

## LITIGATION IN PSYCHIATRY

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'In fact I do not believe I have ever done so, not even when a patient came to see me in H . . . Street with his solicitor. He wanted to sue me for wrongful certification, but when I asked him if he was still Jesus Christ and he assured me that he was, his solicitor quietly took him away.'

The above quotation comes from a letter I received from a psychiatrist, who said that he had never had to seek the aid of the Protection Society, and took the view that, psychiatry being a low risk specialty, its proponents should pay a lower subscription. I do not here propose to follow that argument, but hope to show that while psychiatry may be low risk, free from risk it most certainly is not.

The law does, of course, give psychiatrists a privilege not shared by their colleagues in other specialties. Section 141 of the Mental Health Act lays down that no person is liable to civil or criminal proceedings in respect of anything done in pursuance of the Act unless there has been bad faith or lack of reasonable care. No proceedings can be brought without leave of the High Court, and such leave cannot be given unless the Court is satisfied that there is substantial ground to support the contention that the person to be proceeded against has acted in bad faith or with lack of reasonable care.

One such application to the High Court some years ago came from a doctor who was indeed himself a member of the MPS. It is, however, no function of a protection or defence society to pursue claims in respect of members' own medical treatment, and on behalf of the psychiatrist concerned we had no great difficulty in persuading the Judge that the application was misconceived and wholly without merit.

What sort of allegation, then, can face a psychiatrist with litigation? I propose to confine myself to matters of negligence, assault, defamation and wrongful imprisonment.

One of the causes of allegations of negligence against psychiatrists lies in the separation of psychiatry from other medical specialties. The Court does expect even the ultra-specialist to retain some basic knowledge and skill throughout the whole range of medicine. I well remember the indignation of a psychiatrist served with a writ in a case based on failure to diagnose the tetanus from which the patient died. The psychiatrist had been called in when the patient exhibited a number of bizarre symptoms. Following his examination, he recorded an absence of

psychiatric disability and went on: 'The thought of tetanus went through my head, but I suppose this is nonsense.' He then closed the file and continued his day's work. His humility was misplaced. The next day the diagnosis was obvious and the psychiatrist's failure to alert his physician colleague was indefensible. As he said, had he not mentioned the tetanus no one could have blamed him, but the Court would assuredly hold that any doctor considering such a diagnosis should initiate action.

Suicide cases rate highly in actions against psychiatrists, and they come in two guises. First, there is the patient who commits suicide or suffers injury in the attempt while an in-patient. A case that occurred a few years ago resulted in an award of £19,000 against a hospital authority and this case illustrated a number of the characteristic features. A young man was admitted to a general hospital after taking an overdose. After a day or two the psychiatrist decided that he should be transferred to a psychiatric unit, and it was arranged that this should be done after the weekend. It was not considered that there was any great urgency, the ward sister was experienced in looking after that type of patient, and therefore the psychiatrist did not think to give her any special instructions. The window just by the patient's bed was open and at a time when there was only one nurse in the ward, and she at the other end, the patient without warning jumped out of the window.

Then there is the patient who is discharged from hospital and very shortly afterwards takes his own life. These cases may well be defensible, for it is more and more accepted that suicide does not of itself indicate mental disturbance and in particular it need not indicate mental disturbance of a nature and degree that makes detention in hospital possible under the Mental Health Act. Provided the psychiatrist can say that he examined the patient shortly before discharge and that his condition then was such that he could not be legally detained, then unless there is evidence to the contrary all should be well. If he can add that on adequate examination he found nothing to indicate any imminent suicide attempt then so much the better.

Other allegations of negligence have included the following:

1. Prescribing lithium and failing to arrange for regular checks.
2. Prescribing three drugs, all 'p.r.n'. The psychiatrist

intended that the nurses would give whichever they thought most appropriate, the nurses thought that all three should be given on each occasion. The patient died as a direct result.

3. Gross drug overdose—this tends to occur when there has not been a proper hand-over between junior staff.

Assault in this context is concerned with consent to treatment. The law is in a very unsatisfactory state when it comes to determining who, if anyone, is empowered to authorize treatment to a person who as a result of his mental condition is incapable of understanding the pros and cons of the treatment recommended. At the present time the problem is most acute as regards patients admitted under Section 26, and there are those who would say that such patients cannot be treated unless they are capable of giving valid consent or there is a legally appointed guardian who has given consent on their behalf.

The harmful effects of such an attitude on the vast majority of Section 26 patients is only too apparent. While it cannot be said that the law does authorize treatment of such patients without consent, psychiatrists are recommended to make no change in the procedures which have stood the test of time and to await the outcome of the DHSS inquiry into the working of the Act. Any threats received from any pressure group on this point should be referred to the appropriate protection or defence society.

Allegations of defamation seldom get far but can arise in a number of situations. One of my thickest psychiatric files concerns a patient who quite erroneously attributes most of his misfortunes in life to an alleged conversation between his psychiatrist and his employer. Another case which I am just hoping can now be considered closed relates to correspondence between a psychiatrist and an industrial medical officer. It was obviously in the patient's best financial interest that he should retire on medical grounds, but the correspondence between the doctors which had this sole aim in view has become, in the patient's mind, the reason why he was induced to resign as part of a sinister plot against him. There is really little a psychiatrist can do to protect himself against this sort of thing, but it does help if each document has its purpose clearly stated

in unambiguous terms. Though a court appearance is very unlikely, these cases can cause much anxiety and great waste of time.

Wrongful imprisonment usually relates to the observance or otherwise of the exact wording of the Mental Health Act. A recent example concerned a patient who, having been admitted under Section 29, was transferred to another hospital and the required form was not received there until the next day. The transferring consultant intended to discharge the patient from compulsory detention, but did not give the order in writing, and meanwhile a Section 25 order was completed at the second hospital. The patient was discharged after 28 days, and following complaint to the Ombudsman, the psychiatrist was criticized and the AHAs concerned were recommended to make a payment to the patient.

Perhaps one of the reasons why psychiatrists consider themselves a particularly low risk category is that they have seldom featured in the classical medical negligence cases which have laid down principles as case law has evolved. There have, however, been two cases that do merit special attention. In 1957 *Bolam v. Friern HMC* came to court. Negligence was alleged in failure to warn the patient of the possibility of fractures whilst undergoing ECT and in failure to use relaxants. An expert witness having said that he was opposed to routine relaxants, the Judge said that the plaintiff would have to show that he would have refused treatment if warned and that the defendants were not negligent if they acted in accordance with a practice which had the support of a responsible body of medical men merely because another body took an opposing view.

*Landau v. Werner* 1961 was a case in which the Court of Appeal heard of the social contacts between psychiatrist and patient which the former claimed had therapeutic content. Unfortunately for him the weight of expert opinion was strongly against such contacts, and indeed it did not prove possible to find an expert who would give unqualified support.

These cases combine to illustrate that what commands the support of colleagues is *prima facie* defensible, while he who stands alone in his therapeutic approach will likely find himself equally unsupported in court.