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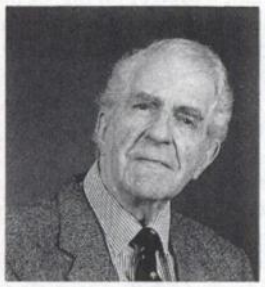
Interview

In conversation with A.K. Ross

Hugh Freeman interviewed Mr Ross recently



Alastair K. Ross
BA Oxford (1936, 1937)
BCL (1939), MA (1940)
Solicitor (1946)

Alastair Ross graduated as BA at Oxford University in 1936 in philosophy and ancient history, and again in 1937 (in law). He then became articled to the town clerk of Manchester, F. E. Warbreck Howell, and qualified as a solicitor in 1946, after a six years' interruption for war service in the Royal Artillery. (Most of that period he spent as an adjutant in regiments operating anti-aircraft guns in the UK; in 1945, when air defence was no longer required in England, he was posted to Washington DC to be with the British secretariat of the civil affairs department of the combined chiefs of staff.)

From 1946 to 1954 he was an assistant solicitor in the Manchester town clerk's department. In 1954, by public competition, he became a legal commissioner of the Board of Control. From 1960, when the Board was dissolved by the Mental Health Act 1959 and not replaced by any central supervisory body, he served as a senior legal assistant in the Ministries of Health and Housing, and until 1983, in the Department of the Environment (as a draftsman of statutory instruments concerning water supply and the control of pollution). From 1963 to 1968 he was a lay member (non-denominational) of the Central Religious Advisory Committee of the BBC.

I think that most readers probably won't be quite clear just what the Board of Control was, and what it did. I wonder if you would be kind enough to start with some basic facts about the Board.

Its origins go back to 1774, when Parliament laid down that five Commissioners appointed by the Royal College of Physicians should inspect private madhouses in and around London. They had no power to close any of these places, and the most severe action they could take was to hang up an adverse report in the censors' room of the College. Then, in 1828, the Metropolitan Commissioners in Lunacy were set up to inspect private houses in the London area. Their responsibilities were extended to the whole of England & Wales in 1842, and they produced a report which led to the passing of two Acts in 1845, one of which changed their name to the Commissioners in Lunacy. Lord Shaftesbury was their chairman for 40 years. They were a board of qualified doctors and barristers whose duty it was to visit patients detained under the law – or indeed against the law – and to report back about them. As more and more county mental hospitals were set up, the Commissioners' field of work steadily increased. However, with the Lunacy Act of 1890, the law relating to unsoundness of mind was classified, and formed the background to the rights of the detained person for a very long time. In 1914, the duties of the Commissioners were extended to cover patients who were mentally defective, as well as those who were mentally unsound, and their title was changed to the Board of Control – a more neutral title. That was its name from 1914 to 1960, when the Board was wound up under the Mental Health Act of 1959.

Whom did it consist of?

In its last years, it usually had five members: the chairman – generally a layman, one Legal Commissioner – a qualified barrister or solicitor – and three medical practitioners; these were the Senior Commissioners. Also, as the eyes and ears of the Board, there were ten Ordinary or Visiting Commissioners – six doctors and four lawyers – who did most of the visiting and reporting. Theoretically, the Board worked as a totally independent body, not beholden to any particular government-appointed person. The Senior Commissioners were appointed by the Crown and the Visiting Commissioners by the Minister of Health, but once they were in post, they simply had to do their duty under the statutes.

You said that when this organisation began, it was concerned mainly with people in private madhouses or those confined individually in their own homes?

Yes. Various scandals had arisen during the early 19th century of people detained in either of these situations. The prime job of the commissioners became to visit the places registered as private hospitals or nursing homes, to see the patients there, and to protect the interests of anyone who got in touch with them and complained that he or she was being wrongfully treated.

Could you tell me about the incident in a novel which you spotted, referring to Samuel Gaskell and John Conolly?

