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Case conference

A solitary mister*

The case

Bob Wandle had lived in the bottom flat of an old block in Birmingham for as long as anyone could remember. All sorts of stories were told about him, but it was never easy to tell whether these were anything near the truth or, whether he, like other unusual characters had been awarded them by society as an eminent academic would earn honorary degrees. He certainly never married, but had lived quietly with his sister until three years before, when she died of cancer in a local hospital. He had been a groom, but had given up work long ago and was in his seventies when I met him first.

He had been on my predecessor's list since before the War, but his card was almost empty of entries, although whether this meant he had not been seen at all was impossible to say. He certainly described himself as having had a healthy life, apart from one episode of pneumonia when a young man. He had fought in the Western Desert, but seems to have been invalided out on psychiatric grounds, and after that time seldom left his home except to go to his work, and seems to have had few friends. He did not drink, but smoked in the privacy of his home. Financially he had managed comfortably from a combination of his work, family money and by dealing in antiques and bric-a-brac with his sister. Although he had not had a prolonged education his vocabulary was extensive, and he clearly had read much when he was younger.

I was called to see him by the Social Services Department early in June because they had had numerous complaints from the neighbours. Regarded by all about him as an eccentric, he had apparently been acting in a way which gave cause for alarm – or offence, it was not clear which. He was often seen peering from behind the filthy curtains at his uncleaned windows at passers-by, and would be heard singing late at night or talking loudly to himself in his empty echoing flat as others went past his front door up the staircase to their own flats. He had not paid his electricity and gas bills and was threatened with having his supply cut off. When he emerged from his flat he was seen to be extremely unkempt and smelly, and he went out to feed a number of cats who inhabited the wasteland nearby. His own food was fairly primitive, but as the summer came it became apparent that he was not clearing up or throwing away his unused food, as an evil smell began to seep under his front door, and wasps and bluebottles buzzed around and out of the gaping letter box.

One of the social workers had visited several times, and eventually had managed to get herself admitted. She reported that the house was very dirty and smelly, as expected, and that decaying food was lying about mixed with newspapers, of which there were hundreds. There was only a bare bulb in the centre of each room, and no obvious source of heat in any of the rooms. His bed was bare of sheets, and the kitchen piled high with rubbish. Bob himself, after his initial suspicions were allayed, seemed to talk fairly easily but would not be pinned down in detail on any issue. He was suspicious of neighbours and officials, but not particularly paranoid, nor obviously depressed. Indeed, he saw himself in need of no extra services, except that he agreed the flat was untidy. The social worker had left with the vague promise from Bob that he would consider meals on wheels, and that he would let her come; but she felt uneasy, and asked me to call.

After several fruitless visits eventually I was accepted into Bob's flat, and found the environment and his mental state much as described by the social worker. There was no major evidence of a psychotic process, nor was he confused. He knew about contemporary events, and answered straightforwardly about his present circumstances, but avoided discussion of the past. He fended off my offer of a physical examination by maintaining that there was nothing wrong with him, and he persisted in this response at each of my visits.

Over the subsequent few months the social services and I had a number of calls from angry or concerned neighbours but we were allowed to offer little to Bob beyond regular clearing up of his flat to decrease the health hazards, and regular superficial chats. On one of my visits in mid December, I met Bob warming his hands by a brazier outside the flats, standing by an old lady similarly dishevelled and unkempt. They clearly shared an interest in the cats, who were seething all about them. (I recalled, and altered, the Thurber cartoon 'Dear Sir, we

*See *The Hunchback in the Park* by Dylan Thomas

have cats like other people have lice'). Instead of the opening lines of Macbeth, which I had half expected, Bob turned to me and with great courtesy introduced me to his companion: 'This is my doctor'. The old lady turned to me with a big wink: 'He says such funny things you know'. It took a little time to get the record straight.

That December was cold, and there was no heating in Bob's flat, nor would he accept any. At an informal case conference I was pressed to admit Bob to hospital, and when it became clear that he would not go voluntarily, I was asked if he could be admitted under one of the relevant sections of the Mental Health Act. I replied, and I still think, that the answer was that he did not have a mental illness as such which made him a danger either to himself or to others, and that he was happy where he was and would be miserable detained against his will in an institution, however comfortable. At my last visit to Bob I tried to explore the idea of a hospital admission with him, and he looked at me as if I were mad!

On the days leading up to Christmas there was a lot of vandalism in the flats. On Christmas Eve Bob's windows were broken with stones. It was a very cold night. On Boxing Day neighbours noticed that there had been no change in the lighting of the flat. The police were called, and they found Bob in a coma on his bed, very cold and breathing shallowly. He was admitted to hospital, and died the next day of hypothermia and pneumonia.

