL RECOMMENDATION

As I have said, the application for admission has to be supported by two written recommendations by registered medical practitioners under Sections 25 and 26, and by only one under Section 29 (for emergency admission). One doctor should have had previous acquaintance with the patient, and clearly this may well be the general practitioner. It is not a legal requirement, however, that either of the two doctors must have known the patient previously—even for Section 29. The second doctor providing the medical recommendation, whether he previously knows the patient or not, must have been approved by a health authority under Section 28 of the Act as being a practitioner with special experience of mental disorder. Psychiatrists normally are appointed but doctors in general practice, such as police surgeons, have also been approved under this section.

Under Sections 25 and 26 the two doctors must have personally examined the patient (as must the single doctor in Section 29) but not necessarily together. If the examinations are done separately the interval between them must not exceed seven days. Section 28 details certain relationships between the two doctors or between a doctor and the patient or applicant which prohibit either one or both doctors from providing the medical recommendations. These include: the two doctors being in partnership together or one the assistant to the other; where a doctor also acts as the applicant or is a partner of the applicant; where a doctor has certain financial interests in the maintenance of the patient; and where certain blood or marriage relationships exist with the patient or the other doctor.

Since Section 26 allows compulsory admission initially for a period up to one year, the medical grounds have to be stated in writing by both doctors in some detail. Although the two statements do not have to be identical, the diagnosis of the mental disorder (or disorders) must, in part at least, be identical. Any recommendation must not give as the sole grounds for admission the fact that the patient was suffering from a psychopathic disorder or subnormality and was not less than 21 years of age.

Disposal

Once the application for admission has been correctly completed, a patient may be taken to a hospital even against his will. A hospital must be found, however, that is willing to take the patient. In other words, "certifying" a patient lays no legal obligation on a hospital to accept him.

Again, under Sections 25, 26, or 29 no specific duty is laid on the police to aid the transfer of a violent or struggling patient

Beyond the Surgery

General practitioner on the lifeboat

O C PARRY-JONES

Little did I think some 20 years ago when I started in general practice that I should be in active service for more than a decade as a lifeboat doctor or HMA (honorary medical adviser), as we are called. Years later I asked the now retired mechanic, who was out with me, about my first trip. Most of the crew at that time were the old "Dick Evans," double Gold Medal crew of the Moelfre Lifeboat. The trip had been what has become more commonplace for me since: transferring in a near gale from the lifeboat to a Jacob's ladder on the cargo vessel that was four or five miles offshore to examine the patient before he was brought ashore. I asked Ian Owen, "What would have happened if I had fallen off that night? Would you have found me? Would you have been able to see me?" "Not at all," he said. And of course after that I went through a period of wondering whether it was a good idea for a family man to continue as a lifeboat doctor, and I almost resigned.

Since then I have become more philosophical and consider it no more than a part of my normal practice duties that extend a few miles offshore, and that is what it is. Having the opportunity of being a lifeboat doctor depends very much on your choice of location for your general practice, and living by the sea has a special responsibility. I have been very fortunate in always having a crew in whose hands I felt completely safe at all times and a coxswain on whom I could rely, so that when he said "jump," I jumped. Normally the HMA is required only in fairly good weather, and a force seven or eight gale would be about the worst, with a bit of luck.

As chairman of the lifeboat station committee I am involved in local lifeboat politics and running the station. I teach the crew first aid, examine new crew members, and re-examine the present crew for three-monthly intervals. A medical newsletter is circulated by the Royal National Lifeboat Institution (RNLI), edited by Dr Geoffrey Hale, and there are regular meetings at the BASICS (British Association for Immediate Care Schemes) annual conference at which the chairman of the Medical and Survival Committee, Professor Sir George Smart, is present. The 200 HMAs provide an immediate care scheme as part of BASICS.

Merchant ships and swimmers

Our lifeboat station is near the shipping lanes to and from Liverpool, and Moelfre Bay is one of the best places to shelter from a gale on the west coast. Calls come at any time of the year, but there is a difference between those in summer and winter. In winter the medical calls are specifically to merchant

Beneilich, Anglesey, Gwynedd
O C PARRY-JONES, Llanfyllter, IMA, general practitioner

The Moelfre lifeboat, RNLI Horace Clarke.

ships in the bay, while in summer most work is in rescuing small boats and swimmers in distress, either using the big boat or more often the small inflatable inshore lifeboat with an outboard motor to rescue children who have floated out on mattresses, for instance. These are the rescues that bring in the victims of drowning or apparent drowning. Tragically, these are often holiday-makers or day-trippers. I like to make a link with the relations of the victims, possible for counselling.