As you know, Charles Reade, the novelist of the mid-Victorian period, is now remembered mainly for *The Cloister and The Hearth*, which is a rather pleasant romantic novel about the early years of Desiderius Erasmus. Not to exaggerate, he had a slight bee in his bonnet about wrongful treatment of alleged mental patients. He had first become interested in prison conditions, which of course needed to be ventilated, but then moved on to the treatment of people alleged to be mentally unsound. His motives were excellent and he was quite right in many of the cases he took up, but his judgement was not perfect. If there was a grievance which he saw could become the subject of correspondence in *The Times* or with someone in authority, he leapt on it. Then he was invited by Charles Dickens to contribute a serial to one of Dickens's magazines. Reade thought this was an opportunity to write a novel around the theme of illegal detention of an individual, and Dickens, who had an eye for the dramatic, agreed. The result was a serial which was called *Very Hard Cash* – that was Dickens's suggestion – and it was eventually brought out also in book form as a three-volume novel, with the title changed to *Hard Cash*. The central figure was a young man whose father had him put way to get at the young man's money. There is a melodramatic description of his life in two private asylums, in one of which he is visited by two Lunacy Commissioners – one a layman and the other a doctor, Dr Eskell. It seems that this name Eskell was chosen because Samuel Gaskell was then a Commissioner. Research by Hunter & McAlpine, set out in a letter to the *Times Literary Supplement* in 1961, gave the background of this episode.

Reade's story came out in fortnightly parts, and it soon dawned on Dickens that Reade was being unjustifiably rude about the Commissioners and in particular, it was unfortunate that he had chosen a name which was very similar to that of an actual Commissioner. So Dickens hastily inserted a footnote – in capital letters – disowning Reade and saying the Commissioners were a very fine body of people! I don't quite know how it all ended, but Reade was actually a friend of one of the members of the Lunacy Commission, Mr Forster, who eventually wrote Dickens's biography.

You mentioned Hunter & McAlpine, and I think you had some contact with them. Could you tell me how that came about?

The headquarters of the Board in the 1950s were in Savile Row, in the building now occupied by English Heritage; we still had some of the old furniture and the books of the original Metropolitan Commissioners. Richard Hunter came along several times to the Board to consult our books and documents. On one occasion, as I had shown myself to be interested in his historical work, he invited me round to his flat in Bayswater to meet his mother, Ida McAlpine, and they picked my brains on the history of the Board. They were rather an impressive couple, very steeped in this history, and I was hard put to it to conjure up anything I felt that they didn't know already. The only occasion when I was able to do that was when Richard Hunter presented me with a book he had edited, which was an account of a Viennese judge who had suffered from severe delusions. I remembered then that in Stanhope's *Conversations with Wellington,* there was an account of the Duke of Wellington visiting Field Marshal Blucher, five or six years after the Battle of Waterloo. He was rather disturbed then to find that Blucher was under the delusion that he was pregnant, and that the father of the infant inside his stomach was an elephant! Blucher protested to Wellington, patting his stomach and saying "Moi, un elephant!" So I was able to contribute one small piece of information to their research.

What was your first impression of the Board of Control?

When I joined it on 1 May 1954, which was a Saturday – we worked on Saturday mornings then – I didn't know that the Royal Commission on Mental Disorder had been set up with the purpose of finding a new role for the Board or possibly of winding it up altogether. However, I soon discovered this, because a few days later, it was suggested that I should go and listen to the first day's hearing of the Commission. The witnesses on that day were representing both the Ministry of Health and the Board of Control. This consisted of the Chairman of the Board, Sir Frederick Armer, who was also Deputy Secretary of the Ministry, the Senior Medical Commissioner, Dr Walter Maclay, who was also a Senior Medical Officer in the Ministry, and the Senior Legal Commissioner, Rupert Green. I sat back, expecting to hear about my glorious new job, but as I listened, it became clear that the witnesses were telling the Commission that the Board was out-moded, that its

functions had ceased to be important, and almost beseeching to have the Board wound up. The argument was that when the National Health Service had come into existence in 1948, all public and voluntary hospitals were taken into the ownership and management of the Minister of Health, whereas previously most of the mental hospitals had been run by the County and County Borough Councils. When you had local authorities running the institutions, it was argued, it was desirable to have a central body to keep an eye on them, report on them, and cross-fertilise them with the good ideas that some were trying out. Now that the Minister of Health was in charge there was no need to have a second Government department acting as a kind of watchdog.

