Table 1—*Numbers of general practitioners giving correct answers to questions about legal provision for compulsory detention of mentally ill people*

Question	No giving correct answer (n = 50)
What is the title and year of the current act ?	2
Which section should be mainstay of formal detention ?	8
May a patient be detained without the approved form A ?	32
Conditions for emergency detention ?	
Mental disorder	3
Urgently necessary	5
Health or safety (of patient) or protection of other persons	0
No alternative to hospital	0
Where practicable, with the consent of a relative or mental health officer	26
How is mental disorder defined in the act ?	1
Are any conditions specifically precluded from being sole grounds for detention ?	26
What period of detention does the emergency order allow ?	30
Does emergency detention include the power to enforce treatment ?	30
May one emergency order follow straight on from another ?	7

We asked about the law, rather than actual procedure in an emergency. Some doctors did state that before using compulsory powers they would always seek specialist advice, but in practice, given urgent circumstances, there may be less time for thought than during our interviews.

The results were disquieting. Our interviewees were uncertain about terminology and generally unable to define basic statutory requirements. Many doctors believed incorrectly that the presence of certain disorders precluded detention and that treatment could be enforced under the emergency provision.

These are not isolated findings, though previous studies have concerned the knowledge of psychiatrists.[3] Medical practitioners base decisions about compulsory hospitalisation on a "needs" rather than a "rights" orientated approach, acting in the patients' best interest and often within the confines of the law.[4] Nevertheless, lack of knowledge about statutory provision may lead to loss of the right to treatment for some or infringement of civil liberties for others in an area of the law where these are least well protected.

Most of the doctors interviewed estimated that they used the emergency powers of detention about once a year and then only after exhaustive attempts to do otherwise. Nevertheless, a fifth had detained three or more patients in the previous 12 months, and general practitioners initiated 86 urgent compulsory admissions to hospital in Edinburgh during the 10 month study period.

It is difficult to identify how this sample might differ from doctors working in other parts of Scotland or further afield. Some priority should be given to the issue of mental health law in continuing professional development for all those who might use compulsory measures, particularly in a jurisdiction where the initial decision to deprive an individual of his or her liberty may be in the hands of a single practitioner. Other findings suggest that there are no grounds for complacency elsewhere.[5]

We thank all those general practitioners who so generously gave us their time to be interviewed for this study.

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Conflict of interest: None.

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Survey of HIV patients' views on confidentiality and non-discrimination policies in general practice

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In Kensington, Chelsea, and Westminster in 1993-4, general practices knew of 761 HIV positive patients but 1186 HIV positive residents consulted HIV services. This discrepancy hinders the establishment of a therapeutic relationship and prevents primary health care teams gaining experience.

Patients may not believe that general practice is secure for confidential information. Therefore as part of a larger questionnaire we asked patients positive for HIV whether in general they were willing to disclose their diagnosis to practice staff, and then if they would be willing for all staff to know their diagnosis if there was a confidentiality or non-discrimination policy displayed at the practice.

Patients, methods, and results

All 1058 surviving HIV patients who attended outpatients departments between October 1992 and March 1994 were approached. We contacted 847 (80%); 170 patients were lost to follow up and 41 were physically unable to respond. There was no difference in risk behaviour between those who could be contacted and those who could not. The questionnaire was completed by 593 men and 69 women (78% of contactable patients, 63% of attenders). Gay men were more likely to respond than other groups (χ^2=38.1, df=1, P<0.0001); 85% (563) of responders were white, 7% (46) Black African, 3% (20) Afro-Caribbean, and 2% (13) Asian. Most respondents (519/656 79%) were registered with a general practitioner, 378 of these (76% of responders, 58% of sample) with a general practitioner who knew their diagnosis.

All patients were asked if they objected to practice receptionists, managers, counsellors, or nurses and a different doctor to their usual general practitioner knowing their diagnosis. Most patients (454/625; 73%) would not want one or more staff groups to know; 159 (35%) objected to all five. There was a clear hierarchy of acceptability: 436 (70%) patients objected to receptionists knowing, 301 (48%) to practice managers, 251 (40%) to a different doctor, 231 (37%) to counsellors, and 222 (36%) to practice nurses. A total of 257 out of 373 patients (69%) whose general practitioner knew their diagnosis still objected to some staff knowing.

