PITFALLS IN "REMOVAL FOR MENTAL OBSERVATION"

BY

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The general practitioner is often called upon to see patients who are showing acute mental symptoms and to advise as to whether their removal to the local observation ward by the relieving officer is indicated. The conditions under which the examination is made are often adverse; there may be considerable confusion and turmoil, and a calm, unhurried appraisal of the case may be difficult. In these circumstances it is not surprising that not infrequently mistakes are made which become obvious in the calm, orderly atmosphere of the hospital. The object of this paper is to consider in the light of experience the snags which the practitioner is most likely to encounter and the chief errors likely to occur, although it is very far indeed from being comprehensive.

The main danger lies in the patients in whom the mental symptoms form part of some severe organic disorder. Many organic cases are eminently suitable for admission to observation wards, and indeed the behaviour of these patients may make this the only practicable method of dealing with them; but a consideration of the cause and of therapeutic possibilities may suggest an alternative means of disposal. The underlying trouble may be completely missed, with resulting complaints from the relatives that the patient has been treated as a lunatic instead of as a sick man.

A great safeguard against this type of mistake is the ability to recognize the "organic" mental picture, which, although described in detail in textbooks of psychiatry, including the psychiatric sections of general medical textbooks, seems to be not nearly widely enough appreciated by the profession. Curran and Slater, in the *Lancet*, 1935, 1, 69, pointed out that physicians often are ill equipped to analyse mental symptoms and lacking in special knowledge of them. For example, a young man the outstanding features of whose condition were failure of memory and disorientation in time, so that he went for his dinner when he should have gone home, and forgot which job he was working on—typical organic symptoms—was regarded as a case of functional insanity by several people, including a junior neurologist, because he showed no neurological signs. Precious months were therefore lost in the treatment of his general paralysis, and all hope of cure vanished.

Signs particularly indicative of an organic origin are memory disturbances with their corollary, disorientation in space and time. Mistakes in identities often occur, and the patient may believe the physician to be a relative or a friend of his or someone who has treated him previously. Excessive concentration of attention or preoccupation with anxieties or abstract ideas of the "absent-minded professor" type is not accompanied by true memory disturbance.

Toxic and Infective Conditions

Most infections may produce delirium, and there is no direct relation between the severity of the mental symptoms and the degree of constitutional disturbance. Alcoholic subjects are peculiarly liable, and, in them, mental symptoms tend to make their appearance early. Pulmonary conditions, cases of typhoid, endogenous intoxications such as uraemia, and a heterogeneous miscellany of febrile states frequently find their way into observation wards for this reason. The general aspect of the patient and the presence of fever and of distinctive physical signs should afford pointers to the correct diagnosis. Meningococcal meningitis may produce sudden furious delirium unaccompanied by fever or meningitic signs. In such cases the history will usually provide evidence of diagnostic value in the shape of prodromal symptoms of a few hours' or a day or two's duration, such as headache, vomiting, and pains in the limbs. Now that sulphapyridine is tending to supplant serum in treatment it is not nearly so detrimental to the interests of the patient to send him into the observation ward instead of to a fever hospital, and he can be nursed there quite satisfactorily.

A good example of the type of meningitic case which gets into the observation ward is afforded by a married woman who complained to her husband, an A.R.P. worker, of nausea, general malaise, and pains in the limbs just before he started off for a twenty-four-hour shift. He thought that she had "flu," and advised her to stay in bed until he came back. On his return he found their flat in great disorder and his wife rushing about wildly, with her clothing disarranged and babbling incoherently.

Cases of neurosyphilis showing mental symptoms are usually most satisfactorily treated in mental hospitals, and removal to the observation ward in the first place is therefore not contra-indicated. Alcoholic confusional and hallucinatory states are also satisfactorily dealt with in the observation ward.

Organic Lesions of the Brain

Numbers of patients with organic cerebral lesions, who would be better sent into general hospitals in the first place, find their way into observation wards; and cases of tumour, both primary and secondary, various vascular conditions, and disseminated sclerosis have passed through my hands in this way. The importance of not regarding absence of neurological signs as indicating absence of organic disease and of recognizing the type of mental disturbance produced by organic conditions is to be stressed. In one case a woman became forgetful and would go into a shop and fail to remember what she wanted to buy there. Her amnesia and confusion increased, but her doctor did not suspect serious disease until she became aphasic and suffered from transient losses of consciousness. She became comatose and died in the observation ward, post-mortem examination revealing a large highly malignant glioma.

