REFRESHER COURSE FOR GENERAL PRACTITIONERS

THE PSYCHIATRIC CASE AND THE LAW—I. GENERAL PRINCIPLES

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Although quite a large proportion of the patients seen by a general practitioner are suffering from psychiatric disorder of one kind or another, the occasions on which he is expected to comply with statutory conditions in order to secure their proper treatment are relatively rare. He is expected by his patients and their relatives, however, to know the law when he is called upon in times of domestic crisis, and the law itself regards him, as a duly qualified medical practitioner, as having some expert knowledge in matters of soundness of mind, responsibility, and psychiatric treatment. To learn intimately the scattered and much-amended structure of the law relating to the consequences of mental disorder is a major task, and it is not to be wondered at that many medical men prefer to avoid any involvement with it. In particular there is often hesitation to sign any kind of document lest it later become the subject of legal action.

If, in fact, he understands the spirit and purpose of the law, knows where and when to seek assistance, and acts in good faith, the practitioner has little to fear. The worst that can happen is that his time will be wasted by the occasional patient who feels he has a grievance, and by the long explanations demanded by relatives whose desire to see the patient treated is tempered by the conviction that his certification is a reflection on the family's mental stability.

The object of this article is to explain the spirit of the law and the ways in which it normally works, and to indicate where the letter of the law may be consulted should the need arise and how to make contact with the appropriate officials. Reference is also made to the conditions in which it is necessary or advisable from the legal point of view to call in a consultant. Part II will deal with the admission of psychiatric cases to hospital.

Some General Principles

1. The statutes which deal with *unsoundness of mind* are not directly concerned with medical diagnosis. They were created for the protection of the individual who is unable through no fault of his own to understand the obligations or to conform to the standards of behaviour normally required of a citizen. They are also concerned with the protection of society from the effects of this kind of disability. The decision whether or not a person is of unsound mind is therefore a social rather than a medical one, and medical terminology has no place in the procedures involved. In fact, when a patient is certified under the Lunacy Act of 1890 the final decision on whether he should be under care rests with a layman—namely, the judicial authority who signs the reception order—although he is usually content to be advised by the certificates of the medical men who have examined the patient. So desirable is it that one of these certificates should be signed by the general practitioner, who has usually had special opportunities of assessing his patient's attitude to the affairs of daily life, that if he is not able to do so the reason must be stated.

2. When questions of *prognosis and treatment* arise the issues are by contrast entirely medical. Although anyone whose name is on the *Medical Register* is regarded as having

special knowledge of mental disorders for the purpose of certification under the Lunacy Acts or for giving evidence in the courts, the more recent Acts lay down that for some types of certification the medical man's name must be on an approved list, and to this extent they recognize the need for a specialist opinion. Such approval is required for the following purposes and is given separately by the authority concerned: (a) For giving one of the certificates necessary for temporary treatment (Mental Treatment Act, 1930, Section 5—Approval by the Ministry of Health). (b) For approving the acceptance of a person under 16 as a voluntary patient in the absence of the usual medical attendant (Mental Treatment Act, Section 1—Approval by the Ministry of Health or by the Local Authority). (c) For giving one of the two certificates required in the case of mental defectives (Mental Deficiency Acts, 1913–27—Approval by Ministry of Health or by Local Authority). (d) For certifying that a child of school age is educationally retarded (Education Act, 1944—Approval by Local Authority). The statutes thus very reasonably call for the intervention of a specialist in the case of the acutely ill but recoverable patient and for the assessment of mental abnormality in children.

3. From time to time patients who have been detained in mental hospitals on reception orders based on medical certificates try to bring actions for damages against the doctors who have signed the certificates. It has been decided in two important cases (*Everett v. Griffiths*, 1921, and *Harnett v. Bond*, 1924) that it is the certificate which is the cause of the patient's detention, and that the doctor may be liable if it can be shown that he has not acted in good faith and exercised reasonable care. In the Mental Treatment Act of 1930 (Section 16), however, the danger to the practitioner even from unsuccessful actions of this kind is recognized, and it is laid down that no proceedings may be brought against him without leave of a High Court judge. The application for leave may be opposed by the doctor, or by a defence organization on his behalf, and it can be granted only if there is substantial ground for the contention that the practitioner has acted in bad faith or without reasonable care. Where the doctor signs the certificate as part of his work for the National Health Service or for a local authority, the Limitation Act of 1939 (Section 21) lays it down that such actions must be brought within one year, thus removing to some extent the possibility of sudden legal action by a patient who has nursed a grievance for a long time.

