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GRAHAM ROOTH

The future (or not) of the medical member

An aspect of the 1983 Mental Health Act review

The present role of the medical member combines considerable common sense strengths with a particular legal weakness. It reflects a compromise between the need to inform the judicial process with an appropriate level of medical expertise, and the risk that information could be presented to the tribunal without being open to challenge by the patient.

Concern over this perceived, but unresearched risk, is reflected in the Green Paper on the *Reform of the Mental Health Act 1983* (Department of Health, 1999). Here the bold solution to a problem of uncertain significance is to remove the offending medical member.

The current situation

At present the medical member, who is, or has been, a consultant psychiatrist, is a fully participating member of the tribunal, and also interviews the patient, reads the notes and speaks to a member of staff some time before the hearing. As a result, the medical member is currently in a unique position to contribute to the decision-making process when it comes to issues relating to the patient's best interests.

However, concerns have been raised about the possibility that the medical member may influence decisions unfairly, by bringing material to the tribunal that is not open to challenge by the patient or the patient's advocate. Of course, it is also possible to look at the present arrangement as one involving the kind of creative compromise on which we pride ourselves in a situation where there is no perfect solution.

Green Paper proposals

Three models have been proposed to replace the present situation, without any evidence being provided to support the view that patients are being in any way harmed by the current arrangement.

The first model has already been ruled out on the grounds of cost and lack of psychiatrists: it would involve a psychiatrist on the tribunal who does not see the patient beforehand and an independent psychiatrist who does, but does not act as a tribunal member.

The second model has a legal president as at present, with two members with mental health experience, whether as users or professionals, and no medical member. It would 'have advice from a panel of approved independent doctors'.

The third model does away with everyone except 'a single specially trained lawyer with access to advice from a panel of experts'.

Discussion

Of the two proposals under active consideration, model three seems less likely to run: the Green Paper notes that it "would place a heavy burden on the substantive tribunal member who would need to take decisions without the opportunity of discussions with colleagues".

It might also have mentioned that replacing the present panel with a single legal member would for most of us, I imagine, represent an unacceptable move backwards towards the procedures available under the Lunacy Act 1890, where a specially appointed justice of the peace, a magistrate or county court judge acted on their own in an inquisitorial capacity.

It is startling that such a model could have been put forward as a serious alternative to the present system. However 'specially trained' and conscientious such lawyers might be, they cannot be expected to acquire the necessary expertise for appraising safely and correctly those health and safety issues that have a major clinical component, and that relate directly to the patient's best interests, as well as having a possible impact on other people.

Model two looks like being the disastrous front runner of the two options considered viable; and the same criticism applies: there will be no medical contribution to the discussions before and after the hearing, where the crucial issues are identified and debated.

The authors of the Report of the Expert Committee (Richardson *et al*, 1999), on which the Green Paper is based, comment that they "felt particularly vulnerable to the charge of encouraging a return to legalism"; and further on they note that their three-person model "may be less acceptable to the psychiatric profession if psychiatry alone among the relevant disciplines is to be excluded from full membership".

They have certainly taken us a long way from the Percy Report (Departments of State and Official Bodies & Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1957), which laid the foundations for our two recent Mental Health Acts, where it was envisaged that each tribunal "should include at least one medical member, and might include more than one".

Medical member's unique role as interpreter

In the same way that the legal member interprets and clarifies the law for his colleagues, the medical member interprets clinical issues. This involves more than clarifying specialist jargon and technical terms. It also includes recognising that there are times when the world of

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psychiatry can present a fairly opaque surface to those unfamiliar with it, and needs sympathetic elucidation.

This kind of insider perspective is, in my view, irreplaceable. It can enhance the tribunal's ability to handle its proceedings sensitively and constructively – and this includes a sensitivity not only to the needs of the patient, but also to the relationship between the patient and those members of staff who are likely to have continuing involvement long after the tribunal has made its decision and gone away.

This is particularly relevant in cases where the tribunal is considering whether or not to exercise its discretion. Although, with models two and three, the independent psychiatrist will presumably be asked to express a view on this during the hearing, this is very different from having such a person available during the discussion in private.

In my experience, cases where the outcome is not clear-cut can require a considerable reviewing and weighing-up of matters that have a substantial clinical component. Even where the issues appear straightforward to the tribunal, bringing them into the open in such a way that the patient can feel that his or her views have been fully expressed and attended to, while the staff have had the opportunity to explain their position, can require some preparatory discussion. Here the medical member's previous contact with the patient can prove invaluable.

Three prospects or possible remedies

Dispensing with the medical member may solve the problem as far as those who find the member's dual role as stumbling block are concerned. However, the same legal stroke will cripple the tribunal's ability to provide safe justice in those not uncommon cases where a full assessment of the patient's best interests requires a medical contribution to the discussion.

Where is the evidence that the present system is failing the patient or society because the medical member's role is a dual one? I don't know of any. My own experience of several hundred tribunals leads me to believe that the issue is a red herring, and that the non-medical members of a tribunal are well able to indicate if the medical member is introducing material that should be discussed in the full meeting.

Rather than remove a component that contributes to the safe and efficient running of the present system, I would suggest three measures: first, state clearly in tribunal guidelines what aspects of the medical member's contribution might jeopardise the patient's interest, and what procedures should be followed to mitigate the potential damage to the patient's case in instances where it is felt that the guidelines have been transgressed; second, strengthen the non-medical balance within the tribunal by enhancing the status of the lay member, perhaps by requiring involvement in relevant further professional development; and third, establish audit procedures – we do not know how well or how badly tribunals are doing, and it makes no sense to change a functioning system radically without knowing what the baselines are.

I suspect that a tightening of procedures and instigation of audit will improve overall performance, but will reveal very few instances of potential harm to patient rights.

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Graham Rooth Medical Member, Mental Health Review Tribunal, 6 Church Avenue, Stoke Bishop, Bristol BS9 1LD; e-mail: roothg@cs.com

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