Nevertheless, to see conviction – and it does not necessarily need to be religious conviction – as part and parcel of someone's life is important. It can form a crucial part of how they evaluate themselves and their world and it is hard to see how one can support them without taking it into account.

Thus a person's personal conviction system is part of their personal history and identity. When George Kelly[3] developed the personal construct theory he demonstrated that everyone has a personal template by which they evaluate life. If we seek to understand and respect this, we discover that we will need also to look at our own understanding because we in turn evaluate others on the basis of our own templates.

Historically, people seem to have regarded psychological processes as coming from the world outside themselves. Mental illness could be 'the work of devils' and even sexual feelings were sometimes perceived as some form of karma that entered people. Today, we have reached the opposite extreme and see that ethics, politics, law and finally religion were not delivered to us by some external agency but were created by ourselves.

With this in mind we can explore the spiritual pilgrimage of our patients with them without imposing on them preconceptions of our own. It is an interesting journey because everyone's pilgrimage is different, and without knowing their story you will not understand where they are in the present, nor what will be the next step in their future.

Those who study religious and ideological traditions will find nuggets of great wisdom in all of them and this understanding is enhanced the more one knows the cultural and historical background in which they originated. We are all on a learning curve but I hope that it will not be long before there are consultants who have a vivid knowledge of religion and ideology from a psychological perspective and who will enhance our ability to understand the individual patients in our care more completely.

The more one tries to understand the depths of other people, the more one deepens one's own understanding and this may help alleviate that hidden isolation, loneliness and even despair that comes from never being properly listened to, or at any rate to find someone who at least tries to understand.

1 Comte-Sponville A. *The Little Book of Atheist Spirituality* (transl N Huston). Penguin, 2007.

2 Dein S, Cook CCH, Powell A, Eagger S. Religion, spirituality and mental health. *Psychiatrist* 2010; **34**: 63–4.

3 Kelly GA. *The Psychology of Personal Constructs*. Norton, 1955.

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When to use DoLS? A further complication

Shah & Heginbotham[1] describe a number of issues relating to the Deprivation of Liberty Safeguards (DoLS) of the Mental Capacity Act. A recent court case[2] appears to complicate matters further. The defendant was a 55-year-old lady with 'a significant impairment in intellectual functioning as a consequence of a learning disability' who developed an endometrial adenocarcinoma. She required major surgery if her life was to be saved. It was agreed that she lacked the capacity to make decisions about her healthcare and treatment.

She also suffered from hospital and needle phobias. Attempts to explain the need for surgery to her had failed and on occasions she refused to attend hospital for treatment (even when she had initially agreed).

The judge agreed the defendant could be sedated to ensure that she attended hospital for the operation and did not 'leave it prematurely after the operation had taken place'. She would 'be given analgesic medication which would have a sedative effect on her, thereby rendering it unlikely that she would be able to abscond. However, it might be necessary to use force as a last resort to ensure that she returned to her hospital bed'.

The judge then said 'In my judgment . . . it will be necessary to detain [the defendant] in hospital during the period of post-operative recovery. After mature consideration, the Official Solicitor, on [the defendant's] behalf, came to the view that it was not necessary to invoke the Deprivation of Liberty Provisions under Schedule 1 of the Act. I agree with that analysis. If it is in [the defendant's] interests (as it plainly is) to have the operation, it is plainly in her interests to recover appropriately from it'.

Given that it was planned, if necessary, to use sedation and/or force to prevent this patient leaving hospital, she was clearly to be deprived of her liberty. The court determined that because the patient lacked capacity and it was in her best interest (two necessary criteria for the use of DoLS), the DoLS were unnecessary.

Other articles in *The Psychiatrist*[1,2,4] discuss the problems surrounding the definition of deprivation of liberty and the interface between the DoLS provisions of the Mental Capacity Act and the Mental Health Act. It now seems there is a further difficulty in determining whether the DoLS provisions are needed even if there is clear deprivation of liberty.

1 Shah A, Heginbotham C. Newly introduced deprivation of liberty safeguards: anomalies and concerns. *Psychiatrist* 2010; **34**: 243–5.

2 *DH NHS Foundation Trust v. PS (by her litigation friend the Official Solicitor)* [2010] All ER (D) 275 (May).

3 Selmes T, Robinson J, Mills E, Branton T, Barlow J. Prevalence of deprivation of liberty: a survey of in-patient services. *Psychiatrist* 2010; **34**: 221–5.

