

## PAPER

# The gap between voluntary admission and detention in mental health units

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## ABSTRACT

This paper presents the case of a young man with a diagnosis of schizophrenia, who agreed to inpatient treatment primarily to avoid being formally detained. I draw on Peter Breggin's early critique of coercion of informal patients to supply an updated discussion of the ethical issues raised. Central questions are whether the admission was coercive, and if so, whether unethical. Whether or not involuntary admission would be justified, moral discomfort surrounds its appearance as a threat. This arises in part from ambivalence about autonomy: although a 'choice' is made, the threat of detention impinges on the patient's choice. Recent legal developments provide some experience of safeguarding those whose consent is not obtained. This highlights the lack of safeguards in this 'gap' and suggests that we have the tools with which to begin to deal with the problem.

## INTRODUCTION

The paper begins by introducing J, a young man who, after deterioration in his mental health, acquiesces to continued admission to a mental health unit primarily because he believes he will otherwise be formally detained. He thereby falls into an ethical and legal gap, wherein his presence on the ward is 'voluntary', yet it is not clear that he is free to leave.

The discussion considers ethical concerns about the way that J's agreement was obtained. The root of these concerns is not obvious: in daily life and in healthcare, consent is routinely accepted despite newly restricted options and avoidance of unwanted consequences. Yet we may still feel a distinct moral discomfort about J's case, which reflection on the concept of coercion may usefully illuminate.

I argue that the source of moral discomfort in J's case is ambivalence about autonomy: J makes a choice, of sorts, but coercion impinges on his choice, calling the validity of his consent into question. In effect, J falls into a gap between genuine consent and legal safeguards. Analogous recent developments in safeguards for those deemed unable to consent to admission may usefully illuminate possible ways forward.

The vignette is for illustration and does not refer to a specific individual; however, it reflects a common clinical scenario.

## J'S ADMISSION

J is a 32-year-old man with a diagnosis of schizophrenia. His family brought him to hospital concerned that he was neglecting himself, behaving

uncharacteristically and expressing vague paranoid thoughts. The family were particularly concerned because these features preceded two severe breakdowns in recent years with distressing psychotic symptoms leading to suicide attempts. After assessment in the emergency department, J agreed to admission to the mental health ward.

J disliked the ward environment and engaged little with social and therapeutic activities. He asked few questions other than when he could go home. His concerns were explored and it was explained that further assessment was necessary. J objected that he was admitted voluntarily and was advised that he could, nevertheless, be detained if he tried to leave against advice. No overt psychotic symptoms were seen but he was noted to be quiet and suspicious. In view of his history, a short inpatient assessment period was planned with initiation of medication before a trial of supported leave.

J began to fear he would be stuck in hospital for weeks. From the ward garden a few days later, he left the grounds and boarded a bus to a friend's home, arriving in an agitated state. Seeing that J was not his usual calm, rational self, his friend called the ward for advice. He was asked to bring J back to the hospital for assessment.

On return, J was calm but suspicious. He spoke little during the assessment but expressed his desire to go home and great anxiety that he had sabotaged this prospect and would be 'sectioned'. There were no other significant changes in his mental state and concern about his recent deterioration led to recommendation of continued admission. J was informed that he could remain informally. J asked what would happen if he did not agree and was told that formal detention would be considered. He said that he would stay informally.

## DISCUSSION

The case illustrates a familiar scenario: an individual acquiescing to admission to a mental health unit primarily to avoid formal detention. J thereby entered an ethically and legally uncertain space wherein his presence on the ward was 'voluntary', yet he was not free to leave. In the following, I call this the 'Breggin gap', after American psychiatrist Peter Breggin, who first drew attention to coercion of voluntary patients in 1964.<sup>1</sup>

