which treatments require consent or a second opinion. For these treatments, if the patient does not consent or is incapable of consenting, a concurring second opinion from a commission doctor will have to be obtained. The treatments here include electroconvulsive therapy and medication but only if medication is continued for more than three months since it was started: in the first three month period the issue of consent does not arise. Where medication is continued without consent after three months the patient's doctor will be required at each renewal of detention (or at any time if asked to do so by the Secretary of State) to submit a report to him on the treatment of the patient and on the patient's condition.

Urgent treatment—None of the above applies to any treatment necessary to save the patient's life. Any treatment, provided that it is not irreversible or hazardous, may be given to prevent a serious deterioration in the patient's condition, to prevent him behaving violently or being a danger to himself or others, or to alleviate serious suffering by the patient. In all these circumstances the issue of consent does not arise.

EXTENSION TO VOLUNTARY PATIENTS

In the final stages of the passage of the Bill through parliament, without discussion or consultation, the clause concerning treatment requiring consent and a second opinion was extended to voluntary patients. This means that any patient asking for certain treatments will not be allowed to have them until he has undergone the procedure of having his case examined by at least five other people. This applies at present only to psycho-surgery and hormone implants but in future other governments

might possibly include electroconvulsive therapy or even phenothiazines. These provisions apply not only to inpatients but also to outpatients and even those who are not under the care of a psychiatrist. Gone is the basic principle of treating voluntary psychiatric patients like those with any other physical disorder and there is now the reintroduction of certification of voluntary patients.

Conclusion

Under this new Act patients may have better rights than before, but with no new resources and the current constraints on the National Health Service these rights may prove to be meaningless and patients may be worse off in terms of getting the treatment they need.

My history of mental health legislation draws largely on the works quoted below of Kathleen Jones and Nigel Walker. While I acknowledge my indebtedness to them both the views expressed are my own and are not necessarily those of the DHSS. Finally, I cannot here hope to represent accurately or comprehensively the provisions of the new Mental Health Act.

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Letters to a Young Doctor

Postgraduate education in general practice

PHILIP RHODES

The system of postgraduate education in general practice overlaps the hospital system described in the previous article (21 May, p 1635), but general practice also has an identifiable system of its own. This is befitting since about a third of all doctors are general practitioners and have their own special requirements. The chief officer is the regional adviser in general practice, appointed by the university. He works closely with the postgraduate dean and in some sense is "on the staff" of the dean. He has, however, much autonomy. He is accountable to the general practice advisory committee. This consists of general practitioner principals and trainees from all around the region as well as university representatives, especially those of a university department of general practice, and the local faculty.

The general practice advisory committee, on the advice of the regional adviser, appoints course organisers and trainers. These

are the adviser's "officers" throughout the region. The trainers are the essential teachers. They are carefully selected for their interest and skills in education. Their practices are inspected for their suitability by the adviser, and they have to agree to undertake sessions that consider educational methods, including assessment of themselves, their practices, and their trainees. Only a proportion of principals in general practice in any one region are so selected. This is fortunate. The teachers are willing and learn their craft. In hospitals every doctor seems to think that he is ordained to teach, though sometimes he has little idea of what this requires. Only rarely do any of them formally learn something of the techniques of teaching.

Course organisers have general oversight of a small group of trainers and trainees, keeping them up to the mark educationally. The regional adviser works through them and through any associate advisers appointed to help him. These various helpers are needed since the region is geographically widespread, and there may be about 300 trainees working in it at any one time. One third of them may be in practices on a one teacher to one pupil basis, and all must be kept in touch. The other two thirds are in hospitals and they too must be kept in touch with the system. There must be negotiations with the consultants to

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provide and help with the education of their juniors. So there may be roughly 300 teachers as well as their trainees. A group of roughly 600 people require some organisation, particularly when they are widely spread and each has his own special needs.

