Journal of medical ethics, 1980, **6**, 35–40

Case conference

A volunteer by family choice

I was asked by a GP a few weeks ago, on a Sunday afternoon, to go and see a patient whom he had been called to see twice during that weekend. She was 70 years old, recently discharged from a general hospital, where she had been complaining that her bowels were not moving. She had other hypochondriacal symptoms. At home she talked incessantly, moved about the house in an agitated manner and was accusing her husband of all sorts of infidelities, etc. (Her husband was 72 and they had been married a year!) Her ceaseless and disconnected talk was getting her husband down. Even her children, who had been initially unsympathetic toward him now supported the old man in the view that something had to be done. The GP had tried to manage with sedatives but the old lady refused to take them. When I arrived her three children plus their spouses and the old man were present, with the old lady lying on the couch. I diagnosed hypomania and believed the situation could be contained by the use of appropriate drugs.

We talked in the kitchen and I suggested my treatment plan, which would avoid hospitalisation, but the family by then had no faith in medicines. The patient didn't want to go into hospital: the relatives wanted hospital admission. Although elated and over talkative the patient had not lost her capacity to reason and was in touch with reality. I did not therefore feel that certification was justified. I was also concerned about the effect of such a step on her relationship with the staff once in hospital, and perhaps on her long term views of her family. When I demurred at compulsory admission, but said I would like her to come voluntarily, the family simply bundled her into one of their cars and took her to the hospital. Once there she willingly stayed and quickly improved with treatment and has been able to return home to her husband.

Was this a miscarriage of the law? – for this was far from voluntary hospitalisation. The relatives took the law into their own hands. Was this assault? Should she also have been made a compulsory patient, or was the good humoured relatives' treatment best? There was the pressure of the social situation. I was quite clear myself that we should try home treatment first, but the home situation did not allow it. There were other pressures too – the time of the day, the demand for an objective medical opinion, simply to support one already made in the family, the attitude of GP, family, husband. I might have found sufficient evidence of derangement to satisfy the Sheriff, but in psychiatry it is important to maintain the relationship of trust with the patient and to put someone on a compulsory order can be very damaging to that relationship.

Commentaries

J B Loudon *Consultant Psychiatrist, Royal Edinburgh Hospital*

My first comment would be that this is a classic instance of how, in psychiatry, a missed diagnosis (a complaint of somatic symptoms and hypochondriasis in a 70 year old should give rise to the suspicion of a depressive illness) can lead to the development of a crisis in which many treatment options are closed because of the heat generated and the anxiety felt by those surrounding the patient. Furthermore, the more the symptoms have developed the less the individual will be amenable to rational persuasion.

Secondly, I would argue that in both mania and depressive illness, the first principle of management must be protection of the patient's long term interests. In my practice I do not find certification, especially by emergency order which lasts for seven days in Scotland, damaging to the subsequent treatment relationship, especially when, following treatment, insight returns and the patient becomes aware of the predicament he and those around him were in. Of course the situation is somewhat different when a compulsory order on a longer term basis is sought especially when the closest relative has to apply to the Court. In this case, treatment is usually effective fairly quickly and that consideration did not arise. By these comments I do not mean that emergency certification should be a common practice, only that a decision whether or not to compel admission must be made on a judgement of a risk to a patient and those around which is real, rather than consideration of possible subsequent recrimination which is problematical.

Hypomania is a potentially dangerous condition in someone of this age, leading to exhaustion, dehydration and poor nutrition as well as the disruptive effect of increased aimless drive and paranoid accusations on the individual's nearest and

dearest, which may prejudice the future happiness of the relationship. For this reason, if the visiting psychiatrist has made it clear that he is not able to admit the patient compulsorily, then I consider the relatives' behaviour in taking her to hospital more altruistic than assaultative. I think that I would have tried to establish a contract with the relatives that if the patient had not improved within 12 hours of my starting treatment at home then they would have my agreement to bring her into hospital. Persuasion of a manic patient to comply voluntarily with drug treatment is a test of professional competence, but can be done, especially if the family doctor is there as a professional known to the patient. In this case, where the relatives were set in their wish to admit the patient the case is lost if the possibility of admission is confirmed by the visiting psychiatrist immediately. It is a fine matter of balance between a wish not to hospitalise a patient and the imposition of further burdens on, in this case, an aged husband; in any event, behaviour has to be guided by the feel of the situation.