In two rather difficult cases there was sudden collapse, after which the patients remained mute although conscious and aware of their surroundings. Both were sent in with a diagnosis of hysterical mutism, but the development within the course of a day or two of a right-sided hemiplegia rendered this untenable. Careful consideration of the history and the circumstances in which the collapse occurred would have prevented the mistake. To arrive at a diagnosis of hysteria purely by exclusion is unwarrantable. The condition is one which presents definite clinical features and a characteristic history and mental state, well described in the textbooks. The dramatic nature and mode of onset of the symptoms; the possibility of their being of some value to the patient by providing him with a solution, albeit an unsatisfactory one, of his difficulties; his emotional attitude to the symptoms; and the tendency in his previous personality to seek the limelight and to create an impression, are important.

Cardiac Failure

The confusional and delirious states associated with congestive cardiac failure are usually transitory and clear up dramatically when the primary condition is adequately treated. It is a mistake, therefore, to rush these patients off to the observation ward in the early stages of their illness if this can be avoided, although a certain small proportion will fail to respond to treatment and become chronically psychotic, in which event removal to a mental hospital may be indicated.

Reaction to Severe Physical Pain

The behaviour of some emotional individuals during an attack of severe pain may be so uncontrolled as to appear completely mad. For example, a doctor was called to a house and was told that a young man who had been visiting a friend there had suddenly been taken ill while his friend was out. When he went into the room the patient clutched his hand desperately and mumbled inarticulately, and was quite incapable of coherent speech. The doctor not unnaturally concluded that the man was insane, and sent for the relieving officer. On arrival at the observation ward the patient appeared quite normal, but stated that he had just had some dreadful pains and described a typical attack of renal colic. When they found out the nature of the hospital to which he had been sent, both he and his family expressed great indignation, and one cannot help feeling that the doctor's reputation in the district suffered considerably as a result of this unfortunate incident.

Failures of complete diagnosis such as those described above are easily rectified and rarely prejudice the welfare of the patient: at the worst they involve him in an unnecessary journey between hospitals, but they are somewhat mortifying to the keen practitioner who prides himself on his professional skill. The patients and their relatives often attach undue importance to these failures because of the faulty attitude of the general public towards mental disease and the sharp distinction which they draw between it and physical disease.

The mistake of removing a person to the observation ward on totally inadequate grounds is not commonly made. Foreigners with little or no knowledge of English are sometimes the victims. I remember particularly a voluble, excitable harbour official from Dunkirk whose behaviour following upon the stress of the evacuation caused unnecessary alarm to harassed refugee reception centre officials accustomed to British phlegm and unfamiliar with the more mercurial temperament of our Latin neighbours. Mere eccentricity or even delusional beliefs in the absence of definite antisocial trends are no grounds for interference with the liberty of the subject. One of my patients was a woman with queer hypochondriacal and religious ideas; but the former were derived from old country superstitions, and the latter were shared by other members of the exotic sect to which she belonged, so there was no justification for regarding them as evidence of insanity.

Delinquents, both children and adults of low intelligence, are sometimes sent for observation. No harm is done thereby, since such people present psychiatric and psychological problems, but they are usually better dealt with in the out-patient clinics which exist for the purpose in most large towns.

The patients for whom Section 20 of the Lunacy Act of 1890 is intended primarily are those whom it is fairly urgently necessary to put under control and restraint. In delirious states especially this urgency is usually much reduced by the administration of 2 drachms of paraldehyde or of a similar drug. The question of suicidal risk in depressed patients is the most difficult one facing the physician in this respect. Co-operative patients who can be dealt with in a more leisurely manner may be brought under treatment by other means. Subjects of functional psychoses can be seen in psychiatric out-patient clinics, and from there, if necessary, arrangements can be made for them to enter mental hospitals as voluntary patients. Cases of suspected tumour and other organic neurological disorders can be sent to general or neurological hospitals for diagnosis and treatment.

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LEPROSY IN THE COLONIAL EMPIRE

Lord MOYNE, formerly Secretary of State for the Colonies, presided over the annual meeting of the British Empire Leprosy Relief Association. Sir WILLIAM PEEL, chairman of the executive committee, in reviewing the work of leprosy control and cure in the Empire, so far as it can be made under war conditions, mentioned the appointment by the Association in 1940 of three doctors to Nigeria, a step which had proved most beneficial to the leper colonies at which they were stationed. The work in this territory was gradually extending, but the estimate of the number of lepers remained very high, though this might be due to a growing readiness of patients to come forward rather than to an actual increase in the number of cases. From the colonies now in enemy hands reports had come of inspiring devotion to duty. Sir William mentioned the leper settlement at Sungei Buloh in the Federated Malay States, perhaps one of the finest settlements of its kind in the world, where its head, Dr. G. A. Ryrie, had remained at his post during the occupation of the colony by the Japanese, and had been requested by the Japanese to continue his work. He added that the Association had offered financial help to this settlement, should it be needed, as soon as contact through the Red Cross or otherwise was made.