A comparable ethically and legally uncertain area is found in the 'Bournewood gap', which describes those not resisting, but lacking capacity to consent to, admission. The Breggin gap, like the Bournewood gap, applies to individuals who do not

actively resist staying in hospital. There are important differences between these areas, which are summarised in table 1. Prolonged informal admission without consent in the Bournewood case was found unlawful by the European Court of Human Rights,<sup>2</sup> triggering development of the Deprivation of Liberty Safeguards, added to the Mental Capacity Act (2005) through the Mental Health Act (2007). Unlike the Breggin gap, the Bournewood gap stipulatively describes mental incapacity regarding consent. For example, the European Court ruling on the Bournewood case defined the patient's 'informal' status as applying to 'compliant mentally incapacitated mentally disordered' patients, as opposed to 'voluntary patients', who 'can in principle dissent'.<sup>2</sup> To avoid a question-begging definition of voluntariness, in what follows I use 'voluntary' and 'informal' interchangeably.

Those in the Breggin gap do not (necessarily) lack decision-making capacity. These individuals may, for example, have sufficient insight into their own predicament to give considered acquiescence to medical recommendations. They may agree on the diagnosis, yet prefer outpatient treatment. Empirical results suggest that insight is the strongest predictor of decision-making capacity in psychosis.<sup>3</sup> Although many mental health inpatients are thought to lack mental capacity regarding major treatment decisions,<sup>4</sup> systematic review of 37 studies of mental capacity showed that most studies suggested that most mental health inpatients retain capacity.<sup>5</sup> This may be more common in informal patients: in one comparison, 75% of informal patients were deemed to have capacity, compared with 17% of those who were detained.<sup>6</sup> Accordingly, although there is plenty of interest to say about the relationship between mental health problems and decision-making, we may reasonably suppose that many of the individuals in question would be considered to retain mental capacity about their admission.

Motivations for agreeing to an unwanted admission are multiple. Formal detention under a section of the Mental Health Act is more stigmatising than voluntary admission.<sup>7</sup> It may also be perceived by staff and patients as more restrictive. For example, in cases such as J's, informal admission may be perceived as more consistent with the 'least restriction principle' of mental health legislation.<sup>8</sup> For all of these reasons, practitioners may prefer to avoid formal detention when the individual agrees to admission. This may be reinforced by desire to compromise with a patient who for similar reasons is very keen to avoid being 'sectioned'.

Notwithstanding these considerations, from the perspective of individuals who, like J, wish to leave hospital, a Mental Health Act assessment might be the lesser evil. After all, the legal rights bestowed by the Mental Health Act (2007), include

an assessment by two senior doctors and a social worker, the right to a tribunal and the right to an independent advocate. Moreover, there is a probability that an insightful individual, who is not, relatively speaking, particularly unwell but rather at risk of deteriorating, might be deemed to not meet criteria for detention; in that case he would be released. Yet this is likely a wager only the most confident and legally savvy patient would place.

Hospital psychiatrists' daily work involves patients for whom discharge is not considered safe, many of whom are admitted informally. Indeed, drives towards community treatment mean that admission often is resorted to precisely because it is no longer practicable or safe to continue community-based management. In other words, many of those who are admitted 'voluntarily' in fact fall into the Breggin gap. This is not to say they would leave if they could—indeed a proportion will have actively sought and desire inpatient treatment—but rather that many could not leave if they wanted to.

### Was J coerced?

On one view, the case depicts the *prima facie* coercive scenario in which J's compliance with an unwanted situation is secured by presenting him with a feared alternative. Popular bioethical definitions of coercion generally involve something like the following: "A person is coerced when her choices are unfavourably narrowed by someone who is trying to get her to do something she would not otherwise do."<sup>9</sup> Following Nozick, we might add the condition that one actually complies with the demands made.<sup>10</sup>

Yet, unfavourably narrowed choices and decisions that would not otherwise have been made are unfortunately a feature of significant illness in general. A surgeon may truthfully inform a patient with cancer that she will probably not survive if she refuses surgery. Similarly, a mental health nurse may correctly perceive that a very disturbed patient would probably be detained if she tried to leave, and be motivated to impart this information to avert subsequent misunderstanding or, indeed, greater duress. Breggin described 'prophylactic coercion', motivated by desire to avoid transferring patients to a more restrictive environment.<sup>1</sup> Is there an ethical difference between the imparting of correct information in these instances?

