Compulsory admission

For half a century the use of compulsory admission for the mentally ill has steadily declined. In this decline the Mental Health Act of 1959 stands out as a landmark. Its main purpose was to enable as many of the mentally ill as possible to be admitted to hospital as informally as other patients and to ensure that the few who needed treatment but refused it were dealt with quickly, easily, and humanely. This Act in its turn has now come under criticism. Some reformists take the view that civil liberty should be paramount and that no one should be admitted to hospital against his or her will. More cautiously, the Department of Health and Social Security has put out a consultative document, based mainly on a comparison of suggestions from the Royal College of Psychiatrists and from MIND (the National Association for Mental Health), on how the Act should best be amended. The Department held an all-day conference on the document on 25 October. If the more extreme views (including one or two of those put forward by MIND) were adopted there would be more difficulty and delay in getting patients admitted to hospital, and their suffering—including that of their relatives—would be intensified. Extra force would then be given to the gibe that the proponents of these views are content to see patients “dying with their rights on.”

In a challenging article in the American Journal of Psychiatry, Paul Chodoff has not been content with defending orthodox psychiatry against such views: he has gone over to the attack. He believes that the rights of the mentally ill to be treated and protected are as important as their civil rights, if not more so, but that the right to treatment is being perilously set aside in favour of freedom. Despite variations in the legal process his analysis—essentially a study of points of view—is wholly transplantable to this side of the Atlantic.

Chodoff distinguishes three viewpoints. The first, the abolitionist, includes those who believe with almost religious fervour that compulsion is never warranted in any circumstance, that liberty is always to be valued above mental health, and that when voluntary compliance with treatment is not forthcoming psychiatrists should withdraw and, if an offence is committed, allow the law to take its course. The abolitionists have included Thomas Szasz, R D Laing, and the several groups of antipsychiatrists. None of the patients described in Chodoff’s paper—a severe depressive, a catatonic, a manic, a deluded schizophrenic, and a patient with delirium tremens—would, if unwilling, have received treatment from any of them.

On the other hand all would probably be treated by Chodoff’s second group, the medical-model psychiatrists, who would regard such people as ill and would recognize an obligation to treat them with compulsion if necessary. That obligation would not, however, apply to individuals not suffering from mental illness but having instead personality disorders, neurotic reactions, or being dependent on alcohol or other drugs of dependence.

The third viewpoint, that of civil liberties lawyers, does not reject the need on occasion for compulsory admission to hospital. But it does reject the medical model, the notion of psychiatric illness, and the expertise that psychiatrists claim in diagnosis. In rejecting medical criteria this group of lawyers exalt the supposedly more objective estimate of dangerousness “to self or others” as the sole or almost sole ground for using compulsion. Chodoff argues—with clinical evidence on his side—that to concentrate on dangerousness (especially to others) as the sole criterion for involuntary admission to hospital deprives many mentally ill persons of the protection and treatment they urgently require.

Though written by an American lawyer, the MIND report does not go quite so far as to suggest dangerousness as a sole criterion. Again the medical model is rejected, but “grave disablement,” meaning the inability of some mentally disordered people to provide for basic personal needs such as food, clothing, and shelter, is seen as justifying formal admission. The report adds that, although dangerousness and grave disablement are indispensable grounds, there ought also to be additional grounds, such as treatability or lack of insight.

There is an important distinction between dangerousness as used in that context and the special use of the same word in the Butler report in connection with offenders and reviewable sentences. In considering the need for compulsory admission MIND applies the word to some features in a person’s behaviour while mentally ill; in the Butler report it refers to a more or less persistent quality of a person whether mentally disordered or not.

There is one more aspect of compulsory treatment which Chodoff barely mentions. Not only is compulsory admission at risk of becoming more difficult because of a narrowing of criteria: the influence of those he calls the antipsychiatrists and abolitionists is also more pervasive. There have been subtle changes in public opinion, including the opinions of many of the younger doctors. Physical methods of treatment, particularly electroconvulsive therapy and psychosurgery, are under something of a cloud and there are growing suspicions of the side effects of drugs. In consequence, perhaps, too much may be hoped for from psychotherapy for too long because of a reluctance to resort to alternatives. Does delay in treating a manic patient cost him and his family too dear? And how many psychiatrists fail to stand their ground, capitulate, and discharge a patient who, though probably unfit for discharge, has appealed to a mental health review tribunal?

We in Britain are not yet faced with moral obloquy if the possibility of compulsory admission is considered (as is the case in some places in the United States), but perhaps we should stop patting ourselves on the back over how few short-term patients need to be compulsorily admitted. Perhaps there should be more.

5 Chodoff, P, American Journal of Psychiatry, 1975, 133, 496.

Brain death

Few medical topics have provoked more public comment than the definition of brain death, but it is also true that few subjects have been more confused by muddled thinking and inadequate expert advice. The need for clinical criteria for the diagnosis of brain death has come from the wide availability of intensive care techniques. It is now routine practice for patients with some kinds of respiratory failure to be maintained on a ventilator, and inevitably many do not recover. The decision to stop ventilation has to be taken in such cases has
nothing to do with transplant surgery or with euthanasia: it is a straight clinical assessment that the patient is dead though his heart is still beating. The clinical decision is, however, a weighty one and for that reason the code of practice agreed by the Conference of Royal Colleges and Faculties of the United Kingdom is welcome (see p 1187). It sets out clear guidelines for the diagnosis of death, including a recommendation that the decision to withdraw artificial support should be taken by two doctors. There is a consensus of medical opinion throughout the western world on the diagnosis of brain death. Perhaps we may now see an end to uninformed comment on the topic.

