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LETTERS

JASON BYE/REX FEATURES

MENTAL CAPACITY AND SUICIDAL BEHAVIOUR

What to do about treatment refusal at 3 am?

The problem of how "serious emotional turmoil" can affect capacity arises every night in emergency departments.[1] Determining capacity on the basis of a distressed person's ability to balance information is difficult and subjective. David and colleagues suggest that at 3 am a casualty officer is unlikely to have the time to do this, and that psychiatric colleagues should accept a key role. However, I suspect that they would find the problem equally difficult.

They suggest using the Mental Health Act to administer lifesaving treatment in this situation. Again, many mental health practitioners might struggle with this. Suicidal thoughts and actions are part of the definitions of several mental disorders, and the authors argue that treating the physical consequences of these symptoms might constitute a treatment. This has not been tested in case law, however, and is not explicit in the statute law. Also, many people who attempt suicide do not have a mental disorder, but this may be difficult to determine at presentation.

A single statute governing involuntary treatment would clarify these issues but seems a distant prospect. For now, casualty officers should get a senior opinion, and in cases of doubt, should err on the side of intervening to preserve life, rather than respecting autonomy, which may turn out to be absent.

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Competing interests: None declared.

1 David AS, Hotopf M, Moran P, Owen G, Szmukler G, Richardson G. Mentally disordered or lacking capacity? Lessons for management of serious deliberate self harm. *BMJ* 2010;341:c4489. (7 September.)

Cite this as: *BMJ* 2010;341:c5477

"If in doubt treat" is not as easy as it sounds

Davies, along with David and colleagues, overlooks the practical problems of giving lifesaving treatment to a person who does not wish to receive it.[1 2] Paracetamol is the most common overdose choice in the UK, and treatment is effective if given early and while the patient still feels well. Every week someone who has recently taken a potentially lethal overdose of paracetamol but does not wish to be treated arrives in my inner city emergency department.

Capacity and the presence of mental disorder are extremely challenging to assess, particularly in a distressed patient who is usually intoxicated with alcohol or drugs and has to compete for my attention with a resuscitation room full of critically ill and injured patients. If I "err on the side of caution" and administer treatment, I may have to physically or chemically restrain the patient, for more than 24 hours if a full course of acetylcysteine is needed. This has profound resource implications and is not without risk to the patient and staff.

As the senior decision maker regularly presiding over this situation I am acutely aware of the competing risks that I am obliged to balance, and to which I am professionally exposed. I cannot be alone in seeking greater clarity and practical solutions to deal with this problem, both to protect my colleagues and provide a better service to our patients.

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Competing interests: None declared.

1 Davies S. What to do about treatment refusal at 3 am? *BMJ* 2010;341:c5477.
2 David AS, Hotopf M, Moran P, Owen G, Szmukler G, Richardson G. Mentally disordered or lacking capacity? Lessons for management of serious deliberate self harm. *BMJ* 2010;341:c4489. (7 September.)

Cite this as: *BMJ* 2010;341:c5478

GOVERNMENT READMISSION PROPOSALS

Better data collection is needed to support these proposals

Recent proposals by Andrew Lansley mean that hospitals would bear the cost of readmission during the 30 days after discharge.[1] Such readmissions cost the NHS £1.6bn (€1.84bn; $2.53bn) a year—about £11m per trust.[2] Greater integration of care is welcome, but not all readmissions are a failure of care, and such legislation may have unintended consequences.

We retrieved data from our plastic surgery unit to assess the effect that these proposals would have on a small surgical specialty.

In the first four months of 2010, 1797 patients were treated and 26 (1.4%) were readmitted within 30 days of discharge. Of those undergoing emergency surgery, 2.2% (15/677) were readmitted, whereas 0.5% of day cases (5/926) and 3.1% of people undergoing elective procedures (6/194) were readmitted.

Most readmissions (62%, n=16) were for recognised surgical complications such as infection and bleeding. Most operations carry a 2-3% chance of postoperative infection (double in the presence of contamination).[3] Such complications cannot be entirely eradicated. So is it legitimate to remove funding for readmissions related to surgical complications?

Seven patients (27%) were incorrectly classified as readmissions and would be inappropriately funded by the hospital rather than the primary care trust under the proposed scheme. Current mechanisms for detecting readmissions are flawed, but rectifying this would probably entail bureaucratic and administrative costs.

Lansley believes that "engaged and empowered professionals will deliver results." Under current proposals our department would see its income fall because of misclassification and unavoidable complications. This may be viewed as an unintended consequence or a covert tariff reduction. To truly engage and empower, Lansley should reconsider this particular innovation.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;340:c5456

FDA ON PROMS

More thought needed

The new Food and Drug Administration (FDA) guidance on patient reported outcome measures (PROMs)[1 2] will affect the use of PROMs in clinical trials and thus the evidence available to licensing and reimbursement authorities worldwide.

