Health Service Guidelines – Patient Consent to Examination or Treatment

DEAR SIRS

The handbook *A Guide to Consent for Examination or Treatment* accompanied a communiqué (NHS Management Executive, HC [90] 22) in 1990. To eliminate misunderstandings, the Department have revised the model forms at Appendix A and B and reissued them as Health Service Guidelines (HSG [92] 32).

We deal mostly with people who lack the capacity to give consent. Our team members, comprising clinical psychologists, chiropodists, nurses, occupational therapists and physiotherapists, are independent practitioners involved in treatment methods for which client consent should be paramount when implementing regimes against their wish, or restricting their liberty. I am not sure what is expected of health professionals other than doctors and dentists under such circumstances. According to Appendix A(3), the health professional must state: "I confirm that I have explained the treatment proposed and such appropriate options as are available to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient." The patient/parent/guardian also signs: "I agree to what is proposed which has been explained to me by the health professional named on this form." (HSG [92] 32, Appendix A [3]). It looks as if the parent's or guardian's consent is just as valid as the patient's consent. I doubt whether this is so when it concerns adults with mental disorder. It is a well established law that no person can give consent on behalf of a mentally handicapped adult. Although it does not automatically mean that just because a person is suffering from a mental disorder, he or she is incapable of giving consent, it may be, in certain cases, that a consent form could be signed by the patient without understanding the significance of it.

According to the Code of Practice, Mental Health Act 1983, medical treatment includes "nursing and also includes care, habilitation and rehabilitation under medical supervision" (Department of Health and Welsh Office [section 15.3, p. 52]). It also says, it is the personal responsibility of any doctor proposing to treat a patient to determine whether the patient has capacity to give a valid consent. (section 15.14, p. 55).

Although the Code of Practice is primarily intended to accommodate mentally disordered persons detained under the Mental Health Act, it accepts that much of the Code is applicable to informal patients (P. viii, 4). Although it "does not impose a legal duty to comply with the Code, failure to follow the Code could be referred to in evidence in legal proceedings." (section 1.1, p. 1).

Appendix B advises: "It is the personal responsibility of any doctor or dentist proposing to treat a patient to determine whether the patient has capacity to give a valid consent – It is good practice to consult relatives and others who are concerned with the care of the patient – Sometimes consultation with a specialist or specialists will be required." (NHS Management Executive HSG [92] 32, Appendix B).

Most forms of treatment given by health professionals could be considered an extension of medical treatment, whether the patients are detained or not, and the issue of consent should be determined according to Appendix B.

To safeguard the interests of dental and medical professionals involved with patients unable to give consent, no doubt Appendix B is sufficient where the doctor or dentist states "In my opinion [the patient] is not capable of giving consent to treatment. In my opinion the treatment proposed is in his/her best interests and should be given."

It is doubtful whether it is appropriate for other professionals to make a decision about a patient's capacity to give a valid consent. To safeguard everybody's interests, whenever treatment methods are used against the patient's wish, or to restrict his/her freedom, the patient's own general practitioner or consultant psychiatrist (if an in-patient) should be contacted and an entry made in the notes by the appropriate doctor that, in his/her opinion, the patient is incapable of giving consent to treatment, and the treatment proposed by the professional concerned is in his or her best interest and can be given.

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Evaluation of a psychiatric training scheme

DEAR SIRS

We read with interest the article 'Evaluation of a Psychiatric Training Scheme' by Khan and Oyebode (*Psychiatric Bulletin*, March 1993, **17**, 158–159). We have kept similar records for the Mersey Region Training Scheme – formerly the Liverpool Training Scheme, and have published data from them in the *Bulletin* (Birchall & Higgins, 1991). Our records now cover seven years from August 1985 to July 1992 and it is interesting to compare the two schemes.

The Mersey Region Training Scheme now covers all psychiatric units in the Mersey region and includes 37 registrar posts and 49 senior house officer posts, although 12–16 SHO posts are usually filled by general practice trainees. Most psychiatric trainees join the Mersey Scheme at SHO level, often straight from house officer posts. This results in a fairly high drop-out rate at SHO level. From a total of 112 trainees

leaving the scheme in the seven years, 50 of them left without completing four years training in psychiatry, and of these 16 went into general practice and 19 continued psychiatric training either part-time in the Mersey region or full-time elsewhere. In our paper mentioned above we found that the average length of stay in the scheme for these trainees was 1 year 7 months.

If only the trainees who completed four years psychiatric training are considered, out of 62 trainees (100%), 39 (63%) gained senior registrar posts, eight (13%) went abroad, either emigrating or returning home, and only five (8%) failed to pass the MRCPsych examinations.

From these results we would agree with the authors' conclusion that a well organised scheme improves the trainees' chances of passing the Membership examinations and of obtaining senior registrar posts. The advantage of a region-wide scheme such as the Mersey Scheme is that all trainees gain experience of working in the peripheral hospitals and in the teaching hospitals and therefore all trainees in the region enjoy equal opportunities for progression in their career.

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Cognitive therapy in literature

DEAR SIRS

I enjoyed Dr Paul Crichton's comments on 'Cognitive Therapy in Literature' (*Psychiatric Bulletin*, March 1993, **17**, 173). In this he makes a comment that "Aaron Beck's great achievement was to recognise the importance of the principles of cognitive therapy." In doing this I think he forgets to mention the work of the other pioneer in this field, Albert Ellis, who developed what he first called "Rational Therapy" and later "Rational Emotive Therapy." Both approaches have many similarities and I believe that Ellis's work may actually have preceded Beck's, although both were pioneers in this field and I feel both merit recognition.

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Community care and registrar training

DEAR SIRS

I read with interest the article by J. Abbati and G. Oles (*Psychiatric Bulletin*, March 1993, **17**, 140–141) on the continuity of care in serious mental illness. The importance of the continuity of care for these patients raises questions for the role of psychiatric trainees in a multidisciplinary team caring for the long-term severely mentally ill. This article highlights the difficulties for the patients of frequent changes of carers and this has to be balanced against the needs of individual doctors' training requirements for frequent changes of post to provide a range of experience. Individual attachments when a psychiatric registrar are often of six months duration, as recommended by the College (*Psychiatric Bulletin*, 1990, **14**, 110–118). Other authors have highlighted the need for psychiatric trainees to be familiar with the conduct of community psychiatry (Freeman, 1985) and maybe this cannot be best met by a six month post.

Perhaps the right balance for all these conflicting needs can best be met by trainees having 12 month posts which can be split partly with a community psychiatric team and partly with an in-patient team to gain the same psychiatric experience over a 12 month period but with less disruption to the care of the seriously mentally ill we are endeavouring to help. This may require imagination to develop these kinds of posts for registrars but, as for senior registrars (Malcom, 1989), may provide a more useful and enjoyable post.

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The "mini-team" system: an improved multidisciplinary approach?

DEAR SIRS

The Child Psychiatry Pre-adolescent Unit at Queen Mary's Hospital for Children, Carshalton, Surrey, consists of ten beds with an additional emergency bed and space for up to three day patients.

Until October 1991, management decisions concerning each child were taken by the consultant-led multidisciplinary team during a two hour session held once per week where each child was discussed. Regular case conferences could take place only every six weeks or so.