Psychosurgery and the Mental Health Act Commission

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It was fully anticipated that the Mental Health Act Commission would take special interest in psychosurgery, and Section 57 is clearly intended to supervise this form of therapy. The Chairman of the Commission, Lord Colville, considerately arranged a visit to our Unit shortly after the implementation of the Act, and this proved to be a most useful meeting. Obviously we were ready to give any help or advice needed, based on our experience of over 1,100 operations carried out over about 20 years. Our world-unique unit has eight beds specifically for the assessment and treatment of patients referred for psychosurgery, although intensive antidepressant medication is sometimes used successfully in order to avoid psychosurgery.[1]

Decisions as to whether or not to offer surgery are made jointly by my neurosurgical colleague, Mr John Bartlett, and myself. We also have the help of our two experienced nursing sisters. A social worker has the special task of obtaining the views of the family and she also gives them information about the treatment. We have all been involved with the Unit for periods of 10 to 15 years. In the clinical decision process I regard my own role as that of an independent expert advising on the referral, which is essentially from the patient's psychiatrist to Mr Bartlett.

For many years this Unit has admitted one patient each week and they are never on a Section of the MHA. Thus, 70 psychiatrists refer patients to us annually, but we decline about one-third of the referrals for various reasons. One operation is carried out each week, and in 1982 this Unit carried out all but three of the psychosurgical operations in Britain. We also have patients who come from overseas.

We attempt to monitor our results in a number of ways. Firstly, every patient who can attend is seen six months post-operatively. Then, at one year, a senior consultant psychiatrist, who has no other contact with the Unit, assesses the patients' progress independently, although the Unit's consultants are with him to advise the patient if there are any problems. He records the outcome on a five-point scale, described in our published reports.[2,3] We also carry out continuing research aimed at the elucidation of aetiological factors in the affective disorders that we treat and attempt to find objective measures which may improve our selection of the patients most likely to respond to the stereotactic tractotomy operation. The basic insuperable obstacle is that there is as yet no objective test for any form of psychiatric illness, so that selection for psychosurgery remains a clinical process.

For all that our clincal practices seem to us to be an attempt at a methodical and caring approach to a controversial though potentially highly effective treatment, we are now experiencing problems with the Commission that seem as much to do with its policies as with the Act itself. Reason tended to make us confident that we would be able to continue our clinical work freely, though perhaps with some supervision from the Commission. In addition, we welcomed the chance of help from the Commission, especially with difficult problems of consent, which hitherto we have had to manage as best we could. We accepted that the Commission might want to investigate the clinical practices of the Unit, no doubt, we thought, with the help of the vast expertise available from the Royal College of Psychiatrists.

But all this reasonableness, as we saw it, was not to be. In relation to psychosurgery the Commission has been aloof and adversarial. Their view seems to be that a unit regularly involved with psychosurgery requires independent supervision. Our clinical decisions to accept patients for psychosurgery are now subject to veto by medical commissioners who have no personal clinical involvement with the patients and little experience of the treatment. Recently, one operation was postponed, and another refused by medical commissioners after we had agreed to operate in both cases. Referral for possible psychosurgery is understandably stressful for patients who are intractably ill. They accept the advice of their own consultant to be referred to our Unit, and thus they accept our assessment of their illness, whether for or against surgery, because they recognize our clear clinical relationship with them.

The MHA seems to cause our patients to be dealt with in a subservient role. They must submit to interviews by one medical and two non-medical commissioners, whether they want to or not. The medical commissioner does not seem to have so much a medical function as a legal one. If he decides against psychosurgery for a patient, we are told that he has no further responsibilities in the case, with regard to alternative treatments in particular. Neither we nor our patients know how doctors on the Commission are selected to supervise our psychosurgical practice. What medical experience is needed? The patients surely have a right to know.

But there is worse to come. The decision of the medical commissioner is final. We are told by the Commission that a further opinion is not possible when our offer of an operation has been vetoed. Thus, doctors, whose credentials with regard to psychosurgery are unknown, can stop an operation recommended by us, whose opinion the patient has freely sought. The commissioner's examination of the patient is compulsory and his edict is infallible by law.

