the columns

correspondence

Serious incident inquiries have a role

Sir: the irrationalities identified by Szmukler (*Psychiatric Bulletin*, January 2000, **24**, 6–10) suggest that serious incident inquiries serve a role well beyond the need to explain how – or even why – something 'untoward' happens. Inquiries are, in fact, attempting to answer questions about fear, stigma, morality and personal responsibility, areas where rational inquiry has a poor record of satisfactory results. The folly of applying rational tools to irrational material becomes clearer when one considers the different perspectives and expectations of the agencies involved. To psychiatrists, inquiries are a quasi-legal form of local service audit, with powers to drive change far in excess of what may rationally be expected from a single case study. For the bereaved they serve a propitiatory role, the inquiry process helping families to make sense of the powerful emotions that accompany homicide. To the public at large, they provide a superficial way to soothe a fear that has troubled us since antiquity, and even more so in our individualistic, comfort-driven culture: 'it could happen to me for no reason'. The idea of a 'methodical' investigation of the causes of such a natural but irrational fear renders it more manageable. To the Government, inquiries into the minutiae of local service provision provide welcome distraction from the simple fact that the psychiatric services generally have always been neglected.

The common theme of these irrationalities is the fear of mental illness. Many have suggested solutions to the problems of inquiries themselves (Eastman, 1996; Buchanan, 1999), but until we address the stigma-driven emotional responses that propel the current serious incident culture, or at least attempt to identify them, it seems that all shall lose and none shall have prizes.

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Children's consent to medical treatment

Sir: Moli Paul, in his letter (*Psychiatric Bulletin*, January 2000, **24**, 31), refers to Section 133 of the Mental Health Act 1993 (he in fact refers to Section 10(2) of the Act which we assume to be a typographical error) which deals with the informal admission of patients, including children, under the Act. He then analyses the guidance in the 1999 Mental Health Act Code of Practice.

The 1999 Mental Health Act Code of Practice has a number of functions, which include providing essential reference guidance on practice and giving guidance on how the law, whether contained in statute or case law, should be applied.

The Code correctly summarises the law in relation to treating a child, that is any person under the age of 18, without their consent (code para. 31.12). The Code refers to the leading case in this area, Re: W, (1992) which states that the refusal of a child to be treated cannot override a consent to treatment by either the court or someone with parental responsibility. The court in Re: W went on to emphasise that the child's refusal:

> ". . . is a very important consideration in making clinical judgements and for parents and the court in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor."

Be that as it may the court, or person with parental responsibility, can and will continue to 'trump' the child's refusal in certain circumstances, even if the child has capacity. The most striking recent example of this was in July 1999 when a judge overrode the wishes of a 15-year-old girl who refused to consent to a heart transplant (Re: M, 1999). The judge's decision was based on the objective of seeking what was best for the child.

Dr Parkin suggests that there are inconsistencies between good clinical practice and the guidance in the Code. It would be more accurate to say that there are inconsistencies between the current law and good clinical practices. The foreword to the Code acknowledges that the Mental Health Act is increasingly out of date. Unfortunately, the Government, in the proposed reform of the Mental Health Act (1999) has not adopted the recommendations of the expert committee in this area. The Committee recommended that there should be a "threshold of 16 years for the presumption of capacity to make treatment decisions i.e. to both accept and refuse treatment" and in the case of children from 10–16 years old there be a rebuttable presumption of capacity.

Dr Paul refers to the Code's guiding principles which provides that a patient should be treated in such a way as to promote to the greatest practicable degree the patient's self-determination and personal responsibility, consistent with their own need and wishes (Code para. 1.1). In practise this means that, insofar as is practicable, the patient's treatment wishes will be respected, but when not practicable their own treatment decisions will be overridden, by using the Mental Health Act.

The difficulty with this discussion is the inter-relationship between the provision of non-consensual medical treatment for mental disorder and the provision of medical treatment without consent. The former can be provided without consent and subject to certain safeguards under the Mental Health Act. The latter in the case of adults depends on an assessment of capacity. If capable an adult cannot be given medical treatment without their consent. If incapable the doctrine of necessity applies and treatment can be given if the treatment is in the patient's best interests (Re: F, 1990). In the case of a child even if the child has capacity their refusal to be treated can be overridden. This is the position as stated in Re: W.

The Mental Health Act abridges a patient's autonomy. As the Act is not age specific this will encompass children. Children do not have complete autonomy in the field of medical treatment, as is reflected in the common law. Code guidance has to incorporate guidance on statute and the common law. The general

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guidance in the Code reflects the qualification of autonomy for detained patients. It can also be applied to the additional reduction of autonomy, which may be experienced by the child patient, even if the child's legal status is informal. The Code reflects reality, tacitly acknowledging an abridgement of autonomy, which in certain circumstances will result in detention.

