In the laboratory we have shown hypertension in the common femoral vein in a pig undergoing laparoscopic Nissen fundoplication. When pneumoperitoneum was established, the femoral venous pressure rose from 4 mm Hg to 9 mm Hg. With duplex Doppler scanning of the common femoral vein in humans we have shown a considerable reduction in peak blood flow velocity and shortening of the flow cycle during the respiratory phase on two occasions, with a return to normal venous blood flow characteristics on removal of the intraperitoneal gas.

These cases highlight the potential for thromboembolism with laparoscopic cholecystectomy. Our early experimental work suggests that the aetiology may be increased venous stasis caused by the raised intra-abdominal pressure associated with pneumoperitoneum. Also, these procedures, in contrast to gynaecological laparoscopy, are performed in the reverse Trendelenberg position, which would compound any venous stasis already present.

Further work must be performed to document the incidence and aetiology of deep venous thrombosis and effective prophylaxis during prolonged therapeutic laparoscopy. Until these issues have been resolved all patients undergoing laparoscopic cholecystectomy should be regarded as at risk of deep venous thrombosis and pulmonary embolism. They should have some intraoperative measure to reduce venous stasis of the lower limbs as well as routine preoperative and postoperative prophylaxis against deep venous thrombosis.

J O JORGENSEN K HANEL
N J LALAK D R HUNT
L NORTH D L MORRIS

Departments of Surgery and Radiology,
St George Hospital,
Kogarah,
Sydney,
NSW 2217,
Australia

1 Chamberlain G, Brown JC. *Gynaecological laparoscopy. The report of a working party in a confidential enquiry of gynaecological laparoscopy.* London: Royal College of Obstetricians and Gynaecologists, 1978.
2 Dubuisson JB, Aubriot FX, Cardone V. Laparoscopic salpingectomy for tubal pregnancy. *Fertil Steril* 1987;47:225-8.
3 Deyo GA. Complications of laparoscopic cholecystectomy. *Surgical Laparoscopy and Endoscopy* 1992;2:41-8.

Consent for surgery for psychiatric patients

EDITOR,—On three occasions in the past two years the duty surgical team have contacted me while on call as duty psychiatrist with a view to giving consent to a surgical procedure on behalf of a patient. The patients were all detained under the Mental Health Act, required urgent surgery or invasive investigation, and were, in the opinion of the surgical team, unable to give informed consent.

On each occasion I felt that insufficient effort had been made by the surgical teams to decide on the capacity to give informed consent, and I was dismayed at the immediate assumption of incapacity because the patient had been sectioned. I must emphasise that I was not asked to determine the capacity to give consent, but simply to complete the paperwork.

My understanding of the law is that an adult patient who is capable of doing so must give consent to any medical treatment if that treatment is to be lawful. At the time of the decision the patient needs a capacity commensurate with the gravity of that decision. If the patient lacks the requisite capacity, then the doctors must act in what they perceive to be his or her best interests, with information garnered from previous knowledge of the patient, discussion with family and friends, and taking into account any relevant directive previously made by the patient. What the legal force and effect of any such directive might be is uncertain; it is unclear whether health care staff are required to carry out the terms of the directive or whether those who act in good faith with the terms of the directive are immune from civil or criminal prosecution. There is, apparently, no case law on this point.

I was unable to find any legal basis under current English law whereby a psychiatrist might give consent (or otherwise) for a patient to have an invasive surgical procedure. Speaking to colleagues informally, I find that this situation is not uncommon. I would remind the surgeons involved in such instances that they, and not the duty psychiatrist, are in the best position to know if an operation is in the best interests of the patient.

NICK KOSKY

Nelson Hospital,
London SW20 8BD

Shetland oil spill

EDITOR,—The study that has been mounted consequent on the grounding of the tanker *Braer* on 5 January 1993 has been inaccurately reported.[1] The study's aim, as approved by the Shetland Health Board Ethical Committee, is "to determine the human health effects of the Shetland oil spillage" on the people resident within 5 km of the spill.

