complexity that GPs deal with, including insulin, cytotoxic drugs, gold injections and steroids: other consultants do not share Dr Armond's anxieties.

Lithium has an important role in the management of affective disorders (Cowen, 1988; Gelder *et al*, 1989), particularly in prevention of recurrence of mania and depression. There is no doubt that the use of lithium does need to be monitored but this is quite easy in general practice, and each doctor should have a plan for monitoring drug levels. My practice is to do levels three-monthly, with an annual check on thyroid and renal function, but some authors (Kehoe & Marder, 1992) feel that this policy is too strict. We need to develop and improve good practice (Aronson & Reynolds, 1992) so that as many people as possible can be treated in the community rather than attending hospitals or local mental health units for blood testing. This issue is not being driven by fund-holding but by good clinical practice.

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Sir: I am glad to reply to Dr D. Faux's letter about general practitioners (GPs) prescribing lithium. The *British National Formulary*, some computer programmes in general practice and several psychiatrists, including myself, (*Prescriber*, 1991, **38**, 81–83) have apparently not been very successful in contributing to the safety of lithium prophylaxis in general practice.

Of 1250 consecutive lithium estimations over several months in 1994 in our borough of 305 000 population, 5 out of the 6 levels above 1.2 mmol/l were found in patients in GPs' care only, even though the vast majority of patients on lithium were in consultant care.

In my original letter, 'General Practitioners and Lithium', *Psychiatric Bulletin*, **19**, 117) research in Edinburgh was quoted as showing that where GPs controlled lithium prophylaxis with advice and reminders from the central hospital, the admission rate for mania rose enormously instead of falling by over 70% as in my clinic and the drop-out rate was 10 times that found in my clinic.

Now, Dr S. Noblett's audit in Macclesfield reveals that "the level of monitoring of serum lithium, renal and thyroid function, is far superior in those patients who attend the clinic nurse in the out-patient department compared to those monitored by the community psychiatric nurse or general practitioner in the community"; and default or non-compliance bring about an immediate follow up.

There is no doubt that a GP can monitor lithium maintenance satisfactorily if prepared to become well informed and to remain up to date, and if it is fully realised that such lithium monitoring is only one part of a much bigger project to keep a manic–depressive patient as well as possible—without which, lithium does more harm than good.

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## Consent, decision making and Common Law

Sir: We were interested to read 'The emergency treatment of overdose: a problem of consent to treatment' by Hardie *et al* (*Psychiatric Bulletin*, January 1995, **19**, 7–9). We welcomed the highlighting of this legally and ethically important topic. However, we have concerns about the methodology and the finding that "there was no clear consensus as to the correct choice of action".

The method involved forced choice responses regarding the management of a vignette. It is doubtful whether answers about a single vignette, particularly given the limited range of choices, adequately reflect clinical practice. Importantly the issue of allowing patients to leave without treatment was not addressed, this being a critical issue in reality. Of the responses available, 75% entailed forced treatment of the patient at some time. Thus, there was a bias towards treatment in the

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 Assocation.

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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.

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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