

major chunk of women's contributions to the *Indian Journal of Psychiatry*. Reviews, invited articles, presidential addresses, editorials, commentaries, orations and critiques by women authors in the journal are negligible.

No woman psychiatrist acts as advisor to the Government of India on policy matters related to mental health in general or in relation to women.<sup>3</sup>

As far as looking after the specific needs related to their family-related roles, there are no guidelines for pregnancy and maternity leave for women postgraduate students in the country. If a woman joins a government job, there is a provision for maternity leave, but this often is not available for postgraduate students. Few hospitals or medical colleges provide reliable on-site day care and school-based childcare is not available when children are older. On discontinuation of a job for family building or other reasons, options for career revival after a certain period are presently unavailable because of age restrictions.

There is no association of women psychiatrists at regional or national level.<sup>2</sup> Unlike high-income countries, where specific needs, aspirations, areas of interest, monetary incentives, working styles, characteristics and other issues related to women psychiatrists have been studied and attempts have been made to address these, there is negligible research in this area in low-income countries. Moreover, women have a negligible role in policy-making in psychiatry.

Currently, there is no system addressing the specific issues related to women doctors as a whole in India and other neighbouring countries on the Indian subcontinent.<sup>2</sup>

- 1 Dutta R, Hawkes SL, Iversen AC, Howard L. Women in academic psychiatry. *Psychiatrist* 2010; **34**: 313–7.
- 2 Sood M, Chadda RK. Women in psychiatry: a view from the Indian subcontinent. *Indian J Psychiatry* 2009; **51**: 199–201.
- 3 Sood M, Chadda RK. Women psychiatrists in India: a reflection of their contributions. *Indian J Psychiatry* 2010; **52**: 396–401.

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doi: 10.1192/pb.34.11.498a

### Is the assessed capacity increased with the seriousness of what is at stake?

In *Re T*<sup>1,2</sup> the Court of Appeal had to consider the case of an adult Jehovah's Witness who refused treatment. A pregnant woman was involved in a car accident and, after speaking with her mother, signed a form of refusal of blood transfusion. After the delivery of a stillborn baby, her condition deteriorated, therefore a Court order was obtained in order to legalise a blood transfusion on the grounds that it was in the woman's best interest. In this case the Court of Appeal addressed the question related to capacity, life-threatening situation and right to refuse a medical treatment, particularly in relation to the degree of risk involved in a particular decision: 'What matters is that the doctor should consider whether at that time he had a capacity which was commensurate with the gravity of the decision. The more serious the decision, the greater the capacity required.' It is interesting to consider, as pointed out by Buchanan,<sup>3</sup> 'What principles then govern the practice, described in *Re T*, whereby the level of capacity required for competence rises in proportion to what is at stake?' In other

terms, is the assessed capacity required for legal competence increased with the seriousness of what is at stake? Perhaps the assessment of capacity has to consider the importance, the risk and the gravity of the decision that the patient has to make. Following this train of thought, maybe different standards of competence are needed in order to ensure that genuine choices are being made.

Buchanan & Brock<sup>4</sup> were more inclined to sustain this view in terms of capacity, whereas Culvert & Gert<sup>5</sup> and Wicclair<sup>6</sup> found the idea of different standards of competence more paternalistic-oriented. Culvert & Gert argued that the capacity related to the degree of risk was against the principle of 'symmetrical competence' and pointed out that the change of external risk can potentially change the status of a person from competent to incompetent, 'a fact inconsistent with the idea that competence is a genuine attribute of a person'.

- 1 *Re T (adult) (refusal of medical treatment)* [1992] 4 All ER 649, (1992) 9 BMLR 46, CA.
- 2 *Re T (adult) (refusal of medical treatment)* [1992] 4 All ER 649.
- 3 Buchanan A. Mental capacity, legal competence and consent to treatment. *J R Soc Med* 2004; **97**: 415–20.
- 4 Buchanan AE, Brock DW. *Deciding for Others: The Ethics of Surrogate Decision Making*. Cambridge University Press, 1989.
- 5 Culvert C, Gert B. The inadequacy of incompetence. *Milbank Q* 1990; **68**: 619–43.
- 6 Wicclair M. Patient decision-making capacity and risk. *Bioethics* 1991; **5**: 91–104.

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doi: 10.1192/pb.34.11.499

### Inconsistencies in Section 136 assessments

Liz Tate<sup>1</sup> rightfully mentioned that there are junior trainees attending to the Section 136 assessments, despite clear guidance in the Mental Health Act Code of Practice that it should be done by Section 12(2)-approved doctors. Further to that, the Code states that a reason should be documented for divulging from the aforementioned practice. In most places this practice of assessments by a non-Section 12(2)-approved doctor is a protocol and a norm.

Every directorate and trust has its own local policies, keeping the Code of Practice as standard. For the formulation of a local policy, representatives from multiple agencies such as police, accident and emergency departments, ambulance services, Social Services and mental health services formulate guidelines for the fluidity of the process of Section 136 assessments. Timescales are set for the completion of these assessments and are regularly reviewed.

There are provisions for middle tier or consultant cover to facilitate the Section 136 assessments. Despite these arrangements, there are units where the attendance of non-Section 12(2)-approved doctors is the first port of call for such assessment; after a detailed history has been taken from the patient, the Section 12(2)-approved doctor is contacted and the assessment completed. Furthermore, it is known that there are places where non-Section 12(2)-approved doctors discharge patients after having discussions over the telephone with a Section 12(2)-approved doctor. It has also been found