Coercion is distinguishable from choices between undesirable options in that the consequences of not complying with coercion are imparted by or on behalf of those who would inflict them. This holds for prototypically coercive situations including being held at gunpoint, blackmail, and—for those inclined to perceive the law as coercive—legal sanctions. Thus a fellow-patient or advocate who warns another that he 'will be sectioned' does not coerce the patient: it is not she who would fulfil the threat. This may suggest that the nurse who warns a patient that a doctor might section her does not act coercively. However, in a multidisciplinary team, it is not obvious that any professional can sufficiently distance herself to disown responsibility.

Thus, only those with greater power in respect of the relevant unwanted consequences can coerce, suggesting the involvement of complex power imbalances within psychiatry. Yet, the situation is more complicated than this. Clearly some individuals will not feel threatened, but rather reassured, by seeing the healthcare team take responsibility for their safety. Noting the diversity of individual's responses to possibly coercive situations, Breggin himself emphasised patients' experiences in determining whether or not coercion took place: "Coercion may be considered the experience of an unusually constraining or intimidating

**Table 1** Comparison of features of the Breggin gap and the Bournewood gap

	Bournewood gap	Breggin gap
Location of patient	Medical or surgical ward, mental health unit or residential care	Mental health unit
Mental capacity	Lacks mental capacity to refuse admission	May retain mental capacity to refuse admission
Patient's wishes	Not always clear; may or may not wish to remain in hospital/care	Wishes to leave
Actively resisting admission?	No	No
Legal protection	Deprivation of liberty safeguards	No formal protection

alternative, so that the individual feels his freedom of choice is pre-empted.<sup>71</sup> The same situation, then, may be coercive or not depending on subtle effects on the individual.

### Was J's continued admission unethical?

For those who understand coercion as necessarily involving the threatened violation of a person's rights, coercion is intrinsically immoral. For example, in Ryan's analysis it is implausible to talk of coercion unless there is a moral objection to the act.<sup>11</sup> In his example:

You are walking along Columbus Avenue when two young thugs grab the camera case you are carrying. You quickly pull out the pistol you carry with you, and threaten to shoot them if they do not give it back. They give it back, and run. [If coercion can occur without moral violation], you have coerced them into not robbing you (and coerced them into fleeing).<sup>11</sup>

From Breggin's strongly libertarian perspective, self-defence is the only justification for an otherwise coercive act. However, this perspective is arguably not consistent with detention at all (Breggin, 2011, personal communication). To focus on the problem of threats per se, for the present purpose I wish to leave open the moral questions surrounding detention. Nevertheless, if Ryan's normative analysis is correct, perhaps threatened detention is coercive (therefore morally wrong) only when detention would be wrong.

However, understanding coercion as intrinsically immoral creates a circularity that prevents the concept from doing any work: it fails to account for problems with threats over and above their fulfilment, or to allow for moral disagreement in this respect. A more useful account of Ryan's example allows ambivalence: Zimmerman, for example, argues that while the assailant *was* coerced, the victim was morally justified.<sup>12</sup>

Even if coercion is not always wrong, insofar as autonomy is valued in healthcare, coercion may be considered deeply problematic just because it restricts individuals' autonomy over their own treatment. There are several levels at which this may be cashed out.

While a central principle of medical ethics,<sup>13</sup> 'autonomy' has been criticised for its vague usage.<sup>14</sup> Feinberg described four meanings of 'autonomy' in political philosophical usage as 'self-government': a condition (*de facto* self-government), a capacity (the ability to self-govern), an ideal and a right.<sup>15</sup> Although the proper analysis of the concept cannot be settled here, Feinberg's categories may clarify various concerns about the effect of coercion on autonomy.

Considered as an ideal to be promoted and a right to be upheld, autonomy is restricted in the Breggin gap through restriction of the individual's options. When J came to believe that he would be detained his options, as he understood them, were restricted from staying or leaving, to staying informally or being formally detained. Individuals in the Breggin gap thereby lose (or perceive as lost) their right to decide about their admission. Again, at this level the Breggin gap appears morally problematic only if the practitioner does not have the right to detain the patient. After all, our options are restricted by others all of the time—through what they permit us to do to them or to their property, legal restrictions and physical structures. Much of the time, such restrictions are justified by the rights of others or by consent, and are therefore not violations.

