REFRESHER COURSE FOR GENERAL PRACTITIONERS

THE PSYCHIATRIC CASE AND THE LAW—II. ADMISSION TO HOSPITAL

BY

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When a patient with mental disorder is unfit for treatment at home or in a general hospital the action to be taken will depend on his attitude to the illness and how he responds to the suggestion that he should enter a mental hospital. He may realize the need for treatment and be prepared to co-operate fully, or he may have little insight into his condition and regard the suggestion as an attack on his personal liberty. He may, on the other hand, be so confused in mind that he is unable to realize his position or to express any volition at all in the matter.

Patients who can Express Volition and are also Co-operative (Mental Treatment Act, 1930, Section 1)

Over half the patients in mental hospitals in this country are *voluntary patients* under the Mental Treatment Act of 1930, and if the patient can be persuaded to seek treatment in this way the whole matter is greatly simplified. If he is over 16 years of age all that is necessary is that he should complete a form of application to be received as a voluntary patient at a hospital at which a vacancy exists. He is then able to leave the hospital provided that he gives at least 72 hours' notice in writing of his intention to do so. The medical superintendent of the hospital is under no obligation to accept the patient, and he or one of his staff will usually wish to see the case beforehand. Except in cases where the patient is likely to change his mind or where he has in fact no real insight into his condition and only agrees with the intention of discharging himself as soon as possible, the possibility of voluntary treatment should always be considered, as it avoids the element of compulsion in the relation between patient and doctor as well as the stigma which is associated with certification in the minds of relatives.

If the patient is under 16 the application is made by the parent or guardian and must be supported by a medical recommendation given either by the usual medical attendant or by a practitioner from a list specially approved for the purpose by the Ministry of Health or by the local authority.

Patients who can Express Volition but are Uncooperative

If the patient is able to state his wishes clearly but is unwilling to accept the view that he is in need of treatment his removal to a mental hospital without his consent may be necessary in the interests of his own safety and that of others.

Urgent Cases (Lunacy Act, 1890, Sections 11, 20, and 21)

If the matter is urgent and the patient must be removed at once lest he attempt suicide, exhaust himself, or harm others, it is usually advisable to arrange his admission to an *observation ward* or part of a hospital set aside for this purpose (Lunacy Act, Section 20; National Health Service Act, Ninth Schedule). The practitioner should telephone the duly authorized officer (see Part I in last week's issue of the *Journal*, page 754). If after seeing the patient the D.A.O. considers that his condition justifies removal to an observation ward he will make arrangements for admission on a "three-day order." If the patient is without relatives, or if it can be considered that he is not properly cared for,

he can be brought before a justice of the peace, who may sign an order which will allow him to remain in the observation ward for 14 days (Lunacy Act, 1890, Section 21, as amended by the National Health Service Act, 1946). Before doing this the D.A.O. will usually ask the practitioner for a note stating that in his opinion the patient is in need of observation to determine his soundness of mind, and is a danger to himself or to others (or some other appropriate formula). This note is not required by law, and the D.A.O. asks for it to "cover himself." There is little point in withholding it; if the practitioner has called on the D.A.O. he will have had good reason for doing so. The decision regarding admission, however, rests with this officer and not with the practitioner.

Once in the observation ward the patient will be seen by a specialist in psychological medicine, who will be able, if the patient does not recover within the initial period or a further period of 14 days permitted after he has been visited by a magistrate, to arrange for his admission to a mental hospital as a *voluntary*, *temporary*, or *certified* patient.

