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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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.

However, routine blood thyroxine estimates on this admission revealed a total thyroxine of greater than 270 (reference range 58–107), and a diagnosis of thyrotoxicosis was made. He was treated initially with propranolol, but later required iodine[131] therapy and neomercazole to achieve euthyroid status. Lithium was discontinued on discovering his thyroid level, but haloperidol was required to control his hypomanic symptoms, and he was later recommenced on lithium following consultation with his physicians. He has since required thyroxine replacement to maintain normal levels, and at an eight year follow-up he has had minor mood swings only which have not required hospital admission.

The relationship between lithium therapy and concomitant thyrotoxicosis remains unclear. Männistö (1980) reviewed 9 of the 11 cases reported so far, and concluded, while lithium may have been a causative agent, there were usually contributing factors (previous thyrotoxicosis, goitre or thyroiditis). He noted that in at least one of the cases reported a reduction of lithium or termination of lithium therapy had unveiled a hidden thyrotoxicosis. The development of thyrotoxicosis during lithium therapy is an unexpected event and may easily be overlooked, especially as the symptoms of this disorder, for example, over-activity and insomnia, resemble those of hypomania. These diagnostic difficulties may be further compounded by co-existing mental handicap.

This case reminds us of the need to remain alert to the possibility of thyrotoxicosis as a rare complication of lithium therapy.

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Overseas doctors

DEAR SIRS

Although Drs Matthew, O'Dwyer and Zafar have made some pertinent points with regards to the Royal College examination for overseas doctors (*Psychiatric Bulletin*, 1991, **15**, 699–700; 1992, **16**, 231–232), they have overlooked the fundamental fact that "overseas doctors" are *not* a homogenous group (*Psychiatric Bulletin*, 1992, **16**, 232). Two of the most important issues at play here are the stage in the overseas doctor's postgraduate career at home before entering British training, and the status of Membership in the home country. As an Indian psychiatrist on the Overseas Doctors Training Scheme (ODTS) I would like to address both these issues, especially as my country is one of the largest contributors of overseas doctors to the NHS.

With the cessation of double sponsorship, successfully applying for the ODTS or passing PLAB are the only viable and practical options commonly available for Indian doctors to work in the UK. Very few Indian postgraduates in psychiatry will be motivated enough to prepare for PLAB, and hence, the ODTS is much the preferred alternative. One of the eligibility criteria for ODTS is a minimum of two years of experience in the home country. However, few candidates will seriously consider breaking off training in India after two years, because most of our academic institutions require continuity in training to be able to take up an Indian psychiatric degree. Therefore, almost all Indian trainees on the ODTS have an Indian DPM and/or MD in psychiatry. This is of paramount importance as the College Membership is *not* recognised in India and doctors returning with British degrees, but having no postgraduate home country qualifications, face enormous difficulties (Patel & Araya, 1992).

To be eligible for "long leave", one has to have been in service for a substantial period, and hence, attained considerable seniority. Not only would few such individuals want to start as senior house officers in the UK, the Overseas Liaison Committee is also likely to hesitate before accepting such senior candidates as trainees in view of the personal dissatisfactions inherent to such situations. Barring the odd instance, the rest of us are supposed to have secure positions on returning home. From a practical point of view, these are unlikely to materialise, whether we have the Membership or not, because most of us have not preserved a continuity in service which is essential for academic medical progress in India. Moreover, our British experience will not be accredited.

The question which begs an answer then is why we come here at all? Apart from varying personal and material reasons, the primary purpose would be to gain specialty and research experience (Gandhi *et al*, 1992), and, as Drs Mann and Caldicott have rightly concluded, not necessarily to acquire the College Membership. The ODTS is, therefore, an excellent scheme for everybody, because while guaranteeing us specialty experience, it also serves the philosophy of *Achieving a Balance*.

And yet, the majority of us will be very disappointed if we return without the Membership. To enumerate a few of the reasons: ego satisfaction; easier absorption into academic medical systems of other countries and international organisations; doubling of consultation fees in Indian private practice; our piquant cultural expectations of acquiring "foreign degrees".