On the Use of Caution Cards in Asylums. By J. MARNAN, M.B., Assistant Medical Officer, Fishponds, Bristol.

FOR a considerable period before the now practically universal system of caution cards was adopted in our asylums, other methods had to be resorted to in order that special attention should be given to suicidal patients. In the earlier established asylums, when the various duties, clerical and otherwise, of both medical officers and attendants were less mapped out for them, when, in addition, the number of patients was very much less, the then existing verbal caution was in general use, and was considered fairly efficient.

As a result both the medical staff and attendants acted to a much greater extent on their own initiative. But our asylums rapidly increased in size, the accumulation of chronic patients did not perhaps overshadow the acute to such an extent as formerly, and it was found that suicidal attempts were happening in larger relative numbers than was considered allowable by the Commissioners.

Tracing their reports through the various Blue-books, we find, as early as 1867, mention made of insufficient notice being given to attendants regarding the suicidal tendencies of patients entrusted to their care. This apparently producing no alteration, we find in the Blue-book for 1870 that "notice of the alleged suicidal tendency of a patient should not only be given in writing to the attendants first taking charge of him, but that this paper should accompany or follow him in every instance of removal from one ward to another, so long as he might remain in the asylum, however marked the supposed mental improvement might meanwhile have been." This was the first indication of the forthcoming caution card, and we are unable to trace any further direct reference to its adoption until five years afterwards, when in 1875 the Commissioners felt themselves obliged to make stringent representations as to the need for adopting a system of written instructions, which should be the means of more directly fixing the responsibility and ensuring unremitting supervision.

To quote from their report, "It consists in the filling up of a form, stating that attempts at self-destruction are likely to be made, and, where practicable, indicating the means likely to be employed. This form is cut from a book in which a counter-

foil remains. It should be printed on parchment, should be passed with the patient from ward to ward, and ultimately filed for reference."

In the years 1881 and 1883 we find suggestions and recommendations as to the adoption of a special card for suicidal patients, and as lately as 1890 we notice recommendations as to the form of caution card the Commissioners consider most suitable, and this more than twenty years after they had been first suggested. But as to the system which should be adopted, the Commissioners very wisely contented themselves by laying recommendations on formal lines, no particular form being prescribed. As a result there is to be found an astonishing diversity of caution cards in various asylums, when it is considered that the object of and the directions contained in the wording should be perfectly simple and concise.

It has occurred to us for some time that, though there is undoubtedly a use, there may be an abuse of the caution card, and there are several points in connection with them which have been brought out by answers to our inquiries, most kindly given by a large number of superintendents.

The first question was as to the date of the adoption of a caution card. Looking over our replies, we find 1879 as the earliest date given, and from that time until as lately as 1896 there has been a steady increase in the number of asylums adopting the system. However, strong as the recommendations of the Commmissioners were, it was with a great amount of reluctance that the new customs were established. This is evident from the fact that the greatest number of asylums determined to give the system a trial in the years 1888 and 1889, or more than twenty years after the necessity for written instructions was mentioned in the Blue-book.

The second question was as to the means previously taken to warn attendants. In almost every case verbal instruction was solely depended on, though in a certain number an attempt was made to impress the attendant with the full significance of the caution by marking the ordinary admission form " suicidal." Before passing from this question it is interesting to note that we have received several expressions of opinion from asylums in England and Ireland to the effect that they would have much preferred to have continued under their old method of verbal caution only.

One superintendent writes, "My own opinion of now over thirty years has brought me to the conclusion that, to prevent suicides and casualties, what is most needful is a thorough knowledge of the personalities of the patient, and a daily review of them. Much more safety is got by this and verbal instructions than by any system of caution cards. I issue cautions in extreme cases only."

Another says, "In my opinion these cards are of little or no use. Verbal instruction is the most perfect way of all."

The following opinion is most emphatic:—"I am glad to reply 'Thank God, never,' to the first query. In this asylum we humbly do our best to teach our attendants their duties, one of which is to look after suicidal patients. The system of caution cards is, in my opinion, pernicious, both from a medical and from an administrative point of view. It is also unfair and absurd, as I think, to fix responsibilities upon our attendants which we would not take upon ourselves."

