aid work in a few royal colleges and faculties—for example, the Royal College of General Practitioners and the Royal College of Nursing.

Another recent development is the shift in Britain's health policy towards an NHS led by primary care. Many models of primary health care have evolved in developing countries over the past three decades, and aid agencies may have contributed to these. Britain's health system could benefit from their experiences, and aid workers are well placed to share knowledge.

The skills acquired through working overseas—managing projects, coping in a crisis, and making

difficult decisions in the face of scarce resources (often in harsh and changing conditions)—are all useful in today's NHS. Perhaps now, more than any other time, an international humanitarian aid posting is very relevant to a career plan and the NHS.

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Ethical Debate

Doctors' legal position in treating temporarily incompetent patients

Doctors in accident and emergency departments are sometimes presented with patients with potentially life threatening conditions who refuse to consent to treatment. The doctors then face a dilemma: to withhold necessary treatment or to act against a patient's express wishes. Two such cases are presented, and we asked a lawyer, two medical ethicists, a psychiatrist, and an accident and emergency physician to comment on the implications.

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Case history: head injury and drunkenness

David W Hodgkinson, Alistair J Gray

A 46 year old man with a history of chronic heavy alcohol consumption fell down a flight of 20 concrete steps and sustained an injury to the left side of his head, bleeding profusely from a scalp laceration. An ambulance was called, and, with some difficulty, he was persuaded to go to hospital with a friend. On arrival at the hospital he refused to enter the accident and emergency department and became verbally and physically aggressive, but his friend eventually persuaded him to be seen in the department.

He initially seemed jovial and cooperative. He smelt strongly of alcohol, was alert and talking, but walked with an unsteady ataxic gait. A doctor assessed him and found him to be alert, uncooperative, and orientated. He had a laceration to the left side of his scalp behind his left ear, and fresh blood was coming from his external auditory canal. His pupils were of equal size and reacted to light, and there were no lateralising neurological signs. A lateral radiograph of his skull confirmed a linear vault fracture of the left parietal bone that extended into the base of the skull.

The patient's condition was explained to him, and he was offered admission to hospital. He immediately refused and walked out of the department despite entreaties not to leave. After the case had been discussed with the accident and emergency consultant on call for the day, the police were asked to bring the patient back to the department for further assessment. Several hours later the patient returned in the company of the police but again refused to stay and was both verbally and physically aggressive. His physical condition seemed unchanged, and he left. The patient was brought back again by the police after a short time, and he agreed to be admitted to the ward.

At this stage a niece who had been contacted arrived in the department. After spending several minutes with the patient, she stated that this was not his normal behaviour even when drunk. The patient discharged himself from the ward, but some hours later he was readmitted of his own volition. His general condition remained unchanged.

Authors' comment

The main subject for debate is whether this patient was competent to make a reasonable decision regarding the need for admission, observation, and possible further investigations. He had probably ingested alcohol, had sustained a skull fracture in a fall, and had presented with abnormal behaviour. Such a patient is at considerable risk of developing an intracranial haemorrhage or of having sustained cerebral contusions.

Should this patient have been held against his will for observation, or sedated until he became compliant, or was he competent to make the decision to discharge himself? He was clearly not suffering from a psychiatric illness that would warrant a compulsory admission order. Should this patient have been physically restrained against his will in the accident and emergency department or on the ward?

Case history: serious drug overdoses

Brian Dalal

A 30 year old man was found by his father in a drowsy confused state with an empty pack of 100 co-dydramol tablets (dihydrocodeine tartrate 10 mg, paracetamol 500 mg) by his side. The pack had been dispensed earlier that day. By the time of his arrival in the casualty department, about two hours after the overdose, the patient was unconscious with pinpoint pupils and a respiratory rate of 6 breaths/min. His father said that his son had been prescribed co-dydramol for a longstanding foot injury. He thought that his son had recently split up with a girlfriend, although he was not certain as they tended not to discuss personal affairs. There were no other relatives who might offer a clearer understanding of the reasons for the overdose, and there was no history of psychiatric illness, deliberate self harm, or alcohol misuse.

The patient was treated with naloxone (an opiate antagonist), with immediate effect. On waking, he was extremely distressed and refused to disclose why he had taken the overdose. He did not seem to be