Another problem is that if our agreement to carry out psychosurgery has been reversed, who is responsible for the

future care of the patient? In one of the cases mentioned, the referring consultant has told us that he had sought our opinion, which he would have readily accepted either way, but as we agreed to operate and the patient wanted this, when someone quite extraneous (to his mind) changes the clinical management, he cannot take further responsibility for the case. Obviously this Unit cannot help further. Surely the medical commissioners cannot claim absolute power yet decline to accept any subsequent clinical responsibility? What if a patient, denied surgery, dies by suicide? What is the responsibility of the Commission?

There are additional restrictions of our patients' human rights with regard to consent. The considerable majority of the patients are clearly able to give full and informed consent, although there are certainly some cases when there is doubt. However, every patient now admitted to the Unit is again required to be interviewed by unrecognized, and not necessarily welcome, non-medical officials. These commissioners have to assess the validity of consent, yet we observe that they sometimes have difficulty in managing distressed patients whose condition thereby tends to be worsened. The Commission has asked that these commissioners should have access to the patient's notes, but we have resisted this.

As many very depressed patients are retarded or pathologically indecisive, psychiatric skill and patience only from those seen to have clinical responsibility for them is often needed to elicit accurately their approval or otherwise of psychosurgery. Such patients may well not be able to give clear consent during the limited single visit of the commissioners. Therefore the more severely depressed patients are going to be those less likely to be allowed to have the only treatment that may help them. Are these unsatisfactory practices, which upset and bewilder patients, really what the MHA requires? In any case, none of this would be necessary if our Unit happened to be in Scotland.

In all of this bureaucracy there is, of course, a strongly implied criticism of the clinical work of this Unit; presumably that we may be biased and over-enthusiastic. If this is so, the accusations should be stated and the reasons given. Our considerable experience seems to actually render us untrustworthy to assess and treat patients independently. This country now seems to be adopting that essentially American folly, long recognized by psychiatrists on this side of the Atlantic, but so appealing to militant moralists, the control of medical practice by means of statute law and committees with non-medical and non-professional members where doctors are in a minority. If our psychosurgical practice is interfered with, then patients may remain chronically ill and incapacitated, known only to nurses in chronic wards and not to the lawyers and committee members. The controversial treatment is controlled or eliminated to suit the individual prejudices of the human rights enthusiasts; their personal irritant has been dealt with and they are satisfied. The care of the patient is of subsidiary importance, as shown by the commissioners' seeming indifference to the patient's subsequent management.

I suggest that doctors will readily recognize that the Commission's present policies are causing serious limitations to our patients' human rights, with relatively little gain. Lawyers may well not understand this because they are unlikely to have much appreciation of the absolute quality of medical confidentiality, the essential freedom of patients to seek medical advice as they wish and the medical duty to care for a patient as an individual. Within the law, clients are always subject to the overriding requirements of society, a reversed situation in relation to medicine. The appealing fallacy involved in the setting up of the Commission is that uncertain and imperfect psychiatry is magically converted to precise and definite law, where all is comfortingly black or white. But it may be that, at the same time, the patient is lost and reappears as a defendant.

The Times Law Report (24 February 1984) of the case of Sidaway v. The Board of Governors of the Joint Hospitals quotes from one of the judges: 'The doctrine of "informed consent" forms no part of English law'. The MHA Commission is the thin end of an ominous wedge, and those in other medical specialties should watch developments closely.

However, we at the Geoffrey Knight Unit still accept referrals as always, and following a recent meeting with the Commission, it has been agreed that the procedures required by the Act will take place almost entirely at the referring hospital or out-patient clinic. This is because weekly visits by three commissioners (necessary because of our one admission each week) have caused considerable distress to our otherwise self-supportive group of in-patients. They have become anxious lest the operation offered will be refused and they have been confused by all the additional questioning, especially as to consent. Some have asked us to help them learn the side-effects so that they will be word-perfect for the commissioners.

The referred patient will continue to be seen initially by Mr Bartlett and myself, either as an out-patient or during a short admission for assessment, as has always been our practice. The patients we accept for operation will go on our waiting list and the commissioners will subsequently visit the patients at the referring hospitals during this waiting period. The visit to assess capacity for consent will take place within four to six weeks of the operation date and might need to be confirmed by one commissioner just before the patient is transferred to our Unit, about two weeks before psychosurgery is planned to be carried out. Only if consent has been in doubt will a commissioner need to visit our Unit. This policy is at present working quite well.