We are aware that caution cards are still not compulsory in Scotland. The system of verbal instruction exists there to-day just as it did in England thirty years ago.

Here is the *modus operandi* of a Scotch asylum as given by the medical superintendent:—"When a patient is admitted the charge nurse is given a *résumé* of the case, and if in the opinion of the physician the case is suicidal, the nurse is told so. In the same way homicidal tendencies are indicated. I have never used caution cards in my fourteen years' experience, and do not think they are in general use in Scotland. Why they should be regarded as essential in one country and not in another I do not know. The Scotch Commissioners do not insist on them. The Scotch asylums are smaller, and the number of patients to each medical officer fewer. Some say English patients are worse than Scotch, but the system of boarding out harmless patients means that, of those in asylums, more in proportion are acute, and the cards would seem to be more required."

We quote these opinions merely from the point of view of their interest, and most interesting they undoubtedly are, since they emanate from men whose years of experience entitle them to our greatest respect.

Caution cards have been in use in Bristol Asylum for many years, and there is no likelihood or wish for their discontinua-

ance, seeing as we do their advantages, and appreciating the many good points which they have when properly employed. In such Scotch asylums as have adopted them, the system does not differ from our own.

The third question was, "What is the form of caution card used in your asylum?" In reply we received about forty specimen cards, of which no two were exactly alike, each superintendent having his own particular idea as to how the watchfulness of the attendant can best be ensured. The specimens were of many shapes, sizes, and colours, three only out of the entire number being of parchment, notwithstanding the Commissioners' suggestion to that effect. With regard to the printed matter, some were brief and to the point, but in many cases the instructions were anything but simply worded, and given at greater length than necessary.

Now the leading feature of a caution card should be its simplicity and brevity. We wish to inform our attendant that a certain patient is suicidal and must not be lost sight of for a moment. If we add the means by which he has already attempted the act, to give the case some distinguishing characteristics, and by so doing impress our attendant with a fuller sense of his responsibility, our caution card is complete. An elaborate card with numerous directions, couched in terms the meaning of which cannot be at once grasped, conduces to carelessness, and will probably be signed unread.

Some issue two cards—one for the actively suicidal, the other for the suspected cases. In our opinion one card answers the purpose. We do not expect our attendants, improved though they undoubtedly are, to discriminate between the two classes as regards the amount of supervision to be exercised; and, as previously stated, we do not issue a caution card to suspects, but only in extreme cases. When we are compelled to do so the case is treated to all intents and purposes as actively suicidal.

Questions Nos. 4 and 5 inquired whether the caution cards were issued to homicidal and suspected cases in addition to the actively suicidal. As might be expected, many are the views held on these points by different superintendents. Here we find caution cards issued in extreme cases only; here, again, suspected cases swell the number; while others include homicidal and escape cases also.

In the Bristol Asylum we make it a rule that unless we get

a definite history of a determined attempt, that patient is not placed upon a caution card. There may be occasional instances when, after conversation with a newly admitted case, we decide in our own mind that he is not to be trusted, and accordingly issue a caution card; but, generally speaking, we are loth to do so with regard to any patient who has merely expressed the intention, realising as we do that in the interests of the patient something should be risked, if necessary, in order that he may more quickly develop self-control, which the feeling of restraint necessitated by the use of the caution card is often too irritating to allow.

The sixth question was, "What percentage of your inmates are on caution cards?" The replies to this give an average of 3·6 *per cent.*, the lowest being 0·4 *per cent.*, and the highest 10 *per cent.* We naturally expect to find the greatest number in those asylums where it is deemed advisable to include homicides and suspects in the suicidal list, but although this must make the number larger we must remember that the class of patients varies in different places. Possibly, owing to greater stress of circumstances, such as exists in some parts of the country, those asylums would appear to receive more than their just share of the suicidal class. Even in the same asylum the number is ever varying, and the change is still more noticeable when we compare different institutions.

The seventh and eighth questions had reference to the distribution of the suicidal patients. The general tendency appears to be in favour of distribution throughout the building, such authorities as insist on this doing so because they are of opinion that the chance of recovery of the patient who forms one of a large group of similar cases is materially lessened. Others, however, prefer to hold the view that the supervision is more adequate when the suicidal patients are collected in one or two wards. We hold the latter view, and have done so for a number of years.