Patients who objected were asked if they would be happy for all staff to know whether there was "a clearly displayed policy of staff confidentiality" or one of "non-discrimination against patients who are black, gay, drug users, or HIV positive" in the surgery; 415/454 (91%) of patients responded. The non-discrimination policy was more effective: 141 patients (34%, 95% confidence interval 29% to 39%) answering yes to the

Table 1—*Effect of confidentiality and non-discriminatory policies on willingness of HIV patients to disclose diagnosis to practice staff. Values are numbers (percentages) of patients who did not want to tell their diagnosis*

	Wouldn't change with policy			Willing to change with policy
	5 Staff groups	2-4 Staff groups	1 Staff group	
Initial response (n=454)	159 (35)	191 (42)	104 (23)	
Confidentiality policy (n=415)	116 (28)	113 (27)	45 (11)	141 (34)
Non-discrimination policy (n=415)	111 (27)	99 (24)	36 (9)	169 (41)

confidentiality statement and 169 (41%, 36% to 45%) to the non-discrimination policy (table 1). Having a general practitioner who was aware of the patient's HIV status significantly increased the chance of a positive response (χ^2=13.7, df=1, P<0.0005 for confidentiality, χ^2=6.0, df=1, P<0.05 for non-discrimination); no other characteristics were significant. Reincluding the 171 (27%) patients with no objection led to an increase in disclosure across the sample to 312/586 (53%) with the confidentiality policy or 340 (58%) with the non-discrimination policy.

Comment

Non-discrimination policies might facilitate shared care by doubling the number of patients disclosing their diagnosis to staff, and such policies should be evaluated in practice. Where practices restrict registration of drug users (between a quarter and a half of practices in North West Thames do so) this should be explicit. Although confidentiality is already a contractual and professional obligation, patients still perceive a risk in disclosing HIV status; adoption of a confidentiality policy could therefore be used to review a practice's working patterns, including policy on life insurance forms. Either or both types of policy could be required to be displayed in surgeries, or to be placed in practice leaflets, by commissioning agencies.

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Conflict of interest: None.

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THE COLLEAGUE WHO CHANGED MY LIFE

One of the just

A great doctor died last December. Few, I believe, would disagree with the adjective, except the man himself. Yet Alan Jacobs was not widely known, worked at a measured pace, and, I guess—being merely his awed senior house officer in 1961—probably shunned office. He carried out one major piece of research—on arterial embolism—based characteristically on painstaking clinical observation. It took him 16 years. His secretary joked she lost as many from her life, endlessly retyping what became, when he was 53, his DM thesis. Livingstone published it as a monograph, a notable honour.

A dignified career then, not an electrifying one, yet Jacobs made an impression on me which still endures 35 years later. For this principle physician was the exemplar of a doctor. Above all, he put patients first. Does that sound trite? Not as he practised it. One instance: he did no private work. Mainly, yes, this was from dogma, for he was a socialist, but to stop there misses the essence of the man. "I would do it," he once said, only half teasing, "except, sooner or later, I would be asked to see an extra private patient at the expense of an NHS one, and I am not sure I could resist the temptation." We gaped. He, the most incorruptible of men, doubted his own character. Where did that leave anyone else? But there was another, subtler lesson to follow. Unlike a lesser man, he said nothing about anyone else. How his acceptance of and compassion for human frailty shone that day. A true socialist, not a vengeful one. The incident never left me.

These qualities—unselfishness, honesty, forgiveness, serenity—informed everything. He delegated, not from laziness or overwork, but as policy, leading deliberately from the rear. Ever watchful, he freed his juniors to educate themselves by being a trustworthy wall against which to bounce their ideas and enthusiasms. You learnt, often without needing to be told, because you ached for his good opinion. Knowing his mind helped you form yours, even if you disagreed. I now realise that ever since, when troubled, not least ethically, I have asked myself what he would do in my place. And to ask has been to know immediately.

Nobody is faultless. Therapeutically he tended to nihilism, out of overconcern for drug side effects. And personally, though friendly and humorous, he was very much the chief set apart. But what did mere camaraderie matter? Jacobs treated his juniors as colleagues, not assistants. Your opinion counted. If you could correct him—if—he accepted it quietly, showing no embarrassment, offering no praise. Neither was necessary. Patients were important, not his ego. Or yours. His kindness to them was remarkable, though (from shyness?) he often hid it behind austerity. He would devote more time to a tramp than a peer—who would have the greater need? Again, no preaching. Yes, he taught by every action, he who by paradox, rarely taught formally at all.

For me, in his moral authority and humanity, he was unforgettable. His lessons are worth relearning in these grasping times. His example should not be buried in the précis of an obituary or eclipsed by shallow celebrity. He was one of the just. If only I could have told him. But, of course, that would have been unthinkable.—NEVILLE CONWAY *is a retired cardiologist in Hampshire*

We welcome filler articles of 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. If possible the article should be supplied on a disk.