In practice, all the practitioner needs to know is printed on the certificates themselves, or in the marginal notes added by the legal stationers who publish them, and if he follows these instructions, does not exceed his duty, and treats the occasion with the seriousness it deserves, he can hardly go wrong. He is not liable if facts are misrepresented to him by others in whose word he might reasonably be expected to have faith.

4. On general grounds it is most unwise for a doctor to take any part in the certification of a patient if the consequent suspension of the patient's rights might possibly be construed as benefiting himself. For this reason the Lunacy Act of 1890 (Section 32) prohibits the giving of certificates by such persons as the medical staff of the hospital to which the patient is being admitted, members of the management committee, or any person interested in money paid on account of the patient. Where two certificates are required,

the doctor signing the second must not be a partner, assistant, or relative of the practitioner signing the first. Further, except in the case of temporary patients, the examinations must be entirely separate. These precautions are necessary when it is considered that even in these enlightened days many relatives of patients are difficult to convince that the doctors are not gaining some advantage by depriving the patient of his liberty. Before the passing of the Lunacy Act of 1846, which followed the efforts of Lord Salisbury, the suspicions of the public were not always without foundation.

5. The aim of legislation in the past 50 years has been gradually to bring the treatment of psychiatric disorders into line with that of other forms of illness and to combat the prejudices which in the past led to early disease being concealed because it was felt that once a patient had entered a "lunatic asylum" all was lost. Successive Acts have brought changes in terminology which mean more to patients and relatives than might appear. In explaining legal formalities to relatives it is most important to use such words as "patient" and "hospital" where possible and never for a moment to be tempted to use colloquialisms or the terminology of the earlier Acts. At the same time it is essential that all concerned should, if possible, understand what is being done and have no ground for subsequent complaint that they had not been told.

Preparation of Certificates

Although medical certificate forms with their marginal notes and instructions leave little to the imagination, a considerable proportion of those scrutinized by H.M. Commissioners have to be returned for minor alterations or because they do not contain satisfactory evidence of unsoundness of mind from the legal point of view. In order to avoid this the practitioner has only to give close attention to detail and keep constantly in mind the purpose of certification. The circumstances in which certificates sometimes have to be prepared make this extremely difficult, and it may be necessary to insist on enough privacy to escape a barrage of distracting advice, questions, and superfluous information, quite apart from any emotional displays provided by the patient or his relatives. At least one responsible relative should be asked to give an independent account of the illness, preferably by coming to the surgery, and if the patient himself is able to give a coherent account he should be seen alone. Notes should be taken at these interviews and should include in the case of the patient some verbatim material. The certificate, which must be as brief as possible, can be based on these notes, which should always be kept with a copy of the certificate.

In the course of his inquiries the practitioner must first of all satisfy himself that it is right for the patient to lose his liberty in the interest either of himself or of the public. Having done this he must then find from the history given by the relatives and from his own examination the evidence which, when seen in writing, will convince even the most sceptical person, medical or lay, that the patient is of unsound mind.

The patient must always be examined specially for the purpose and should be afforded the opportunity of giving a "free" history before leading questions are asked. It is important to ascertain whether he is normally oriented in place and time, and whether he mistakes identities or remembers events which have not taken place. The possibility of hallucinations and of suicidal tendencies must always be explored, for they are often missed if specific inquiry is not made. These inquiries should be left to the end of the examination, though if tactfully made they give rise to protest far more rarely than is generally thought.

The section of the certificate for "facts observed by myself at the time of the examination" should be completed solely on the basis of the clinical state observed and the information elicited or confirmed at the interview. The patient's demeanour and behaviour should be briefly

described if they are abnormal, as well as his expression, any irrelevance in his answers, or the fact that he is mute. Specific instances are much superior to general statements. "He states that he is the Lord Harry" is much more convincing than "He speaks as if he were a person of great importance." Similarly, "He believes that his bowels are stopped up" is much better than "He is preoccupied with gloomy hypochondriacal ideas." Verbatim material may be given on the certificate. Much patience is often needed to elicit the fact that the patient suffers from delusions, is hallucinated, or contemplates suicide, but such features are convincing evidence if obtained.

