lost, but the law makes an important qualification: a mentally competent person is entitled to make decisions for irrational reasons.³ The law does not permit assessment of competence by examination of the reasonableness of the decision, contrary to Grant Gillett's ethical position.

Contrary to Zbigniew Szawarski's suggestion of a presumption of incompetence, the law presumes that every adult has mental capacity unless that presumption is rebutted. Any medical practice to the contrary would potentially undermine patients' firmly entrenched right to physical autonomy.

D W Yates seems to suggest that an authority to treat may arise from a patient being brought in by a relative. While this might be a pragmatic solution, it is ruled out by court decisions holding that, in the case of adult patients, no relative has the power to consent to or to refuse medical treatment on their behalf, although medical practice may require that a relative is consulted.⁴

In the case of an unconscious patient, in the absence of convincing evidence of a valid advance directive refusing treatment, doctors are free to provide whatever treatment they consider in their clinical judgment to be in the patient's best interests: any treatment necessary to save the patient's life is likely to come into that category. In the case of an uncooperative conscious patient the position is more difficult. The patient's competence must be assessed, and only if the doctors are satisfied that the patient lacks competence are they free to provide treatment against the patient's will in what they consider to be his or her best interests. This may include detaining the patient if that is in accordance with proper medical practice, but it is doubtful whether in such circumstances the police have any powers over and above those of the private citizen in cases in which the Mental Health Act does not apply.

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1 Hodgkinson DW, Gray AJ, Dalal B, Wilson P, Szawarski Z, Sensky T, *et al.* Doctors' legal position in treating temporarily incompetent patients. *BMJ* 1995;311:115-8. (8 July.)

2 In re C [1994] 1 WLR 290.

3 Sidaway [1985] AC 871, 905, 905.

4 In re F [1990] AC 1, 78.

No reasonable doubt that patient was incompetent

EDITOR,—A recent ethical debate centres on two patients who had refused treatment in an accident and emergency department.¹ One patient was admitted unconscious after an overdose of co-dydramol and was awakened by a dose of naloxone but then refused further treatment. He was, however, treated when the effects of the naloxone wore off and unconsciousness returned. The ethics and medical commentators agreed with this course of action, but the legal expert thought that the action was "difficult to justify." This conclusion cannot go unchallenged.

The right to refuse treatment was considered in the case of Re T, when Lord Donaldson said, "A patient's interest consists of his right to self determination. Society's interest is in upholding the concept that all human life is sacred and should be preserved if possible. In a situation where these two interests conflict, the right of the individual is paramount. But where there is doubt, the doubt falls to be resolved in favour of the preservation of life."²

Consider the patient discussed in the article. His system contained enough co-dydramol to cause unconsciousness. He was artificially stimulated into temporary wakefulness. Can anyone, doctor or layperson, say that there was not doubt about his capacity to understand the nature, purpose, and effect of the proffered treatment? If there was doubt then his life should have been preserved. It is doctors' duty to preserve the life of those unable

to give consent (see Lord Brandon's speech in the case of F v West Berkshire Health Authority³).

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2 Re T (adult: refusal of medical treatment) [1992] 9 BMLR 46.

3 F v West Berkshire HA [1989] 4 BMLR 1 at 8.

General practitioners can help with patients who take their own discharge

EDITOR,—Patients who insist on taking their own discharge against medical advice when under the influence of alcohol, drugs, or head injury present a serious problem for accident and emergency staff, particularly if there is no responsible adult to care for the patients.¹ I have found that in cases in which there is no serious concern about immediate deterioration and the patient has been allowed to go home, general practitioners are usually willing to pay a home visit a few hours later to reassess the patient if they are contacted by the accident and emergency department. The hospital should not abdicate its responsibility for those patients who must be detained for their own good, but back up in the community can help to avoid unpleasant confrontations with other patients.

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1 Hodgkinson DW, Gray AJ, Dalal B, Wilson P, Szawarski Z, Sensky T, *et al.* Doctors' legal position in treating temporarily incompetent patients. *BMJ* 1995;311:115-8. (8 July.)