What was the background to this self-immolation?

The previous year, 1953, after the previous Chairman of the Board, Sir Percy Barter, had retired, – he was an out-and-out Board of Control man – the Minister of Health appointed the Deputy Secretary of the Ministry to be Chairman of the Board. It dawned on me gradually that Sir Frederick Armer was a kind of Trojan horse, in that he came from the Ministry, and that from then on, their views would be very much dominant in the doings of the Board. In spite of that, after six years as Chairman, Sir Frederick became very attached to his new bailiwick and shortly before the appointed day for abolishing the Board, said he really was quite sorry to see it go. He had realised the value of the work it was doing much more than when he was an outsider, but by then, of course, it was too late.

What were the most valuable aspects of the Board's work?

One was that it was the central body to which anyone who believed he or she was wrongfully detained, either on the grounds of mental illness or mental deficiency (as it was called then), had the right to apply to it in writing. Alternatively, when a commissioner was in his hospital, anyone could demand an interview. So there was this clearly identified body and these clearly identified individuals, whose duty it was to listen to complaints about wrongful detention. The Board also had an obligation to visit all mental institutions at regular intervals – the large mental hospitals and mental deficiency hospitals at least once a year, and the privately run establishments several times a year. Patients who were in guardianship were also entitled to regular visits. The commissioners also had a duty to report in broad terms on the quality of each hospital, so that the five senior members received regular reports on all the psychiatric institutions in the country, both publicly and privately run.

There were about four categories of private institutions; one was the mental nursing homes, called licensed houses. These were registered charitable hospitals which were not run by the Minister of Health – well-known examples were The Retreat at York, and Cheadle Royal, south of Manchester. These were not operated for private profit and had the opportunity of using innovative methods of treatment. In a typical year, the Board – and through them the Minister of Health – would have a pile of reports, which would cover every institution in the country in which patients were cared for or detained on grounds of mental illness or mental defect. The function of the visiting commissioners, of whom I was one, was simply to report; it was for the senior members of the Board and the Minister of Health to treat our reports, we hoped, as valuable information about what was going on up and down the country.

Before 1939, the Board of Control used to publish a bulky annual report, which gave a very good picture of life in the various mental institutions, but during the war this was discontinued. Afterwards, the Board produced just a two- or three-page report, which consisted of rather dull statistics and gave very little indication of what things were really like.

How were the visits made?

Before 1939, the visits to publicly run hospitals were unannounced in advance; there was genuine surprise when the commissioners came. I remember the medical superintendent of the hospital at Lichfield saying, "We had an arrangement with the station master, who would ring us once a year and say, 'Doctor, I thought you might want to know that two gentlemen in tail-coats and top hats have just alighted from the 9.23', and everybody knew what he was talking about". But during the war, surprise visiting was discontinued, and afterwards it was not re-started. The whole thing was done in a co-operative and amicable way. However, in the case of privately run institutions, there was no such prior notice; anybody running a private mental institution couldn't know when the commissioners were going to turn up, and the element of surprise remained in these cases until 1960.

How did you come to be interested in this work yourself?

When I joined the staff, I was a conscientious young lawyer, coming from local government. I had been working in the Manchester Town Clerk's office, which included advising the Health Department. That was where my interest in mental health had arisen.

What were the particular local circumstances in Manchester?