Or in the heart or in the head?

The use of pacemakers has trebled in Britain in the past four years: they are now implanted at an annual rate of 56 per million population. Yet this is only one-fifth of the American rate of 270 per million population and appreciably less than most European countries, where rates vary from 75 per million in Spain and Portugal to 178 per million in Sweden. There are three possible explanations for this disparity. The incidence of conduction disturbances requiring pacing might be less in Britain than elsewhere in the world—but there is no evidence that this is so. Alternatively, the indications for pacing in Britain might be correct, in which case most other countries would be guilty of excessive pacemaker implantation. Finally, many patients in Britain who might benefit from pacing might be being denied proper treatment. The rapid increase in the rate of pacemaker implantation suggests that the third explanation is the true one, but that is not to say that excessive enthusiasm for the procedure may not have led to too high a rate of implantation in some countries.

Most patients with complete or intermittent heart block causing Adams-Stokes attacks or cardiac failure are referred for pacemaker implantation sooner or later. As the sick sinus syndrome (a comparatively newly recognised disease) is recognised more often, so too will the rate of pacemaker implantation increase. There is justifiable caution in Britain about prophylactic pacing of asymptomatic patients with electrocardiographic evidence of bundle branch block and an abnormal cardiac electrical axis. But what of those patients with minor degrees of rhythm disturbance which are possibly causing cerebral or cardiac symptoms?

Abdon and Malmcrona have suggested that many patients with neurological symptoms—dizziness, confusion, and syncope—are incorrectly diagnosed as having minor cerebral ischaemic episodes due to cerebrovascular disease, whereas the real cause is a transient disturbance of cardiac rhythm amenable to treatment by pacing. In their unit in Sweden this concept of "cardiogenic neurology" has prompted screening of patients with apparent cerebrovascular disease for rhythm disturbances. As a result, their local rate of pacemaker implantation is twice that found in the rest of Sweden and nearly six times the British figure. The variety of arrhythmias they found causing symptoms was remarkable: sinus bradyarrhythmia, severe sinus arrhythmia, sinoatrial block, sick sinus syndrome, atrial fibrillation with asystolic periods or a slow ventricular rate, slow nodal rhythm, and intermittent or permanent heart block in varying degrees.

On the face of it, then, it seems that many patients with neurological symptoms could be cured by pacing. Nevertheless, the average age of the Swedish patients was 70. In elderly men and women cerebrovascular disease and conduction abnormalities may be expected to coexist, so that to attribute symptoms to one rather than the other calls for careful clinical judgment. Facilities for ambulatory electrocardiographic recording over a prolonged period may help in reaching a decision. If in the end doubt remains—as indeed it often does—it may be justifiable to implant a pacemaker. The encouraging results from a review in Britain by Edgar Sowton (p 1182) support this view: not only is the morbidity and mortality associated with the procedure negligible, but patients with pacemakers have a normal employment potential, and insurance companies have no evidence that these patients are at an increased risk. Even more important, perhaps, is the impact of pacemaker implantation on the scope and range of the leisure activities among retired patients. If we care about quality of life in our over-70s we should hope that the rate of pacemaker implantation will continue to increase rapidly in Britain.


The ultimate cost of malnutrition

The long-term effects of protein-energy malnutrition on intellectual achievement have been the subject of enormous research effort and repeated discussion in recent years. Research in animals has shown that there are critical periods in the most rapid phase of brain growth when malnutrition impairs the velocity of the growth spurt; the result is a permanent reduction in the size of the brain. Whether or not these experiments are relevant in man is a difficult problem fraught with complexities. Most clinical observers have concluded that there is a significant long-term impairment of intellectual potential after an episode of protein-energy malnutrition. Indeed, some believe that there is no need for further studies, arguing that more concern should be given to the whole problem of prevention. Nevertheless, many children are still destined to suffer the acute and often protracted misery of malnutrition. For them some remedy is needed and at least three questions still remain to be answered.

Firstly, we do not yet know how much a part the deprivation of learning, energy, and activity which may precede or result from malnutrition plays in the long-term deficit. Richardson et al tried to score the mental stimulation provided in the homes of malnourished and control boys, and could distinguish four subsets: malnourished and non-malnourished boys and low and high "intelligent" stimulation. The general intelligence measured between 6 and 10 years of age showed the expected order, with the non-malnourished boys from stimulating homes 18 points above the malnourished boys from homes with low stimulation, and with the two other groups between. Clearly any rehabilitation after malnutrition must provide both adequate nutrition and educational stimulation, for inevitably it is the total sum of the effects of malnutrition and deprivation which makes up the human syndrome.

Secondly, very few studies have looked at the ultimate cost...