being used too often in our hospital. We wish to report the results of a Section 5(2) audit at Glanrhyd Hospital, Bridgend, Mid-Glamorgan which provides in-patient psychiatric care for the catchment area population of 160,000. We studied all the Section 5(2) applications from 1 January until 31 December 1989. According to our local *Hospital Doctors' Handbook*, the Section 5(2) should if possible be signed by the patient's Responsible Medical Officer (RMO). If he/she is not in the hospital, the junior doctor, who sees the patient, should contact the RMO or other acting consultant. The junior doctor can then complete Form 12 after discussion of the case.

Section 5(2) was implemented 42 times; [on three of these occasions the person was already detained on Section 5(4)]. These implementations refer to 37 persons, as one person was detained three times and three others were each detained twice during the year. Friday was the single most common day for implementation of Section 5(2) with 12 occurring. Twenty-one Section 5(2) (one half of the total) were implemented between 16.00 and 20.00 hours. More than half the patients were under 45 years old but seven were over 65. The primary diagnosis of the patients (ICD-9) was a psychotic condition (290–299) in 29 cases, personality disorder (301) in five cases, and other (302–311 and 345) in eight cases. The time interval between admission to hospital, and placement on Section 5(2) varied from 10 minutes to 7.5 years with 16 in the first 24 hours and another 18 within 10 days. Five Section 5(2) were applied by consultants, one by a senior registrar, and the remaining 36 by junior doctors. In 16 cases the junior doctor did not discuss the case with the consultant. Most patients were assessed by the RMO within 72 hours but in three cases there was no evidence of assessment until the seventh, eleventh and twelfth day after implementation. Twenty of the 42 Section 5(2) applications were converted to Section 2 or Section 3. Three patients were allowed home within 72 hours and six were made informal within 72 hours but stayed on in hospital; 13 became informal at the expiry of the 72 hours for which they were detained.

A worrying trend is that eight patients were placed on Section 5(2) within two hours of arriving on a ward (four within one hour). Most Section 5(2) are implemented by junior doctors, sometimes without discussion with the consultant, while the Code of Practice recommends that junior doctors should always discuss these cases with the consultant. Outside normal working hours it is usual practice for the nominated deputy to be the junior doctor on call but from 09.00 until 17.00 it is unclear who this is. We feel it would clarify the position if consultants nominate one junior doctor as their nominated deputy during working hours. Thirteen patients became informal after 72 hours. As three were not assessed by the RMO within 72 hours, that leaves ten who were assessed but were left on Section 5(2) for its duration. This is contrary to the Code of Practice. We recommend that all staff be aware of the admission procedures required before a patient is deemed to be informally admitted, that junior doctors always discuss these cases with consultants, that there be one nominated deputy during normal working hours as well as outside normal working hours, and that the RMO assess all patients placed on Section 5(2) within 72 hours.

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Appeals against Section 2 of the Mental Health Act 1983

DEAR SIRS

Since the introduction of the 1983 Mental Health Act there have been changes in the pattern of admission to psychiatric hospitals. In particular, there has been a general trend towards more informal admissions (Winterton & Barraclough, 1985; Sackett, 1987; Durani & Ford, 1989). There has been an increase in admissions under Section 2 with a decrease in Section 4 when compared to those admitted under the corresponding sections of the Mental Health Act of 1959. Webster & Dean (1989) have pointed out problems in patients knowing about rights of appeal. We wish to give a summary of our findings in a large district health authority.*

The records of all patients admitted under Section 2 to Leicester Psychiatric Hospitals over two years were studied retrospectively. Leicester has a population of 885,000 and has three mental illness units, one in a district general hospital and the other two in traditional psychiatric hospitals. Four hundred patients were admitted in this period; 47% were men. The district general unit admitted 35% of patients, and the two other hospitals 39% and 26%; 15.5% were of Asian origin. The total number of appeals was 36 (9%) with an equal sex ratio. Their average age was 37.5 years ranging from 20–69 years. Two-thirds of these patients were from the district general

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unit, with the two psychiatric hospitals accounting for 30% and 27% respectively; 11.1% of those appealing were of Asian origin. Of those appealing, 44.5% had a diagnosis of paranoid schizophrenia, 39% of manic depressive psychosis, 5.3% organic psychosis, and 2.7% (one patient) anorexia nervosa and depression.

Of the 36 who appealed, only six were released by right of appeal i.e. only 1.5% of those originally admitted. Five of the six were women, contrasting with the previous equal sex incidence, and they tended to be older than the rest of the appealing population (average age 50.2 years). None of the successful appealers were of Asian origin. Four of the six released were from the district general hospital, the other two being from one of the psychiatric hospitals and the other hospital having none released. One interesting finding was in relation to the month of admission. There was a fairly even distribution of admissions throughout the year, but of those who appealed 50% did so in the summer months ($P < 0.005$). Therefore few people were released by right of appeal from a Section 2. We have identified epidemiological factors which merit further attention, seasonal variations, sex ratios, and ethnic factors, but the small number of patients involved makes such work difficult.

One of the hospitals had a very low number of appeals compared to the other two which raises questions as to the whole process of appealing as it exists in different hospitals. A tribunal is expensive in terms of tribunal costs and hidden costs of professional time from different disciplines. Low release rates may reflect: the appropriateness of nearly all admissions, improvement caused by comprehensive treatment, the need to appeal in writing, and that a mechanism other than the 14 day limit is needed to give an opportunity for patients to appeal. Further prospective studies are needed for the evaluation of such factors.

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NHS newspeak

Dear Sirs

Nearly 150 years ago Carlyle wrote:

> "Our life is not a mutual helpfulness; but rather cloaked under due laws-of-war, named 'fair competition' and so forth, it is a mutual hostility. We have profoundly forgotten everywhere that *cash payment* is not the sole relation of human beings . . ."

It is distressing to find these words (from *Past and Present*) so relevant to present day life in the National Health Service. For all my professional life I have enjoyed the fact that mutual respect and dignity and not *cash payment* determined my relationship with my patients. Now, as I approach retirement, I find a chilling alteration in the discourse; accompanying the organisational changes, a shift in language and assumptions ("NHS newspeak") is taking place, serving to conceal or re-define the values embodied in the service.

Given the overwhelming public support for the values incorporated in the National Health Service, one might have expected that the current reorganisation would have been carried out at least in the name of these values, but this has not been the case. Perhaps the extent of the cuts and shortfalls and the almost unanimous professional opposition to the changes proposed were too great a challenge for even the slickest copywriter; patients at the end of long waiting lists reading of successive ward closures can hardly be expected to applaud the idea that "less is more". Whether for this reason or on more general ideological grounds the approach adopted has been one of imposing the language of the supposedly triumphant market on the discussions. It is, of course, the language rather than the reality that has been imported, for few believe that the economic realities of this century can be adequately described in terms of Adam Smith's street market, and the proposed NHS is still an enterprise that has no product to sell, with structures that offer no more than a pretence of competition. Even were one to accept that cash payment should be the "sole relation of human beings", this arrangement would be a shoddy expression of such beliefs. In reality, the health service is neither a street market nor a supermarket; it is an unfortunately costly overhead in the gigantic firm of Thatcherism plc (now itself undergoing a minor reorganisation) and this being so, the aim of management must be to keep the cost down. The rhetoric about the market serves to conceal, or seeks to justify, the policy of consistent under-resourcing of health care, a policy which most people, were it clearly proposed, would oppose.

Nowadays, to talk in terms of health care delivery or of professional standards and requirements brands one at once as an old fogey, whereas mention business plans, ring fencing and income generation,