In some regions a tutor in general practice is attached to each postgraduate centre. He may also be a course organiser or trainer or both. As tutor he advises the clinical tutor on educational programmes to be run in the centre. Thus he is like the other tutors in surgery, medicine, obstetrics, pathology, and so on. They are part of the largely unrecognised faculty of each centre. If any junior doctor wishes for advice he has a large circle to call on. The consultant or principal with whom he is working is first, and thereafter the system is most easily tapped through the clinical tutor. If he does not know the answers to questions then he can direct the inquirer to his colleagues or to the postgraduate dean.

The major colleges and faculties appoint a regional adviser in their subjects to each region. He is the liaison between the "centre" institution and the region. College and faculty policies and regulations are constantly changing and he must know of these and interpret them to the region. He is often in contact with the postgraduate dean, with his consultant colleagues in the region, with trainees, and with junior doctors of all grades. He serves on his appropriate education subcommittees and may be a valuable source of advice to junior doctors who wish to use his services.

Specialist in community medicine

Another useful person to know is the specialist in community medicine at the regional health authority concerned with manpower and personnel. He monitors and controls all medical posts in the region and looks after a definite budget. So he often determines the implementation of policies to do with junior posts and with part time supernumerary posts for those with domestic commitments. This officer and the postgraduate dean are in almost constant communication with one another over junior doctors and their posts. Educational matters are very much in the hands of the postgraduate dean and all his advisory committees and people, but these often require money to put them into effect.

Although there is an agreed budget allotted to graduate education by the regional health authority and the district health authorities each year and given directly and indirectly to the postgraduate dean, there are many exceptions to the rules, with special courses and contingencies as well as problems arising that affect individual doctors. These may need special consideration, and for finance the final say may rest with the specialist in community medicine or the regional medical officer, in consultation with other National Health Service administrators. Here again is to be seen the close cooperation of the educational arm with the service. They cannot work independently, but only with negotiation and agreement. In big organisations such as the NHS there is little autonomy for anyone. People have to be persuaded about the value or otherwise of any course of action.

The final control of the educational system resides with the colleges and faculties, who set the standards required for obtaining their diplomas and for appointing senior registrars and consultants. Indirectly, of course, this sets the standards for registrar and senior house officer appointments. On every appointing committee for consultants and senior registrars there has to be a representative of the appropriate college or faculty to see that appointees reach the standards required. Standards are of knowledge and skills. Knowledge is tested by examination, and much is done in the regions to help junior doctors to acquire this knowledge. There is learning on the job, lectures in postgraduate centres, libraries, audiovisual aids and tape slides, long and short courses in basic and clinical sciences, tutorials and seminars, special lectures, national courses, and block release and day release courses. For most of these money is provided for teachers and students, often with travelling and subsistence

allowances. The input into education of doctors in the NHS is massive.

Inspections

In formal examinations it is virtually impossible, without undue effort, to test skills at an advanced level. The alternative is to see that appropriate experience is gained by those taking diplomas. This explains the widespread practice of inspection of posts undertaken by colleges and faculties. At first their major concern was with senior registrar posts. This can be a mammoth task on a nationwide scale. Some colleges therefore came together to form joint higher training committees, but there are so many different specialties that these joint committees had to farm out their work of inspection to specialist advisory committees, which send out visitors to all regions in small teams of two or three. These report their findings to the whole advisory committee, which reports to the joint committees. A similar principle holds with more specialised colleges and faculties which simply have higher training committees that send out small teams of visitors acting on their behalf.

Recently the colleges and faculties have inspected registrar and sometimes senior house officer posts. This is an even bigger task than inspecting senior registrar posts since there are so many more of them. The object, as with all inspections, is to make sure that the experience of the incumbents of the posts is of a sufficiently high standard both for admission to examinations and for the benefit of patients. The emphasis on the experience of the doctor for educational purposes must not be allowed to obscure the fact that in the final analysis it is for the benefit of patients, the good name of the profession, and the standards of practice of the NHS.