In the section devoted to "facts communicated by others" the name and description of each informant must be given followed by the essential part of their story—for example, "P.C. Alfred Parkins, Whinshire County Constabulary, states that this morning he prevented the patient from throwing himself into the canal and that the patient said, 'The Treens are controlling my body with magnetic rays.'" Particular difficulty may be encountered with patients who have delusions of persecution but who are well aware of the significance of the examination and attempt to conceal their beliefs, and with epileptics who are subject to attacks of violent behaviour but are no more than sullen in the intervals. Here the strength of the certificate may have to lie in the facts communicated by others. Attempts at suicide, violence, self-neglect, or shameless behaviour described by credible witnesses must be carefully set out in this section.

When the certificate is complete and the documents are being assembled it is wise to allow a colleague or an experienced duly authorized officer (D.A.O.) to look through it for minor errors of detail.

Fees for Certification

When a general practitioner is asked to examine and certify a patient he is entitled to reasonable remuneration (National Health Service Amendment Act, 1949) from the local authority unless it is considered to be part of the general medical services he renders to his patients under the National Health Service Act. Some areas pay a fee on the ground that there is no reference to certification in the practitioner's contract and that it cannot be regarded as a normal service. This matter is still the subject of negotiation. In the case of a private patient the basic fee charged by the practitioner is usually two guineas.

The Duly Authorized Officer

The D.A.O. is an official of the local authority under the direction of the medical officer of health. These officials were first described in the Mental Deficiency Act, 1913; and the Mental Treatment Act, 1930, widened their powers to enable them to deal with persons of unsound mind. The D.A.O. is appointed by the local health authority to carry out in a prescribed area certain duties in connexion with the finding and admission to hospital of psychotic patients and mental defectives. Most of these duties were formerly carried out by relieving officers under the Lunacy Act, and the dissociation of mental health duties from the Poor Law atmosphere has been a welcome change. In cities, and in areas where the density of the population is sufficient to warrant it, the D.A.O. may devote the whole of his time to this work and he becomes, in effect, a lay mental health officer who often develops by experience a considerable knowledge of the practical and legal aspects of the subject. In areas where a full-time officer has not been appointed other officials are authorized to act when necessary. Courses are now being organized for the training of D.A.O.s who may also undertake mental aftercare work for the local authority as well as the supervision of mental defectives. It is probable that before long there will be throughout the country much greater uniformity in their duties and in the standard of training and experience acceptable in applicants for these posts. The telephone number of the D.A.O. and

of his deputy should be kept to hand. They will usually be found in the telephone directory under the name of the local authority health department. In cities there is often a rota of D.A.O.s on duty, and particulars of this can be obtained from the office of the medical officer of health.

It is important to remember that the practitioner, in notifying the D.A.O. of the existence of a person of unsound mind, must leave the action to be taken to the discretion of that official, with whom the final responsibility rests. A position quite often arises, as it did before 1948 with relieving officers, in which the doctor may feel that he should tell the lay official what to do about the case. The D.A.O. on the other hand may compensate for any sense of inferiority he feels by making it quite clear that the statutes lay it down that any action is entirely at his discretion, as in fact it is. He will often know more about the legal possibilities than the doctor and may have seen many more acute psychiatric cases. Both have much to gain from mutual co-operation in the interests of the patient, and the practitioner will do well to discuss the matter with his lay colleague and to ask his advice about the statutory procedure to be adopted. The D.A.O. on the other hand will usually prefer to have his decisions backed by a medical opinion. A good understanding with the D.A.O. will, in fact, greatly simplify the practitioner's task in dealing with acute mental cases in his area, and, moreover, the D.A.O. is usually a most useful source of information both on the statutes relating to his work and on the different social agencies which can help with psychiatric problems.

[Part II will be published in our next issue.]

MISSION TO LATIN AMERICA

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Political and economic circumstances have been largely responsible for the lack of contact between the medical profession in Great Britain and in the countries of South and Central America. The war years and the restrictions on travel maintained this isolation, and it has only been in the last few years that an organized visit or tour could be regarded as practicable. There were indications from various quarters that a mission would be welcome, and that a friendly reception would be given to a small group of doctors from Britain who would be able to spend six or eight weeks visiting selected medical centres in Latin America. Four medical men were therefore chosen to form a mission, which was sponsored by the British Medical Association, and travelled with the administrative help of the Foreign Office.

