that the use of ketoconazole is 'rarely necessary'. Fluconazole is a good substitute for ketoconazole as an antifungal agent but at higher concentrations ketoconazole also has widespread inhibitory effects on the cytochrome P-450 enzymes involved in adrenocortical steroidogenesis (Raven & Hinson, 1996). As these include 17α-hydroxylase and 11β-hydroxylase but not 21-hydroxylase, there is no consequent increase in ACTH and resulting 'cortisol escape'. For this reason, ketoconazole is recommended as the drug of choice to decrease excess cortisol production (American Medical Association, 1993). Because of its cortisol-lowering effect, ketoconazole has also been advocated as a treatment for major depression, a disorder associated with hypercortisolaemia.

AMERICAN MEDICAL ASSOCIATION (1993) *Drug Evaluations Annual.* Chicago: American Medical Association.

RAVEN, P. W. & HINSON, J. P. (1996) Transport, actions and metabolism of adrenal hormones and pathology and pharmacology of the adrenal gland. In *The Adrenal in Toxicology* (ed. P. W. Harvey), pp. 53–79. London: Taylor & Francis.

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Consent to treatment

SIR: We read with interest the recent article by Brabbins *et al* (1996) in which the authors make a strong argument for clinicians seeking informed consent for neuroleptic treatment in the majority of schizophrenic patients. They conclude that a pro forma could be used to record patient consent which would include a record of information given, benefits and risks discussed, measurement of capacity to consent and the absence of duress.

While agreeing with the argument for pursuing informed consent in this patient group, it is not so clear to us that the use of a formalised pro forma is the best method of recording consent. A recent American Psychiatric Association task force report (1992) recommended that informed consent for neuroleptic treatment should be documented by a progress note rather than by use of consent forms. This was felt to reflect an understanding of informed consent as a process rather than an event. Such thinking is consistent with recommended UK practice, i.e. that 'consent' is the voluntary and continuing permission of the patient to receive a particular treatment (Department of Health, 1993). In a recent survey of 81 British consultant psychiatrists we asked whether they would consider using a standardised consent form for patients on long-term neuroleptic treatment. Only 31% responded positively despite 73% admitting to concerns in regard to future litigation from patients going on to develop tardive dyskinesia. There is clearly some resistance among British clinicians to the use of formalised consent forms. The obtaining of informed consent for treatment is an ongoing process and should be recorded in such a manner that reflects this process. A single pro forma, however detailed, may therefore be counter-productive.

BRABBINS, C., BUTLER, J. & BENTALL, R. (1996) Consent to neuroleptic medication for schizophrenia: clinical, ethical and legal issues. *British Journal of Psychiatry,* **168,** 540–544.

DEPARTMENT OF HEALTH (1993) Code of Practice of the Mental Health Act 1983.

AMERICAN PSYCHIATRIC ASSOCIATION (1992) *Tardive Dyskinesia: A Task Force Report of the American Psychiatric Association.* Washington, D.C: APA.

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SIR: There are many issues involved in the prescribing of medication to those who may be unable to give consent. Some of these have been reviewed recently in the context of schizophrenia (Brabbins *et al*, 1996). However the problems arising with drug use in patients with dementia have been less well aired. Brabbins *et al* suggest that clinicians should document attempts to obtain informed consent, but do not answer the question, 'what should we do if this cannot be given?'. In those patients who have psychotic disorders the argument revolves around whether or not to invoke Mental Health legislation. Where patients have severe cognitive impairment informed consent is usually impossible to obtain. Current practice is to give medication without consideration of the legal status of the patient; it is administered unless the patient actively refuses to take it. Yet, there is doubt as to the efficacy of these drugs in managing behaviour related to dementia (Schneider *et al*, 1990). We feel quite comfortable prescribing drugs which have a definite benefit to such patients e.g. diuretics, antibiotics and cardiac drugs. However, should the use of drugs which frequently benefit the carers or other patients rather than the recipient themselves and have a high incidence of often irreversible side-effects continue in those who are