Some colleges and faculties have tried to extend their duties of inspection to include direct supervision of their trainees. This is because the boundaries between the central organisations and the regions are still being fought over. It is, however, impossible for each college and faculty to keep track of all those who are studying its subjects because of the numbers and because they are often great distances away from London. The day to day concern for the standards of all the posts and all the incumbents must be a regional responsibility. Thus most regions have review panels for senior registrars and registrars. These are set up by the regional postgraduate medical education committee to inspect posts and to review the progress of individual doctors in post. The panels interview the holders of posts, inspect all the facilities available, and interview the consultants concerned with the posts and the people. The central organisations inspect only about every five years. The regional system inspects every one or two years, as it were in the interim, to see that nothing is going adrift. At the same time there is the opportunity to discuss each junior doctor's career and advise how it might be kept on the right lines.

The inspection system is widely misunderstood. It is often seen as bureaucratic nonsense designed to keep certain people in employment. But it is about standards in the NHS. Left to our own devices, all of us tend to become aberrant, thinking that we know what is best and failing to see the beams in our eyes. We all need others, sympathetic yet external to ourselves, to help us cast out the beams. No one who has witnessed visitations over the past few years can doubt their value in improving equipment, resources, and space throughout the NHS and the postgraduate centres. As a result of inspections the educational experiences of doctors have been vastly improved and thereby it is hoped, and it is likely, that service to patients has improved also. Inspections help to keep the service on its toes.

Graduate education in the NHS is largely persuasive. No one can be forced to take part, but those who do not as junior doctors do not get higher qualifications and their careers reach a dead end. For senior doctors the threat is that educational recognition may be withdrawn from the junior posts that they are concerned with. If this happened they would be condemned as

providing inferior opportunities for their juniors so that they might finally be unable to have any. This bitter blow is almost always avoided because the consultants and principals have to pull their socks up and put right what has seemed to be wrong by visiting teams. An adverse report gives them some leverage with their administrations and colleagues so that they may persuade them to improve facilities for their juniors and their patients.

This article is mainly concerned with the regional system. Individual doctors may, however, have problems directly concerned with their colleges and faculties. These will usually have to do with examinations and have to be resolved by writing to the secretaries of the central institutions, and perhaps visiting them as necessary.

The rest of the central organisation may be dealt with briefly. There are councils for postgraduate medical education in England and Wales, in Scotland, and in Northern Ireland. They have members representing all the central educational bodies including colleges and faculties, the General Medical Council, postgraduate deans, and the Department of Health and Social Security. Naturally, the councils attempt to resolve problems among all these bodies. One of their committees is the advisory committee of the postgraduate deans. This keeps the regional systems in touch with the national ones.

General Medical Council and Department of Health

The General Medical Council has only recently been concerned in the education of graduates. Its original remit was for undergraduate medical education. Now it has been specifically asked to look into coordination of all stages of medical education—"horizontal" coordination between subjects and "vertical" integration between the undergraduate and postgraduate years. It is developing liaisons with the colleges and faculties, the British Medical Association, and other educational organisations. The General Medical Council is of special concern to overseas doctors in matters of registration. Their other source of advice is the National Advice Centre, which is run from the office of the Council for Postgraduate Medical Education in England and Wales.

It is hoped that this brief and incomplete survey of the

Clinical encounter: Death on the train

Nowadays you can travel to a meeting in London and back to Newcastle on the same day, but it is expedient if you do not want to pay for a full scale dinner on the way back to get your hamburger and chips soon after the train leaves King's Cross. So when I was returning from a surprisingly stormy meeting of the British Society for the History of Medicine I settled in my seat long enough only to look around and notice, among the other passengers, a good looking young woman on the other side of the gangway. As soon as the train started moving I rose hurriedly and made my way towards the buffet. I was nearly at the end of the next carriage when an elderly man toppled over from his seat in front of me, dead. It turned out later that he was on his way to a naval reunion. He had hurried to catch the train and remained short of breath until he collapsed. He had tablets of isosorbide with him.

