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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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 associated with hypomanic episodes. He had been commenced on lithium three years previously, at which time he was noted to be euthyroid.