R N M MacLean QC *Member of the Scots Bar*

The reference by the reporting psychiatrist to satisfying the Sheriff with sufficient evidence of derangement indicates a Scottish context and therefore justifies an examination of the legal issues, at least, from the predominant standpoint of Scots law. In support of an application for the compulsory admission of the lady in terms of Section 24 of the Mental Health (Scotland) Act 1960 the psychiatrist and his medical colleague would have had to state and agree upon the form of mental disorder from which the lady was suffering. They would also have had to state that the disorder required or was susceptible to medical treatment and was of a nature or degree which warranted the lady's attention in hospital. Finally, their medical recommendations would have had to include a statement that the interests of the health or safety of the lady or the protection of others could not be secured otherwise than by her detention in hospital. The English provisions relating to applications for admission for observation or for treatment under Sections 25 and 26 of the Mental Health Act 1959 are not so markedly different in substance, except of course that such applications for admission do not have to pass the independent scrutiny and approval of a judicial authority, namely the Sheriff in Scotland.

I have set out the provisions of Section 24 of the Scottish Act because it seems to me that the psychiatrist could not have honestly held the opinion, which had to be embodied in his statement, that the interests of the health of the patient could not be secured otherwise than by detention, *unless* he felt that the relatives' attitude to her was such that her health would have suffered in their care. The patient herself appears not to have been averse to home drug treatment. I doubt also from what he has said whether the psychiatrist could really have said that the mental disorder from which the lady was suffering was of a nature or degree which warranted her detention. Detention was the obvious expedient to accommodate the wishes of the family, not that of the patient. So, if there was any miscarriage, it would surely have resulted from an application for admission under Section 24. Was her entry to hospital correctly described as far from voluntary hospitalisation?' The point is that once she had physically arrived at the hospital, she willingly stayed. Of course what immediately preceded her arrival at the hospital gates may not have been so freely entered into. Assault legally has been defined as any attack upon the person of another. Although the word 'attack' has a flexible content, it is doubtful whether the act of bundling the lady into a car would quite amount to that. She appears not to have been carried off protesting or resisting. She went with her relatives, and once at the hospital willingly entered it and stayed, with beneficial effect, as a voluntary patient.

If the psychiatrist, presented with the medical and moral dilemma he describes, turned a Nelsonian eye towards the manner of his patient's departure from home, he surely need not search his conscience very far about that. No other course of action in the circumstances would have had so satisfactory a result for his patient. If that view is attacked as being dependent largely upon hindsight, it could quite reasonably be said in response that medically no other course was at the time properly open. Indeed it would have been difficult for the psychiatrist not to strive to secure treatment for the lady. Fortunately, the end justified the slightly dubious nature of the means adopted to secure such treatment for her. I am clear that the law, at least, would not have disapproved of the action taken.

Linda Pollock *Community Nursing Sister, Royal Edinburgh Hospital*

I am sure that the majority of patients who come for psychiatric help as hospital in-patients, do so, in a sense, involuntarily. It may be the result of pressure from the GP (if you don't go to hospital I'll have to certify you') or family ('if you don't we'll have nothing more to do with you') or from work ('if you don't you'll lose your job') or neighbour ('we'll complain to the police'). In the strictest sense of the word 'voluntary', voluntary hospitalisation is not as it may appear to be.

On the other hand, I do not believe this lady was assaulted if she walked to the car (albeit shouting verbal protestations), rather than being dragged there physically. It is likely that she was genuinely terrified about going into hospital, if she had never

been before, and had visions of it as an asylum for lunatics with padded cells and strait jackets. Perhaps it might have helped for a community nurse to have talked to the lady about the ward and told her about the daily routine and ward activities. It seems she needed gentle persuasion to come in. Yet, once admitted, she seemed quite happy. She did not try to leave or refuse to take drugs, and the nurses had no difficulty in looking after her. In the light of this, it seems to me that it was totally unrealistic of the psychiatrist to suggest medication at home. She had previously refused to co-operate in attempts at home care, and it is not surprising the relatives had no enthusiasm for this suggestion. (I presume liquid medication, as opposed to tablets had also been tried.)

