

response options. Furthermore, since 83% of respondents ultimately advocated treatment there was clear consensus about the final choice of action.

We agree with the recommendations that accurate contemporaneous records should be made, and would emphasise the need for these to be adequately detailed (*Medical Ethics Today, Its Practice and Philosophy*). While we support the recommendation of consultation with colleagues before treating without consent, applications to the High Court may be impractical in view of time constraints.

In addition we feel it would be useful for national guidelines to be developed. We have contacted the British Medical Association, the Royal Colleges of Psychiatrists and of General Practitioners, the British Association of Accident and Emergency Medicine, the General Medical Council, the Medical Defence Union and the Medical Protection Society, all of whom state that they have no recommendations to make about the management of patients who refuse treatment following an overdose. Thus, this appears to be an issue worthy of further debate in these litigious times.

Medical Ethics Today, Its Practice and Philosophy. P23. Section 1:6 Refusal of treatment. London: British Medical Association.

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Sir: I read with interest the paper by Hardie *et al*, regarding problems with consent in the emergency treatment of overdose (*Psychiatric Bulletin*, January 1995, **19**, 7–9).

Guidance to doctors clearly states that they must respect the 'competent' patient's refusal of treatment. However, in emergencies a doctor may do what is reasonably necessary to preserve life or prevent deterioration in health without first obtaining the patient's formal consent. "The guiding principle is to act in good faith and in the immediate best interests of the patient's health and safety" (Palmer, 1991). The authority for such action is embodied in Common Law. This refers to a body of law that is not enshrined in parliamentary statutes but is derived from

the rulings of judges and thus may be in constant flux. Hopefully it corresponds with contemporary 'common sense'. Helpfully, the new Code of Practice for the Mental Health Act 1983 (HMSO, 1993) discusses Common Law and consent to treatment, and outlines situations where treatment may be given without consent including the emergency treatment of someone "suffering from a mental disorder which is leading to behaviour that is an immediate serious danger to himself . . . may be given such treatment as represents the minimum necessary response to avert that danger."

Such statements are helpful in clarifying for psychiatrists how to proceed in many cases. The immediate issue is the degree of medical risk involved if treatment is not performed. This is not an appropriate task for a psychiatrist, as was suggested by Hardie *et al*, but should be made by the attending physician or surgeon. Consideration can then be made as to whether this justifies compelling treatment under Common Law. Treatment thereafter should withstand the scrutiny of the classic Bolam negligence test whereby a doctor is free of blame if the treatment provided was "in accordance with a practice accepted as proper, by a responsible body of medical men" (Bolam v. Friern Hospital Management Committee, 1957).

These points should not be interpreted as giving doctors a free hand in treating people against their will, but should be considered when difficult clinical situations arise. Junior doctors are well advised to seek guidance from senior colleagues and if necessary to obtain professional legal advice. In all cases a thorough attempt should have been made to persuade a patient to accept necessary treatment voluntarily.

BOLAM. V., FRIERN HOSPITAL MANAGEMENT COMMITTEE [1957] 1 WLR 582.

HMSO (1993) *Code of Practice: Mental Health Act 1983*. London:HMSO.

PALMER, R. N. (1991) *Consent and Confidentiality*. London:Medical Protection Society.

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Sir: We are grateful that Chambers *et al* have pointed out that our treatment may not accurately reflect all possible clinical situations. The patient in our vignette was not attempting to leave, and this was specified

so that the management options could be logically narrowed to those used. This allowed for easier completion by respondents and aided interpretation of the results. It does, of course, tell us nothing about how psychiatrists would respond if the patient wanted to leave, which would require another vignette. Our treatment options were designed to reflect issues of consent to treatment. Option (b) may entail prolonged non-consensual treatment, for administration of an antidote, which could present practical difficulties on a medical ward. Option (c) may involve treating a confused patient and may also entail considerable risk to the patient's life. We agree that options (a), (b) and (c) involve treating the non-consenting patient, but we felt they were sufficiently different to warrant separate categories.

We agree with Dr McCartney that doctors should act in "good faith and in the immediate best interest of the patient". We do not agree that this extends to the giving of emergency treatment if the patient has refused consent and has the mental capacity to do so. Lord Donaldson MR (1992, page 799) stated "every adult has the right and capacity to decide whether or not he will accept medical treatment, even if refusal may risk permanent injury to his health or even lead to premature death. Furthermore it matters not whether the reasons for the refusal were rational, irrational, unknown or even non-existent." In addition, the Law Commission (1995) have now published further discussion and draft legislation on mental incapacity. When considering doctors who were "conscientious objectors" to the right of competent patients to refuse treatment they argued (page 77): "If the principle of self determination means anything, the patient's refusal must be respected."

Dr McCartney has suggested that the immediate issue is one of "medical risk". Our interpretation of the current law and the Law Commission's current standpoint is that the immediate issue is one of mental capacity. Lord Donaldson (1992, page 796) also stated: "the more serious the decision, the greater the capacity required", so clearly medical risk should be considered as impinging on the level of mental capacity required for a valid decision. However, he also stated (page 796) and the Law Commission (1995, pages 74-75) have emphasised that in cases of doubt the decision should be: "resolved in favour of the preservation of life".

There is currently no test of mental capacity, but the draft legislation from the Law Commission (1995, page 36) suggests that the patient should at least suffer from a "mental disability" to have mental incapacity. This would be applicable even though the case of *Re C.* (1994) has underlined that a patient with a mental disability (in this case schizophrenia) may still be able to validly refuse treatment. We have found clinically that casualty officers sometimes value the opinion of a psychiatrist when a patient is refusing treatment, and certainly if mental disability is used as a threshold test of incapacity, then psychiatrists are likely to become more involved in such treatment decisions. It is not our opinion that psychiatrists should be assessing "medical risk", as Dr McCartney suggests, but we do believe that psychiatrists may have something to offer in the assessment of mental disability which might contribute towards lack of mental capacity.

LAW COMMISSION (1995) *Mental Incapacity—Item 9 of the Fourth Programme of Law Reform: Mentally Incapacitated Adults*. London:HMSO.

RE T. (Adult: Refusal of Treatment) (1992) *Weekly Law Reports*, 3, 782-805.

RE C. (Adult: Refusal of Treatment) (1994) *Weekly Law Reports*, 1, 290-296.

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Violence to junior psychiatrists

Sir: We read with interest the article by Lillywhite *et al* (*Psychiatric Bulletin*, January 1995, 19, 24-27) on the risk of violence to junior psychiatrists and the work they had done to diminish the risk.

We produced *A Report on Violence at Work and its Impact on the Medical Profession within Hospitals and the Community* (Schnieden & Maguire, 1993), to focus attention on areas of possible change within the health system and to provide guidance for employers and employees. The report makes a number of recommendations, including the establishment of a core communication training module as part of the undergraduate curriculum including a section for dealing with difficult/violent patients. Information on policies and procedures should be incorporated in each induction course and there should be regular updates of courses and continued