Caring for those who refuse help

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What is already known about this topic

"Widening participation"—that is, encouraging pupils from non-traditional groups into higher education—is currently a political priority in Britain

There is no agreed index by which medical schools can measure their success in widening participation

What this study adds

We have developed an index of widening participation that is easily calculated from publicly available data and which allows comparisons by sex, ethnicity, and socioeconomic status; between medical schools; and across time

admission ratio is a composite index—being derived from both the proportion of people who apply to medical school in any subgroup and the proportion of applicants who get accepted—and hence should be interpreted with caution.

With these caveats, we believe the standardised admission ratio will be a useful "bottom line" index for quantifying the inequalities in medical school entry (and entry to any higher education course) between subgroups as widening participation initiatives are implemented and evaluated. In our companion paper, we explore the reasons for the wide differences in admission by social class.[5]

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Competing interests: None declared.

1 Secretary of State for Education. *Medical schools: delivering the doctors of the future.* London: Department for Education and Skills, 2004.
2 Universities UK. *Fair enough: wider access to university by identifying potential to succeed.* London: Universities UK, 2003.
3 Higher Education Funding Council. *Social class and participation: good practice in widening access to education (follow-up to 'From elitism to inclusion').* London: Higher Education Funding Council, 2003.
4 McManus IC. Medical school applications—a critical situation. *BMJ* 2002;325:786-7.
5 Greenhalgh T, Seyan K, Boynton P. "Not a university type": focus group study of social class, ethnic, and sex differences in school pupils' perceptions about medical school. *BMJ* 2004;328:1541-4.

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A memorable patient

Caring for those who refuse help

John is 85 years old, and his condition has been getting worse over the past few months. He is forgetful, not taking his drugs, and forgetting to eat his "meals on wheels." His family are helpful but cannot be with him all day. His prostate specific antigen concentration is sky high, and nobody knows quite what happened when he went to the urology outpatient clinic: he never saw the registrar and somehow found his own way home.

The deputising GP service saw him last night and said he must be urgently reviewed today, Saturday. He is lying on the floor, crumpled, his pants are soiled, and his food is down his trousers. His mini-mental state score is 13. He has dementia and is prone to falling over. His digoxin box should be half empty, but it is still sealed.

He is beyond the scope of home care and needs to be in hospital, but he has other views: "Please don't make me go there again."

"I think we need to get you seen in hospital, just to make sure there isn't anything wrong. If I get an ambulance will you go with them?"

"No." His intention is clear. He needs to be admitted, and it will have to be against his will.

The psychiatrists are very supportive but feel that, even though he spent Wednesday night in casualty, he needs to be seen by the "medics." The health care of the elderly team are a little hesitant but agree to assess him to exclude an "organic cause." But he still will not go in the ambulance. The view from the social worker and psychiatrist is that we can admit him under common law for his own protection. Ambulance control say they will not take him against his will unless he has been "sectioned" under the Mental Health Act, and they want the police present. The police will only attend to prevent a breach of the peace.

Time to speak to the consultant, who agrees to let the registrar assess him under the Mental Health Act, so finally we all meet in John's bedroom. We talk about Rosie, his dead wife, and how she keeps an eye on him. He does not agree to go to hospital, but he is tired and doesn't actually refuse. The ambulance crew swaddle him in a red blanket and carry him downstairs. We have been at this for five hours.

"Would you have sectioned him if he had refused?" I ask the psychiatrists.

"Oh no," they reply. "He isn't mentally ill."

There seems to be a huge hole opening up in care for those with dementia. This man needed sanctuary, where he could be cared for; all of the teams agreed this, yet nobody could actually agree to deliver it. Even though this patient had marked dementia, a mental illness, he is not regarded as being "mentally ill." Even though he is just as much a risk to himself as people with other severe mental illness, the law (under the Mental Health Act) does not protect him. The suggestion that we could treat him under common law (that is, where no law is written down) does not wash with ambulance and police teams, who are concerned about accusations of assault.

It is time to reconsider the scope of the Mental Health Act and stop this artificial and spurious distinction between organic and psychiatric causation of symptoms, and to use the act to protect those who refuse treatment but are "mentally ill" in a broader sense and at real risk to themselves.

John died three weeks after being admitted.

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. Please submit the article on http://submit.bmj.com Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.