We have two comments. Firstly, the guidance conflicts with recommendations from other bodies. For example, generic measures, as favoured by the National Institute for Health and Clinical Excellence (NICE), will rarely be appropriate for submissions to the FDA.[3]

Secondly, the FDA guidance recommends scoring each PROM item and change in response choice equally. This assumes that all items, and the difference between all response choices, are equally important. This could result in misleading or difficult to interpret results. Furthermore, changes in scores may not reflect changes in quality of life that patients themselves value.[4]

In contrast, economic evaluation scores health status using preferences, whereby items and response choices are weighted according to the impact respondents believe they will have on their quality of life. Such a system would allow patients to indicate what matters to them, not what happens to them. This is more consistent with the earlier stages of PROM development recommended by the FDA that emphasises patient involvement and rigorous techniques in the development of PROMs.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;341:c5454

MILLENNIUM DEVELOPMENT GOALS

Meeting the needs of healthcare workers is crucial

Lawn suggests four key priorities in the next crucial five years,[1] but I would like to add a fifth—to focus on the needs of the existing health workforce in the 57 crisis countries, especially mid-level and primary healthcare workers.

The millennium development goals will be achieved only if we focus on these.

Giving a voice to health workers and strengthening the effectiveness of national and international support for them requires interdisciplinary communication, mutual understanding, and collective advocacy. One example of this is the HIFA2015 project,[2] which has almost 5000 members ranging from senior WHO executives to grassroots rural health workers, interacting through three email forums. Our shared goal is: "By 2015, every person worldwide will have access to an informed healthcare provider" (www.hifa2015.org).

Meanwhile, existing initiatives that focus on empowering the health workforce, such as the Capacity Plus project and the Global Health Workforce Alliance, need strengthening.

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Competing interests: None declared.

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Cite this as: *BMJ* 2010;341:c5466

Healthcare workers want practical assistance

I agree with Pakenham-Walsh's call to focus on the needs of healthcare workers.[1] Access to essential drugs and equipment would boost morale for our colleagues in developing countries, many of whom deliver health care under appalling conditions, as would access to good quality postgraduate education. These basic steps will save lives and take us closer to achieving millennium development goals 4 and 5.[2]

At Scotland Malawi Anaesthesia, we deliver postgraduate educational courses for anaesthetic clinical officers in Malawi, according to their requests. They overwhelmingly request refresher courses on managing critically ill patients and obstetric, paediatric, and intraoperative emergencies, as well as delivery of essential anaesthetic and intensive care equipment. Colleagues from other countries provide similar courses in sub-Saharan Africa. The WHO integrated management for emergency and essential surgical care toolkit also delivers practical assistance in the form of equipment, drugs, and supervision at the coalface.

Research has a place, but when resources are limited, they should be used wisely for the best practical effects. Many exercises have assessed needs and produced vital information to help focus efforts on areas of need, but healthcare workers' pleas for help delivering the absolute basics can become lost in the depths of reports. Now is the time to listen to frontline healthcare workers and support them in setting up sustainable safe services.

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Competing interests: None declared.

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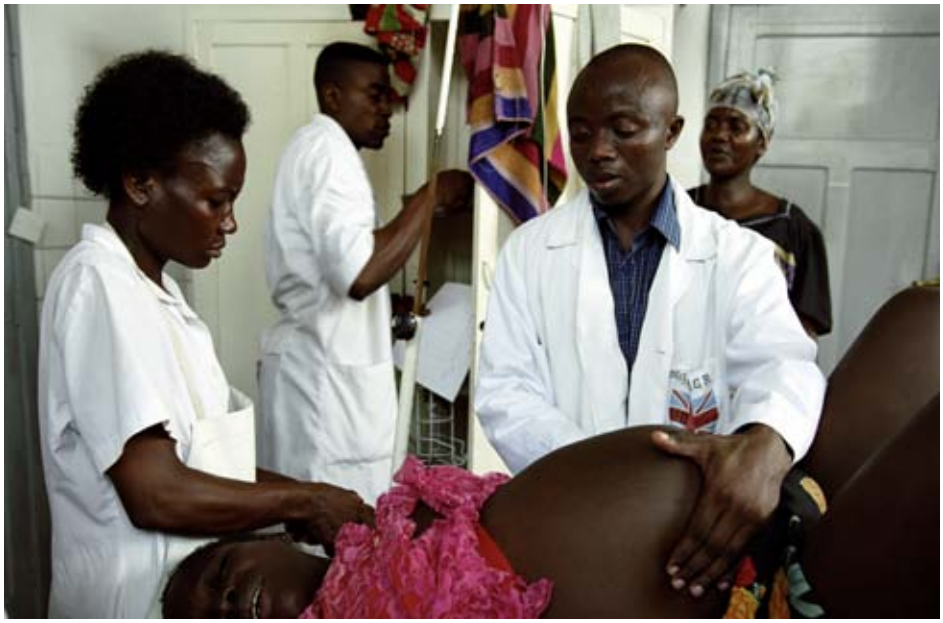

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