opinion because of anxiety about his mental health. He presented with a two-month history of depressive symptoms with prominent biological features.

His mother killed herself when he was aged 7, and his elder brother had also committed suicide three years previously. A second brother and his cousin were both victims of homicide. The patient had suffered a major depressive illness three years before, following his brothers death, and this had responded to out-patient treatment with antidepressants. His premorbid personality was extroverted.

On examination he was severely depressed, perplexed, and held the delusional belief that he, and not the hospital, was responsible for his wife's death. He also believed that psychiatrists knew this and were in league with his wife's family to punish him. He was admitted and treated with amitriptyline and chlorpromazine. Suicidal ideas and impulses emerged, and he required intensive nursing for a month. Over the next six months his illness followed a protracted and fluctuating course. Although no longer severely depressed, he still believes that he will not be well until the Health Authority is successfully sued, thus absolving him of all blame.

We think he has had a morbid grief reaction complicated by a psychotic depression in which compensation could be a maintaining factor. We are not aware of any reports of such cases in the UK literature, but this may become an increasingly common phenomenon in the wake of tragedies such as Bradford and Zeebrugge. Our patient, like many survivors of those tragedies, has suffered multiple losses and is also involved in a compensation claim.

Rosenblatt (1983) suggests that lawyers involved with this client group should be aware of their special needs, and that "the recurrent review of the loss brought about by involvement in a suit may disrupt the normal detaching process, thus leading to a morbid grief reaction". Litigation may also be an increasingly fashionable style of response to such losses. While it is tempting to speculate further, there remains little systematic evidence on which to base important clinical decisions about management. This is an area which merits further study.

LYN PILOWSKY
ALAN LEE

*The Maudsley Hospital*
*Denmark Hill*
*London SE5*

### References

ROSENBLATT, P. (1983) Grief and involvement in wrongful death litigation. *Law and Human Behaviour*, 7, 353–359.

## Consent to Investigation

SIR: The philosophy of the Mental Health Act 1983 was to "strengthen the rights and safeguard the liberties of the mentally disordered" (Bluglass, 1984). This ethos emerged in the innovative consent-to-treatment area of the Act. However, the relevant sections are specific in nature, and thus situations could arise which are not dealt with by the Act. The following case report illustrates such a problem in organising investigations.

*Case report:* A 47-year-old housewife was admitted under Section 2 of the Mental Health Act 1983, suffering from her first psychiatric illness of an episode of typical agitated depression. After a four-week trial of amitriptyline and chlorpromazine there was no improvement, and ECT was prescribed. The patient refused consent to this treatment, and so Section 3 was applied. The Mental Health Commissioner agreed to a course of ECT, as the patient was unable to eat or drink. Two months later there was a little improvement, but a request for a second course of ECT was declined by the Commissioner on the grounds that even though the patient remained ill the situation was no longer life-threatening.

Throughout the hospital stay the patient refused investigations. Consequently, even though she was not responding to medication or ECT, an organic cause for her illness could not be excluded because of her non-cooperation. Enquiries were made to discover whether investigations could be performed without consent. The Mental Health Commission stated that the issue was not covered by the Act and a medical defence organisation advised us not to proceed, as so doing would probably constitute a battery.

Half-way through the duration of the patient's treatment under Section 3 the Commissioner returned to decide if the patient could be given medication against her consent. A treatment plan was provided suggesting a trial of lithium, in view of the failure to respond to antidepressants alone. However, if approved, the legality of forcing investigations to monitor serum lithium was not known. Further correspondence with a medical defence organisation revealed that they too were unsure. Fortunately, the Commissioner resolved the problem by agreeing to the treatment plan and to the investigation of the patient. Necessary blood tests were therefore taken, and an EEG was performed. The latter was reported as normal, and the patient responded well to the trial of lithium.

The requirement to consult Mental Health Commissioners in order to plan the treatment of detained patients is appropriate to safeguard their liberty. However, investigations are an important component of the management, but as they are not dealt with specifically by the Act they are covered by common law, which permits procedures only to be performed against or without consent if they are life-saving. Investigations are rarely life-saving, and so necessitate consent.

The importance of investigations are highlighted by the above patient, whose unresponsiveness to treatment may have been due to an organic cause. If

this had been so, then the four-month delay before the investigations were carried out could have been detrimental. Investigation for an organic cause for mental illness is important to allow appropriate management. Just as patients do not understand or consent to treatment, they may also misunderstand or be frightened by investigations.

It is surprising that this point regarding investigations did not occur during the drafting of the Act or subsequently, but this patient and the difficulties and delays encountered exemplify the need for clarification on the point. Possibly the issue of investigations could be dealt with in the same manner as treatment presently is under the Act, and be administered by the nominated Commissioners.

IAN EVERALL

*Maudsley Hospital*
*Denmark Hill*
*London SE5*

### Reference

BLUGLASS, R. (1984). The origins of the Mental Health Act 1983 – doctors in the house. *The Bulletin of the Royal College of Psychiatrists*, **8**, 127–134.

## CORRIGENDUM

*Journal*, August 1987, **151**, 160–165 (Wig *et al*). The names of Jørgen Achton Nielsen and Grethe Thestrup, from the Aarhus Psychiatric Hospital, Risskov, Denmark, should be added to the list of authors.

## A HUNDRED YEARS AGO

### Lunacy regulations in France

In consequence of certain irregularities revealed by the investigations into the case of Baron Seillières, who, it was alleged, was improperly detained in a lunatic asylum near Paris after he recovered his mental equilibrium, the Minister of the Interior, M. Fallières, has issued a circular to all prefects directing them rigidly to obey the enactment which requires them to make periodical visits to all asylums, public or private, within their jurisdiction. It is directed that these visits should be paid unexpectedly, and not less frequently than once a quarter; that patients who desire to leave the asylum should be interviewed, and in every doubtful case subsequently subjected to a special medical inquiry; that the use of the shower-bath as a punishment should be forbidden; that the period of observation should be reduced to the shortest possible time; and that frequent transfers from one establishment to another should be discouraged.

### Reference

*The British Medical Journal*, 13 August 1887, 368.