An address was given by Dr. H. G. ANDERSON, medical secretary of the Church Missionary Society, who said that in view of the wide publicity it had received it was rather sad to have to record that the diphtheria toxoid treatment of leprosy had not fulfilled the early claims made for it, though a negative

result of this sort had its value. No praise could be too high for the biochemists who had explored the field of synthetic chemistry. By the yardstick of history their work was still young, but the pace was quickening, and their triumphs were only the first indications of great possibilities. One problem facing the association in the future was that of still further aid to and liaison with the laboratory. He thought the first step should be an enlargement of the association's clinical staff, for, after all, it was the clinician who was the senior partner in the association between medicine and the biochemists. It would be wise, after the succession of frontal advances in their work, to consider seriously the more adequate consolidation of the bases created over-seas. As a first move he suggested the doubling of the staff of qualified doctors. With such an addition the survey and clinical laboratory work would automatically be able to take their vital share in the attack on leprosy.

ANAEMIA IN X-RAY WORKERS

A number of workers in x-ray departments in E.M.S. hospitals have been taken off work because they were considered to be suffering from minor degrees of anaemia due to the effects of x rays. Such action, states the Director-General, E.M.S., in a letter to Regional Hospital Officers and Sector Hospital Officers, is unnecessary, as the anaemia from which these persons may be suffering is almost certainly not due to the specific action of x rays. In order to allay any uneasiness and to guide hospitals in the treatment of such cases, it is asked that the information in the following note on blood examinations in x-ray workers be passed on to all E.M.S. hospitals with x-ray departments.

Blood Examinations

Periodic blood examinations of x-ray workers have been carried out in many institutions over a long period of years. Many such records are available. In none of these institutions has a single case of aplastic anaemia occurred, and there appears to be no record in the literature of aplastic anaemia developing in any x-ray worker who was not also in contact with radium.

A few cases of ordinary secondary anaemia are found from time to time, and these appear to result from the conditions of employment rather than from any specific action of the rays. Very rare examples have been met with in which the white cell count has been seriously reduced, but recovery has taken place after a short absence from work. One interesting and apparently extremely rare example has been observed at King's College Hospital of a girl who, on return to work, developed a severe leucopenia for the second time and was advised to find some other occupation.

It seems generally agreed that periodic blood examinations—at intervals of 6 to 12 months—are advisable as a means of detecting haemoglobin and red cell deficiencies in persons working under unfavourable surroundings, of discovering the very exceptional x-ray worker who may develop serious white cell deficiency, and as a reassurance to radiographers in general. It is also a reasonable procedure to make a blood examination of all candidates for employment in an x-ray department before they start work. Minor degrees of anaemia need not be treated more seriously among radiographers than similar conditions in other occupations. Minor degrees of leucopenia should suggest a further examination at a short interval—e.g., two weeks—and if confirmed and progressive should entail removal from work until the blood state is re-established and the count found to remain constant.

The term "x-ray anaemia" has no particular meaning and should be avoided.

Eleven distinguished medical men, representing the home country, the Dominions, and the United States, have been elected to the Honorary Fellowship of the Royal Society of Medicine at a special meeting. The two from the home country were Lord Horder and Sir John Herbert Parsons, a former President of the Society. The two from Canada were Prof. W. E. Gallie, Dean of the Medical Faculty of the University of Toronto, and Prof. Jonathan Meakins, Director of the Department of Medicine at McGill. The two from Australia were Sir Charles Blackburn, consulting physician, Royal Prince Alfred Hospital, Sydney, and Sir Hugh Devine, Lecturer in Surgery at the University of Melbourne. New Zealand and South Africa each had one representative—namely, Sir Henry Lindo Ferguson, Professor of Ophthalmology and Dean of the Medical Faculty, Otago University, and Dr. A. W. Falconer, Professor of Medicine at the University of Capetown. The three medical men in the U.S.A. were Dr. Hugh Cabot, consulting surgeon at the Mayo Clinic, Dr. David Cheever, Associate Professor of Surgical Anatomy at Harvard (who had charge of the Harvard Surgical Unit which was sent to the Western Front in 1915-16), and Dr. W. T. Longcope, physician-in-chief, Johns Hopkins Hospital, Baltimore.