But, the suggestion that compulsory admission might have been considered, seems quite inappropriate for this situation, as the lady was clearly coping with her daily activities and eating, and sleeping well, and was not a danger to herself or others. Indeed, if it had been implemented, a compulsory admission could have adversely affected her future relationship with staff and family and would, in my opinion, have been a miscarriage of justice. Such a step could only be justified had the lady remained at home, still refusing medication, and as a result suffered a severe deterioration in her condition.

In summary, I believe that admission to a psychiatric hospital was in this lady's best interests in order to persuade her to take the necessary medication and to help her recover from the manic swing which had followed on her earlier period of depression while a patient in a general hospital. With the wisdom of hindsight, we might suggest that it would have been better if her spell in a general hospital had been seen as an opportunity to treat her depression, but since this did not happen, treatment in a psychiatric hospital was probably the best way of handling the subsequent crisis.

Chris McGregor *Principal Social Worker, Royal Edinburgh Hospital*

This case raises issues around compulsory admissions and brings to mind thoughts about the importance of understanding people's attitudes, and about alternatives to hospital care and treatment of the elderly.

Compulsory admission procedures

Social workers can be involved in compulsory admission procedures as mental health officers but in terms of present legislation, the role is ill-defined and often presents dilemmas. The Mental Health (Scotland) Act 1960 to some readings, requires a social worker to be little more than a clerk, filling up the application form to the Sheriff on behalf of relatives, but most social workers want to bring their professional skills into the human situations of such cases. The two decades which have passed since the present Act went on statute, have shown advances in social work training and availability. The profession is emerging, finding its voice on issues and is keen to contribute to the review of Mental Health legislation which must come soon in Scotland. Meantime, social workers are among those currently concerned about psychiatric compulsory admissions and the actual methods employed in getting people into hospital. The medical profession can sometimes be seen to be too ready to get the psychiatrically disturbed (often including the eccentric, the confused, the non-conforming, the low-spirited) into wards and, of course, it is hard to stand by and watch someone live in a pathological way when one thinks treatment could help. But there are worrying examples of duping patients to get them to hospital premises, barely justified compulsory orders and paternalistic attitudes among doctors. Other professionals must demand a share in ethical decisions about compelling someone to be in hospital.

In the case under discussion, it is gratifying to find a consultant resisting compulsory measures and questioning if the new law had been upheld. Although most of us would probably feel, in this instance, that the end justified the means, the questions have to be asked and answered, and what is pragmatic must not be allowed unquestionably to supersede what is ethical.

The dynamics of the demand for hospital treatment

Some research shows that often families and GP's,[1–4] not psychiatrists, decide if a patient goes into psychiatric hospital and, therefore, it would seem important to understand the dynamics of potential hospital admission cases. We are not given much information about the stances people took in this situation although there are hints of familial tensions and we know that over-all, the consultant psychiatrist viewed the relatives as good-intentioned. Careful assessment of attitudes and feelings in a crisis can often enable the specialist professional to offer alternatives. In this case numerous questions arise: was the desire to get the old lady into hospital arising from fears that the younger relatives might have to give extra care and attention with disruption to their own life-styles, or was it anger that she had married but her new husband was not coping in the emergency; was it exasperation at yet another illness, or were there inter sibling rivalries about who could offer that which only mother 'having to go to hospital' would resolve; was the old man reacting to discovering that he might have taken on an 'always sick' wife; was the old lady afraid of psychiatric hospital, enjoying the furore she was causing, or

simply not wanting to leave her own home; did the GP want rid of the responsibility for a while?

