PRACTICE OBSERVED

Practice Research

General practitioners, court reports, and alcohol related offences

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Abstract

General practitioners may be asked to submit medical reports to the courts on patients who have a suspected alcohol problem. 96% of such requests coming from magistrates courts. When, however, a defendant decides to plead "not guilty" to an offence on the grounds of intoxication general practitioners are often asked to prepare a report to support the plea. We present guidelines on preparing such reports and discuss the implications of the contents.

Introduction

General practitioners may be asked by the courts to submit a medical report on a defendant with a suspected alcohol problem. Ninety eight per cent of criminal cases are dealt with in magistrates courts and most requests for medical reports therefore come from them when a defendant has been convicted of an offence and the magistrates require further information including social history and medical reports before they pass sentence. If the defendant has pleaded not guilty and has chosen trial by jury the case will go to a crown court. Under these circumstances a medical report is sometimes requested by the defending solicitors to support a plea of not guilty on the grounds of intoxication

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at the time of the offence. We will discuss this in more detail. Sometimes a probation officer is aware of the alcohol problem and recommends that the court requests a medical report, and sometimes the defendant himself will draw the court's attention to his alcohol abuse and request help.

A wide range of offences may be related to alcohol abuse. Gath showed that half of those convicted of offences related to drunkenness are physically dependent on alcohol.¹ Theft, burglary, violence, and sexual offences are all more likely to occur under the disinhibiting effect of alcohol. Many of those convicted of such offences have a longstanding problem of alcohol dependence that is not recognised because the offence is not one of obvious drunkenness.

How to prepare and write a court report

Often the general practitioner has the most thorough medical knowledge of a defendant with a suspected alcohol problem and therefore needs to know what information the court requires and how to present it clearly. The medical, legal, ethical, and practical aspects of psychiatric court reports have been reviewed in detail by Biagioli,² and the Butler report has discussed the quality of medical reports submitted to the courts.³ They both make important general points that apply to any medical report, whether submitted by a psychiatrist, general practitioner, or other specialist, and which we now discuss.

The doctor preparing a report must always remember that it does not retain the usual confidentiality once submitted to the court and may be made widely available to prosecution and defence, as well as to the defendant, probation officers, and possibly prison staff and parole boards. Highly sensitive information of which the defendant is unaware may therefore need to be excluded. Above all, the patient's written consent must be obtained before the report is submitted to the court. The BMA's *Handbook of Medical Ethics* states that "when asked by a court to disclose information without the patient's consent the doctor should refuse on the grounds of professional confidence," and that if then ordered to disclose it "is a decision to refuse, which is not necessarily unethical."⁴ It is also important to remember that the

report is addressed to laymen and must therefore give clear explanations of medical terms and that it is an independent report giving a balanced medical opinion, whether requested by the court or by the defence. The report must state clearly in the first paragraph the sources of information on which it is based. It must include details of interviews with the defendant and other informants, and state what other information—such as social inquiry reports and hospital case notes—was available. Although a social inquiry report will often be prepared at the same time, it is important to summarise the relevant personal history and then to discuss in more detail the extent of the alcohol problem and its relation to the offence. A brief assessment of mental state at interview must then be given, followed by a clear summary of the assessment of the patient. Finally, recommendations are given to the court.

Alcohol dependence and criminal offences

The court does not need to know the quantities of alcohol consumed by the defendant but does require an assessment of the extent of his dependence on alcohol both psychologically and physically and the implications for treatment. For example, it may be necessary to state that physical dependence means that the patient will suffer withdrawal symptoms on stopping drinking and that detoxification may safely take place only under medical supervision. Psychological dependence implies loss of control of drinking, so that the patient can never be certain whether he can stop his alcohol intake at any time after the first drink. The court needs to know that under these circumstances abstinence is the only safe method of treatment and that an attempt to continue "controlled" drinking is highly likely to fail.