Who has the right to detain patients in hospital? Detention is legally sanctioned only after appropriate assessments. This suggests that the most practitioners should impart is that they will request assessment. However, at this superficial level no

distinction is made between J's autonomy when threatened with detention and when legally detained: in both cases he is simply not free to leave. This again fails to answer the intuition that there is more to J's situation than simply detention.

Considered in terms of legal rights, the Breggin gap is a just that, a gap in the legal protection of those in mental health wards. Lord Steyn's comments on the Bournemouth gap may be found analogous:

[P]rofessionals [...] will almost invariably act in what they consider to be the best interests of the patient. But neither habeas corpus nor judicial review are sufficient safeguards against misjudgements and professional lapses in the case of compliant incapacitated patients. Given that such patients are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of [the 1983 Act] from a large class of vulnerable mentally incapacitated individuals. Their moral right to be treated with dignity requires nothing less.<sup>3</sup>

At a socio-political level both the capacity for autonomy and *de facto* autonomy may be considered undermined by the exercise of power over the individual. From this perspective, coercion affects the perceived options available, and also the actual choice made. J, for example, wanted to leave hospital, but his fear of detention led him to choose to remain. This reveals the paradox of coercion: the subject of coercion *chooses* the option which has in fact been chosen by others.

The extent to which this is problematic depends on how we understand *de facto* autonomy. We might think of it as making our own choices, and also involvement in the conditions in which we choose. In particular, we often want to be involved in discussions determining restrictions on our lives. The idea of consent rests on these notions, insofar as it requires that we understand our options, and do not feel oppressed through exclusion from the processes determining our options.

A great deal of discussion in political philosophy has been concerned with understanding how these issues impinge on the validity of social contracts. For Hobbes, because "the Validity of Covenants begins not but with the Constitution of a Civil Power, sufficient to compel men to keep them", coercion was a necessary part of a social contract.<sup>16</sup> Many since Hobbes, anarchists aside, who agree that social contracts may be valid, require that they are enforceable. As noted, not all follow Hobbes in considering their just enforcement to be coercive.

Is mental health law a valid social contract? It seems insensitive to justify the Breggin gap by claiming that those it affects were somehow part of the process of forming the legislation, particularly if we consider these laws to have developed regarding a historically disenfranchised group. Moreover, because a *gap* in the law is in question, it is very unclear how this sort of justification would follow. Nonetheless, informal admission—in accordance with the absence of legislation—proceeds as if consent were obtained. Notwithstanding enforcement of valid social contracts, most coercive practices would undermine important features of consent, notably, as Elliott puts it, the idea that "a decision is made for which (the decision-maker) can truly be held accountable."<sup>17</sup> In the Breggin gap, although a 'choice', of sorts, is made, there is reason to think that the choice was not free. This is consistent with a broadly intuitive account of coercive choices in general. For example, choices made under threat are not usually considered 'free'; contracts signed under duress are invalid, and being coerced into committing a crime, in general, diminishes one's blameworthiness.

The corresponding features of decisions in which the decision-maker is autonomous and accountable appear absent in the

Breggin gap. The loss of responsibility for the decision—which, after all, is someone else's decision—disempowers the decision-maker, while maintaining the appearance of 'choice'. It is this, I think, that is most discomforting about the Breggin gap: the exercise of power over the individual in the absence of both the legal safeguards that should obtain if admission is decided by others, and the absence of genuine consent if it is the patient's decision.

### Can the Breggin gap be closed?

It may be objected that the professionals in J's case were simply doing bad psychiatry, and should not have allowed J to be coerced into staying but instead should have either formalised his detention or discharged him. Even if not unfair to efforts to provide appropriate care in an obviously grey area, this fails to acknowledge the regularity with which this scenario occurs—arguably the most reliable sign of a systemic, as opposed to individual, problem. As noted, coercion fundamentally depends on an imbalance of power. In psychiatry, this is manifest, as elsewhere in medicine, through expertise and control of resources. But uniquely in psychiatry, power to enforce treatment adds a further dimension.

