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-consenual 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.

TIM HARDIE, *Reaside Clinic, Rubery, Birmingham, B45 9BE;* KAMALDEEP BHUI, *Maudsley Hospital, London SE5 8AZ* and PHILLIP BROWN, *Edenfield Centre, Prestwich Hospital, Manchester M25 9BL*

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

https://doi.org/10.1192/pb.19.8.519 Published online by Cambridge University Press

postgraduate education to ensure that individuals are informed of topical issues, current management and medical procedures. Those who carry out the training should ensure that they themselves are adequately trained. Hospitals are advised to establish policies to cover both physical and verbal abuse. There should also be implementation of a procedure for reporting violent incidents and an audit of these incidents. Employers should carry out a risk assessment and provide staff with adequate training to understand the risks involved and enable them to defuse dangerous situations and only as a last resort to take physical action to deal with violent attacks. Procedures to minimise post-traumatic stress disorder should be instituted by the availability of confidential counselling.

The importance of dealing with violence in order to reduce stress among doctors must not be underestimated. This issue must be taken seriously to protect the most precious resource of the health service—its staff.

SCHNIEDEN, V. & MAGUIRE, J. (1993) *A Report on Violence at Work and its Impact on the Medical Profession within Hospitals and the Community.* BMA North Thames Office. Copies of the report are available from the North Thames Office.

*Correspondence VIVIENNE SCHNIEDEN and JANET MAGUIRE, *Clinical Research Unit for Anxiety Disorders, 299 Forbes Street, Darlinghurst 2010, New South Wales, Australia*

Pro re nata medication: a risk factor for suicide

Sir: We read with interest the paper by Elizabth King (*British Journal of Psychiatry*, 1994, **165**, 658–663) on suicide in the mentally ill. Establishing factors predicting suicide is invaluable. We wish to report an interesting observation.

A near fatal suicide attempt by a schizophrenic patient was preceded by an unusual request for a p.r.n. neuroleptic. Following this a review of p.r.n. medication preceding successful suicides since 1975 in our Special Hospital was undertaken. The case-notes of nine of ten suicides were traced. Six had requested p.r.n. medication prior to their suicidal acts (range four hours to four days). Three of these were regular p.r.n. requesters. The other three had requested p.r.n. neuroleptic medication in the 24 hours prior to committing suicide. In these three patients, the requests were most unusual, these patients not having had any p.r.n. medication for more than six months in two cases and for three months in the third case.

We feel that an unusual demand for p.r.n. medication by a long-stay in-patient may be a sign of increasing patient distress that could predate suicide and may be worthy of objective study.

PRIYADARSHAN JOSHI and J. D. COLLINS, *Ashworth Hospital, Parkbourn, Maghull, Liverpool L31 1HW*

Proposals on continuing medical education (CME)

Sir: Sensky's study (1994) on the experiences and opinions of consultant psychiatrists on CME takes into consideration teaching and attendance at educational meetings. I would like to comment on the latter point.

The assumption that attendance at academic meetings achieves what it purports to accomplish, that is the acquisition of knowledge, may be incorrect. Meetings differ in quality and, unless objective evaluations are carried out, the value of particular meetings may be questionable.

Multiple choice question tests are reliable methods to assess acquired knowledge, easy to administer and to mark with the aid of computers. I propose that speakers and lecturers should prepare a few (say five) MCQs on their topics which would be distributed at the end of the talk. The format should be similar to that used in the MRCPsych examination (i.e. correct, false, and don't know answers). An optimum interval or range of response rate for each item of a question should be agreed in advance to eliminate questions with low discrimination power. To facilitate the analysis, there should be a box to indicate that each particular item in a stem question was known or unknown to the respondent prior to the lecture. A minimum number of respondents or percentage of the audience, or both, should be agreed in advance if results are to be

https://doi.org/10.1192/pb.19.8.519 Published online by Cambridge University Press