In alcohol dependence alcohol is often used deliberately for its disinhibiting effect, so that the person concerned can release strong emotions and behaviour which are normally tightly controlled. A common sequence of this pattern of abuse of alcohol is the release of explosive anger and aggression, which easily results in violence or other criminal offences. The defendant will often claim not to be responsible for such behaviour because it was committed when intoxicated. Sometimes defending solicitors use this as the basis for a plea of not guilty on the grounds that the defendant was incapable of forming the intent to commit the offence owing to extreme intoxication. This is almost never a valid defence either medically or legally. The court may need to be told that pharmacological alcohol is a depressant drug and does not diminish the capacity to form an intent to commit an action but does diminish the capacity to resist that impulse. In other words, someone when intoxicated is more likely to act on the impulse to commit an offence rather than less likely. No one who drinks regularly may claim to be unaware of this disinhibiting effect of alcohol, and its deliberate use does not in any way absolve the individual from responsibility for the consequences. It might be possible to use this defence if the defendant was also taking other medication which interacted powerfully with alcohol, without having been warned of this danger by the prescribing doctor and advised not to drink alcohol while taking the drug. It is only when "consciousness is so clouded as to be all but obliterated that the capacity to form an intent is lost and a state of automatism exists in which the act is regarded as involuntary."

This discussion of the relation between the defendant's alcohol consumption and the offence should be followed by a summary giving the diagnosis and opinion of the patient and of the treat-

ment that is appropriate. The question of voluntary or compulsory treatment must be considered. In our opinion voluntary treatment for alcoholism should always be offered except perhaps if the patient is suffering from severe organic impairment. Since courts sometimes make treatment compulsory as a condition of probation the voluntary nature and likely duration of treatment must be presented to the court. It is important not to give an impression that the patient is "cured" after treatment for alcoholism and it is always useful to state that the outcome of treatment remains unpredictable. It may help to draw the court's attention to the fact that abstinence from alcohol will render further alcohol related offences less likely. It is, of course, essential to make clear to the court whether the treatment you recommend is something that you will offer, that has been arranged with another doctor, or has yet to be organised. The court may well impose a sentence which allows the defendant to take up treatment that you have recommended, and the doctor preparing the report must not recommend treatment which is later found to be impossible to implement. Those recommendations for treatment depend entirely on the facilities available. The court needs to have a clear recommendation as to the sentence that will most effectively facilitate appropriate treatment. Even where treatment is not made compulsory there is an expectation by the court that treatment will be taken up by the defendant and this brings a certain amount of pressure to bear. A deferred sentence, for instance, requires a review in a few months' time and sentence given depending on events in the meantime. A suspended sentence carries the threat that it will be immediately implemented if further offences occur. Community service orders and probation orders provide a period of compulsory supervision of the offender in the community and voluntary treatment for alcoholism may be taken in parallel with these. Deferred or suspended sentences and probation and community service orders are all possibilities if the court wishes to retain some control over the offender, but minor offences related to alcohol are often dealt with by a conditional discharge or a fine. A recent paper has suggested that compulsory supervised disulfram as a condition of probation is an effective sentence and form of treatment for the habitual drunken offender, but we think that this claim is not substantiated and includes an unacceptable degree of compulsion in treatment.

Finally, the need for treatment is only one factor that the court will consider when deciding sentence. It will, however, always place great value on a report that is clear, brief, and relevant, uses non-technical language, and gives realistic recommendations.

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Response to paper on "Audit of the use of vitamin B₁₂ in general practice"

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We are interested in whether the research papers that we publish in *Practice Observed* have much influence on anybody. We have, accordingly, asked four general practitioners to write briefly about how they responded to the paper by Professor Robin C Fraser, Dr Malcolm Garkner, and Dr Helen Smeeth on "Audit of the use of vitamin B₁₂ in general practice" (10 September 1983, p 729) and whether they have changed their practice in any way because of it. Ed, BMJ.

Dr Taylor's response

I had seen but not read this paper when I was invited to comment on it. Like most doctors faced with the impossibility of absorbing more than a fraction of the written material arriving "I scan what I can" and "read what I need." What gets through the sifting process is a mix of material of special interest and that which is novel or interesting; if it is not quickly apparent that something needs to be read it is either discarded or put on one side.

The fate of vitamin B₁₂ did not excite me much. I recalled that in my own practice a few years back there was a rise towards nurses administering Neo-Cytamen at intervals of two to three months, and had rather left it at that. Practice research and audit both interest me, but audit isn't research is it? Except perhaps rarely. I know that Professor Fraser holds this view and writes sensibly about audit. Was this one of those occasions when an audit was research? In the absence of a summary I had to read the whole paper to find this out; clearly this was audit and not research, but a very workmanlike audit and a good model to follow. The authors and the anonymous Dr D, who carried out a similar audit with similar results while a trainee in Lincolnshire in 1980, are to be congratulated.