There was little worth doing beyond raising the legs and giving a thumb on the chest, and these measures were ineffective. With no defibrillator available I thought I had to appear to do everything possible (we were still in the compartment) so, with the help of a Metropolitan policewoman and a competent African paediatric registrar, I went into the routine—I say routine, but your readers will know that an aging physician is seldom a protagonist when these affairs are on foot in the ward. We did not achieve an effective circulation, and exhausted after 10 minutes we pulled the poor man to the embrasure by the door, covered him with a tablecloth, and waited till we reached the next station, where an ambulance would meet us.

The railway staff, particularly the guard, were cool and competent throughout. He explained on the speaker system that an elderly man was in serious trouble and would soon be taken off by ambulance.

graduate medical education system may be of value in understanding the outlines. The DHSS is at all times interested in and concerned with the education of doctors in the NHS. It is very permissive in this, as the *Terms and Conditions of Service for Hospital Medical and Dental Staff* show. The evolution of medicine in the United Kingdom, however, has been such that the government, through the DHSS, has chosen to hand over educational functions to the medical profession, in the belief that only the profession is fully capable of deciding appropriate standards to which its members in their various specialties must conform. Therefore the DHSS in running the service chooses to take advice on educational matters from the educational bodies.

It is a valuable working partnership, especially as the DHSS pays for most of graduate medical education whose policies it does not determine. Again this is not fully true since the DHSS is privy to much of the educational consultation that goes on and therefore has some power to influence it, and the DHSS in its policies always takes into account the educational implications if any. Service and education are integrated at many levels. It may be a useful abstraction to think of the two separately when considering the whole organisation and who does what within it, but in practice they are inseparable as they should be and the concern of those who work in the system is to try to make reconciliations of claims for each when they conflict.

All human organisations err at times. Those in the educational system of the NHS are in general helpful, though there must be exceptions. They will try to use the organisation to help you in your legitimate educational aims. Knowing the structure and function of the system will help you to use it. But you need not try too hard to try to find the right place at which to contact it. Any one of the people mentioned may be approached, and they will attempt to get you in the right stream for your purposes. If the person you approach turns out to be of little value to you, there are others to turn to. And if you know the organisation there is always a higher level to which you may appeal against any decisions that may seem to you to be unnecessarily adverse. In this way wrongs may be righted, though the appellant may ultimately have to realise that he may have been in the wrong.

In the final article of this series I shall discuss relationships with others.

While we were waiting by the body a curious thing happened. The young woman from the seat near mine appeared, carrying my brief case. She seemed disconcerted when she saw me standing there, and blurted out: "We wondered whether you would need this." "How kind of you," I said, "But—as a matter of fact—no, I don't think I need it. I'll take it back to my place." "Oh no, I'm going back there, I'll put it back on the rack." And she fled.

Half an hour or more later, after my hamburger and a much needed restorative, I found my way back to my compartment. The young lady came over, still embarrassed. "You must have thought it very strange, my coming along with your bag." "Oh no, you were wanting to help." "Well, I was—you see (pregnant pause)—we thought it was you."

Are there any risks to the residents of a house whose cavity walls have been insulated by mineral wool?

There are no risks to the residents of a house whose cavity walls have been insulated by mineral wool. Epidemiological studies of workers with long periods of exposure in the mineral wool industry have not shown any evidence of pneumoconiosis, respiratory symptoms, or changes in lung function attributable to these walls. Other studies of workers producing these materials have failed to show any excess of respiratory malignancy.^{1 2}—W R LEE, professor of occupational health, Manchester.

¹ Parkes WR. *Occupational lung disorders*. 2nd ed. London: Butterworth, 1982:319.

² Health & Safety Commission. *Man-made mineral fibres*. London: HMSO, 1979. Discussion document.