The project was designed in epidemiological terms, not as "health checks" on the population. A health check, in my opinion, involves a clinical examination and intervention, where appropriate, based on the findings. This is the province of an individual's general medical or occupational health practitioner, not of an epidemiologist. When this study was mounted participants were advised in writing that all findings would be reported to their medical practitioner, whom they should consult for their individual results.

Many laboratories have cooperated at short notice and are analysing large numbers of samples. Over 1200 biochemistry and haematology specimens were examined and reported in an eight day period in the laboratory of the Gilbert Bain Hospital, Lerwick. Samples are also being examined by the Department of Forensic Medicine and Science, Glasgow University, the National Poisons Unit, Guy's Hospital, and the Medical Research Council's cell mutation and toxicology units.

This inquiry is a joint initiative of the Shetland Health Board and the Environmental Health (Scotland) Unit, a Scottish Health Service organisation. Though funded by the Scottish Office, Home and Health Department, the study is totally independent of central government and will present its findings directly to its clients, the people of the Shetland islands.

That the initial phase of the project has been carried out so quickly and smoothly is a tribute to the dedication and professionalism of many health care workers throughout Shetland. I doubt such a venture could have been undertaken so rapidly elsewhere.

D M CAMPBELL

Environmental Health (Scotland) Unit,
Ruchill Hospital,
Glasgow G20 9NB

1 Christie B. Shetland oil spill prompts health checks on islanders. *BMJ* 1993;306:230. (23 January.)

Receiving new patients' notes from FHSAs

EDITOR,—New patients registering with our general practice often complain about the time it takes us to get their NHS notes from the family health services authority. The patient's charter states that general practitioners should receive new patients' notes from their family health services authority within six weeks of requesting them. To assess the extent of the problem and attempt to bring ourselves into line with the patient's charter we conducted a simple audit of the delays in our practice.

Manor House Surgery serves 7200 patients in a medium sized industrial town. All patients new to the practice are given a temporary folder, which is stamped with the date that the permanent notes were requested from the family health services authority. The temporary notes are then kept together in a box, separate from the other files of notes. When the permanent notes arrive the two sets are joined up and filed in the usual way.

On 16 September 1992, 115 patients were waiting for their notes. On that day we scrutinised all the temporary folders in the box and noted the time that had elapsed since the proper notes had been requested. About half of the patients had been waiting for their notes for less than six weeks, but 19 had been waiting for over six months, 14 for over a year, and six for over two years. The average wait was 20 weeks.

This simple audit, which took less than nine hours, has led us, as a first step, to chase up all notes that have not been received within 12 weeks. This should reduce the average wait for notes from 20 weeks to 4·6 weeks. This approaches the standard set by the patient's charter.

New patients' NHS notes are essential for general practitioners: they contain specific details of past treatment and confirm what the patients say about their current treatment. General practitioners are best placed to ensure that this particular specification in the patient's charter is met.

J BEAVEN
LINDA MASSEY
CAROL WEST

Manor House Surgery,
Glossop,
Derbyshire SK13 7PS

What the regions say

EDITOR,—In West Midlands Regional Health Authority "one or two" providers have been "in difficulty," a spokesperson said.[1] Those are weasel words. The West Midlands is a desert.

Take our non-trust district general hospital. We had finished most of the contractual work by late November 1992. If we had continued to treat patients at the same rate—there has been an unprecedented, inexplicable, and hence unforeseeable rise of 12% in medical emergencies—we would have been at least £0·5m in the red by the end of the financial year. To husband that 1·7% of our income we have had to close half of our operating sessions, a third of our operating theatres, and a sixth of our beds, most of them surgical. We also closed beds at the satellite rheumatology hospital—a subregional centre. The effect on staff has been dreadful. The spectre of redundancy has been raised, and morale from top to bottom has become a cause for deep concern. All this six years after the hospital was opened at a cost to the taxpayer of £27m (the region's "flagship"). In short, we are seriously poor.

True, we have reopened a few beds—for the patients of fundholding general practitioners. And we treat emergencies, "urgencies," and also-rans who may or may not survive two years on a waiting list. So that's all right, then. Just a small local difficulty.

P V SCOTT

Alexandra Hospital,
Redditch,
Worcestershire B98 7UB

1 Kingman S. What the regions say. *BMJ* 1993;306:228-9. (23 January.)