

Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

What's important in the doctor-patient relationship?

While most of the published research into the doctor-patient relationship focuses on communication skills and behaviours, the paper by Dr Lings and colleagues (April 2003 *JRSM*¹) provides further insight into the non-behavioural aspects of these relationships. Their findings point to 'liking' as a key factor of the doctor-patient relationship. This concept, however (or 'interpersonal attraction' as it is sometimes called), is not new to the realms of psychological research on the doctor-patient relationship. Like and Zyzanski² found positive associations between how much the physician liked the patient and both the doctor's and the patient's satisfaction with the visit. Hall *et al.*³ expanded the investigation of doctors' liking of patients and again reported a positive association between physician liking and patient satisfaction as well as finding that physicians report higher liking of patients who were male and in good health. This might lead to the notion that liking and satisfaction are synonymous, however Hall *et al.*⁴ now suggest that liking is not simply redundant with satisfaction and is indeed an important psychological characteristic of the doctor-patient relationship. They also reported a reciprocity in terms of liking, whereby how much each liked the other was related to how much each was liked.

Given the evidence that liking and satisfaction may be single entities,⁴ where does that leave rapport? If liking is being defined as 'having an easy and comfortable relationship with the doctor'¹ and it includes 'warmth, respect, interest and enthusiasm for seeing the patient',² how is this different from the concept of rapport? Is liking merely redundant of rapport or is liking at the crux of establishing a good rapport between doctors and patients? Determining the relation between liking and rapport may be another step in the process of clarifying the non-behavioural aspects important in doctor-patient communication.

Angela Kubacki

Imperial College London Medical School, Department of Psychological Medicine, St Mary's Campus, Paterson Centre, 20 South Wharf Road, London W2 1PD, UK
E-mail: a.kubacki@imperial.ac.uk

REFERENCES

- 1 Lings P, Evans P, Seamark D, Seamark C, Sweeney K, Dixon M, Gray DP. The doctor-patient relationship in US primary care. *J R Soc Med* 2003;**96**:180-4
- 2 Like R, Zyzanski S. Patient satisfaction with the clinical encounter: social psychological determinants. *Soc Sci Med* 1987;**24**(4):351-7

- 3 Hall J, Epstein A, DeCiantis ML, McNeil B. Physicians' liking for their patients: more evidence for the role of affect in medical care. *Health Psychol* 1993;**12**:140-6
- 4 Hall J, Horgan TG, Stein T, Roter DL. Liking in the physician-patient relationship. *Patient Educ Couns* 2002;**48**:69-77

Standard care

Dr Samanta's premonitory review (March 2003 *JRSM*¹) of the post-*Bolitho* scene is timely. Evidence is now required, but is it there? As Samanta *et al.* point out, defensive medicine and its guidelines remain uncoded. Thus a choice between *table d'hôte* and *à la carte* must be made from a menu without prices.

To keep it simple, there were guidelines sixty years ago: 'Always undress your patient. Always examine both sides'. If this excellent advice was followed today, primary care could seize up.

Instead a *Bolam*-friendly consensus exists that the costs exceed the benefits. But is this so? We simply do not know. Practitioners glance at a protruded foot and reach for the script pad, and no one seems much the worse. The costs, of course, are hidden. What is not managed at one level is dealt with elsewhere or not at all.

It is this useful pragmatism that is now under threat. Whether mandatory protocols (however helpful) that need constant updating will prove more effective only time can tell.

H M C Corfield

The Old Parsonage Barn, Barn Street, Crewkerne TA18 8BP, UK

REFERENCE

- 1 Samanta A, Samanta J, Gunn M. Legal considerations of clinical guidelines: will NICE make a difference? *J R Soc Med* 2003;**96**:133-8

Hyperthyroidism with low thyroid hormone

We agree with Dr Obuobie and Dr Jones (April 2003 *JRSM*¹) that thyroid function tests (TFTs) are often inappropriately requested in acutely ill patients. We examined requests for TFTs made on patients over the age of 65 years to a medical assessment unit. Of 2648 samples, 82.5% revealed a serum thyroid stimulating hormone (TSH) within normal limits (0.2-6 IU/L). On review of patients at the extremes of biochemical dysfunction (TSH >20 or <0.05 IU/L), a new diagnosis of hypothyroidism was made in only 4 patients (0.15%) and no new diagnoses of thyrotoxicosis were made.