How could our referred patients be more humanely helped within the terms of this Act? Clearly, the patient is only caringly served by the professional staff actually involved in a clinical relationship. Therefore a consultant and one of the non-medical professionals of this Unit should be recognized by the Commission, perhaps only dealing with psycho-

surgery. Their unique experience would then be available to the Commission and to psychiatrists wishing to refer patients for psychosurgery locally. Of course, the opinions of other appropriate commissioners would be obtained as needed. There may be protestations that the Commission must remain totally independent. But if specially experienced doctors cannot be trusted, substitution by lawyers and multi-professional committees is a most unsatisfactory clinical alternative.

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Compulsory Treatment in the Community: Is it Authorized under the Mental Health Act 1983?

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The Mental Health Act 1983 stimulated discussion on all aspects of compulsion in psychiatry. It has been the practice at St. Mary Abbots Hospital to use the powers granted by Section 39 of the 1959 Act and Section 17 of the 1983 Act as a means of compelling a small number of seriously ill patients to take medicines in the community, and I described this practice briefly in a recent article.[1]

Lydia Sinclair, Legal Officer for MIND, in a long and detailed letter,[2] critizes this practice:

> The purpose of Section 3 (old Section 26), admission for treatment, is to admit to hospital and detain for the period allowed. The procedure and criteria for admission are clearly stated in the Act, detention in hospital and in-patient treatment are intended. Leave of absence under Section 17 of the Act is to be given for temporary absence, a specific occasion, or a period of trial of the patient's suitability for discharge (memorandum to the Act). The Act does not authorize leave of absence to be used indefinitely as a means of enabling medicines to be given under a detention order, or to facilitate the patient's quick return to hospital under the recall provisions of Section 17 (4).

Unfortunately, the *British Medical Journal* were unable to publish my reply for reasons of space and because 'the correspondence is now above the heads of most of our readers'. This issue deserves further airing and clarification in the proposed Code of Practice to be issued by the Mental Health Commission.

The clinical problem can by briefly stated. How do we treat the small group of seriously ill patients who remain well only if they take treatment in the community, yet refuse to take that treatment? In practice, that treatment is, virtually always, medicines. By definition, these patients relapse if they do not take the treatment; therefore, the real alternatives to compulsory treatment in the community are deterioration in the mental state, or compulsory treatment as an in-patient. The bone of contention between myself and MIND's legal officer is whether compulsory treatment is lawful under the present Act and, if so, under which Section. Does the wording of the Act and its Memorandum justify Mrs Sinclair's statement? The 1983 Act says (Section 17):

> 1. The responsible medical officer may grant to any patient who is for the time being liable to be detained in a hospital under this part of the Act, leave to be absent from the hospital subject to such conditions (if any) that the Officer considers necessary in the interests of the patient or for the protection of other persons.
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> Leave of absence may be granted to a patient under this Section either indefinitely or on specified occasions, or for any specified period. Where leave is so granted for a specified period, that period may be extended by further leave granted in the absence of the patient.

Note that the Act specifically states that the responsible medical officer can make conditions and grant leave indefinitely. This appears to me to justify medicines in the community on a long-term basis ('conditions' and 'indefinitely'). Mrs Sinclair quotes the Memorandum of the Act in support of her contention that the Act does not authorize leave of absence to be used indefinitely. The relevant Section, Paragraph 72 of the Memorandum, says: 'Leave of absence can be given either for a temporary absence or on a specific occasion after which a patient is expected to return to hospital, or as a period of trial of the patient's suitability for discharge.' It is certainly true that the Memorandum omits the word 'indefinitely'. However, the Memorandum is not an 'authoritative' interpretation of the law, this is specifically disclaimed in Paragraph 2 of the Memorandum itself. The implication therefore is that where there is conflict we should prefer the Act itself to the Memorandum.

The wording of the relevant sections on leave in the 1959 Act (Paragraph 39) and the 1983 Act (Paragraph 17) is identical, so that any discussions that may have taken place concerning the 1959 Act are relevant. The Royal Commission on the law relating to mental illness and mental