It is one of the rules in certain asylums that the actively suicidal cases shall be kept in bed until the acute symptoms have passed off. When by keeping the patient in bed we mean sending him to the infirmary ward, this plan is not devoid of good points. Such a patient can be kept under constant supervision, and at the same time free from the feeling that he is being watched.

The ninth question was, "What arrangements are made for bringing caution cards under the immediate supervision of the night attendant?" Here, again, we find numerous methods employed to achieve the same end. Some superintendents insist that the suicidal card shall accompany the patient to the dormitory nightly, where it is handed over to the night attendant and eventually signed by him. In most instances the nightly signature is dispensed with. Others prefer to rely upon a night report-book, in which is inserted the names of the suicidal patients, and this book receives the signature. As an additional precaution it may be the custom to note hourly whether the patient is asleep or awake. Quite a number of asylums issue two cards in respect of each patient, one each for the day and night attendant.

In the Bristol Asylum we do not consider it necessary to employ any of the foregoing methods. When a markedly suicidal patient is admitted a caution card is issued, and is handed by the head attendant to the charge attendant of the ward. The patient is then placed in bed, where, like all fresh cases, he remains during that day. This night only his caution card accompanies him to the dormitory, and both patient and card are entrusted to the care of the night attendant. The night attendant signs the caution card, and before taking over charge of the dormitory he has to satisfy himself that he is acquainted with all his suicidal cases. In addition, this card is signed by all the other night attendants, so that in the event of one relieving another each one becomes responsible in turn.

We sleep our suicides mostly in the same dormitory, practically in a row, and near the attendant's chair. They are, as a consequence, thoroughly under observation. Should anything occur to call him away from their immediate neighbourhood, although busy elsewhere, he can always watch from a distance that particular part where most of his observation is needed. Such cases as do not sleep in this dormitory, probably owing to bodily as well as mental infirmity, are located in the infirmary ward, where exactly similar rules are obeyed. With a trustworthy attendant we find this method most satisfactory and in every way adequate.

The tenth and final question was, "How often are the caution cards inspected, and under what conditions are they discontinued?" Looking over the varied replies to this, the most

important question of all, we find the following:—"Every three weeks," "weekly," "every fortnight," "monthly," "every two or three months," "frequently," "at uncertain intervals." Judging from the total replies, the favourite periods are weekly and monthly.

We consider once a month a reasonable time for systematic inspection, and accordingly inspect our caution cards monthly as a routine, though in the intervals between two such inspections we frequently review the list with a view to lessening the number whenever opportunity offers.

As regards the second part of the question, we must own that it does not admit of a very definite reply, because no two of the cases are exactly alike, and each must be judged on its merits. Consequently we consider it of the utmost importance that each case should be watched individually as far as possible. The less the number of caution cards, the more easily can this be done. We notice that the cancelling of the caution cards is often left to the discretion of the medical officer in charge of the case, but we are of opinion that no card should be discontinued without consultation with the medical superintendent, who is more competent to express an opinion in difficult matters of this kind.

Briefly speaking, the chief advantages of the caution-card system are:—Firstly, the cases are thereby focalised to both assistant medical officer and attendant; reviewing suicidal patients is a simple matter under these circumstances. Secondly, the grouping of cases under supervision renders a less number of attendants necessary; this is important, as we consider that none but most trustworthy attendants should be placed in charge of suicidal patients. Thirdly, the focalising and grouping of the cases are a guarantee that they will individually receive special attention.

We might mention a few disadvantages:—Firstly, the grouping of inharmonious cases, almost always necessary to some extent, however much we may endeavour to avoid it, the effect of which may be depressing and deteriorating. Secondly, the routine management of the patient by both medical officer and attendant—a tendency, as it were, to look upon the patient as a caution-card case and nothing more. With the knowledge that every suicidal case is in charge of an attendant who has signed himself responsible, it is unfortunately a by no means

difficult matter to unintentionally, though none the less effectually, neglect these cases. The attendant, for his part, is prone to develop haphazard and mechanical methods. Thirdly, the unfortunate tendency to prolong the period of special supervision.

