Insect bite allergy.

Drug reaction to sulphapyridine.

Insect bite allergy—Large blisters, which are usually not itching, can occur on the legs of susceptible individuals.

Bullous drug eruptions

Fixed drug eruptions can develop bullae, and some drugs can cause a generalised bullous eruption, particularly:

Barbiturates (particularly if taken in overdose)

Sulphonamides

Penicillamine (captopril, penicillins (which produce pemphigus-like bullae))

Fruzemide (may be phototoxic)

Remember that there may be an associated erythematous eruption.

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Medicolegal

Consent to treatment and criminal responsibility in the mentally ill

CLARE DYER

With more and more people surviving into their 80s and 90s inevitably more will be suffering from dementia in their later years. A decision by the High Court last month should make it easier for elderly people whose mental powers are declining to arrange for someone they trust to handle their affairs on their behalf. The two cases, referred to the High Court by the Court of Protection,^{1,2} highlight a common problem for the families of elderly people whose faculties are dimmed by age: by the time it occurs to the family that some means of managing the aged relative's property and affairs may be necessary his or her mental capacity may already be in doubt.

Problems of power of attorney

Until last year, when the Enduring Powers of Attorney Act 1985 came into force, the problem was much more acute. Previously a power of attorney entered into when the donor of the power was in full possession of his faculties was automatically revoked if he later became mentally incapable, leaving the attorney without any authority to act. So just when the power was most needed it became worthless, and relatives had to resort to the more cumbersome and costly procedure of having a receiver appointed by the Court of Protection. The enduring power of attorney was introduced to deal with this problem by allowing a person, while he still had the capacity, to give a power of attorney to someone of his choice to take

over the management of his affairs either straight away or in the event that he later became incapacitated. Notwithstanding the incapacity, the power remained in force as long as the donor had had the capacity when he entered into it.

The question that arose in the two cases that went to the High Court was: if a person is already incapable of managing his affairs can he still have the legal capacity to enter into a power of attorney? In both the cases the master of the Court of Protection found that, although the donors were incapable of managing their own affairs, they were able to understand what an enduring power of attorney was and that the relatives who were given the power were to be their attorneys under an enduring power of attorney. The master referred the question of the validity of the power to the court. Mr Justice Hoffman ruled that a person may validly create an enduring power of attorney even if he is already incapable of managing his property and affairs by reason of mental disorder. It is necessary only that he understands the nature and effect of the power when he creates it.

The decision was welcomed at last month's symposium organised by the British Medical Association and the British Academy of Forensic Sciences on mental health and legal capacity, which, in a wide ranging debate, also tackled the issues of consent to treatment and criminal responsibility. The morning session, which dealt with the civil law, was chaired by Mrs A B McFarlane, master of the Court of Protection. When the court receives an application for a receiver to be appointed or discharged (if the patient recovers mental capacity, which happens infrequently) or if there is a question of testamentary capacity the court may send a psychiatrist, one of the Lord Chancellor's medical visitors, to visit and make a report. Dr E F Carr, one of the six part time medical visitors, outlined their work.

They were, he said, the eyes and ears of the court, helping to put a more human face on bureaucracy. A frequent reason for requesting

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a visit was the absence or inadequacy of medical evidence supporting the application. There was still widespread ignorance about the Court of Protection, and some doctors tended to drag their feet when faced with the request for the medical certificate, which constituted the most important piece of evidence the court had to consider. Experience suggested that some general practitioners disliked stating that their patients were incompetent, which, combined with clinical caution, resulted in certificates that were indefinite or full of provisos.

Mr William Bingley, assistant director (legal services) of MIND, the national association for mental health, warned that the issue of the legal and social consequences of mental incapacity would become increasingly prominent because of the growing number of people over 85. By the end of the century the number was expected to reach almost one million.

In deciding whether a person had the legal capacity, for instance, to enter into contracts or to make a will, the question was not whether he could perform the function in a sensible way but whether he could understand in broad terms what he was doing and the likely consequences. To make a valid will the testator should have a rough idea of what a will is and be generally aware of what he has to leave and to whom he might leave it, even if he decides not to leave it to them.