The coroner made public some very critical comments about 'Victorian standards of care', and indicated clearly, in our absence, that the social worker and I had neglected our duties and Bob should have been in institutional care. Bob's death was a boon to the local journalists. Such criticisms are hard to refute. I am still sure that Bob was not critical of our action.

The discussion

PSYCHIATRIST

The borderline between eccentricity and madness is very difficult to define and often forms the focal point of dissension and distrust between doctors and society. Here clearly many lay people thought that 'something should be done' and for some this must have meant that Bob was acting madly and should therefore be treated as madmen are, and put away. This rather unenlightened approach to mental illness has two problems to face, the first being whether Bob was mad in any way, and the second as to whether this madness would have been appropriately treated or contained in a mental hospital. Let us consider the first problem. However good the description, we do not have much to go on in assessing Bob's mental state beyond the feeling that Bob was suspicious of authority, fiercely independent, vague about the past, fairly clear about the present and had an unhealthy disregard for the well-being of his immediate surroundings. He was certainly not depressed, though I should have liked, myself, to be sure that he was not suffering from any definable physical illness, heart failure, vitamin deficiency, etc. However, to examine people physically against their will may be assault unless one can prove that there was a direct good to emerge; and certainly this would have risked the relationship that had been delicately and carefully built up by both GP and social worker over the months, and the situation might then have been worse. The post-mortem presumably did not find any signs of other disease, although we are not told that specifically. Hypothermia and pneumonia have clear signs that would not have masked other gross diseases.

If then he did not have an obvious physical cause for his abnormal behaviour, was there a psychological cause, and did this amount to a mental illness? Two factors stand out. The first is his discharge from the Army, which might have been due to battle stress, but which could have been due to the emergence of another illness like schizophrenia. It was clear that after this breakdown he was protected and cared for by his sister, and that he became partially rehabilitated. However, after her death, not only was his support and 'cover' withdrawn (and at this point his unusual physical habits began to make themselves known) but also he may in some way have blamed himself for her death. That we may be seeing an unusual and prolonged bereavement reaction is another possibility that does not seem to have been explored. We can almost, although not quite, exclude alcoholism but the possibility of an underlying psychotic process still exists. His elderly fellow cat enthusiast clearly thought that he did on occasions make unusual or even mad conversation, but oddly the professionals in the case never picked this sort of thing up, or else did not notice it. Even if we could prove that Bob had an underlying mental illness, however, I cannot see many doctors and social workers being able to admit him compulsorily to hospital under the terms of the Mental Health Act, nor many consultants being able to keep him there against his will.

SOCIAL WORKER

I agree, but you have restricted your discussion to the consideration of Bob's behaviour as an illness. If we can see it in neutral terms just as behaviour, then we may try and define whether enough was done to help this behaviour. I find it hard to believe that more positive help could not have been given with regard to heating and meals, although this is easy to say. Since Bob agreed to having his flat cleared out, a negative procedure, he might have agreed to having something more positive done, like buying in more bedding for him or providing proper heating. The tragedy was only foreseeable in general terms.

HEALTH VISITOR

This is an example at one extreme of life of the problems we certainly face at the other when we have to intervene with accidental injury to children in mind. One develops a sixth sense which is so important in these matters, but still there are many cases where the extreme is worrying, and in these cases I think it is terribly important to discuss and share the case with other professionals. With Bob, the social worker and doctors could easily have summoned 'second opinions' in the shape of a health visitor, or domiciliary psychiatric assessment. As a health visitor one has always a tiny portion of one's eye fixed on the blank space of future local and national front pages.

GENERAL PRACTITIONER

Perhaps this is one of the weaknesses of family practice in this country – that apart from one's partners it is not easy to get informal help with a problem, and there is no-one else to take the responsibility for one's errors away from one. This is both the exciting challenge and the creeping dread of this type of problem, where we are on the borderlines. It also emphasises the line between public good in public health terms and the rights of privacy of individuals. I agree that we would have had no right to deprive Bob of his liberty, but could he have been a major health hazard? Under different circumstances I think one might have had to take stronger action to prevent Bob from creating a rubbish tip in his own home, just as a local authority might prevent someone setting up a zoo or factory. Seen in the context of public health or local authority bye laws, some of the restrictions we fear to impose on the individual in the name of medicine might seem very straightforward regulations to allow people to live together in reasonable peace. I am not happy about the general practitioner being used in this way, however, as his function seems to be in an entirely different sphere.