The Health Department there was under a dynamic medical officer, Dr Metcalfe Brown, who was also a

barrister-at-law. A county borough health department in those days had very wide responsibilities, including maternity and child welfare and the employment of Duly Authorised Officers, whose job was to investigate incidents of mental illness in people's homes and intervene if there was danger to the patient or the public. They were the forerunners of today's mental health social workers. The local authorities also had hospitals of their own up to 1948, although this tends to be forgotten today. They had come into their control as Public Assistance Hospitals as an outcome of the Poor Law legislation of 1928–29, and some of these included accommodation for the mentally ill and mentally handicapped. These buildings, although gaunt and institutional to look at, were useful accommodation. When they received these hospitals in the 1930s, a number of local authorities turned them into valuable contributions to hospital resources, side-by-side with the others in their areas, which were mainly voluntary or charitable, and not responsible to any central body. Hospitals run by the local authority gave rise to various legal problems, which came to me; I was already interested in medicine, as my father and sister were doctors.

How did the Board allocate its work?

We had eight visiting commissioners, and England & Wales were divided up into four areas for us, roughly metropolitan, south-west, midlands, and north. I seem to have concentrated mainly on the midlands and north, with occasional visits in the London area. One commissioner was specifically attached to Wales and the west; I visited occasional hospitals in Wales, but none in the south-west.

What was it like in the mid-1950s, going round the mental hospitals – both the NHS and private ones?

A typical week in my work would start with Monday and Tuesday taken up with one visit to a hospital if it was near London, or if it was in the provinces, probably Tuesday and Wednesday. We would turn up at the hospital in the middle of the morning, having previously arranged the date with the medical superintendent. We would meet the superintendent and have a preliminary talk with him and then perhaps go round one or two wards. The main part of the visit would be in the afternoon of the Monday, but if it was a very large hospital – as many were – we would continue on the Tuesday morning. By the Tuesday afternoon, we would have covered the whole hospital including the kitchen, laundry, and other service departments. I found, though, that the number of interesting things you could say and ways in which you could express enthusiasm about kitchens or laundries were rather limited.

On the second afternoon, we would sit down in the committee room and a large, bound, foolscap volume would be put in front of us; we wrote our report in longhand, and then it was typed at the hospital. In the case of mental hospitals, the convention was that it was the lawyer who wrote in the book, while the doctor provided opinions on the psychiatric aspects. The report was then signed by both commissioners. However, in the case of mental deficiency hospitals, the converse operated: we didn't have a visitors' book, and we didn't write immediately after we had been round, but when we got back to Savile Row.

We would have been provided with statistics from the hospital, but the rest of our report would be based on our observations. During the visit, we jotted down things of interest to be included. The general spirit was to present the situation we found in the best possible light. We were not there as adverse critics or to pick holes; we were to report objectively what we saw, found, and heard. If there were things that needed to be criticised, we tended to let these be gleaned more through what we did not say. However, before we looked round, we would read the report from the previous year. On one occasion, in a particular ward, the last report said, "In this ward, the fire exit appeared to lead into a broom cupboard, but we were shown a plan on which this was not the case". In cases like that, you would read between the lines.

In my first six months, I was unsure what sort of comments I should be making, but then I came to realise what valuable work was being done in a most unspectacular way. I said to myself, "Don't be depressed. Look at the staff. If you feel they are doing their job well, then it's going to follow that the hospital is well run". Once I had come to that conclusion, I found the work much more congenial. One was still critical, but managed to voice these criticisms tactfully: for instance, "I wonder if you know what they're doing at Warlingham Park?"

The cross-fertilisation element was paramount in our work, and this may have been lost, to some extent, by the abolition of the Board of Control. Of course, one made certain allowances for the fact that we were there as central government inspectors, and therefore it would be tactful for them to be pleasant to us. However, I got a feeling that our visits were looked on as of value, that they felt they might learn from what we brought from other hospitals, or that they simply enjoyed being told they were running a good show, when this was the case. I don't know how that was replaced when the Board ceased to exist – if it was at all.

What was the first mental hospital you ever went into?