Coercion of some informal patients appears an inevitable consequence of the possibility of involuntary treatment, however good the therapeutic intentions. The wishes of patients who acquiesce to staying in hospital because they perceive no choice may remain unheard. Where detention is possible, after all, being or feeling threatened with detention is possible; equally insidious 'warnings' about the probability and circumstances of detention are unlikely to be fully avoidable under the present system. Locked doors or 'managed exits' in some units, the presence of others who are formally detained, 'observations' confirming patients' whereabouts or restricting time outdoors, and the terminology of 'abscension' as opposed to self-discharge all contribute to an atmosphere in which, as Breggin wrote, "the threat is so pervasive that it hardly needs to be mentioned by the therapist."<sup>1</sup>

A great deal has of course changed since Breggin's early analysis, and psychiatry proceeds amid a wider range of treatments and more legislation and safeguards than ever. Mental capacity legislation and 'Deprivation of Liberty Safeguards' provided new experience of legal protection offered to those deemed unable to object. Some UK mental health services now produce guidelines and patient information addressing informal patients. One leaflet states:

You have the right to insist on leaving hospital. You will then be allowed to leave unless there is a good reason to keep you here under the Mental Health Act (1983). If these powers are implemented there are systems as part of the act which are used to protect you and your rights.<sup>18</sup>

Unfortunately, in many ways this sort of information simply makes explicit the original predicament: you will be 'allowed' to exercise your rights, 'unless...'. Specifically addressing the issue of locked wards, Cleary *et al* endorse recommendations for notices on doors stating that 'informal patients could request to leave the ward at any time'.<sup>19</sup> Again, stating that patients 'could request to leave' is not the same as stating that they *can leave*, and as the authors note, "Coercion can inadvertently occur through the stalling of voluntary patients' efforts to leave the ward or the mistaken belief that voluntary patients are not permitted to leave."<sup>19</sup> Nevertheless, transparency about the legal situation appears imperative in striving against abuses.

Further empirical work may shed greater light on the complex relationship between perceived coercion and legal status. For

example, one Norwegian study found that many patients were not aware of their legal status, but revealed a continuum of perceived coercion through voluntary, 'persuaded' and involuntary admissions which unsurprisingly correlated with greater perceived restrictions and lower patient satisfaction.<sup>20</sup> Clearer information for patients would also seem likely to improve the possibility of involvement in decision-making.

As demonstrated by implementation of the Deprivation of Liberty Safeguards in response to the Bournemouth case, the legal protection offered to detained patients is conceptually and practically separable from detention. This suggests that patients who are not formally detained could have equal access to legal safeguards, such as access to an independent opinion or advocate, transparent specification of restrictions on their liberty and facilitation of appeals. Ultimately, only efforts to level the playing field through practitioners' awareness of their power, transparency in its exercise and vigilance against misuse appear likely to protect against coercion of the individuals psychiatry seeks to protect.

### CONCLUSION

J's agreement was obtained through his desire to avoid a feared alternative, suggesting a coercive scenario. This failed to respect his autonomy in several ways: effects on his perceived options, his decision-making, his responsibility for the decision made, and his rights. In undermining J's autonomy, these effects undermined the validity of his consent. Where consent is questionable, as seen elsewhere in medical law, we are entitled to expect safeguards. I argued that J's admission occurred in an ethically and legally grey area between genuine consent and legal protection. This 'Breggin gap', I argue, is analogous to the 'Bournemouth gap'. Legislation addressing the latter protects patients whose admissions, while not actively resisted, do not satisfy a conception of consent. Legislation cannot, of course, fully encompass the complex human aspects and inequalities in power inextricable from this area. Nevertheless, these developments suggest that consideration may be applied to more rigorous protection of the moral rights of those admitted informally to mental health units.