Diabetes and breast feeding

Support is available for diabetic mothers

EDITOR,—D F O'Sullivan raises an important point about information about breast feeding for diabetic mothers.¹ Women with diabetes may experience particular difficulties in establishing breast feeding owing to early separation from their babies, delays in the initiation of breast feeding, increased use of supplements, and the high rate of caesarean section.² Together with rapid changes in insulin requirements in the early days this means that appropriate support and information are critical.

All women with diabetes and midwives caring for them should be made aware of the evidence that breast feeding for 9-12 months reduces the risk of diabetes developing in children with a family history of the condition,³ helps to improve glucose and lipid metabolism, and promotes postpartum weight loss.⁴ Women with well controlled diabetes produce breast milk with a normal composition of macronutrients and fatty acids⁵; this is the best food for their babies.

The National Childbirth Trust's counsellors on breast feeding are trained to provide information and support for any breast feeding mother. The trust's breast feeding special situations register includes details of mothers with diabetes who are willing to talk about their experiences with other parents. The register can be contacted on 01332 702386.

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- O'Sullivan DF. Diabetes and breast feeding. *BMJ* 1995;311:123. (8 July.)
- Ferris AM, Neubauer SH, Bendel RB, Green KW. Perinatal lactation protocol and outcome in mothers insulin-dependent diabetes mellitus. *Am J Clin Nutr* 1993;58:43-8.
- Kiln MR, Henschel D, Kiln L. Breast feeding and diabetes mellitus. *BMJ* 1994;308:534-5.
- Dewey KG, Heinig MJ, Nommsen LA. Maternal weight-loss patterns during prolonged lactation. *Am J Clin Nutr* 1993;58:162-6.
- van Beusekom CM, Zeegers TA, Martini IA, Velvis HJR, Visser CHA, van Doormaal JJ, *et al.* Milk of patients with tightly controlled insulin-dependent diabetes mellitus has normal macronutrient and fatty acid composition. *Am J Clin Nutr* 1993;57:938-43.

Carbohydrate requirements are increased

EDITOR,—D F O'Sullivan found that advice on breast feeding for his diabetic wife was hard to come by.¹ This is surprising, since as long ago as 1983 Dodderidge and Wichelow conducted a survey at the diabetic pregnancy unit at King's College Hospital and found that, with good antenatal advice and encouragement, three quarters of mothers were breast feeding at six weeks.²

Two important factors emerged from this study: firstly, as might be expected, babies who were encouraged to suckle within 12 hours of delivery were more likely to be breast fed successfully than those put to the breast after this time, and, secondly, the mother's dietary carbohydrate allowance should be increased by 50 g as a contribution to the extra 2.5 MJ needed daily during lactation. This increase is best taken as an extra pint of milk daily and two extra portions of carbohydrate taken at tea or dinner and as a bedtime snack, when the mother is likely to be hungry, rather than earlier in the day. Insulin requirements are not likely to alter during lactation. Mrs O'Sullivan's experience of hypoglycaemia during lactation was probably the result of an inadequate increase in carbohydrate intake and was similar to the experience of the mothers at King's College Hospital, who also reported a decrease in their supply of milk if they had low blood glucose concentrations.

It is disappointing that O'Sullivan got no help from the British Diabetic Association since its pamphlet *Pregnancy, Diabetes and You* contains an excellent section on breast feeding and diabetes.³

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- O'Sullivan DF. Diabetes and breast feeding. *BMJ* 1995;311:123. (8 July.)
- Wichelow MJ, Dodderidge MC. Lactation in diabetic women. *BMJ* 1983;287:649-50.
- British Diabetic Association. *Pregnancy, diabetes and you*. London: BDA, 1995.

Ambulance staff exercise discretion over resuscitation decision

EDITOR,—Andrew Marsden and colleagues are to be commended on their courage in tackling the complicated and controversial area of "futile" resuscitation in cases of out of hospital cardiac arrest.¹ At the time of writing they would have been unaware of recently published data from South Glamorgan which suggests that in practice ambulance staff already exercise some degree of discretion.² In that data set, of 370 patients in whom no resuscitation attempt was made, 274 (74%) were clearly inappropriate for resuscitation ("rigor mortis," "already certified dead," "terminal cancer") and in 96 cases (26%) the reasons were less clear cut. "Unknown," "police or relatives' instructions," or "severe injury" would not immediately seem to justify no attempt. Ambulance staff are currently placed in the difficult