As the Code correctly summarises the law it is incorrect to state that it 'creates' inconsistencies (Parkin, *Psychiatric Bulletin*, October 1999, **23**, 887–889) or undermines the child's rights. All the Code does is highlight what may be regarded as the conflicts between the current law, current clinical practice and the child's human rights. This is the area where the debate needs to be focused. In particular whether the competent child's human rights have been infringed where a decision to override their treatment decisions has been made.

References

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Serotonin syndrome

Sir: Mir & Taylor (*Psychiatric Bulletin*, December 1999, **23**, 742–747) in their review of serotonin syndrome reminded us of the diagnostic criteria (Sternbach's criteria) for the diagnosis of this syndrome at a time when we had recently changed the drug therapy of a patient from trazodone to paroxetine. In this patient we saw the emergence of five symptoms listed in Sternbach's criteria (agitation, myoclonus, shivering, tremor and incoordination). We have two points to make: we noted that the most severe symptoms in this patient were nausea and vomiting. Although, it is accepted that nausea and vomiting may occur as part of the serotonin syndrome (Lane & Baldwin, 1997) they are not diagnostic criteria. Gastrointestinal symptoms are well-recognised effects of increased serotoninergic activity and it is surprising that there is little emphasis on them in the literature relating to this subject. Where serotonin syndrome is a result of changing drug therapy the possibility of a discontinuation syndrome should be considered as an alternative diagnosis because of the overlap in symptomatology between the two syndromes.

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Sir: It may be helpful for clinicians to appreciate that the great weight of recent evidence indicates that a spectrum model best explains serotonin syndrome phenomena. Serotonergic side-effects merge imperceptibly into 'toxic' effects or serotonin syndrome. Much confusion exists in the literature because in many reports an insufficiently precise distinction is being made between side-effects and toxicity.

At present the evidence is that life-threatening morbidity or mortality, only arises from combinations of monoamine oxidase inhibitors (this definitely does include so-called 'RIMAs' (reversible inhibitors of monoamine oxidase A) such as moclobemide) and drugs able to act as serotonin reuptake inhibitors (which includes some narcotic analgesics). The risk remains unclear for catechol-*O*-methyltransferase inhibitors.

I also wish to draw attention to some valuable prospectively gathered and systematically documented data specifically addressing the issues of what symptoms and signs characterise toxicity from various drugs when taken in overdose. These data come from Ian Whyte's group. In a series of over 5000 cases of self-poisoning 10% were with a single, primarily serotonergic, drug. Of these, 16% met the Sternbach criteria for serotonin syndrome.

The only serotonin reuptake inhibitor that was significantly different from the reference drug (sertraline) in its frequency of association with the serotonin syndrome was clomipramine, with which serotonin syndrome was only one-tenth as frequent (odds ratio 0.1 and 95% CI was 0.0–0.9). This may be because clomipramine is a potent 5-HT_{2A} antagonist.

Our extensive database of references about serotonin syndrome is available to researchers at www.psychotropical.com.

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Sir: Mir & Taylor (Psychiatric Bulletin, **23**, 742–747) make an error in their article on serotonin syndrome. They start their article by stating that serotonin syndrome appears to be a new phenomenon; this is untrue. Serotonin syndrome is well-known to be an element of the carcinoid syndrome, a medical disorder characterised by high levels of circulating catecholamines due to inappropriate secretion by a tumour, for example, of the gut or adrenal medulla. This is not a drug side-effect.

The implications of this are potentially serious; a patient could present with the symptoms described without having a drug-induced serotonin syndrome, and the differential diagnosis is not discussed in this paper. The sections on 'Causes of serotonin syndrome' and 'Biochemical mechanism of serotonin syndrome' are, therefore, dangerously misleading. This could result in missed diagnoses of carcinoid syndrome, or misattribution of systemic serotonergic effects because other causes have not been considered.

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College comments on the Fallon Inquiry

Sir: I refer to Dr Veasey's letter (*Psychiatric Bulletin*, November 1999, **13**, 690) asking who at the College was responsible for the College's comments on the Fallon Inquiry Report on Ashworth Hospital. I thought it appropriate to reply to Dr Veasey. I am now well briefed and informed about the controversy which gave him particular concern.

In this regard my information is that the College's response to the report on the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital (chaired by Judge Fallon) was first drafted by my predecessor Dr Robert Kendell and then finalised, following extensive discussion at the Executive and Finance Committee and then subsequently at Council on the 3 February 1999. I am sure that the intent was not to act in an unjust and unfair way against any individual psychiatrist. Let us hope, however, that structures are now in place which will make this fraught situation less likely to occur in the future.

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Martial arts for psychiatrists

Sir: Once a peer-reviewed article appears in a reputable journal it carries a certain cachet of validity, any editorial disclaimers

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