It was on the Isle of Wight – the one that had the fire escape which led into a broom cupboard! That was

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quite an instructive example, because the island is a circumscribed area and the hospital was obviously a valuable institution in the community; any idea that it was a feared and distant place was certainly not the case there. With most hospitals, that was what I found, although occasionally one would come across one where the architects had done their worst, and one sympathised enormously with people who had to live in those gaunt, prison-like edifices. For instance, if you look out of the window as the train goes past Stafford, you see two long brick buildings, which are almost identical; one is the prison and the other the mental hospital. They were built by the same architect, and I think with the same ideas in his mind.

The same is true at Wakefield, I think.

Yes, but once you were inside a building like that, however repellent it looked from the outside, you soon realised that it was the spirit of the staff and of the whole hospital that was important. I remember going to Rainhill Hospital, where the superintendent was of very short stature. We were wandering around one of the large airing courts, as they were called, and wanted to find the medical superintendent's office, so we accosted one elderly female patient who had probably been there for many years, and said, "We're looking for Dr... ". She replied, "Oh, he's over there, through that passage way, but if I'd known you wanted him, I'd have tucked him under me arm and brought him".

At this time, when you started visiting, the neuroleptics were just beginning to be used in this country.

Yes. The open-door policy was being introduced, and that presumably resulted to a large extent from the wider use of major tranquillisers. Mapperley Hospital at Nottingham and Warlingham Park at Croydon were pioneers in England in that respect. As time went on, one was much less conscious of locked wards, and padded cells became almost things of the past – one saw them as kind of museum pieces.

Did any of the private hospitals you visited particularly strike you?

The Retreat at York was very interesting. It was a Quaker foundation, of course, and you could feel the spirit there – it was a delightful place, with much stress on occupational therapy and other activities. As you entered, it didn't look like a hospital, but like a large private house. Cheadle Royal, near Manchester, was an attractive place in a similar way. The private nursing homes and licensed houses seemed to be generally kindly places – not the sort you would find in the novels of Charles Reade. There was only one instance during my six years where the Board intervened to suggest to the managers of a private institution that it should be closed down. There was no cruelty, but it was just that there seemed to be something wrong, and that nobody in charge seemed to have spotted this. We had paid a number of visits over a period of two years, and eventually it was closed.

What was your impression of the medical superintendents?

Their general standard was one of the most cheering things that I gleaned. However, by this time, there was a feeling, particularly among some of the younger doctors, that having a single person in charge of a hospital was rather outmoded, and that the whole thing should be done democratically. Yet I found that the hospitals which sent me away with the happiest feelings were those where the three people at the top – the medical superintendent, hospital secretary, and head of the nursing staff (who would then almost always be the matron) – were working hand-in-glove. So direction from the top wasn't out of place, provided it was humanely and imaginatively exercised. I felt the calibre of the medical superintendents in general was very high, and that they had a very responsible job.

Any individuals you particularly recall?

Mapperley Hospital was one of the chief pioneers of the open-door policy, and Dr Macmillan was the person in charge. He wasn't a dramatic leader at all; he must have done everything by persuasion and by suggesting to people that this was the sensible way to do it, but that if they could think of something better, he would like to know. Similarly, at Warlingham Park, the superintendent was T. P. Rees, who was in fact a member of the Royal Commission. He was also a pioneer of the 'open door' and of the stress on voluntary treatment rather than detention. I used to look at a new medical superintendent and say to myself, "If I were on the verge of being mentally ill, is that the kind of man I would like to have as my psychiatrist? If the answer was yes, he would usually be somebody who didn't have any heroic characteristics; he was just a kindly person who you felt would listen if you had something to say.

What about some of the people at the centre, such as the Commissioners?

The Board itself, in my time, was comprised firstly of the Chairman, Sir Frederick Armer, who had come over from the Ministry of Health. Then, the Senior Medical Commissioner was Walter Maclay, who was a hard-headed but humane Scotsman, and fitted well the characteristics of the person I would have liked to have as my psychiatrist, had I needed one.

