mechanisms underlying tardive dyskinesia(s) will, we hope, be better understood.

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COMPULSORY ADMISSION

DEAR SIR,

I certainly agree with Dr Srinivasan and his colleagues (*Journal*, February 1980, **136**, 200–201) that factual evidence about the multiple effects of compulsory hospital admission is badly needed. However, I doubt that this will be provided by the study they outline in their letter.

I am concerned that the views of 20 out of a sample of 50 patients are brushed aside with the judgement that *some* of them were unable to show enough 'critical judgement and insight'—what exactly was required?

Then there is the host of questions raised by patients 'admitting they were ill' (was this sufficient to justify compulsory admission?) or feeling that the hospital stay was 'helpful'. There is a marked tendency on the part of hospital staff to inculcate both these platitudes upon patients and relatives during the traumatic period surrounding such an admission. It is, indeed, an independently-minded patient who does not answer in appropriate fashion similar questions asked by any hospital authority. The five patients who did answer negatively, not surprisingly, blamed circumstantial features such as ward conditions.

The next-of-kin is the person required to sign the section form: simple theories of cognitive dissonance predict they will agree that the patient was 'ill' and that the hospital stay was 'helpful'.

Leaving aside, then, the strange calculation of percentages, this study needs much improvement before it is extended to other hospitals. Patients still resident in the hospital are likely to include representatives of the least conforming subsample, and it should be possible to obtain the views of some of this group. What is meant by a 'helpful' admission: perhaps the same help could be given in another way? The views of other relatives, social workers and persons concerned around the time of admission, are important.

Without such modifications, publication of the study may encourage unjustified complacency. Let us not increase government inertia on mental health matters!

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EMERGENCY MANAGEMENT OF THE STARVING PSYCHIATRIC PATIENT

DEAR SIR,

We wish to report how the use of a naso-gastric tube relatively easily saved a depressive patient who was determinedly starving herself to death. She was aged 55 with a particularly intractable depressive illness, severely agitated and deluded that she 'had no stomach and therefore could not eat'. Her brother had died of starvation in this institution two years before. When our patient had drunk only two cups of tea in 24 hours we feared for her life and decided to use a naso-gastric tube.

The technique was as follows: A Ch. 8 gauge naso-enteral tube was employed. For convenience and for the comfort of the patient, the tube was inserted while the patient was still unconscious following ECT. It was found that the supplied introducer was not needed, and the narrow-bore tube was easily guided into the oesophagus with a pair of Magill endotracheal forceps, under direct vision with a laryngoscope. The position of the distal end of the tube was checked, firstly by blowing air down it and auscultating over