The authors set out to examine their use of vitamin B₁₂, and to achieve more appropriate use of it, and they succeeded. Their criteria for the use of vitamin B₁₂—the diagnosis of pernicious anaemia—and the administration of B₁₂ are all reasonable; their finding of so few patients with "non-specific indications" for vitamin B₁₂, treatment is encouraging, and the finding of only 23% with all diagnostic criteria is probably still better than most could show. Most of all, the authors and their colleagues set out on a road of change with improved diagnosis in new patients, a halving of the number of re-injections, and improved monitoring.

What criticisms I have are for the presentation of the paper. To be honest, I found it a little dull, particularly the introduc-

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tion, and I wondered why, if this was largely a trainee project, it had not been written up solely by the trainees. It was misleading to use the expression "I was widely prescribed by general practitioners for non-specific indications" for a survey as long ago as 1970. On the other hand, it would have been interesting to see a comparison of the present findings with both those of the 1970 paper and those of the survey by Cochrane and Moore of prescribing in 1966 and reported in 1971.¹ There is confusion of incidence with prevalence of pernicious anaemia in the discussion; the authors state that the incidence of pernicious anaemia was 1.8 per 1000 when surely they mean prevalence. These criticisms, though, are pedantic and my only major criticism is of the presentation, for I feel that if research and audit had not been confused and if there had been a summary all would have been clearer and more readers might have been attracted. (Summaries were not published with papers in *Practice Observed* at the time, alas, BMJ.)

I said earlier that the fate of vitamin B₁₂ did not excite me much; it still doesn't, but having read the paper by Professor Fraser and his colleagues it did seem important to look at our own use of vitamin B₁₂. It was simple to identify the patients—the practice nurse and community nurses supplied their individual lists and it was evident that almost all patients had injections at intervals of two months, sometimes more, but there were far more patients than would be expected from the prevalence of pernicious anaemia; a preliminary "audit" suggests that there are a large number of patients with past gastrointestinal surgery and some elderly patients with normal haematology and reportedly low serum B₁₂ concentrations. Perhaps this needs looking into, but that is another story.

Dr Nathan's response

The confirmation of a diagnosis of pernicious anaemia and its successful treatment is one of the satisfying experiences of general practice. It requires clinical acumen, examination skills, and laboratory investigations, resulting in the resolution of symptoms and a grateful patient.

The diagnostic criteria of macrocytic anaemia and a low serum B₁₂ concentration with a normal folate concentration are readily detectable, and we, flushed with success, rely on clinical response to confirm the diagnosis without checking the reticulocyte count.

Mine is a three year old practice in a new town. Most patients who receive treatment were having monthly injections before we arrived here and were receiving hydroxycobalamin. I have diagnosed three cases of pernicious anaemia by the first two criteria and failed to look for a reticulocyte response. My first patient received a monthly dose of 1000 µg. The second, a man aged 75, regularly complained of a return of symptoms three weeks after his injection. It seemed prudent to comply with his wishes and he is pleased to have his three weekly injections. The third patient was recently diagnosed and will have a reticulocyte count done in the near future. She will receive two monthly injections as the first step towards attempting to change practice rituals.

I question the necessity for annual haematological checks, but if performed we could use a similar recall system for checking thyroid function in patients with myxoedema and for

urea and creatinine concentrations in patients with hypertension.

The optimum dose of hydroxycobalamin for pernicious anaemia is 1000 µg every eight weeks, yet many patients receive monthly injections. Perhaps there is justification for this. A well organised, well staffed practice may ensure that patients can be followed up every two months. I suspect, however, that the longer the interval the poorer the compliance will be. It is relatively easy for an elderly patient to remember a monthly visit to the doctor's surgery, but the same elderly person may find it difficult to remember after two months, and indeed may think that the injection was given last month. Perhaps the return of symptoms will be a reminder, but again I suspect that the elderly patient may not recognise these symptoms.

The regular monthly habit probably maintains compliance and also provides an opportunity for an, albeit brief, assessment of an elderly patient by the district nurse. This is invaluable compared with the meagre savings of halving the dose. I think my third patient will, after all, receive monthly injections.

Dr Gibbins's response

I am sure that in our group practice there are patients who are receiving inappropriate treatment for their illness, and that there are few practices in which this is not the case. Professor Fraser and his colleagues have, in their paper, picked on one of the more easily defined groups in terms of both diagnostic criteria and response to treatment, and they have shown that even in a well organised group practice there is plenty of room for improvement. They have also shown that by introducing a simple set of rules the necessary improvement may easily be achieved.