We cannot be certain that those patients from whom blood was taken for TFTs were representative of all acute medical admission in this age group. Probably TFTs would be requested more often from those in whom there was suspicion of thyroid disease, in which case the true

incidence of abnormal TFTs in unselected admissions would be even lower. There is no evidence to support routine screening for thyroid disease in elderly patients admitted with acute medical disorders. In these circumstances TFTs should be measured only if there is clinical reason to suspect thyroid disease.

M K Harkness

R D Hardern

Acute Medicine, General Infirmary at Leeds, Leeds LS1 3EX

J H Barth

Department of Clinical Biochemistry and Immunology, General Infirmary at Leeds, Leeds LS1 3EX, UK

REFERENCE

- 1 Obuobie K, Jones MK. Hyperthyroidism with low thyroid hormone. *J R Soc Med* 2003;**96**:185–6

Dr Obuobie and Dr Jones (April 2003 *JRSM*¹) attribute the hyperthyroidism with low serum thyroid hormone concentrations in their patient to suppression of the thyroid hormone concentrations by an infective illness which lasted only one week. It is more likely that this patient had painless thyroiditis. In the days before thyroid hormone concentrations could be measured, the clinical diagnosis of thyrotoxicosis was confirmed by a high uptake of radioactive iodine. Occasionally, the hyperthyroidism was found to be associated with a low uptake. The hyperthyroid phase was due to liberation of thyroid hormones into the blood from the damaged gland. Patients with painless thyroiditis usually became well after a month or so when the thyroid hormones and TSH returned to normal. When the diagnosis of painless thyroiditis was missed, patients ran the risk of receiving antithyroid drugs for as long as one or two years.

P B S Fowler

Shirley Holms, 4 South Park Drive, Gerrards Cross, Buckinghamshire SL9 8JH, UK

REFERENCE

- 1 Obuobie K, Jones MK. Hyperthyroidism with low thyroid hormone. *J R Soc Med* 2003;**96**:185–6

Cocaine by internal mail

Mr Swan and his co-authors describe two 'body packer' cases (April 2003 *JRSM*¹) that required surgical intervention. In their closing statement they say that drugs packages are invariably radio-opaque, and this is incorrect. Although the majority of packages may be visualized with plain abdominal radiographs, there are numerous reports of 'false-negative' radiographs and subsequently missed packages.^{2–4} In equivocal cases the use of CT, ultrasound or contrast meals should be considered; plain radiographs should not be relied

on entirely. Doctors dealing with potential body packers should also be aware of disturbing reports from the United States of children acting as surgical mules.⁵ The diagnosis must therefore be considered within the paediatric population as well.

John Bycroft

Institute of Urology & Nephrology,
48 Riding House Street, London W1W 7EY, UK

REFERENCES

- 1 Swan MC, Byrom R, Nicolaou M, Paes T. Cocaine by internal mail: two surgical cases. *J R Soc Med* 2003;**96**:188–9
- 2 Caruana DS, Weinbach B, Goerg D, Gardner LB. Cocaine-packet ingestion. Diagnosis, management, and natural history. *Ann Intern Med* 1984;**100**:73–4
- 3 Gherardi R, Marc B, Alberti X, Baud F, Diamant-Berger O. A cocaine body packer with normal abdominal plain radiograms. Value of drug detection in urine and contrast study of the bowel. *Am J Forens Med Pathol* 1990;**11**:154–7
- 4 McCarron MM, Wood JD. The cocaine 'body packer' syndrome. Diagnosis and treatment. *JAMA* 1983;**250**:1417–20
- 5 Traub SJ, Kohn GL, Hoffman RS, Nelson LS. Pediatric 'body packing'. *Arch Pediatr Adolesc Med* 2003;**157**:174–7

Consent to treatment and mental health

Dr Agell (March 2003 *JRSM*¹) highlights the misuse of the Mental Health Act as a means of authorizing treatment for physical conditions. His letter reflects my own experience, as a lawyer specializing in mental health issues, of the need for greater education in the law of consent. This is one of the areas on which we are most often asked to advise or provide training. With that in mind, I offer here a summary of the law of consent as it affects psychiatric patients.

