

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.

D. K. ARYA

Queen's Medical Centre
Nottingham NG7 2UH

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.

P. V. F. COSGROVE

Child and Family Guidance Service
Health Clinic, The Holve
Trowbridge, Wiltshire BA14 8SA
Telephone number: 0225 766161

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

IAN S. CLARKE

Elmhill House
Royal Cornhill Hospital
Aberdeen AB9 2ZY

Obtaining consent for treatment with clozapine

DEAR SIRS

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