Fourthly, assertive outreach teams have been established throughout England. Their aim is to minimise hospitalisation and care for those patients who have been "difficult to engage" or who—in plain English—want nothing to do with services. Although teams do not formally exercise any legal power, patients are undeniably put under pressure to comply with treatment. Whatever the therapeutic intentions, administering treatment to someone who does not want it without a legal basis for compulsion poses an ethical dilemma.[10] It is also a proactive institutionalising step, although the institution in this case is a community based service and not defined by bricks and mortar.

Similarly, the new early intervention teams might be seen as being in line with reinstitutionalisation. They aim to turn individuals who otherwise would not yet be treated into psychiatric patients and subjects of ongoing treatment interventions. This approach is supported by little if any research evidence[11] and is based on the assumption that early psychiatric treatment will prevent a more negative course of illness—an assumption prevalent among psychiatrists in the 19th century, which made them successfully demand more and bigger asylums.[12]

One might disagree with our interpretation of some of these phenomena, but it would be hard to dismiss them completely. They may provide the historical and international context for the current debate on the draft Mental Health Bill in the United Kingdom. Mental health care has entered a new era of reinstitutionalisation in its long historical balancing act between social control and therapeutic aspiration. We may now even start to witness a clearer split between the two, with an increasing market for patients who actively seek treatment and can directly or indirectly pay for it, contrasting with reinstitutionalisation for patients with more severe mental disorders who may upset the public. This split is likely to affect primary as well as secondary care.

What seems needed, in any case, is an informed debate on the values behind reinstitutionalisation and systematic research on its reasons, costs, and effects. As with research on deinstitutionalisation, a non-parochial perspective will be required alongside reliable and comprehensive data that are currently so difficult to obtain. A proper understanding of deinstitutionalisation and reinstitutionalisation can help avoid the stigmatising policies that so often marginalise mental illness.

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BMJ Learning

A suite of online services to meet doctors' needs will be launched this year

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The surprise about appraisal and revalidation for doctors in the United Kingdom is not that it is happening but that it was not introduced earlier.[1–3] For appraisal to be successful it will have to be centred on learning, which in conceptual terms allows the learner to take control in the way that education—with its top down connotations—rarely seemed to. This change in emphasis is also reflected this week in an interview with Professor Graeme Catto (p 183), president of the General Medical Council, and the start of an ABC series on learning and teaching in medicine (p 213). Helping doctors to learn is central to the *BMJ* mission, which is why we are launching BMJ Learning.

The proposition is simple. If doctors have access to online learning resources, based on the best available evidence, they will be better equipped to improve quality of care. If they can record their learning experiences systematically they should feel more confident about appraisal. As five successful appraisals seem likely to be the main requirement for revalidation, it may make that hurdle seem less daunting. We envisage that this service will develop into a learning resource for all doctors internationally, but the initial emphasis will be on appraisal in the United Kingdom because that is where many of our readers are hurting.

How should we build a successful medical learning service? We have looked at possible models from around the world and reviewed available evidence. In the United States, much online continuing medical education is driven by the need to accumulate points and by the product awareness campaigns of pharmaceutical companies. Among the exceptions is a website devoted to the medical response to weapons of mass destruction, with 10 modules covering subjects ranging from anthrax to smallpox.[4] North of the 49th parallel, the story is more positive. The Royal College of Physi-

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cians and Surgeons of Canada has led many of the initiatives in self directed learning that regulators in the United Kingdom now wish to implement. Although many interesting initiatives have started in response to this regulatory drive, in Europe and North America, our judgment is that there is no comprehensive service that adequately meets doctors' learning needs.

Over the past year we have conducted focus groups and interviews with general practitioners in the United Kingdom to help understand what users want from such a service. There are few tears for the demise of the old system but widespread suspicion that appraisal will prove to be a disciplinary process dressed up in the sheep's clothing of self directed development. Most doctors have little understanding of what appraisal requires and see it as yet another exam to be passed, but one for which there are no past papers to look up.

Three strong requirements shine through. Doctors want a wide range of high quality learning resources to suit different learning styles. BMJ Learning's offerings will include case histories, video lectures, and a new resource for busy clinicians called just in time learning. All of these will build on existing BMJ Publishing Group resources, such as *Clinical Evidence*. Doctors also like the idea of an online personal development plan and record that catalogues the needs they identify and the learning they undertake—be it online or by traditional means, such as lectures and postgraduate meetings. They value a guide to the emerging range of learning resources from universities and other publishers. But all this depends on the service being fun, bite sized chunks of learning, and being confidential.

So that is what we are building, and we hope to launch in autumn of this year. BMJ Learning will be internet based but it will complement, not replace, human contact with tutors and colleagues that can make learning a professional pleasure. We want the service to be free for users and the best way to ensure that would be to secure central funding from the United Kingdom's department of health or the NHS. We plan to start small but think big, and grow rapidly if successful. One day it may mean providing learning resources that will enable medical professionals to learn from their first day at medical school to wherever their career may finally take them—and beyond. Life long learning is becoming an integral part of other professions. Medicine is following suit and we intend BMJ Learning to support doctors in this changing and uncertain climate.

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Non-invasive ventilation in chronic obstructive pulmonary disease

Effective in exacerbations with hypercapnic respiratory failure

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Chronic obstructive pulmonary disease is a leading cause of global morbidity and mortality, and about 15% of adults in industrialised countries have chronic obstructive pulmonary disease when defined by spirometry. Mild exacerbations are common, and the development of hospital at home services for acute exacerbations has improved the treatment options for managing mild exacerbations safely in the community. Severe exacerbations, however, remain the largest single cause of emergency admissions for respiratory disease (far higher than for asthma), with a mean hospital stay of around 10 days. According to hospital episode statistics from the Department of Health, exacerbations of chronic obstructive pulmonary disease resulted in 135 000 admissions and just under a million bed days in England in 2000-1 (www.doh.gov.uk/hes). These account for over a third of the overall healthcare costs associated with treating chronic obstructive pulmonary disease in the United Kingdom. Exacerbations are not only expensive but can impair lung function and quality of life and are associated with further readmissions.

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Severe exacerbations with impaired gas exchange are associated with death rates of up to 14%.[1] In particular, admission to an intensive care unit and acute hypercapnic respiratory failure are associated with higher death rates—up to 59% at one year.[2] Non-invasive ventilation is now recognised as an important tool in the treatment of acute hypercapnic respiratory failure associated with exacerbations of chronic obstructive pulmonary disease. The procedure provides ventilatory support to the upper airway by using facial or nasal devices, can avoid the morbidity and mortality associated with tracheal intubation, and is useful for patients in whom invasive intervention is considered inappropriate.

A series of randomised trials of non-invasive ventilation in acute exacerbations of chronic obstructive pulmonary disease has been performed, but in different ward settings. In the intensive care unit, non-invasive ventilation has shown significant reductions in tracheal intubation rates but not in overall mortality.[3 4] Studies conducted outside intensive care units have also shown inconsistent results, some of which can be explained by differences in the severity of exacerbations[5] and study design, such as comparison with historical controls.[6] The largest randomised