sufficient for them to practise psychotherapy? Should it be encouraged? Should a 'talk with doctor' be given the status of psychotherapy? In a broader sense – Who should be the best person for an individual in crisis? Does it have to be a medically trained psychiatrist? Do we need to redefine the boundaries and specify which type of patients go for which type of psychotherapy? (earlier suggested by Ludwig & Othmer (1977). Does it become doctor's business to get involved in the intricacies of an individual's life and further have we still not learnt that psychotherapy is aimed at cure and not at making perfect human beings?

I tend to differ with those who decided to challenge the credentials of Bruce Charlton for having given this stimulating piece for self-inspection. I can only congratulate the editorial board for accepting it.

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References

ARYA, D. K. (1991) Future of psychotherapy. *British Journal of Psychiatry*, **159**, 883–884.

LUDWIG, A. M. & OTHMER, E. (1977) The medical basis of psychiatry. *American Journal of Psychiatry*, **134**, 1087.

Attention Deficit Hyperactivity Disorder

DEAR SIRS

I would like to make contact with any child psychiatrists involved in the pharmacological treatment of the Attention Deficit Hyperactivity Disorder. I would also like to hear about their experience in the use of ADHD rating scales in diagnosis and in monitoring the progress of treatment.

I think there may be a minority of British child psychiatrists recognising either the reality or the frequency of occurrence of ADHD. For my part, some companionship and sharing of clinical experience would be greatly appreciated.

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Clozapine autonomy v. paternalism

DEAR SIRS

I read with interest the recent number of articles on the practical usage of clozapine (*Psychiatric Bulletin*, 1991, **15**, 223–224; *Psychiatric Bulletin*, 1991, **15**, 645–646 (correspondence). In this country it is being used primarily in treatment resistant schizophrenia. Concerns over the risk of agranulocytosis has meant that regular blood sampling is imperative to the point that the company will not dispense the drug to individual patients without first securing blood samples. By definition then, treatment with clozapine includes initial weekly blood sampling.

It has been suggested that this situation is analogous to the use of lithium-carbonate (*Psychiatric Bulletin*, 1991, **15**, 645, correspondence). However, in patients known to respond well to lithium, but unwilling to submit to blood testing, it can be considered appropriate to continue to prescribe it, albeit with close supervision for signs of toxicity. This constitutes an important difference from treating with clozapine.

The current situation with clozapine also brings into the question of practice of compulsory treatment orders under part IV of the Mental Health Act 1983 (part X of the Mental Health (Scotland) Act 1984). By definition, those people being treated with clozapine are intractable schizophrenics who, through the nature of their illness, are quite likely to be unfit to give formal consent. Under the terms of the Mental Health Act, a drug may then be given without the patient's consent. Clearly, however, the act does not enable the responsible medical officer to secure blood samples without consent. In legal terms, the latter action is tantamount to assault. However, given that clozapine has the potential to improve some patients' intractable symptomatology dramatically, the situation can invoke a strong paternalism in the medical practitioner, perhaps with concomitant disregard for the autonomy of the individual.

In the light of increasing concerns over the safety of medicines in recent years, it is more than likely that similar treatments which involve regular blood monitoring will continue to come onto the market in the future. Surely some form of national guide-lines should be forthcoming involving both legal and medical professions. The central issues appear to be two-fold.

(a) Is it medically and legally justifiable to perform venepuncture on a patient taking clozapine without that patient's consent?

(b) If it is not, what is the risk/benefit analysis of commencing clozapine in a patient whom one knows will not consent willingly to regular venepuncture?

These topics seem worthy of urgent debate

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Obtaining consent for treatment with clozapine

DEAR SIRS

The problems of obtaining consent for treatment with clozapine, which includes, of necessity, frequent and

regular venepuncture (initially weekly) was usefully highlighted recently by Ball & Lipsedge (*Psychiatric Bulletin*, 1991, **15**, 645–646). Undoubtedly, with the increase in the use of clozapine or clozapine-like drugs in the management of schizophrenic illness that is anticipated, it will be useful to look further at why patients who are able to consent will not do so because of the need for blood screening. Just how much of a problem for management such non-compliance will be remains to be seen.

With the advent of early clinical trials testing clozapine analogues we will be allowed a chance to address more systematically the complex problem of consent to this form of treatment in the schizophrenic population generally. In an ongoing early clinical trial of a clozapine analogue for acute or chronic schizophrenia with acute exacerbation (in a non-treatment refractory group) I have ascertained why all eligible patients screened for the trial were not willing to consent. Out of 66 eligible patients, 10 (15%) gave as the only reason for non-consent the requirement of weekly venepuncture, 43 (65%) otherwise elegible patients were not willing to consent in total. On the basis of these results, recruitment to the trial would have been increased by nearly 50% if the venepuncture requirement could have been removed, or alternatively and more realistically, if the reasons for dislike or fear of venepuncture could have been overcome. Of course, this assumes that the reason given for non-consent as 'only venepuncture' is valid and not a function of other trial-related factors.

With further study we may be able to develop our understanding of patients' subjective appraisal of necessary procedures such as venepuncture in the treatment of psychotic illness so that, at least for a subgroup of non-consenters, we may be able to facilitate change from a position of non-consent to one of consent.

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The meaning of 'psychosis'

DEAR SIRS

If we interpret the study by Ramell (*Psychiatric Bulletin*, **15**, 779–780) correctly, he (or she) concludes that because one third of mental health care professionals understand the word 'psychosis' to mean something outside the ICD-9 definition, its use should be abandoned. This would seem as absurd to us as the abandonment of the word 'schizophrenia' simply because this word is misused by, for example, the media (*Psychiatric Bulletin*, **15**, 795).

In current usage, the word 'psychosis' has a precise and definite meaning; rather than advocate its abandonment we should avoid its abuse and challenge those in our and other professions who use the word loosely to cover any behaviour which seems to them incomprehensible.

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