

MEDICAL PRACTICE

Contemporary Themes

Self-poisoning: management of patients in Nottingham, 1976

D R BLAKE, J R A MITCHELL

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Summary and conclusions

Analysis of the management of a sample of patients with drug overdoses in Nottingham in 1976 showed that some 10% of the patients who arrived in the casualty department after an overdose were neither admitted nor seen by a psychiatrist. Of the patients who were admitted to medical wards for psychiatric evaluation, 31% were thought to need no further psychiatric action while the default-rate in those who were referred to a psychiatric outpatient clinic was 43%. Both these end-points showed considerable variations among the 10 psychiatric teams, but of every 100 patients with drug overdose who arrived in the casualty department, 51 left hospital without continuing psychiatric or social action having been taken.

As the recommendations of the Hill Committee are not being implemented we suggest that they should be critically re-examined and that the indications for, and value of, psychiatric intervention should be determined.

Introduction

It is commonly held that every drug overdose is a cry for skilled psychiatric help. The Department of Health recommends that

every case of deliberate self-poisoning should be seen by a psychiatrist,¹ and this view was reinforced in 1968, when the Hill Committee² recommended that: "All cases of deliberate self-poisoning should receive psychological and social evaluation and help," and that, "A psychological and social evaluation needs to be made whatever the motive may appear to have been, without distinguishing between suicidal gesture, attempted suicide, and other such formulations." The committee also considered that patients who were not transferred to inpatient psychiatric care and were therefore discharged home should receive continuing psychiatric and social support.

Nine years have now elapsed since the Hill Committee reported, and we have therefore examined the services provided for cases of self-poisoning in the Nottingham area to see how far they meet the original suggestions. We report the results of our studies and reappraise the Hill Committee recommendations.

Methods

IDENTIFICATION OF CASES OF SELF-POISONING

To establish the annual admission rate for cases of self-poisoning admitted to the medical wards of the two acute Nottingham hospitals (City and General), we abstracted information from the Hospital Inpatient Activity Analysis diagnostic index. The record clerks, who code the information from the notes after the patient has been discharged, may be uncertain whether the patient was admitted as a case of intentional or unintentional self-poisoning. Until 1973, cases in which there was doubt were coded as "attempted suicide"; after this date they were coded as "adverse reactions to drugs." To appreciate the true size of the overdose problem it is therefore essential to combine both sets of figures (fig 1).

Department of Medicine, General Hospital, Nottingham NG1 6HA

D R BLAKE, MB, CHB, senior house officer, vocational training scheme (present appointment: medical registrar, Newcastle General Hospital and Royal Victoria Infirmary, Newcastle upon Tyne)

J R A MITCHELL, MD, FRCP, professor of medicine

THE PROBLEM AS PRESENTED TO THE CASUALTY DEPARTMENT

The only adult casualty department for the Nottingham conurbation (650 000 people) is at the General Hospital, and over 90% of cases

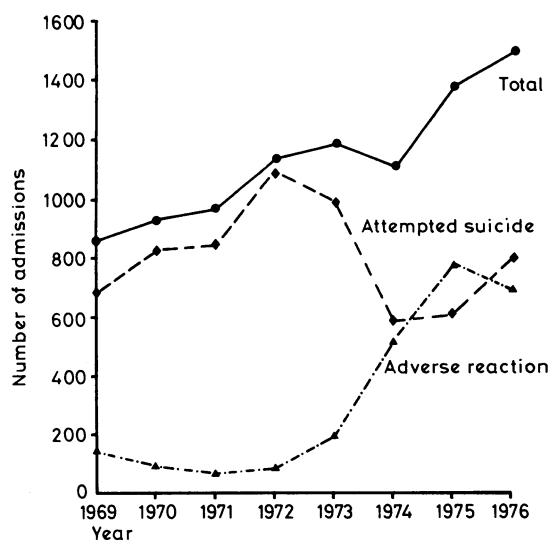


FIG 1—Yearly admission rates for drug overdose to Nottingham hospitals.

admitted to the medical wards of the City and General Hospitals for self-poisoning pass through this department. The two hospitals admit rung-in medical emergencies on a daily rota, and on the days when the City Hospital is on medical reception, patients with overdoses are transferred there from the General Hospital Casualty Department, provided they are considered to be sufficiently fit for the 4-8 km journey.