Consent to treatment

On the question of consent and patients who are mentally incapable, Mr Bingley asked what safeguards should be introduced into the current, almost non-existent, legal framework. He suggested two possibilities: a much clearer statement of what was required from those charged with the patient's care and the creation of a new, independent substitute judgment procedure. England and Wales was one of the few common law jurisdictions without a wide ranging power of adult guardianship. He suspected that it would not be long before proposals for such a power were forthcoming; whether we should run a mile from such proposals or welcome them as a way of equitably coping with mental incapacity was an issue we would all have to face.

Dr John Wall, deputy secretary of the Medical Defence Union, emphasised that the status of a patient under the mental health legislation did not indicate whether he had the capacity to consent. Doctors often said: "The patient's civil status is such and such; he is under the Court of Protection, with a power of attorney in favour of his brother. Does this make a difference in whether he can consent to the treatment?" On the advice of solicitors the Medical Defence Union had regularly been advising doctors for many years that the patient who was incapable of managing his own affairs—for instance, the patient who might be incapable of making a will that would stand up in court—might yet be capable of giving a valid consent to treatment. Dr Wall commended the 1985 consultation paper issued by the Mental Health Act Commission,³ which, he said, contained admirably clear discussions of doctors' dilemmas about consent and patients who are mentally incapable.

Criminal responsibility

The afternoon session, chaired by Sir Roger Ormrod, a former lord justice of appeal, looked at the question of mental capacity and the criminal law. All three speakers—Dr John Hamilton

(medical director and consultant forensic psychiatrist at Broadmoor), Mr Alex Samuels (former reader in law at the University of Southampton), and Mr Roger Henderson QC—criticised the existing law on insanity and diminished responsibility.

Dr Hamilton said that the McNaghten rules, laid down in 1843—which for a verdict of not guilty by reason of insanity require that "it must be clearly proved that at the time of committing the act, the party accused was labouring under such defect of reason from disease of the mind as not to know the nature and quality of the act he was doing, or if he did show it, that he did not know that what he was doing was wrong"—were generally agreed to be unsatisfactory and based on an outdated concept of mental disorder. For long it had been recognised that many mentally abnormal offenders knew what they were doing but their judgment was affected by severe mental disorder: whereas their cognitive capacity was often intact, delusions might have led them to commit homicide. Such individuals, however, could not be found to be insane because they did not fit the criteria of the rules.

Mr Alex Samuels pointed out that insanity was almost never pleaded nowadays because of the stigma and the resulting indeterminate period of detention, probably life, in Broadmoor or a similar institution. Diminished responsibility, which reduces a charge of murder to manslaughter if the accused "is suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts or omissions in doing or being a party to the killing," carries a discretionary sentence, which could be detention for life, or even a non-custodial sentence in "compassionate" cases.

The case of the Yorkshire Ripper, however, had shown up difficulties about diminished responsibility and mental condition generally. Though doctors on both sides agreed that the Yorkshire Ripper was a paranoid schizophrenic, the jury found that diminished responsibility was not made out and he was convicted of murder. Mr Samuels called for the abolition of the mandatory life sentence for murder; the creation of a separate offence of homicide to be broken down into various categories; and the acquittal of those who are substantially mentally impaired to be followed by civil disposal under mental health legislation. Offenders who are mentally impaired should not face imprisonment because of criminal conviction or the unwillingness of doctors to take them as patients, he urged.

Reform of criminal responsibility and mental state was not a matter with much mileage, said Mr Roger Henderson, but surely it was time homicide was categorised according to degree. One possible reform would be to allow the jury to decide whether the defendant was deprived of all culpability, or substantially or moderately deprived of culpability, because of his mental state. He suggested that judges should be given discretion in all cases to mitigate the sentence or exonerate the offender if his mental responsibility was impaired. All too often mentally ill offenders were in prison because doctors were unwilling to make the necessary diagnosis or offer them a bed. He concurred with the view that offenders who were mentally handicapped should be acquitted and that a man should be discharged from the criminal system if he did not carry any criminal responsibility.

References

- 1 Herbert S. Law report. In re K; In re F. *Guardian* 1987 Nov 4:11 (cols 1-3).
- 2 Anonymous. Law report. *The Times* 1987 Nov 16:43 (cols 1-6).
- 3 Mental Health Act Commission. *Consent to treatment*. London: Mental Health Act Commission, 1985.