I suspect, however, that this was not the only reason for carrying out the audit, or for publishing it. It seems to me that this paper is primarily intended to show the value of audit in general practice and that the whole process is reasonably simple, not too time consuming, and may eventually lead to a reduction in workload for practice staff and financial savings for both the practice and the Health Service. The project also undoubtedly provided valuable research experience for the two trainees, which is another good reason for tackling an easily definable subject.

Thus the paper shows that vitamin B₁₂ is often misused in general practice, that it may be used more efficiently and cheaply, and that most importantly "audit" is worth while. But is it going to change what I do? This is the crux of the question really, because I think that we are often prepared to change our own habits only when we have been shown that the change is needed. I am already doing research—call it audit if you like. I have an irrational dislike of the word—so that part of the argument is already won. As far as my patients on B₁₂ are concerned, I shall try to ensure that they are all having the right dose at the right interval for the right reasons, though some are likely to slip through the net until we do our own audit and can be shown by the results into arranging things properly. The most daunting task, however, will be convincing the frugal Neo-Cytamen addicts who "feel wonderful, doctor, but only for a week after the injection," that the new stuff is just as good and that they really do need to have only one injection every eight weeks.

Dr Gau's response

The request to review a paper as to whether it had influenced either myself or my practice's behaviour and whether I had found the paper relevant and interesting partly assumes that at least some papers are written to try to influence people's behaviour—this I find a doubtful premise. A quick look at the fascinating

series, "Papers that have changed my practice" does not reveal more than a handful of such papers, and I would not, on a priori grounds expect it to be otherwise. A few papers do change our behaviour—recent prescribing of oral contraceptives is a case in point—but if this were the sole criteria for publishing, our regular reading would be meretricious. The point is that Audit is important, and thus has to be taught. It seems that this paper was the outcome of two trainees carrying out an audit in their training practice. The fact that it was published in the *BMJ* gives the process a seal of approval, and if the trainees wrote the paper (and not the professor, but then should he not have been listed on the list of authors?) another useful educational objective would have been achieved.

It is a truism, also mentioned in the paper, that it is the performance of the audit that is educational in itself, and it is surely not to be expected that I would find anything new or interesting in it. All papers on audits can have only limited interest to outsiders.

I found the style of the paper interesting. "... to be shocked that patients have inadequate monitoring of their haematology" (and no evidence of subacute combined degeneration): what would have been their reaction to an available death? To halve the number of injections for 24 patients is hardly going to release much of the nurse's time for taking blood pressures. The statistics in the paper were straightforward, but I of the original 27 patients had died or left the practice, and we are not told if any of these were in the group of unnecessary B₁₂ users who stopped having the injections.

In short, it is a well performed audit, well written and presented, but of little or no use to those of us outside the practice. Perhaps the *BMJ* could perform a service by accepting these papers (so the authors are satisfied) but only publishing the title?

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Diary of Urban Marks: 1880-1840

Jarvis became enamoured with Ada Price, whose brother managed a hotel in Swansea. He bought her a lovely diamond ring but persuaded the jeweller to let him have it on the promise that it would be paid in a few days as Jarvis was expecting to receive money and let the salary from him. Ada was very pleased with the ring and there was a talk of marriage when the war was over. Now Ada was not a man's enemy. She must have been well over 40 but she was also a woman of the world. It is a tribute to Jarvis's persuasive powers that she was guided as well as John Jarvis, who had as hard a head as any man I ever met. Towards the end of the sixth month after Jarvis had come here he persuaded John to advance him some money running into hundreds of pounds on the plea that he had to go to London to settle up his own affairs since he intended to remain in Swansea. He told John that he had a flat in London which he wished to dispose of and there were other things besides. John did not know that Jarvis had told the BMA about this and that he had left and let Jarvis have the money. Jarvis promised to return in three days but as he did not do so, Puntan tried to the address Jarvis had given to him in London. The wire was returned as address unknown. And so passed Jarvis, and it was not until about three years after the armistice that we saw a photograph of him in the London papers. The photograph was recognised by many people here and during his trial for swindling part of his career was mentioned in court. I forget what sentence he received, but whatever it was he deserved every minute of it.