Crisis intervention

It seems well-nigh impossible for one professional to sum up the variables likely in the situation described with a view to altering unhelpful stances, and to offering a plan which would allay anxieties and allow for treatment. Models of crisis intervention service where two professionals (psychiatrist and nurse, psychiatrist and social worker) meet at the home with GP, if possible, allow for inter-professional support and more thorough assessment of what is going on. In this particular case, the consultant may well have been able to hold to his opinion if supported by a colleague. The family and GP might have been persuaded to amend their attitudes by acknowledgement of the pressure on them and offers of appropriate support. In finely-balanced situations of people's rights and need for treatment, more than one professional opinion is desirable.

Holding to the notion that this case would have been one suitable for a crisis intervention service, what could have been offered? We are given a diagnosis, a statement of how the illness could be treated and the clear specialist opinion that the person could be treated at home. But the family required satisfactory answers to their objections, and this is where the back-up of a colleague and the assessment of attitudes would have been helpful.

An assurance that a home help could be available, that a community nurse would be calling to help with medicines and that the crisis team would call again might just have enabled the relatives and GP to consider what they could offer in the situation, or have brought into relief the fact that in that relationship tensions were really basic to the crisis. Longer term work might have had to be offered; for instance, marital therapy should not be regarded as wasted on newly married seventy year olds.

Frail resistance humoured away

In some instances of admission to, and indeed retention in, hospital, it appears that the elderly are extended less rights than younger people in similar psychiatric states and situations. Their objections are humoured away, their frail resistance handled gently but discounted, locked ward doors are for safety rather than detention. Motives are often of the best, there is rarely malevolence but it does seem that being old gives you less chance of having your opinion taken seriously. It is likely that the circumstances of our case would have been altered markedly if the patient had been a younger person and to that extent one must feel some disquiet despite the happy ending.

References

[1]Richards, H (1960). *Psychiatric referrals from general practice.* Unpublished thesis.
[2]Rawnsley, K and London J B (1962). *British journal of preventive & social medicine*, **16**.
[3]Johnson, D A (1973b). *British journal of psychiatry*, **123**.
[4]Kaeser, A C and Cooper, B (1971). *Psychological medicine*, **1**, 312.

I E Thompson *Research Fellow, Edinburgh Medical Group*

Because the contingencies of this case have been very adequately discussed by the other contributors I suggest that it may be helpful to review the arguments from a different perspective, namely, by examining the kinds of strategies adopted by the professionals in the attempt to resolve the moral dilemmas posed by the consultant in charge.

The consultant presents us with a situation in which he is caught in the middle, trying to mediate as a professional, between the rights of the patient on the one hand and the rights of the relatives on the other. On the one hand there is a potential conflict between the right of the patient to refuse treatment (insofar as 'treatment' in this case includes the possibility of hospitalisation) and the professional responsibility of the doctor to decide on a course of treatment 'in the best interests of the patient'. However, in this case the consultant's professional judgment ('I was quite clear myself that we should try home treatment first') coincides with the patient's desires and happens therefore to place him in the position of an advocate defending the patient's rights. On the other hand, in his professional role as a doctor, answerable to his profession, to the Courts and to the general public, the consultant feels obliged to take into account the common good, and thus seeks to accommodate to some extent the rights and interests of the family.

Personalist values and the common good

The consultant has a dual role: as a caring professional with a direct responsibility to and for his patient, and as an expert with a public office and wider social responsibilities. This confronts him immediately with a possible conflict between two kinds of values: the highly personal values predicated upon his confidential relationship with his patient, and the more universal values which are predicated upon his professional office as an agent of the common good. This conflict may be expressed formally in terms of the conflict between an ethics of compassion and an ethics of duty. However, in practice both of these are subject to interpretation depending on whether the rights of the patient or the authority of the professional are given greater emphasis. In an ethics of compassion what is right

in a given case may be defined in terms of the rights of the patient or in terms of the professional's judgement as to what is best for the patient in the circumstances, and these represent different kinds of justification for what is right. In an ethics of duty what is right, in the sense of what is in the best interests of all, can be decided either by attempting to safeguard the rights of all parties in the best possible way, or by professionals deciding what course of action will bring the greatest benefit or least harm to all parties involved.

