other injuries during seizures, including cuts, bruises, and falls (57 patients); scalp and facial lacerations (nine fractures and dislocations of joints (17); and oral injuries or damage to the teeth (13). Eighteen patients reported multiple injuries. Injuries other than burns were equally prevalent among the patients who had and had not sustained burns during seizures (32 patients (63%) and 47 (56%) respectively). Table III shows the advice and warnings that the patients recalled being given.

The 80 patients with diabetes treated with insulin who were questioned were comparable in age with the patients with epilepsy (median age 42, range 17-78 years); the median duration of diabetes was 19 (1-40) years, and the median frequency of symptomatic episodes of hypoglycaemia was 12 (0-200) a year. Eight of these patients recalled a burn that was not related to hypoglycaemia; only one patient had been burnt during a hypoglycaemic episode when he fell into an open fire. Fourteen patients with diabetes (18%) had sustained other injuries during episodes of hypoglycaemia.

Discussion

Patients with epilepsy often injure themselves during seizures and are usually warned at the time of diagnosis about the dangers of heights, swimming alone, and working with machinery. We confirmed that burns sustained during seizures are common and may be severe, yet they are commonly overlooked in reports of the hazards of epilepsy⁷ and are not mentioned in a standard textbook about the disease.⁸ Burns were less common than simple cuts, bruises, and falls but more common than the well recognised risks of injuries to bones and damage to teeth. There is a lack of awareness among patients of the risk of receiving burns during seizures; only seven patients with epilepsy (5%) could recall receiving warnings about this risk, and two of these were warned only after they had been burnt. Although the reported incidence of burns received during normal consciousness was similar for both patients with epilepsy (7%) and those with diabetes controlled by insulin (10%), the risk of burns during altered consciousness was greater in patients with epilepsy. Interestingly, one patient with both diabetes and epilepsy reported that although he had not suffered any burns attributable to episodes of hypoglycaemia, he had fallen into an open fire and burnt himself seriously during a seizure.

Analysis of the circumstances of burns suggests that many are avoidable. Most burns occurred in the home while patients were

performing everyday domestic tasks. Contact with a hot kettle was the cause of 14 burns in patients with epilepsy, and insulated plastic kettles, which are now widely available, should be recommended. A further 14 burns were received while cooking; two patients who burnt themselves in this fashion subsequently cooked only when their spouse was in the home. Fitted guards on cookers may be helpful, and for those most at risk a microwave oven could reduce danger. Two patients had sustained burns from chip pans, and one patient, although not burnt herself, had caused a serious house fire when she had a seizure while using an open chip pan; self sealing deep fat fryers are a far safer alternative for patients with epilepsy. Nineteen burns were received from fires and heating appliances; lying against a central heating radiator was the most common cause of such injuries, and we suggest that radiators as well as solid fuel fires should be fitted with guards. The four burns that were received from cigarettes and the three from hot water bottles could have been easily avoided. In addition, patients with epilepsy should be advised not to light bonfires unattended.

This study indicates that epileptic seizures often result in burns, which may be serious. At present the association between burns and seizures is inadequately recognised by doctors, and patients should be warned of the risk at the time of diagnosis. Simple measures could reduce the risk of such injuries.

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Medicolegal

Mental Health Commission defeated over paedophile

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The Mental Health Act Commission, set up by the 1983 Mental Health Act as a watchdog for mental patients' rights, has lost the first court challenge to the exercise of its powers. On 26 May the High Court ruled that the commission had no jurisdiction to try to stop the treatment of a convicted paedophile with the luteinising hormone releasing hormone analogue goserelin. Even if the

commissioners had jurisdiction, said Lord Justice Stuart Smith and Mr Justice Farquharson, their decision not to allow the treatment to go ahead would be quashed on the grounds that they took into account matters they should not have taken into account, applied the wrong test, and reached a decision that was unreasonable.

Section 57 of the Mental Health Act stipulates that certain controversial treatments for "mental disorder" can be given only if three Mental Health Act commissioners certify that the patient is capable of understanding the nature, purpose, and likely effects of the treatment and has consented to it. In addition, the treatment cannot be given unless a Mental Health Act Commission doctor has certified—after consultation with two professionals other than a doctor concerned with the medical treatment—that the treatment

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should be given, having regard to the likelihood of its relieving or preventing a deterioration of the patient's condition.

The section applies to only two classes of treatment: psychosurgery ("any surgical operation for destroying brain tissue or for destroying the functioning of brain tissue") and "the surgical implantation of hormones for the purpose of reducing male sex drive"—intended to regulate the use of the oestrogen oestradiol.