4 Cairns R, Richardson G, Hotopf M. Deprivation of liberty: Mental Capacity Act safeguards versus the Mental Health Act. *Psychiatrist* 2010; **34**: 246–7.

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Doctors are not adhering to General Medical Council prescribing guidelines

In light of recent media coverage of the General Medical Council (GMC) suspension of Adam Osborne,[1] we became interested in the issue of doctors prescribing to non-patients: friends, family and self. The GMC recommends that doctors do not self-prescribe or prescribe to family and friends, except in an emergency.[2]

We audited prescribing practices among doctors working in London to determine whether GMC guidelines are being followed. We composed a 13-question online questionnaire

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about prescribing practices, and invited doctors, all above F1 training level, to complete this by email.

We emailed 120 doctors and received 72 completed questionnaires; 52.1% of the respondents were female, 53.4% had more than 6 years' experience as a doctor and 66.0% had prescribed to non-patients. Of that last group, 93.3% did not inform the person's regular general practitioner, with 95.0% feeling it was unnecessary to do so. The most commonly prescribed medications were antibiotics (77.3%), followed by analgesics (25.0%) and the oral contraceptive pill (18.2%). Of note, a number of respondents stated that they had prescribed sleeping pills (16.8%) and smoking cessation medications (8.5%).

Most doctors felt it appropriate to prescribe antibiotics, analgesics and inhalers, and some felt it was acceptable to prescribe the oral contraceptive pill and antipsychotic medication, to family and friends; 58.9% admitted to self-prescribing.

Although the majority of doctors had used private prescriptions, approximately a fifth had used National Health Service prescriptions (21%). Finally, 55.3% reported never reading the GMC guidelines on prescribing.

Our results show that a large proportion of doctors are not adhering to GMC guidelines on medication prescribing. In many cases this may be attributable to simply not reading the guidelines. We suggest that the GMC considers publicising its prescribing guidance more widely to ensure good medical practice and to avoid the consequences of escalating poor prescribing habits.

1 Press Association. GMC finds Osborne brother guilty. *The Guardian*, 22 February 2010 (http://www.guardian.co.uk/uk/feedarticle/8957107).

2 General Medical Council. *Good Practice in Prescribing Medicines – Guidance for Doctors*. GMC, 2008 (http://www.gmc-uk.org/guidance/ethical_guidance/prescriptions_faqs.asp).

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Three consultants for one patient

Singhal *et al*[1] concluded that communication between consultants is vital but is not necessarily the key to success in provision of service for patients. The model in their study quite rightly looked at the role of two key workers (consultants), but did not look at the provision of care for patients in the intervening period between discharge from hospital and follow-up appointments with the community mental health team (CMHT) consultant. The crisis resolution home treatment team (CRHTT) plays a vital role in this intervening period. In an evaluation of our services, we found 44% of patients are now discharged into the CRHTT. The teams are obliged to care for these patients until their mental state is sufficiently stable for safe and effective transfer to the CMHT, and this period of intervention varies from a few days to several weeks. In effect, with the New Ways of Working,[2] over a third of patients with an in-patient stay would have received care from three different consultants. While the patient is under the care of the CRHTT there may be changes to the overall care plan including changes to psychotropic medication. For these patients it is then three consultants for one patient and maybe four consultants if they have comorbid drug and alcohol dependence as well. It is therefore not surprising that most patients are not aware of the demarcations between the services. Communication and sharing of information with service users and their carers is as important as it is between two or more consultants and their teams.

Of the 170 mental health professionals who participated in Singhal *et al*'s study, only two were from the liaison service. In our experience of working in a CRHTT, some patients were unaware of the role of the consultant despite being fully informed by the team. It is not unusual for patients to request to remain permanently under the care of the CRHTT. Singhal *et al*'s suggestion that there is a need for a larger nationwide study is necessary and most welcome. Although the jury is still out on the advantages and disadvantages of two consultants for one patient, the current process of service provision for a significant number of patients involves a third consultant in the CRHTT, and we recommend that further studies should seek the views of mental health professionals and service users who received care from a third consultant. Crisis resolution home treatment teams have to a large extent filled the gap created by New Ways of Working with regard to continuity of care and their role in provision of service should not be overlooked.

1 Singhal A, Garg D, Rana AK, Naheed M. Two consultants for one patient: service users' and service providers' views on 'New Ways'. *Psychiatrist* 2010; **34**: 181–6.

2 Department of Health. *Mental Health: New Ways of Working for Everyone*. Department of Health, 2007.

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