His colleagues were firstly, Dr Isabel Wilson – also a Scot and also very humane – who had had quite wide experience in mental hospitals before.

You may have noticed the marble head of her in the College.

Yes, I did.

Secondly, there was Dr William Rees Thomas, who had been medical superintendent at Rampton Hospital, which must be – now as then – one of the toughest jobs of that kind. I remember him saying, when discussing how to deal with committees, that if he made a report suggesting a certain course of action and the committee indicated that they weren't very taken with it, he wouldn't waste time in arguing with them. He would withdraw the report at once and resubmit later on, when it was often accepted without much trouble.

The Legal Commissioner was Rupert Green, who had been a barrister in Manchester; his job of maintaining the legal character of the Board wasn't an easy one, because in the 1950s, the law had come to be looked on with some suspicion in mental health circles, having often become synonymous with red-tape, bureaucracy, and the finding of reasons for not doing sensible things. However, I'm glad to say he was able to uphold the law, *and* to make it palatable. When he was outnumbered, he had to say, "Yes. That's very sensible, but it's not in the Lunacy Act 1890".

How did you find the atmosphere in mental hospitals in the mid-1950s?

At this time, the NHS had been going for six years and national standards of expenditure were beginning to make a difference – wards were redecorated and furnished in 'Festival of Britain' pastel shades, in place of the greens, browns, and creams that had been thought suitable for all public institutions.

A stranger visiting one of the larger hospitals like Friern in north London or Hanwell, in West London – now Ealing (St Bernards) – might have been rather put off at first, simply by the gaunt, echoing corridors. One had to take a grip of oneself to begin with, though, to see what was in fact being done. On the whole, those were good hospitals. The situation usually boiled down to the relationship between a particular patient on the one hand, and on the other, the two or three members of staff who normally dealt with him and the 20 or so patients in his ward or group. Provided a patient was happy in that context, the forbidding nature of the building wasn't quite so important. Certainly, some of the wards were very large: perhaps 30 or 40 beds lined up on the walls and at the far end, a day room with comfortable chairs, but in 1954 not yet the menace of perpetual television. The atmosphere could be very pleasant, and for many of the long-term patients it was 'home'; there wasn't any point in saying, "What a pity they have to live there" – they did have to live there, as things were then, and the objective was to make it as comfortable and pleasant as possible. The Royal Commission's Report brought the magic words 'community care' before us, but Katharine Whitehorn once said that "community care consists of one elderly relative who is already over-worked". It can sound rather marvellous, but in practice isn't always so. If I were given the choice of being dumped in an unfriendly street or accomodated in a large, rather gaunt, but comfortable ward, I think I would choose the ward.

What did you do when the end of the Board came, in 1960?

The 1959 Act provided that any commissioner or member of the Board staff who was still in office and didn't want to retire would be transferred automatically to the staff of the Ministry of Health. So on 1 November 1960, I found myself as a senior legal assistant in the Ministry of Health, concerned with the operation of the National Health Service. One part of the work was dealing with appeals arising from local committees, where a patient had complained about the conduct of a doctor, optician, pharmacist, or dentist. There was a set of appeal procedures under which the first complaint was heard locally by the Medical Practice or similar Committee, but if either party didn't agree with its decision, he could appeal to the Minister. This meant that a small appeals committee would either be set up in the Ministry or would travel to the area concerned. It would consist of a member of the legal staff as chairman, with two practitioners in the specialty service. If it was a complaint against a doctor, the committee would include one medical officer on the staff of the Ministry of Health and a doctor nominated usually by the BMA. This was interesting and I hope valuable work, because appeals were mostly from the patient. The re-hearing of the complaint was done informally, but in a fairly set pattern, as both parties were allowed to have an advocate. If only one party was legally represented, though, it was our job to see that the unrepresented party was given a fair deal. In the early 1960s, one barrister who was briefed on a number of occasions by the Medical Defence Union was a youngish man called Geoffrey Howe. He was an absolute model of what an advocate should be in those circumstances – very persuasive, never taking offence at what the other side said – and sometimes the other side said some pretty startling things. The committee would report to the Minister, which in effect meant perhaps to the Deputy Secretary of the Ministry, and then the decision would be given. We travelled round the

country when there were provincial complaints. I remember one patient in Leeds who had been prescribed some false teeth by a National Health Service dentist. He was an engine driver and the gist of this complaint was when he had his own teeth, he was able to clamber all over his machine, clutching his monkey wrench between his natural teeth, but with his false teeth, it tended to fall out! We had to try and persuade him that dentists had a lot of things to do, but this was not one of their responsibilities.