The casualty department staff keep their records on a triplicate form, the third copy of which is processed by the Trent Regional Health Authority in Sheffield for research purposes. A 10% sample of these records showed 129 separate episodes of intentional self-poisoning during 1976, giving a calculated figure of 1290 separate episodes of self-poisoning seen during the year. Of the 129, 13 (seven men and six women) were neither admitted to medical wards nor seen by a psychiatrist. Three women and one man were referred to the social service department, but no patient was referred for a psychiatric outpatient appointment. Two patients were referred to the physicians on call, but neither was considered to warrant admission on medical grounds. Three men were allowed to take their own discharge unhindered.

SERVICES PROVIDED IN MEDICAL WARDS

Once patients are admitted to medical wards after self-poisoning they are automatically referred for a psychiatric consultation. Patients

who live within the former Nottingham City boundaries are referred to the psychiatric staff of Mapperley Hospital (catchment population about 300 000), while most patients from the former Nottinghamshire County areas are seen by the staff of Saxondale Hospital.

During 1976, ten psychiatric consultants from Mapperley Hospital regularly managed these patients. They worked from a fixed duty rota covering each weekday, one consultant being on call for the City Hospital and another for the General Hospital. The duty consultant covered both hospitals during the weekend. From the medical case-notes we identified the members of the psychiatric teams who saw the patients. Four consultants saw a considerable proportion of cases allocated to them but allowed their junior staff to see some cases depending on their psychiatric experience. The junior staff of the other six consultants deputised more. The junior staff varied considerably in their seniority and experience. In 1976 half of them had had less than 12 months' psychiatric experience, and two were general-practitioner trainees undertaking a six-month appointment as part of a vocational training scheme.

The psychiatric staff from Mapperley Hospital complete a "contact form" on all patients seen on medical wards. This form specifies the consultant team by which the patient was seen and details the age, sex, and marital status of the patient, previous contact with psychiatrists, the psychiatric diagnosis, and the method of disposal. The latter is recorded as (a) admission to a psychiatric bed, (b) referral to a psychiatric outpatient department, (c) referral to the social services, and (d) no follow-up.

Results

An analysis of these contact forms for 1976 showed that the psychiatric staff from Mapperley Hospital had seen 785 separate episodes of self-poisoning; 575 (73%) of the forms contained sufficient detail for analysis. The patients were evenly distributed between the City and General Hospitals, and 37% were male and 63% female; 39% of the patients had had previous contact with the psychiatrists while 61% had not.

The age distribution of the 575 patients was 14 and under (3%), 15-24 (34%), 25-34 (30%), 35-44 (17%), 45-54 (8%), 55-64 (4%), 65-74 (3%), and 75 and over (1%). Forty-one per cent were single, 39% married, 4% widowed, 6% divorced, and 10% separated. Of these patients, 19% were admitted, 32% referred to outpatient clinics, 18% referred to the social services, and no action was taken on 31%.

Table I shows how individual psychiatric teams handled the referrals. The 10 psychiatric teams are listed in the table according to the hospital they visited and the day of the week on which the consultation took place. All teams contributed to weekend cover and the cases seen then are included in the figures for the appropriate teams. About 5% of patients referred to psychiatric clinics were also referred to the social services. Some 43% of patients referred to the psychiatric outpatient department failed to attend and table II shows the variation among the individual psychiatric teams.