It is a very simple matter to issue a caution card and by so doing relieve ourselves of all responsibility, but we should also bear in mind that the situation presents a far more serious aspect when we come to consider the advisability of removing his name therefrom.

In conclusion, we would add that the labelling and segregating of patients, when prolonged unnecessarily, is more suggestive of suicide than recovery. It is most important that the strain of constant supervision should be relaxed at the earliest opportunity, and with this end in view the suicidal cards should be regularly inspected; the attendant in charge frequently consulted as to the general conduct of the patient; any mental improvement, however slight, noted; the attention of the attendant called to the same, and every effort made to interest him in his work. Given a moderately intelligent class of attendant—and we are thankful to say such a class does now exist,—the views of those who see more of the patients than the most assiduous medical officer will go a long way towards helping us to acquire a more thorough knowledge of our charges. The longer we allow a patient's name to remain on the caution-card list, the more difficult will it become for us to remove him from its influence—an influence which, as before stated, in time becomes both irritating and deteriorating.

Even as lately as 1902 the Commissioners found it necessary to dwell on the importance of "a frequent revision of the list, and when properly possible a reduction of the number, as desirable in the interest of attendants and patients."

Discussion

At the Meeting of the South-Western Division, November 3rd, 1903.

Dr. Miller was inclined to think that they must acknowledge to their sorrow that the very existence of the caution card showed the terrible weakness in their administration. The very able way in which Dr. Marnan had entered into the history of the caution card rather demonstrated that fact. Unfortunately, in this country they were obliged to protect themselves, so to speak, by having these caution cards, but the less obtrusive the card was the better, and the limit of its use ought to be as close as possible. He failed to see how it would be possible in any asylum, unless staffed in an extraordinary way, to put 10 *per cent.* of the patients under continuous supervision. He thought they were apt, by the use of

the caution card, to deter a possible improvement in the condition of the patients. To congregate a number of patients in one ward might be all very well for the happiness of the staff, but absolutely wrong for the treatment of the patient. To regard the question from the point of view of economy was wrong, and he contended that they ought to try to find out that system of treatment best calculated to cure the disease.

Dr. STEWART said that the idea Dr. Miller had suggested was a very practical one, and one which commended itself very much to all of them who were anxious that the feelings of the patients should have every consideration. He believed with him that the association of all suicidal patients in one room for the purpose of having them under special observation was a faulty arrangement, and might retard convalescence.

Dr. ALDRIDGE said that in discussing any particular form of treatment it was usual to contrast the results obtained under that treatment with those obtained before such treatment was instituted, and in the matter under discussion it would be interesting to know if there was any diminution in the number of suicides during the time the caution cards had been in use, and whether less or more suicides had occurred where a more stringent use of the cards obtained.

Dr. MACDONALD said that the point raised by Dr. Aldridge was perhaps the crux of the whole matter. Had caution cards reduced the number of suicides? A careful perusal of the Commissioners' Blue-books did not prove that the use of caution cards had reduced the number of suicides. For the year 1902 there was one suicide to every four thousand patients in the public asylums of this country. This proportion has varied considerably during the past thirty years—the average for thirty-one years being one suicide to every five and a half thousand patients. He was of opinion that these caution cards should not be used for any other class of case than the actively suicidal, and then only after mature consideration. He was not sure these caution cards were of the value Dr. Marnan would have them believe in the prevention of regrettable accidents. Such had not been his experience. He would not deny that they had nurses and attendants to whom these cards might be a help, but what he disliked was this mechanical method of inducing nurses to do their duty. If asked not to lose sight of the patient, the nurse should be trusted to carry out the order, and not be openly assured of the distrust surrounding her by having to sign a special card. He was inclined to think the more they brought into the daily life of these institutions the idea of mechanical checks and aids, the more they rendered the individual a mere piece of artificial mechanism, and the less apparent was that mutual healthy trust and confidence without which we were indeed poverty-stricken. Our aim should be to raise the standard of individual responsibility among the members of our staff, and this, he said, could only be done by a free and untrammelled system of inspired trust and confidence.