Part IV of the Mental Health Act sets out the provisions relating to treatment of detained patients and gives procedures and safeguards in relation to specific groups of treatment for mental disorder. It does not apply to other types of treatment. Treatment for physical disorders and for mental disorders in patients who do *not* come within Part IV of the Act are covered by the common law; the Mental Health Act has no application in such cases. According to common law, consent (informed and free from the pressure of undue influence) must be obtained for all treatment for all patients unless it can be shown that the patient lacks the capacity to consent or the Act applies.

What are the relevant sections of the Mental Health Act 1983, Part IV?

Section 63 provides that the consent of a person is not required for any medical treatment given to him for the mental disorder from which he is suffering (not being treatment falling under Section 57 or Section 58) if the treatment is given to him by or under the direction of the Responsible Medical Officer. The section only applies to

formally detained patients. To fall within the ambit of Section 63 the treatment must be:

- Medical treatment Section 145 defines this very widely. The definition includes nursing and care, habilitation and rehabilitation under medical supervision. Although it does not specifically refer to surgical treatment this is not expressly excluded
- In respect of a patient with a mental disorder as defined in the Act
- Treatment given to the patient for the mental disorder
- Given under the direction of the Responsible Medical Officer.

It has been held that Section 63 covers treatment of the symptoms of mental disorder and therefore includes, for example, the force-feeding of a patient with anorexia nervosa.

Section 57 provides for certain psychiatric treatments which can only be given with the patient's consent and with authorization from a second-opinion doctor. Examples are psychosurgery and the surgical implantation of hormones for the purpose of reducing male sex drive.

Section 58 likewise provides for certain psychiatric treatments to be given but in this case requires consent or authorization from a second opinion doctor in the absence of consent. This covers treatment such as electroconvulsive therapy and also the administration of medicine for mental disorder if 3 months have elapsed since the first time the medicine was given during the period of detention.

Section 62 provides that the procedural restrictions in Sections 57 and 58 do not apply to any treatment for mental disorder which comes within the remit of sections 57 and 58:

- Which is immediately necessary to save the patient's life; or
- Which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
- Which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- Which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

The safeguards provided in Sections 57 and 58 therefore do not apply to certain categories of urgent treatment for mental disorder which can accordingly be given to the patient without his consent.

Treatment without consent for other types of treatment for mental disorders can be administered by virtue of the power given to the patient's Responsible Medical Officer by Section 63. However, treatment for physical conditions of either capable patients who refuse to consent or incapable patients cannot be undertaken under the Mental Health Act, and the detention of patients simply for that purported purpose would almost certainly be unlawful.

In summary, Part IV of the Act allows treatment of detained patients for mental disorder without the patient's consent as set out in Sections 57, 58, 62 and 63. Where the Act does not apply and for treatment for physical disorders the common law principles apply.

A patient not falling within Part IV of the Act who is capable of giving consent is entitled to refuse treatment. A patient not falling within Part IV of the Act who is incapable of giving consent can be given treatment but only if it is in the patient's best interests and of urgent necessity to save the patient's life or to ensure improvement or prevent deterioration in physical or mental health. The treatment must be in accordance with good practice accepted by a proper body of medical opinion. Section 63 does not permit treatment simply for physical disorders and such treatment cannot be given without consent unless justification can be found under common law.

In cases of doubt as to capacity where the Act does not apply the doctor should not hesitate to apply to the Court for a declaration that treatment may be given. Reference should be made to the guidelines handed down by the Court of Appeal in *Ex Parte S²* as to the approach to be taken in these sort of cases.

Andrew Parsons

Radcliffes Le Brasseur, 5 Great College Street,
London SW1P 3SJ, UK
E-mail: andrew.parsons@rlb-law.com

REFERENCES

- 1 Agell I. Capacity and consent. *J R Soc Med* 2003;96:157
- 2 St George's Healthcare National Health Service Trust v S (no. 2) Regina v Collins & Others *Ex parte S* (no. 2) 3898 TLR