TABLE I—Method of disposal by individual psychiatric teams for 575 patients for whom contact forms were completed

Psychiatric team	Hospital	Day	Total No of cases	Percentage admitted to psychiatric hospital	Percentage referred to outpatient department	Percentage referred to social services	Percentage when no action taken
1	C	Mon	61	18	17	23	42
2	C	Tues	62	23	43	16	18
3	C	Wed	73	12	49	15	24
4	C	Thurs	72	18	27	22	33
5	C	Fri	44	25	23	18	34
6	G	Mon	52	13	25	12	50
7	G	Tues	43	21	35	9	35
8	G	Wed	49	24	37	35	4
9	G	Thurs	62	23	45	13	19
10	G	Fri	57	19	19	11	51
Range				12-25	17-49	9-35	4-51

C = City Hospital. G = General Hospital.

TABLE II—Attendance rate for patients referred to a psychiatric outpatient clinic after self-poisoning

Psychiatric team:	1	2	3	4	5	6	7	8	9	10
No referred to outpatients and percentage attended	10 (30)	27 (59)	36 (69)	19 (42)	10 (50)	13 (61)	15 (47)	18 (39)	28 (78)	11 (45)

The patient's age might have been expected to influence the method of disposal: the admission rate was indeed highest in the three oldest age groups, but 40% of patients aged 65-74 and 25% of patients aged 75 and over were discharged without further psychiatric or social support (table III). The patient's sex did influence admission rates, the male:female ratio in the group as a whole being 37:63 while in the patients admitted to a psychiatric unit it was 45:55.

TABLE III—Method of disposal (%) in relation to age of patient

Age (years):	≤14	-24	-34	-44	-54	-64	-74	≥75
Admitted	0	12	19	27	18	33	30	38
Referred to outpatient department	20	30	34	38	33	41	25	12
Referred to social services	60	20	16	12	16	13	5	25
No action	20	38	31	23	33	13	40	25

Discussion

Advisory bodies recommend that after an overdose every patient should be given skilled psychiatric help. Nevertheless, the issues facing individual doctors confronted with individual patients are less clear cut. The problems posed at each stage of managing an overdose illustrate these difficulties. Firstly, in the casualty department, where it is not easy to decide what constitutes an overdose: 100 aspirin tablets would clearly do so, but what should the casualty officer do when he is told that a patient has taken 10 oral contraceptive tablets, or eight ampicillin tablets, or six ferrous sulphate tablets, or four barbiturate tablets? Does he attempt to differentiate between the physical harm that this may produce and the motives that lay behind the ingestion? If so, he runs counter to the Hill Committee recommendations that covered "all cases of deliberate self-poisoning . . . whatever the motive may have been . . . and without distinguishing between suicidal gesture, attempted suicide, and other such formulations."

Secondly, in the casualty department and on subsequent admission to a medical ward, can overdose victims be regarded as "patients" at this initial assessment? The patients with whom most doctors in acute general hospitals are familiar have asked for medical help, and when this help is given a contract has been made between the patient and the doctor. If the subject who has taken an overdose is using the overdose to manipulate his surroundings or to end his life does he want to be helped, and is there a treatment contract between him and his doctor so that an appropriate line of action can be mutually agreed?

Thirdly, within a medical ward, the on-take team is accustomed to making a complete appraisal of their patients' problems. Such an appraisal will include "psychological and social evaluations" for patients with chronic bronchitis, myocardial infarction, and multiple sclerosis, some of whom will be referred to psychiatric and social agencies. The medical team will, however, choose which patients to refer; in medical referrals they will also choose the consultant colleague from whom they wish to seek advice. The responsibility for the patient thus remains firmly with the ward team so that no evasion or dilution of this responsibility should occur. The problem for the person who has taken an overdose is totally different; for if referral to a psychiatrist is automatic the ward team may feel that it is absolved from ascertaining those social and personal details that it obtains from the other patients. This transfer of responsibility means that the nursing and medical staff who see the patient for the longest period feel they have no part to play in his management, since this will be determined by a relatively brief contact with a psychiatric team whose composition is determined by rota rather than by ward-based choice. We found that psychiatric and vocational scheme trainees may act as their consultants' deputies. They do not have sufficient experience either in psychiatry or in general medicine to convince the medical ward team that the consultation has added to their own

appraisal of the problem. Moreover, in Britain as a whole most such junior staff are foreign medical graduates, so linguistic and cultural barriers may impair their ability to assess the complex problems in our society that the patient with an overdose exemplifies.