In this case the consultant attempted to resolve his dilemma by giving precedence to more personalist values over considerations of the common good. He seeks to avoid certifying the patient and hospitalising her:

a) Because it is against her will and he considers her *compos mentis*, and
b) Because he considers home treatment in *her* best interests.

He vacillates between a clear defence of the woman's rights and a medical justification of his decision, but he decides nevertheless in her interests rather than in terms of the family's. His continuing uneasiness about the rightness of his decision arises because the family's action frustrated his plan, undermined his authority and wrested the moral initiative from him.

Dubious means to a good end

Significantly the community nurse and the social worker are both much more concerned with the rights of the family. What the consultant sees as 'the pressure of the social situation', they see more in terms of respect for the feelings and attitudes of the various family members. Although the social worker is 'worried' about 'examples of duping patients to get them to hospital premises', 'feels some disquiet despite the happy ending' and evokes general concern about the patient's rights, nevertheless she feels that crisis intervention to deal with the dynamics of familial tensions is the answer. Likewise the community nurse while arguing that 'the majority of patients who come for psychiatric help as hospital in-patients do so, in a sense involuntarily' – because of pressure from GP's, family, employers and neighbours – nevertheless she feels that 'it might have helped for a community nurse to have talked to the lady'. Both community nurse and social worker understandably see 'the problem' from the standpoint of their respective professions and in terms of the relevance of their own professional expertise, in terms of what they might do about it. The moral dilemma is to some extent avoided by being re-defined as a practical problem amenable to proper professional management. The fact that dubious means were used to get the old lady into hospital though regretted is justified by both in terms of the outcome and knowledge by professionals of the likely outcome.

The lawyer effectively dodges the moral issue by taking refuge in an exposition of the law regarding compulsory admissions and by giving a carefully considered opinion whether on technical legal grounds the action taken against the woman would constitute assault, whether technically she could be said to be suffering from a mental disorder which required or was susceptible to medical treatment, and whether it could be reasonably said that any other course of action was open to the doctor at the time. He does not commit himself on the moral rights and wrongs of the case. Does knowledge of the law excuse?

The opinion of the second consultant is interesting in that he also tends to avoid the moral issue by making it appear that it was, or ought to have been resolved as a matter of technical medical judgment. Given his premises the use of an emergency order (Section 31) would have been justified and the issue of the conflict of rights between patient and relatives resolved at a stroke. Cutting the Gordian Knot in this way means that the psychiatrist takes the whole burden of responsibility upon himself (if he doesn't decide the matter indirectly in the relatives' interest), but the fact that he continues to have doubts about the propriety of this courageous action is shown by his argument that he would have 'tried to establish a contract with the relatives that if the patient had not improved within 12 hours of my starting treatment at home, then they would have my agreement to bring her into hospital'.

Rights and consequences

In order to avoid giving the impression that moral judgments are arbitrary or purely subjective we attempt to ground them in facts or reality. One way of doing this is to argue that human beings as such have certain intrinsic rights, that given the nature of human beings certain rights are necessary if they are to be guaranteed a human life and humane treatment. Another way of attempting to ground moral judgments is to appeal to evidence of the likely or actual consequences of certain actions. When we seek to defend the interests of the individual patient we most commonly appeal to the person's human rights, but when our own expertise or authority is at stake we usually appeal to the kind of evidence we are best trained to assess, hence professionals tend almost invariably to fall back on consequentialist and utilitarian arguments to justify their moral decisions. Professionals (as we have seen in the foregoing comments) prefer to use utilitarian arguments because they can be seen as the experts in the assessment of probable consequences for the individual or society. These arguments can be either of an act-utilitarian (and

compassionate) kind concerned with the consequences for the particular patient, or of the rule-utilitarian (and more universal) kind concerned with the common good. Significantly none of the contributors (with the possible exception of the first consultant) make much of the argument from rights; all of them opt either for act-utilitarian or rule-utilitarian arguments to justify their professional and moral judgments. However, the dubiety of arguments which suggest that 'the end justifies the means' cannot be demonstrated on utilitarian grounds but requires other moral premises.