If facilities do not exist for the admission of urgent cases under Section 20 of the Act in this way or if it is desirable to admit the patient direct to a mental hospital, as is always the case with private patients, use is made of an *Urgency Order* (Lunacy Act, 1890, Section 11, as amended by the Mental Treatment Act, 1930, Section 17). The order must be signed by the patient's husband or wife or a near relative who has seen the patient within two days, or by the D.A.O. of the local health authority in whose area the patient is at the time. It must be supported by one medical certificate (see Part I) and by a statement of the reasons why the patient should be placed under care forthwith. The urgency order remains in force for seven days, by which time arrangements can be made, if necessary, for certification for a longer period. In practice the medical superintendent is asked in advance if he can take the case, and the medical certificate is signed by the practitioner or by a consultant if one has been called in. Forms incorporating the necessary certificates and statements on one folded sheet of paper can be obtained from a legal stationer or, usually, from the medical superintendent of the hospital. They will be carried by a consultant if one is called in. As the situation may be regarded as urgent in a large proportion of cases in which a practitioner is called upon to act, the urgency order is a convenient and frequently used method of arranging for the admission of private patients to hospital.

Cases of Gradual Onset

Most patients under certificate in public mental hospitals have either been certified at observation wards or admitted to the hospital as urgent cases and subsequently certified within the hospital, so that the practitioner has not been concerned in the final certification. When time permits, however, use is made of the *reception order on petition* (Lunacy Act, 1890, Sections 4-8). It is, in practice, used much more often in the case of private patients and when administration of the patient's property is later likely to necessitate the appointment of a receiver.

The *petition* is written on a statutory form and is made preferably by the next-of-kin of the patient. This is supported by a statement of particulars, also on a form, and

two medical certificates. The petition must be taken to a judicial authority—that is, a stipendiary magistrate or a justice of the peace specially appointed for the purpose—who must satisfy himself that the person named in the petition is of unsound mind and a proper person to be admitted to a mental hospital. If satisfied, he signs a reception order for the patient, addressed to the medical superintendent of the hospital. For patients who have been admitted to hospital under urgency orders and who are subsequently certified on petition the single certificate already given can serve as one of the two certificates required (see Part I).

Patients who Cannot Give Expression to their Wishes but have a Good Prognosis (Mental Treatment Act, 1930, Section 5)

The sections of the Mental Treatment Act dealing with *temporary treatment* were introduced with the object of avoid certification in the case of patients suffering from states of confusion in whom the outlook for early recovery is good and who are likely to agree to become voluntary patients as soon as they are able to express any wish at all. The use of this method of admission will therefore depend upon a skilled appraisal of the patient's clinical state and of the prognosis, and for this reason one of the two certificates necessary must be given by a specialist approved for the purpose.

When the confusion is merely an incident in a case of severe psychosis of long duration, temporary treatment is unsuitable, and this method of admission should be reserved for cases of confusion, delirium, or stupor, such as occur in the puerperium, in association with toxic illnesses, or after operations. The extent of its use varies in different areas, but where it is offered it is much preferred by the relatives and, retrospectively, by the patients themselves. It is not available in Scotland. The principle is an excellent one, although it places rather more responsibility on the staff of the mental hospital, who must take action at once when the patient becomes able to express his wishes clearly and must review the case after six months, with a view either to extending the period of temporary treatment or to accepting the patient voluntarily or under certificate. A patient may enter hospital in this way from an observation ward. The practitioner, however, will be concerned with temporary treatment only when it is desirable to admit the patient to a mental hospital direct from his home.

The best method is to call in a consultant, who will almost certainly be on the list of specialists approved for the purpose. The consultant will bring with him the necessary forms, which are usually printed in one folder. They consist of an application which must be filled in by the husband or wife or a relative or by a D.A.O. from the local authority area in which the patient is seen. This is supported by a recommendation to be filled in by the consultant, in which he gives the reasons for his conclusions, and an attached medical certificate, to be given, if at all possible, by the regular medical attendant. The two medical men, who may examine the patient either together or separately, then jointly sign the recommendation and give a brief statement of such particulars about the patient as are available at the time. It is essential to contact the medical superintendent of the hospital in the first instance to be sure that a vacancy exists and that he is willing to accept a temporary patient.

The provisions for admission of temporary patients have the advantage from the point of view of the general practitioner of being less formal and more professional in nature. Like those of the urgency order they can be complied with without bringing in any public official and work well within the usual framework of a consultation or domiciliary visit.