The medical calls can be as varied as those in ordinary general practice. Often the crisis is that the ship is bound for foreign waters and that any time wasted ashore or anchored in the bay is time lost by the committee, therefore the sick person has to be got ashore as quickly as possible. The person may be suffering from a coronary with chest pains, abdominal pain precipitated by the celebrations of the last night ashore, an accident on a tanker or fishing vessel, and even a gynaecological condition such as an abortion in the wife of a crew member. In these cases the lifeboat may act just like an ambulance for what is called a medical evacuation, but often the person has to be examined while aboard and the condition stabilised before taking him ashore. It is therefore wise for the lifeboat HMA to have a fair idea of what type of cases he might be called to treat and to carry a special bag at all times with fresh supplies of equipment such as pain killers, intravenous fluids, drugs and antibiotics, antiseptics, not forgetting insulin, glucagon, and an antiarrhythmic.

Our boat is among the few in the fleet that carry Entonox (nitrous oxide), and I think that I was the first to use this in the inshore lifeboat years ago on a schoolboy who fractured a tibia in a cliff fall. A modern lifeboat, unless it is one of the large ones, is just not equipped to treat sick persons on board. Our particular lifeboat, the Rother, is 37 ft (11.4 m) long and has accommodation if necessary for 70 survivors, but in the forward cabin where I usually work there is room at most for

to hospital, but usually the police are helpful as are ambulance crews.

A doctor may consider giving some tranquillising drug in these circumstances, and if the patient consents to the treatment no difficulty arises. From the very nature of the problem, however, the patient is usually unable or unwilling to consent. Might a doctor lay himself open to a legal action by forcibly treating the patient against his will by, say, giving him an injection of chlorpromazine? If the patient was being admitted under Section 26 the words "for treatment" are actually stated in the section and so no difficulty should arise. Sections 25 and 29 do not contain such a phrase, however, and some argue that there is no specific legal authority for the doctor to treat patients under these sections against their will. All that is allowed is the authority to transfer the patients to hospital and observe them. Treatment may then only be given compulsorily if the section is converted into an admission.

Parliament presumably intended, however, that having authorised a patient's transfer to hospital against his will if necessary, the doctor should be able to ensure that this happens peacefully and should be able to give suitable drugs. Similarly permission to use drugs to quieten a restless patient so as to prevent personal injury is perhaps also implied in Section 25.

Clinical Curio: diligence rewarded

The temptation to stop thinking about a diagnostic problem is sometimes irresistible, especially when a press of patients is outside the consulting room door. Even in the more leisurely atmosphere of the ward a press of negative investigations may lure the clinician into a forest of false assumptions. At least one of our patients owes his survival to an assiduous medical registrar who refused to give up.

The patient, a bachelor lecturing in metallurgy, was then aged 51 and had suffered intermittent fever for three years or more. He was cachectic, normally demented, and had increasing bowel symptoms and a severe peripheral neuropathy. What misled his own general practitioner and the first referral specialist was his history. At the age of 26 he had undergone an operation for sarcoma of the tonsil. He subsequently had a succession of sore throats and respiratory illnesses that seemed to culminate in the febrile episodes for which he was eventually referred to hospital. Apart from an erythrocyte sedimentation rate of 13 mm in the first hour, the results of all tests were negative. His liver and spleen were palpable, but a liver biopsy showed no abnormality. The patient remained in hospital for five weeks and was thoroughly investigated (sinus). "The diagnostic favourites were some form of reticulosis, brucellosis, or perhaps sarcoidosis," wrote the registrar at the first hospital. No confirmatory evidence was forthcoming.

In March 1966 the patient was referred to a teaching hospital under one of London's most scintillating diagnosticians. Gall stones were found, and a lymphangiogram showed an enlarged group of para-aortic glands and possibly glands in the groin. A biopsy of one of these showed no abnormality. Lymphosarcoma or other tumour was suspected, especially as the sections from the original tonsil operation were proved to be reticulum-cell sarcoma. Laparotomy was advised, but the patient was unwilling, a viewpoint with which the first consultant concurred. Six months later, despite a general remission, the patient was suffering odd aches in the stomach and bouts of vomiting. A barium-meal examination suggested partial obstruction of the small bowel. The report referred to an abnormal mucosal pattern. The patient now agreed to laparotomy, which confirmed the enlarged para-aortic and mesenteric lymph-glands, but no reticulosis was found. Over the next few months his abdominal symptoms continued, there was a pronounced deterioration in his mental state, and he was asked to give up his job. In May I received a call from his mother, with whom he lived, saying that he was worried about his behaviour. I was met at the door by the patient, who took me into a side-room to tell me in a confidential whisper that his mother had gone out of her mind. I listened sympathetically,

These views have never been challenged in the courts but the specific absence of such authorisation in the Act is worrying.

Section 136 or a mad MP

Occasionally a general practitioner may be contacted for information by the police when a constable has removed one of his patients to a place of safety (which may be a police station) under Section 136. The patient must have been in a public place or a place to which the public have access (not in his own home in other words) for this action to take place, and the period of detention can be up to 72 hours.

For those general practitioners who have patients who are Members of Parliament it is interesting to note that the MPs' authority admirably provides for the specially committed care in the Act (Section 137). It is complicated by the fact that on detention the MP has to be examined by, in addition to the usual two doctors, other specially appointed medical practitioners who have to report back to the Speaker. In due course his seat may be declared vacant. Such provisions do not exist for members of the House of Lords, who, of course, have no seats to vacate.