Did you have any experience with special hospitals?

The special hospitals, which meant mainly Broadmoor and Rampton, with Moss Side as a more distant example, were managed up to 1960 by the Board of Control, which meant the five Senior Commissioners. They weren't inspected by Commissioner's visits, as ordinary hospitals were, but as junior Visiting Commissioners, we would occasionally accompany one of the Seniors who was there in his capacity as a manager. We would be shown round the wards, but wouldn't report on them. Whereas in a typical visit to the average mental hospital perhaps four or five patients would wish to exercise their right to speak to a Commissioner, usually in Rampton there would be about 20 or 25. I felt that those interviews were beneficial, even if in most cases the gist of the complaint wasn't particularly justified. The interview could be with the patient alone or, if the patient agreed, a member of the nursing or medical staff could sit in. In those cases, I would write a brief report on the gist of the complaint and on my reaction to it. If the doctor or nurse sitting in had had something to say, I would record that also. In most cases, my view was that the complaints were not bitter ones. They expressed more a feeling by the patient – and this must be particularly acute in somewhere like Rampton – that the staff were old faces who were seen every day, so that if one made representations to them, it wasn't going to get anywhere. It was useful to have a new face to speak to, and possibly the staff would have to be stimulated to put the official reply in a rather more palatable way.

On the whole, nothing dramatic came out of those interviews, but there was one particular case of a rather bright but violent male patient. He was a kind of barrack-room lawyer, and was humorously accepted in that capacity by both the staff and the patients. On one occasion, the gist of his complaint was that he had asked his charge nurse if he could purchase a copy of the Mental Deficiency Act 1913 out of his own money, but that the nurse had not responded. I imagine the nurse felt this patient would be wasting his money. The outcome was that I recorded this complaint and in fact he got his copy of the Mental Deficiency Act.

Visiting Rampton, I didn't have a feeling of boiling violence under the surface; it seemed to be a humanely run place: quite a number of patients were walking about, not all locked up in their wards. One of my most vivid memories of it is that one afternoon, a female patient climbed up on to the roof and sat there. She remained for about half an hour and exchanged words with staff and other patients, who would say, "Come on Elsie. You've made your point. Come down". She replied, "No I think I'll stay here a little longer". When the episode closed, I felt it had been handled very well by everybody; the result was that she had made her protest, had been helped in it by both the nurses and the patients, and that was that.

What was the Board of Control's procedure?

In the Board Room, as it was called, at Savile Row, the procedure was very informal. Every week, one or two of the junior Commissioners were on duty for the whole day; the main duty was to go through the documents which had come up from the hospitals relating to the detention of patients. These were either the original certificates on which patients were detained or the documents recommending that detention should be extended after the statutory period. The Commissioner on duty had to see whether there were any legal flaws in the evidence, and look at the medical opinions at the time of the original detention. These included a summary of the grounds for admission, the patient's mental state, and whether he was deluded, violent, manic, or depressed. Similarly, when an extension was asked for, the hospital had to provide grounds which were convincing, even if rather briefly expressed. Naturally, I wasn't competent to judge the psychiatric content of these grounds, but I always had a medical colleague to refer to. Quite often the grounds could be convincing even to a layman, and there would be no need to question them, but if there was any doubt, it would be for a doctor to decide whether to return the documents to the hospital and ask them to be more explicit and justify the case. That was called 'doing the boxes' – enormous boxes of documents came in every day and had to be gone through.