Dr. SOUTAR said that caution cards were undoubtedly of great value in preventing preventable suicides. It was well known that from time to time suicides which no foresight could prevent occurred in asylums. They could not read what was going on in the minds of patients, and it sometimes happened that when to all appearance that stage of improvement had been reached which in the patient's best interests indicated a relaxation of restrictions, a long-concealed suicidal intention was carried out. For such accidents as these they were not blamed. It was one of the justifiable risks they must run in guiding a patient back to health. What they would rightly be blamed for would be for omitting to take every precaution against suicide in the case of those patients who were known to have, or might reasonably be suspected to have, a suicidal tendency. He thought that in those cases specially written directions should be given to the attendants, and that for the comparatively limited number of actively suicidal patients caution cards should be issued. He maintained that this imposing of definite instructions on attendants should not be regarded as a shifting of responsibility from their superiors, but rather as a means of securing co-operative action on the part of all concerned in the treatment of the patient. As far as one could judge from Dr. Marnan's paper, the great majority of asylum superintendents were agreed on the general principle that the issuing of special directions in suicidal cases was necessary. The practical value and great interest of the paper lay in the summary he had made of the practice of others, and in his statement as to how suicidal

cases were dealt with in the asylum with which he was connected. There was agreement in principle, with variations in the methods of applying it. The purpose in view was to secure the safety of the patient, and to assist the attendants—as definite instructions did assist them—in the discharge of their duty. He (Dr. Soutar) said that he divided suicidal cases into three classes:—First, those patients who had not developed, but from the type of their mental disorder might possibly develop, suicidal tendencies. The names of those patients were written in red ink on the charge attendant's list. These were cases for observation on the part of attendants, who, constantly associating with the patients, would from close observation be able to assist the medical officer in arriving at a decision as to whether the patient should or should not remain on the suicidal list. He valued highly the assistance of observant attendants in this class of case. Second, those patients who were definitely suicidal—perhaps had made an attempt at suicide, and would under favouring circumstances attempt it again. These patients must never be away from observation by day or night, and must be specially guarded from temptations which suggest, or opportunities which facilitate, the suicidal act. For these patients there is issued a red card, which is signed by all attendants on day and night duty who have anything to do with the case. Third, this class is fortunately a small one. It consisted of those patients whose insanity showed itself in a determination to die. They generally showed very little emotional disturbance, they revealed no delusions, and they were generally intelligent and often seemingly interested in all the ordinary pursuits of life; yet their purpose was suicide. They were ever seeking opportunity to effect this purpose, and their ingenuity in discovering the opportunity could be believed only by those who had charge of them. A patient of this type required to have a special attendant close to her at all times by day and night. These patients were generally women. In these cases he issued a blue card warning the attendant of the condition of the patient. The attendant while in charge of the patient had this card in her possession; she had no other duty, and until the card was handed over to another attendant her responsibility continued. As a general rule the obtrusive watching of patients should be avoided, and the tactful attendant would do his duty without aggressiveness; but in the last class of cases there should be no hesitation in telling the patient what the restrictions were and why they were imposed. The frequent revision of the suicidal list was most important, but when to withdraw a blue card was one of the most difficult and responsible of duties.

Dr. AVELINE asked if the caution cards might not be defended on the ground that written instructions were very much better in evidence than verbal instructions. It would have been interesting if Dr. Marnan could have given them any statistics with regard to the value of the caution cards.

Dr. BENHAM said he was practically in entire agreement with the paper read by Dr. Marnan, and also with the remarks of Dr. Soutar. The method he had sketched out was, in his opinion, admirable. It had been suggested that to segregate patients in particular wards very much retarded recovery and inflicted pain upon them, but that had not been his experience. He had no hesitation in telling the patients they were under suspicion. In his asylum they had one ward in which there were twelve suicidal patients under caution cards, and he did not think they suffered because they were thus segregated, or that the nurses suffered from the strain.

Dr. MARNAN briefly replied to the discussion.

On the Experimental Use of Antiserums in Acute Insanity. By LEWIS C. BRUCE, M.D.Edin.

DURING the past year we have frequently used antiserums experimentally in cases of acute insanity because we have been led to believe from our observations that many of these cases,

https://doi.org/10.1192/bjp.50.209.250 Published online by Cambridge University Press