We also found a wide range of action (table I) from the visiting psychiatric teams, despite the virtually random allocation of the patients on whom they were advising. It seems improbable that differences in the patients seen could account for the finding that 51% of patients seen by one team were thought to require neither further psychiatric nor any social intervention, while only 4% of the patients seen by another team were judged to require no action. These wide variations suggest that there is no agreed way of handling such patients which reflects a clear psychiatric diagnosis. The range of disagreement about direct admission to

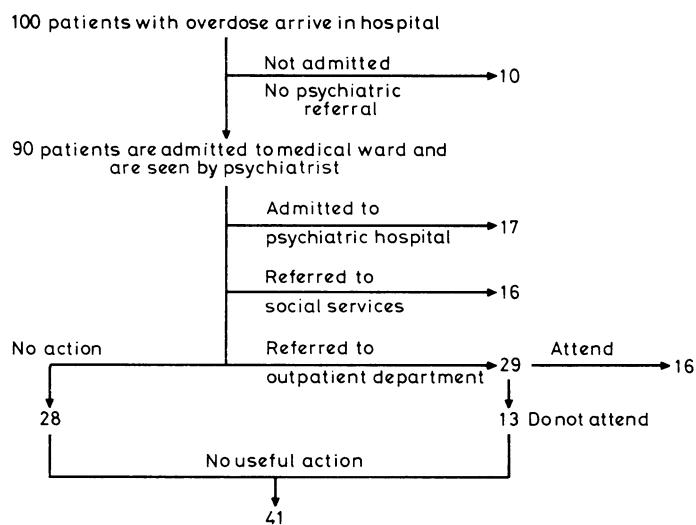


FIG 2—Flow diagram for overdose management in Nottingham in 1976.

a psychiatric hospital (12-25%) was, however, much narrower, suggesting that where this is the outcome, agreed and discernible psychiatric conditions are present, such as depression.

An equally striking finding is the wide variation among the teams in the frequency with which their patients kept the psychiatric follow-up appointments: for one team, the loss rate was 70%, while for another it was only 22%. A poor attendance rate after self-poisoning has been described^{3,4}; the siting of the clinic is probably important, and the team with the highest attendance figure (78%) saw their patients in a medical rather than a psychiatric clinic. The net effect of the various losses is shown in the flow diagram (fig 2), and of 100 patients arriving in the Nottingham hospitals, no continuing action in a social or psychiatric sense was taken in 51 (10 not admitted or referred; 28 no action; and 13 defaulters from an arranged outpatient clinic).

Conclusions

We suggest that the time has come to re-examine the widely held assumption that every overdose is a cry for skilled psychiatric help. We have emphasised the difficulty of defining overdose and skill and have shown that on the present system, some 51% of our Nottingham patients receive no continuing help. We have made no attempt to evaluate success or failure in management, since client, doctor, family, and society might define these terms differently, but since our study was completed, Gardner *et al*⁵ have compared the outcome in self-poisoned patients randomly allocated to medical or to psychiatric teams on admission to Addenbrooke's Hospital, Cambridge. They reasoned that: "If

specialist psychiatric advice is necessary for all self-poisoned patients, we should have found that the patients assessed by the medical teams had fared less well than those assessed by psychiatrists. But . . . there was no significant difference between the groups in the incidence of relapse during the trial." They considered that, "a specialist psychiatric training is not essential for the purpose of assessing suicidal risk" and conclude that there is "a strong case for amending the recommendation in the Hill Report so that physicians may decide in each case of self-poisoning whether a psychiatric opinion is necessary."