Certification by Courts of Summary Jurisdiction (Criminal Justice Act, 1948, Section 24)

When attention has been drawn to an abnormal state of mind because the patient has been brought to a police court, the court can make an order for his reception in a mental

hospital, provided that it is satisfied that the patient has committed the offence with which he is charged, and that the offence is one which is normally punishable by imprisonment. Such an order has to be supported by the certificates or testimony of two medical practitioners, who must state whether in their opinion the patient is dangerous and unfit to be at large. This is a duty which may come the way of any practitioner who examines cases at the request of the police. The certification procedure does not differ from that employed in the reception order on petition.

Aged Patients

The certification of patients over 65, or of those whose mental illness is dependent on degenerative physical disease such as arteriosclerosis or renal failure, is not desirable, especially when it is clear that the patient may not live very long. Patients of this kind are usually too ill or too lacking in enterprise to be of much danger to others, apart from the episodes of confusion which often occur in the course of a general decline in their mental powers. The need for dealing with such episodes without moving the patient is recognized at most geriatric units, and many nursing-homes specializing in old people take patients who, while certifiable, have nothing to gain from certification. No special legal provision exists for patients over 65. There is no obligation to certify a patient for whom room can be found in a geriatric ward, provided that facilities exist there for dealing with episodes of disturbed behaviour if they occur. Admission to an observation ward (Lunacy Act, Section 20) may allow time for the confusion to subside, so that if admission to a mental hospital is still necessary it can be as a voluntary patient. It is to be hoped that when enough accommodation in geriatric units becomes available the certification of patients in a terminal confusion or dementia will cease to be necessary.

Escaped Patients

The relatives of a patient who has escaped from a mental hospital and has returned to them may ask how to proceed. If the patient has been away from the hospital for less than 14 days he can be retaken without a fresh order and certificates (Lunacy Act, Section 85). He can be taken back by any member of the staff of the hospital from which he has escaped or by any person whom the medical superintendent authorizes in writing. Relatives frequently first consult the police, who are often unwilling to interest themselves in the matter unless the patient has committed an offence or is likely to do so. The first thing to do is to notify the medical superintendent of the hospital; he may decide to send one or more of his staff to collect the patient, but if the distance is great and there is little time to lose, and the patient is causing difficulty, it is well to ask the D.A.O. to help. The necessary authority can be given to the D.A.O. by the medical superintendent by telegram, provided that this is later confirmed by letter, and this will enable him to hold the patient until the hospital can send an escort. If the patient's condition gives rise to anxiety he can be admitted to an observation ward by the D.A.O. on a three-day order as a "person of unsound mind wandering at large."

If 14 days have elapsed since the patient's escape he is automatically discharged by operation of the law, and if his condition justifies certification he will, of course, have to be dealt with *de novo*. The idea that a patient who escapes in Scotland is at once free in England and Wales, and vice versa, is quite erroneous, as the necessary authority to recapture can be obtained through the Commissioners of the country in which the escape occurred (Lunacy Act, Sections 86-88). When a patient appears at the house of his relatives or in the surgery and announces that he has remained outside the hospital for the necessary period it is well to make sure that he has in fact been at large for 14 clear days—the day of the escape does not count—as it is occasionally possible to obtain an order to retake him just before the full period has expired. The arrival of an

escaped patient who proves on inquiry to be a voluntary patient is not unknown; if he wishes to return to the hospital and the medical superintendent is willing to accept him he must once again sign a form of application. Sometimes when a patient has escaped it is difficult for the doctor who sees him to be sure that he is still of unsound mind. This, however, is not important, as he can be retaken, provided that his certificates are in order, and the question of his fitness for discharge can then be decided on his return to the hospital in the light of his previous history and mental state at the time.

