law. With respect to physical illness, *Patient Consent to Examination or Treatment* (DOH, 1990) states that a patient may under common law withhold consent prior to examination or treatment. However, this maybe carried out without consent if the patient is incapable of giving that consent by reason of mental disorder and if it is in his best interests. The circular goes further in saying that it may indeed be the doctor's *common law duty* to act on the grounds of necessity in operating on or giving treatment to adult patients disabled from giving their consent.

It is likely, therefore, that this case would have been deemed to have been managed correctly under common law, although each case would be judged on its individual details in a court of law. Guidelines for acting under common law are not as well defined as those acting under the MHA. In *Patient Consent to Examination or Treatment*:

> "A proposed operation or treatment is lawful if it is in the best interests of the patient and unlawful if it is not . . . the standard of care required of the doctor concerned is that he or she must act in accordance with a responsible body of relevant professional opinion."

The Code of Practice (DOH and Welsh Office, 1990) goes further in explaining "in the best interests of the patient" in saying that the treatment should be:

> "necessary to save life or prevent a deterioration or ensure an improvement in the patient's physical or mental health."

This case report highlights the danger that a restrictive interpretation of the MHA and a misunderstanding of a patient's common law rights may lead to professionals failing in their common law duty to appropriately treat patients . . . In the current climate of defensive medicine it seems prudent to have the legalities of such situations clear so that they can be applied in the patient's best interests.

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Attendance at multidisciplinary case meetings

DEAR SIRS

Over the past few years I have found it increasingly difficult to provide properly planned and coordinated care to inpatients because of the difficulty in persuading key staff to attend the weekly multidisciplinary case meeting, and I wonder if other psychiatrists have similar problems. During the month of November 1991 I kept records of staff attendancies at case meetings with the following results.

During the one month period studied there were four case meetings containing a total of 41 case discussion episodes. There were eight admissions and eight discharges during the month. Attendance of key staff at these meetings was as follows:

Ward key worker: 51%
Community key worker: 35%
Both ward and community workers present: 22%
Both ward and community workers absent: 37%

It will be seen that over three-quarters of case meetings proceeded in the absence of one or other key worker, and in over a third of cases in the absence of both.

The first case meeting after admission is especially important in planning treatment, and the last before discharge equally so in planning after-care. In the case of the eight admissions neither ward nor community key workers were present at 50% of the initial case meetings, and in the case of the eight discharged patients neither ward nor community work was present at 63% of the case meetings prior to discharge.

As RMO I appear to be responsible for the standard of care received by my patients in hospital and after discharge. In practice I have no authority over other staff, and I find it extremely difficult to deliver properly planned and coordinated care when other professionals are so frequently absent from case meetings.

Name and address supplied

Thyrotoxicosis during lithium therapy in a mentally handicapped patient

DEAR SIRS

While lithium was a well recognised cause of hypothyroidism, its use may rarely be associated with the development of thyrotoxicosis. In a review of the literature, we discovered eleven such cases reported. This phenomenon has not been previously described in a patient with mental handicap.

A 53-year-old mildly mentally handicapped man with a 30 year history of bipolar illness, but no history of thyroid disease, was admitted to a specialist psychiatric ward in a mental handicap hospital following a recent onset of over-activity, sexual disinhibition and weight loss. These symptoms had been previously assoicated with hypomanic episodes. He had been commenced on lithium three years previously, at which time he was noted to be euthyroid.