The case

W, a compulsive paedophile with 16 convictions for indecency and indecent assault on young boys, applied for judicial review of the commissioners' decisions that treatment with goserelin fell within section 57 and that the certificate would not be issued. On his release from prison in September 1986 he had sought drug treatment as a voluntary patient to control his sex drive from Dr Gerald Silverman, consultant psychiatrist at St Bernard's Hospital, Ealing. Medroxyprogesterone acetate (Depo-Provera) and cyproterone acetate (Androcur) proved insufficient to suppress his urges, and Dr Silverman took advice from a consultant endocrinologist, who suggested goserelin (marketed by ICI as Zoladex), a new drug licensed only for the treatment of prostate cancer. The drug is given monthly in the form of a depot injection. A cylinder of polymer injected under the skin degrades over the month, releasing the drug. The drug completely eliminated W's sex drive, but after three injections the Mental Health Act Commission made it clear to Dr Silverman that no further injections could be given without the commission's certificate. The certificate could not be given because there were difficulties in finding two other professionals concerned in the treatment whom the commissioners could consult.

At this stage no question was raised as to W's consent and capacity to understand the treatment. Indeed, the commission's chairman, Viscount Colville, wrote to Dr Silverman: "I understand that the three commissioners felt able to agree that the patient is capable of understanding the nature, purpose and likely effects of the treatment and is consenting to it." After a second interview with W, however, they changed their minds. According to a court affidavit by Dr Peter Jeffreys, the medical commissioner, "it was our opinion that his understanding, and therefore capacity to consent, had changed in important respects from our previous assessment" (three months before). In his report after the second interview with W, Dr Jeffreys wrote: "He did not understand that the primary site of action of the drug was on the brain (the hypothalamus) and believed only the testes were affected directly by the drug. In addition he denied the possibility of any medium or long term side effects of the drug." (Dr Jeffreys later explained that the reference to the hypothalamus should have been to the hypothalamic-pituitary axis.)

Two questions for the court

The first two questions for the court were: was the treatment with goserelin a "surgical implantation of hormones for the purpose of reducing male sexual drive" and, if so, was it a treatment for mental disorder? Lord Justice Stuart Smith said that goserelin was correctly described as a synthetic analogue of luteinising hormone releasing hormone. Although initially the effects of goserelin and luteinising hormone releasing hormone were similar, very soon the effect of goserelin was the opposite and it was correctly described as a hormone antagonist. Professor Michael Besser described luteinising hormone releasing hormone as the key that opened the lock, whereas goserelin only half turned the lock and then jammed it, preventing it from being opened by the real key. His lordship said he preferred the opinions of Professor Michael Besser, Professor

David London, and Professor Robert Buglass that the term "hormone" should not be extended to include hormone analogues to those of Dr Jeffreys and Professor Robert Shaw, who sought to give it a wide definition, depending on the ultimate effect.

Going on to the question of whether the drug was administered by a surgical implant, Lord Justice Stuart Smith said that to his mind the use of the syringe to inject the drug was almost indistinguishable from a conventional injection, save for the large bore of the needle. No surgical incision was made and no stitches required. Oestradiol could be administered by means of a trocar and cannula, but this required a surgical incision and subsequent suturing. It clearly fell on one side of the line, goserelin on the other.

On the question of mental disorder, the act lays down that a person shall not be considered mentally disordered simply because of sexual deviancy, but his lordship said that in practice it seemed likely that the sexual problem would be inextricably linked with a mental disorder, so that treatment for the one would be treatment for the other, as in this case. In his lordship's opinion the treatment did not fall within the ambit of the act, but if it did, what about the questions of capacity and consent? The act uses the words "capable of understanding," not "understands." It also refers to capacity to understand the likely effects of the treatment, not side effects, however remote. The consent had to be an informed consent in the sense that the patient knew the nature and likely effects of the treatment. Undoubtedly W knew this. In this case, in which the treatment was not routinely used for control of sexual urges and was not sold for this purpose, it was important that the patient should realise that the use on him was a novel one and the full implications of use on young men had not been studied, as trials had been concerned only with animals and older men. Again, it was perfectly clear that W knew this. His lordship said he could not accept that the patient had to understand the precise physiological process before he could be said to be capable of understanding the nature and likely effects of the treatment and could consent to it. In the absence of any suggestion that there had been a serious deterioration in W's mental condition between August and November to explain how it came about that what he understood in August he did not in November, his lordship said he could only conclude that the decision was irrational.

Other patients awaiting verdict

It was plain that in exercising his discretion the medical commissioner must first consider whether the proposed treatment was likely to alleviate the condition or prevent its deterioration. If he concluded that this was not likely then he must refuse a certificate. If he concluded that it was likely then no doubt he might balance the benefit against what he conceived to be the disadvantages. It did not seem that Dr Jeffreys had approached the matter in this way, Lord Justice Stuart Smith said. On the evidence it would seem that the answer to the first question was not only that the treatment was likely to alleviate W's condition but that it had done so, he said. If nevertheless it was not to be permitted on the grounds that other considerations outweighed these advantages it seemed that in the circumstances of this case, where most of those considerations were criticisms of Dr Silverman, at the very least they should have been discussed with him, and that a failure to do so amounted to unfairness to W, or the taking into account of irrelevant matters. After the ruling Dr Silverman said he had two other patients anxious for treatment with goserelin who had been awaiting the outcome of the case.

The Mental Health Act Commission is considering an appeal. The use of hormone implants is rare—only three applications for a certificate have been made since the regulations were passed—but the commission is concerned about the implications for psychosurgery, for which around 50 applications a year are received, of the part of the judgment dealing with consent.