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### REFERENCES

1. **Breggin PR.** Coercion of voluntary patients in an open hospital. *Arch Gen Psychiatry* 1964;**10**:173–81.
2. *HL v the United Kingdom.* 45508/99 ECHR 850. 2002.
3. **Owen GS,** David AS, Richardson G, *et al.* Mental capacity, diagnosis and insight in psychiatric in-patients: a cross-sectional study. *Psychol Med* 2009;**39**:1389–98.
4. **Owen GS,** Richardson G, David AS, *et al.* Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. *BMJ* 2008;**337**:a448.
5. **Okai D,** Owen G, McGuire H, *et al.* Mental capacity in psychiatric patients: systematic review. *Br J Psychiatry* 2007;**191**:291–7.
6. **Cairns R,** Maddock C, Buchanan A, *et al.* Prevalence and predictors of mental incapacity in psychiatric in-patients. *Br J Psychiatry* 2005;**187**:379–85.
7. **Thornicroft G,** Brohan E, Rose D, *et al.* Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *Lancet* 2009;**373**:408–15.

8. **Department of Health.** *Code of Practice: Mental Health Act 1983.* UK: The Stationary Office, 2008.
9. **Hawkins JS,** Emanuel EJ. Clarifying confusions about coercion. *Hastings Cent Rep* 2005;**35**:16–19.
10. **Nozick R.** Coercion. In: Morgenbesser S, Suppes P, White M, eds. *Philosophy, Science, Method: Essays in Honor of Ernest Nagel.* New York: St. Martin's Press, 1969:440–72.
11. **Ryan CC.** The normative concept of coercion. *Mind* 1980;**356**:481–98.
12. **Zimmerman D.** Taking Liberties: the Perils of 'Moralizing' freedom and coercion in social Theory and practice. *Soc Theory Pract* 2002;**28**:577–609.
13. **Beauchamp TL,** Childress JF. *Principles of Biomedical Ethics.* Oxford: OUP, 1989.
14. **Walker RL.** Medical ethics needs a new view of autonomy. *J Med Philos* 2008;**33**:594–608.
15. **Feinberg J.** *Harm to Self: The Moral Limits of the Criminal Law.* Oxford: OUP, 1989:385.
16. **Hobbes T.** *Leviathan.* 1651. <http://www.gutenberg.org/files/3207/3207-h/3207-h.htm> (accessed 30 Jun 2011).
17. **Elliott K.** *Bioethics, Culture and Identity: a Philosophical Disease.* London: Routledge, 1999:94.
18. **Berkshire healthcare NHS Foundation Trust.** *Informal Patients' Rights, Version 3.* 2011. [http://www.berkshirehealthcare.nhs.uk/\\_store/documents/ccr083rinformalpatientsrightsversion3.pdf](http://www.berkshirehealthcare.nhs.uk/_store/documents/ccr083rinformalpatientsrightsversion3.pdf) (accessed 11 Aug 2011).
19. **Cleary M,** Hunt GE, Walter G, *et al.* Locked inpatient units in modern mental health care: values and practice issues. *J Med Ethics* 2009;**35**:644–6.
20. **Sørgaard KW.** Satisfaction and coercion among voluntary, persuaded/pressured and committed patients in acute psychiatric treatment. *Scand J Caring Sci* 2007;**21**:214–19.

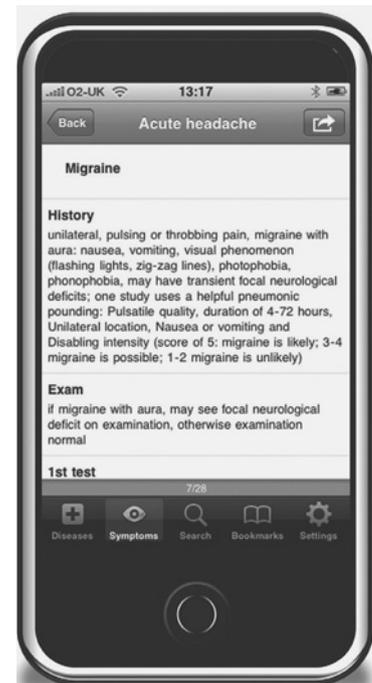
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