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for access to the sample of records, and we are grateful to the records staff at Mapperley Hospital for their help with the contact forms.

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If I Had . . .

If I had carcinoma of the middle third of the rectum

H A F DUDLEY

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Background

Surgically, there has hardly been a more extensively studied tumour than carcinoma of the rectum. We know that it can be detected relatively early (though not in the biological sense) because of its obvious symptoms of bleeding, mucus discharge, and tenesmus. Spread occurs distally and laterally, as well as in the more conventional way to lymph nodes on the superior rectal vessels in the mesentery of the rectosigmoid, and thus by the portal venous system to the liver. The centrifugal nature of spread makes it more difficult to cure the more distal is the growth,¹ or once it is through the full thickness of the rectal wall. These facts have led to the development of the standard operation of abdominoperineal excision of the rectum for middle and distal third growths, which removes en bloc the rectum, perirectal tissues, anal canal, and perineal skin in addition to the rectosigmoid and its lymphatic drainage.

Surgical skill has brought this operation to a stage where the resectability rate is 98%² and the mortality rate of the order of 2.5%.³ Furthermore, surgery does cure the disease. For tumours in the wall only (Dukes's A) the five-year survival rate is up to 90%; for those with transmural spread (Dukes's B), somewhat less but yet remarkably good (71%); and even in the presence of lymph node metastases (Dukes's C), though it is less again, a respectable 38%. In addition, the operation, by eliminating the fungating or ulcerating eccentric fixed rectal bolus of tumour, abolishes the distressing problem of rectal discharge, bleeding, and tenesmus. As an aside, it should be recorded that this cannot be achieved with proximal colostomy alone: one of my many abiding bad memories is of McNeil Dixon, Glasgow's illuminatory professor of moral philosophy, being subjected to this procedure and thereafter quietly and calmly committing suicide.

The price of abdominoperineal resection is a permanent left iliac colostomy, an appreciable incidence of problems of emptying the urinary bladder, and, in men, a 30-50% incidence of sexual dysfunction up to and including impotence.^{4,5} Scarce wonder that Devlin and his colleagues⁶—whose contribution to the subject has been both original and heterodox—found many individuals severely isolated, depressed, and needing to use a variety of "deviant" mechanisms to hide or contain their problem. An example of embarrassment would well be the patient who said, "How would you like to be standing talking to an attractive woman at a cocktail party conscious of the fact that your bowels are emptying—perhaps audibly—into a point just above the level of your left hand trouser pocket."

COLOSTOMY MANAGEMENT

Colostomy management has advanced tremendously since 30 years ago, when, as a resident, I was advising my patients to cover the stoma with sheets from the *Scotsman* or *Edinburgh Evening News* and hope for the best. In spite of what I may say later about organisations in relation to 'ostomy care, pressure by concerned patients and a few thinking surgeons has produced well-sealed and thus relatively odour-proof appliances which remove the stigma of smell if not of noise. The American alternative of irrigation, though possibly marginally more time-consuming, can keep the large bowel empty and permit the patient to be virtually without appliance or embarrassment. Clearly, however, many feel totally insecure with a colostomy, even though to us it appears quite satisfactory.

The alternatives to abdominoperineal excision and left iliac colostomy are four: panproctocolectomy and ileostomy; local surgical resection with reconstruction^{7,8}; the analogous if not identical procedure of in situ destruction by diathermy or cryosurgery; and some type of reconstructive procedure after conventional radical excision. The first I will return to later. The second and third have the chief potential advantage of much less pelvic dissection and therefore, perhaps (and it is a big perhaps), less disturbance of bladder and sexual function. They have certainly not been subject to the same degree of critical

Academic Surgical Unit, St Mary's Hospital, London W2

H A F DUDLEY, FRCS, director