Aims and Composition of the Mission

The aim of the mission was to establish professional and cultural relations in Latin America, and to open channels for a freer exchange of medical information and experience. In many of these countries geographical and economic factors have limited postgraduate training for young doctors to visits to their North American neighbours, whereas before the war their seniors had been able to come to Europe. It was felt that a mission might stimulate the desire to visit

the educational centres of Europe; and that those interested in special aspects of medicine might travel more freely between the two continents. These aims were endorsed by a number of the more senior medical men in the countries visited. Time and financial resources unfortunately restricted the final programme, so that it proved impossible to visit several countries which had expressed a wish to receive the mission.

The team of four consisted of two physicians, a surgeon, and an anaesthetist. Each member submitted in advance a list and summary of lectures and demonstrations in his own speciality which he thought to be representative of the work in Britain, and in each country which was visited a reception committee, consisting of senior members of the universities, faculties, academies, and colleges, was set up and this body selected and prepared a programme. At most places each member gave three or four lectures, and in addition a number of operations were performed. Some 40 to 100 doctors and students were usually present at these lectures, but many more people attended the addresses of a less technical character and of a more general interest. As is usual, the informal addresses and demonstrations that followed lectures were keenly discussed and debated. The hospitality accorded to the mission was as complete as the programmes.

The Itinerary

The mission left England in October, 1951, and flew in great comfort by B.O.A.C. via Lisbon and Dakar to Brazil, where, in Rio de Janeiro, Professor Jorge Grey generously made the facilities of his surgical clinic available, and undertook much of the organization. Dr. Mario Almeida—an honorary member of the British Association of Anaesthetists—had developed an efficient service in a subject that had been previously rather neglected. The Director of the Oswaldo Cruz Institute, Dr. Henrique Aragao, showed the mission round his hospital and stressed the social importance of schistosomiasis. He also demonstrated patients from the forests of the north suffering from the acute and chronic forms of Chagas heart disease. This condition is one of the very common causes of enlargement of the heart in Brazil, although it is almost unknown in Europe. Dr. Pedro Nava, the president of the Rheumatic Association, showed that the local problems of rheumatism were similar to those in Britain.

In São Paulo, only one and a half hours distant by aeroplane, there was a most active university medical centre in a rapidly growing city. Operations and lectures were carried out at the Hospitals Clinicas and Santa Casa.

Port of Spain in Trinidad was reached by a non-stop flight, punctuated by many thunderstorms, from Rio across Central Brazil. Here the mission was welcomed at two in the morning by the members of the Island's B.M.A. While the surgeon, with the assistance of Mr. Joe Pierre, operated at the new Caura Sanatorium (Dr. Branday), the physicians were consulted on the various problems of social and general medicine that were peculiar to Trinidad. At San Fernando in the south of the island the members of the mission climbed the skeleton of the new Colonial Hospital (Mr. Shepherd) that is being built, and helped in the planning of a modern physical medicine department. At the oilfields there were well staffed and equipped hospitals where the clinical work was excellent, although Dr. Finlayson, the C.M.O. of Trinidad Leaseholds, and Dr. Ahin, of Shell, pointed out that they were only now beginning to tackle the problems of social and industrial rehabilitation.

Five days later the mission flew to the coastal airport of Caracas, the capital of Venezuela. Here the hospitals are both of old colonial and modern pattern, and the old city hospital, Vargas, was reminiscent of many hospitals in Paris and Spain. Professors Perez Carreño and Borja were in charge of large and efficient surgical clinics, and Dr. Alberto Paris, who had worked in England as a British Council scholar, kindly made arrangements for operations to be performed in his own hospital and other institutions. Centro Medico, a large private clinic, was a most lavishly equipped building in which many of the leading doctors had their consulting suites. There were some 60 rooms for private patients, who paid as many dollars for their keep as they would have done pounds in London. Dr. Tervel, another British Council scholar, was equally helpful to the physicians.

Maracaibo, the city of the Venezuelan oilfields, has sprung up in the last 25 years from a village to a large city of over a quarter of a million inhabitants, and is the centre of the University of Sullia. Professor Leonardi, in charge of the Surgi-