the physical environment. The aim, the ethos, and the values of the service are fundamental and determine whether emotional needs should be recognised and responded to. In a therapeutic corporate culture the service is organised around the need to understand how patients feel. This contrasts with a persecutory culture in which emotional patients are regarded as a nuisance and their feelings as a burden which interferes with the treatment. Such cultures are fuelled by anxiety and staff are motivated by criticism and disapproval. Empathy cannot survive in such conditions.

Abusers have often suffered from abuse and the oppressed can easily turn into the oppressors. This is the danger of a persecutory culture. Staff who work for an organisation that ignores their emotional needs are in danger of being insensitive to their patients' feelings. If the persecuted tend to become persecutors, then the cared for tend to care. Empathy begets empathy. Caring for staff, recognising their emotional needs, valuing and supporting them is the best way to ensure that they listen to and understand their patients.

Managers and clinicians actually have the same goal. They both want a caring service that is efficient and effective. Effectiveness depends upon good clinical practice, efficiency upon sound management, and caring on an understanding of human nature. They must therefore work together to produce a well managed and clinically proficient service that is sensitive to individual need, to create a therapeutic culture in which the emotional needs of managers, clinicians and patients are attended to. Empathy is managed by empathy.

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Prescription charges and recurrent depression

Recently a patient attending my out-patient clinic suffering from recurrent depression, became unwell again. She is normally maintained on a combination of lithium and a tricyclic anti-depressant. She relapsed because she had stopped her medication, claiming that she could not afford the prescription charges. Her insight has never been good, and she receives scant support from her husband, who is in full-time employment earning a low wage. My patient looks after her young children. The family just fail to qualify for help with prescription charges, although they are the typical sort of family described in a recent national survey as being likely to have financial difficulties (Laurance, 1992). It is well established that women in such families have a high rate of depression.

The World Health Organization now advises prophylactic medication for patients with recurrent episodes of unipolar depression. I have certainly found this strategy to be useful. I would have thought that a case could now be made for sufferers of recurrent depression to be made exempt from prescription charges. The Department of Health leaflet P. 11 states that sufferers of diabetes, epilepsy and hypothyroidism (plus others) are entitled to free prescription, presumably because they require medication to remain well as opposed to needing treatment to get better, so why not extend this principle to those who need maintenance psychotropic drugs to keep them euthymic? Perhaps the Royal College of Psychiatrists could take up this issue in its forthcoming campaign to "Beat Depression".

The recently announced increase in prescription charges does not, I fear, improve the immediate prognosis for my patient.

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Professor A. C. P. Sims, President, writes "Thank you for making this useful point; the matter will be discussed further at the Executive and Finance Committee of the College".

Reference

LAURANCE, J. (1992) More families fall into debt. *Times*, 27 February, 3.

Treating physical illness without consent

DEAR SIRS

It is well known that the Mental Health Act does not contain provisions to enable treatment of physical disorders without consent. However, it seems less widely known that it is possible to first detain someone under the MHA, and then under common law treat a physical disorder without consent, if the physical disorder is *caused* by a mental disorder or is itself the *cause* of a mental disorder, and treatment of the physical disorder is considered to be in the best interests of the patient.

One of our patients who suffers from schizophrenia presented with a history and clinical signs consistent with a major head injury. He was unwilling to undergo investigation or treatment and the MHA was used to facilitate doing so. The patient was found to have sustained an extradural haematoma and underwent an emergency craniotomy and drainage.

Although initially detained at the psychiatric hospital under Section 4, the investigation of the physical disorder was carried out under common

law. With respect to physical illness, *Patient Consent to Examination or Treatment* (DOH, 1990) states that a patient may under common law withhold consent prior to examination or treatment. However, this maybe carried out without consent if the patient is incapable of giving that consent by reason of mental disorder and if it is in his best interests. The circular goes further in saying that it may indeed be the doctor's *common law duty* to act on the grounds of necessity in operating on or giving treatment to adult patients disabled from giving their consent.

It is likely, therefore, that this case would have been deemed to have been managed correctly under common law, although each case would be judged on its individual details in a court of law. Guidelines for acting under common law are not as well defined as those acting under the MHA. In *Patient Consent to Examination or Treatment*:

> "A proposed operation or treatment is lawful if it is in the best interests of the patient and unlawful if it is not . . . the standard of care required of the doctor concerned is that he or she must act in accordance with a responsible body of relevant professional opinion."

The Code of Practice (DOH and Welsh Office, 1990) goes further in explaining "in the best interests of the patient" in saying that the treatment should be:

> "necessary to save life or prevent a deterioration or ensure an improvement in the patient's physical or mental health."

This case report highlights the danger that a restrictive interpretation of the MHA and a misunderstanding of a patient's common law rights may lead to professionals failing in their common law duty to appropriately treat patients . . . In the current climate of defensive medicine it seems prudent to have the legalities of such situations clear so that they can be applied in the patient's best interests.

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References

DEPARTMENT OF HEALTH (1990) *Patient Consent to Examination or Treatment*, HC(90)22.
—— and WELSH OFFICE (1990) *Code of Practice Mental Health Act 1983*. London: HMSO.

Attendance at multidisciplinary case meetings

DEAR SIRS

Over the past few years I have found it increasingly difficult to provide properly planned and coordinated care to inpatients because of the difficulty in persuading key staff to attend the weekly multidisciplinary case meeting, and I wonder if other psychiatrists have similar problems. During the month of November 1991 I kept records of staff attendancies at case meetings with the following results.

During the one month period studied there were four case meetings containing a total of 41 case discussion episodes. There were eight admissions and eight discharges during the month. Attendance of key staff at these meetings was as follows:

Ward key worker: 51%
Community key worker: 35%
Both ward and community workers present: 22%
Both ward and community workers absent: 37%

It will be seen that over three-quarters of case meetings proceeded in the absence of one or other key worker, and in over a third of cases in the absence of both.

The first case meeting after admission is especially important in planning treatment, and the last before discharge equally so in planning after-care. In the case of the eight admissions neither ward nor community key workers were present at 50% of the initial case meetings, and in the case of the eight discharged patients neither ward nor community work was present at 63% of the case meetings prior to discharge.

As RMO I appear to be responsible for the standard of care received by my patients in hospital and after discharge. In practice I have no authority over other staff, and I find it extremely difficult to deliver properly planned and coordinated care when other professionals are so frequently absent from case meetings.

Name and address supplied

Thyrotoxicosis during lithium therapy in a mentally handicapped patient

DEAR SIRS

While lithium was a well recognised cause of hypothyroidism, its use may rarely be associated with the development of thyrotoxicosis. In a review of the literature, we discovered eleven such cases reported. This phenomenon has not been previously described in a patient with mental handicap.

A 53-year-old mildly mentally handicapped man with a 30 year history of bipolar illness, but no history of thyroid disease, was admitted to a specialist psychiatric ward in a mental handicap hospital following a recent onset of over-activity, sexual disinhibition and weight loss. These symptoms had been previously assoicated with hypomanic episodes. He had been commenced on lithium three years previously, at which time he was noted to be euthyroid.