When I was a young psychiatrist, there was a piece of folklore that when you were completing certificates, you had to fill in all the lines on the form completely, and that if any blank space was left, the form would come back to you from the Board, asking for more information. Was there any justification in that?

There may have been. I remember having roughed out a list of things one had to check for, and these were quite a lot. Since somebody was going to be detained perhaps for up to five years, one had to be very careful that the letter of the law was being observed. Admittedly, one did feel that perhaps one

was being a little pedantic at times. One bone of contention was about patients who suffered from delusions: occasionally, the hospital would describe these in terms which could have been perfectly true, without an indication of unsound mind. For instance, there were cases where somebody thought his or her spouse was being unfaithful, which on the face of it was an unjustified suspicion, but when the matter was gone into more closely, it turned out to be an absolutely correct suspicion. Therefore, if the certificate said, "The patient is deluded: he thinks his wife is unfaithful to him," we would invariably send that back and say "Please indicate the evidence on which this is to be regarded as delusional and not a statement of fact". Over the course of time, this came to be generally understood, so that the contents of delusions would be described, together with the facts on which they were shown to be delusions. However, one case where perhaps our exhortations were taken more literally than necessary was when a woman patient was described as being deluded. The doctor stated that, "She thinks she is the Blessed Virgin Mary," and then he put in brackets "This is not the case". But we felt our message was getting across and that this was an error in the right direction.

We had a pleasant convention whereby at 4 o'clock, all the members of the Board came into the Board Room and had a cup of tea and a slice of sponge cake, brought in by the messenger. To an outsider, this might have looked like a number of lazy civil servants wasting their time, but I soon realised that this was one of the valuable parts of the Board's activities, because you met your colleagues in an informal way, and could bring up any sort of topic. However, if no points of this kind came up, we would often hear reminiscences of World War I or Civil Service gossip. But I never felt that excessive red tape was being applied by the Board. When I looked at correspondence dealing with complaints of a legalistic nature, I was impressed by the humane way in which these were dealt with, usually by reference to the law in the first place, but when that had been stated, something would be added to indicate that there was a human being at the other end, and that if the writer still had a complaint or doubt, this would be listened to.

During the late 1950s, there was evidence of major changes to come in the mental health services, particularly epitomised by Enoch Powell's speech in early 1961. In the work of the Board itself then, was there a feeling that things were about to change in a big way in the mental hospitals, or did life go on as much as usual?

I don't think there was much of a feeling like that; I know that various papers were being written within the Ministry which implied that it should be possible in the fairly near future to dispense with a large number of beds in mental hospitals, replacing them by 'community care'. My own personal feeling was that this was a pious hope, and that I couldn't quite see how it was going to be brought about. Even now, in the 1990s, the matter is still under discussion. At the same time, there are television programmes about the number of patients who are out in the street, not being properly looked after because their wards have been closed.

I think there is a fairly prevalent feeling that the mental hospital system as a whole was a repressive, rather cruel, very authoritarian one, which wasn't therapeutic in general. Would your experience of seeing many of these hospitals be in line with that view?

No. Admittedly, as a Commissioner visiting by prearrangement with the authorities, one probably saw things at their best, but I think one gradually learnt to read between the lines and to see what was windowdressing and what was genuine. Sometimes, one would run into something which seemed rather backward, for instance, a hospital where individual patients were still all photographed, rather like Scotland Yard; I remember one Senior Medical Commissioner dropping a hint that surely this was not needed now. If you take into account, though, that there was a very large number of people employed as mental hospital staff, by the law of averages, there are going to be some eccentric or deviant people among them. It's not fair to judge the system by the occasional person who drops a brick when talking to you or shouts at a patient when you're going down the ward. My general feeling about the system was very favourable. My older colleagues were a fairly hard-headed body of people. They didn't overlook things which were going wrong, but took a pretty realistic view of what was happening. I would have trusted them to spot pretty well anything that was going wrong in a hospital.