Discharge at Request of Relatives

The relatives of a patient who has been admitted to a mental hospital may feel his certification was not justified and may try to enlist the aid of the family doctor to get the patient discharged. If the patient has been detained under a reception order on petition the relative who signed the petition may, if he has become convinced that the patient should no longer be detained, ask for him to be discharged (Lunacy Act, Section 72). The medical superintendent can, however, prevent this in the case of a really dangerous patient by certifying in writing that he is dangerous and unfit to be at large (the "barring certificate"). In many cases it will be evident to the practitioner that the relatives' request is not in the patient's best interests, and he may be able to dissuade them from asking for the discharge. Often they have been influenced by the appeals of the patient on visiting day and have made a rash promise. In other cases the relatives feel that the certification of one of their kin is a reflection on their own mental health, and with this less reasonable group there may sometimes be no alternative but to discharge the patient and let them find out for themselves how impossible it is for him to lead a normal life. It is tempting, when they finally bring the patient and ask for him to be readmitted, to point out their error, but it is not in the patient's interests to delay his readmission, and recrimination serves no purpose.

A patient may also be discharged to the care of a relative or friend (Lunacy Act, Section 79) if an undertaking is given that he will be properly cared for and prevented from doing injury to himself or others. The discharge is given by two members of the hospital management committee, who must first satisfy themselves that the relative or friend can really look after the patient. Inquiries are usually made on behalf of the committee members by a psychiatric social worker, who may ask the practitioner, if he knows the family well, for his opinion of the home circumstances. Sometimes, when a patient in a mental hospital is convalescent from a severe illness but not fully recovered and the relatives have made careful plans for his care and rehabilitation, discharge by this route is quite reasonable. Should the patient have been certified under the Criminal Justice Act (Section 24) the provisions for discharge at the request of relatives will not, of course, apply.

Next Refresher Course Article.—"Treatment of Gonorrhoea," by Dr. T. E. Osmond.

For the guidance of those interested in the formation of medical libraries in teaching and non-teaching hospitals the medical section of the Library Association compiled in 1949 a basic list of books and periodicals in the English language in steady demand and suitable for such libraries. This book list has now been revised and published under the title *Books and Periodicals for Medical Libraries in Hospitals* (Library Association, Malet Place, London, W.C.1. 16 pp. 2s.). It includes an article giving "hints on the formation of medical libraries in hospitals," which appeared in the *Lancet* (1949, 2, 430).

MR. SAMPSON HANDLEY AT 80

On April 12 Mr. Sampson Handley celebrates his 80th birthday, and we gladly take this opportunity to offer him congratulations. In a photograph of the medical staff at the Middlesex Hospital, taken as long ago as 1905, Mr. Handley, who had then been qualified for 10 years, and was Doctor of Medicine and Master of Surgery of the University of London, appears in the background. In the front are such well-remembered Middlesex men as Douglas Powell, Henry Morris, Kingston Fowler, and Bland-Sutton. The last-named was Handley's immediate chief, whom he once described as the John Hunter of his

time. He himself carried on the Bland-Sutton tradition, with his zeal for research and his inventiveness and versatility in surgical procedures.

At about that period, the middle of the first decade of the century, Mr. Sampson Handley was just beginning his investigations in the cancer research laboratories at Middlesex. In his *Cancer of the Breast and its Operative Treatment*, first published in 1906, he expounded his theory that cancer spreads mainly by lymphatic permeation. The work was almost immediately translated into French and aroused interest amongst Continental surgeons, who declared that it opened new horizons. Much later, in his *The Genesis of Cancer*, Mr. Handley suggested that, in so far as a single constant precursor can be regarded as the essential cause of cancer, it is lymph stasis. He once said that he wished to be remembered only for those two theories—the spread of cancer by lymphatic permeation, and the role of localized lymphatic stasis in the aetiology.

But in fact he has been much more than a laboratory experimenter. He has been one of the most brilliant and original surgeons of his generation, and this was recognized in 1931 by his election to the vice-presidency of the Royal College of Surgeons. In a long series of lec-