We shall be pleased to consider for publication other interesting clinical observations in general practice.—Ed, BMJ.

only two stretcher cases in very cramped conditions. The stretcher is invariably the most versatile of all—the Neill Robertson model. We can sometimes sling another one or two on the deck. In fact last year we treated a cardiac arrest on deck on top of the cabin for the three-hour journey from the Liverpool-to-Dublin car ferry back to the slipway. He was one of the rare cases that was a fake. He was a real case of Münchhausen syndrome, having simulated cardiac arrest on the car ferry, fooling three medical members of the intensive care team of Jervis Street Hospital, Dublin. He also took me in. I took an electrocardiogram in the ambulance by the boat house but it was not until the next morning after he had been in hospital several hours that he was shown to be a maligner. That is a very unusual story, however. Most of our cases are quite genuine even if they do sometimes walk ashore unaided.

Sometimes Anglesey Radio, the General Post Office radio station, will ask me to speak to the skipper of a merchant ship maybe 100 miles away who is approaching our area asking for medical advice. This past autumn I treated the captain of a small Navy minesweeper who was brought ashore by his own boat to my local beach 200 yards from my surgery. The Post Office radio station is apparently directed to ask for medical advice from the nearest hospital. This sometimes causes difficulties, and I have been asked to attend at a hospital asking the skipper to bring the patient ashore so that he can be seen in outpatients next morning! When a vessel approaches our patch, Anglesey Radio has agreed to ask me for advice. Being the doctor most rewarding work and the most in evidence there may not be the slightest bit of difference from one's council estate patients ringing up during surgery time for advice, for this is the responsibility one has in general practice—to provide primary care.

Rescues

Rescues are entirely in the charge of the area coastguard rescue headquarters, in our case Holyhead. They may ask for the assistance of a helicopter from the RAF Search and Rescue Squadron 22 at Valley. Once the coastguard think that it is necessary to launch the lifeboat, he or she (we have lady coastguards) will inform the honorary secretary of the lifeboat station who will authorise launching. I will have been given the relevant information already and possibly discussed the patient with the ship's captain. If I am in the surgery it will take me only a few minutes to go down to the lifeboat station; otherwise I can be informed by radio in my car. It will then take only a

few minutes to slip on my Javelin boots and an extra jumper and, putting my flasher on top of my car and sometimes using my siren, judiciously, to approach the boat house. I have my personal RNLI protective clothing and air jacket hanging in the boat house and wear crash-helmet-type headgear. I always receive every courtesy from the crew, and the head launcher or one of the shore crew, who are such a very essential part of any lifeboat station, take charge of my ignition key until the boat is retrieved.

If the weather is easier it can be difficult, and until our new breaker is built we have to shelter in the Menai Straits and are off station for some hours.

The coastguard will have also informed the ambulance station to stand by and an ambulance will be waiting for us when we return to the slipway. I always find the launch down the slipway particularly exciting, and I am sure that one of the steepers in the country. I think everybody who does emergency work secretly enjoys that little extra perk of the thrill of the job—in my case to be involved in an exhilarating launch. Once at sea everyone knows his place and I just keep out of everybody's way. I think in this respect that there is some similarity between the lifeboat HMA and the ship's surgeon in the Royal Navy. It has been said, "Like the engineer, the surgeon had a long battle before his status as a naval officer was recognised."

The view of the sea surgeon, which—unchanging as the sea—still holds today, is a blend of acceptance and rejection, of a claim to transcend the methods while conducting the surgeon's services. Dismissed as a man taking no part in the life on the ship, he is accorded the guarded welcome of the stranger within the gates. Once one gets to know the crew, however, and has the good nature to haul on a line here and there and keep out of the way during launching and retrieval, one is treated with the greatest of good nature and one has great affection for one's boat.

RNLI

The RNLI, as everybody knows, is a voluntary organisation that depends on charity. It is also a Christian organisation and new lifeboats are dedicated and blessed by the archbishop and representatives of other denominations and faiths. This gives the crew and their families great comfort. Last year in Moelfre it was our 150th anniversary, and we were honoured by the presence of His Grace the Archbishop of Wales at the ceremony.

"In May we all lived and slept in the big family bed in the room above the surgery, at the front of the boat house. My father did not come to bed. He would lie for a while at the end of the bed with fluffy clothes and then go out again on his calls. In his car he had Winchester's of mistal and mist expect and he would give out in the street to the group of colliers staggering home from work with their arms round each other to support themselves. He told me that of six miners coming home in tux, two would probably die within 24 hours of the epidemic, but when we looked through the fence into the yard next door we realised with sadness that our mangle was also condemned to remain for ever in this stately graveyard of immobile wheelchairs. AUSTIN WILSON, general practitioner, Aberystwyth.

We shall be pleased to consider for publication other interesting stories in general practice.—Ed, BMJ.