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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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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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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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

position of having to follow "always try" protocols which they do not support; their only alternative is the exercise of unlicensed discretion. It is thus as much to regulate that inappropriate exercise of discretion as to prevent futile resuscitation attempts, that guidelines are to be welcomed.

We suggest that the algorithm drawn up by Marsden and colleagues could form the useful basis of a discussion by a group ideally working under the joint auspices of the UK and European Resuscitation Councils. In facing difficult situations ambulance staff deserve the clarity of instruction that definitive guidelines would bring.

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Pig sticking injuries are no joke

EDITOR,—Tim Owen makes the serious allegation of fraud about an article published in the *BMJ*, which he does not even reference.¹ I assume that he is referring to an editorial I wrote that recommended safe hunting practices.² This was based on a case series of 20 injuries caused by pigs published in the *Medical Journal of Australia*,³ and Owen should have viewed the published pictures of a gangrenous bowel, sucking chest wound, and scrotal injury before making statements about scientific validity.

Perhaps Owen has not been responsible for treating people with severe injuries caused by pigs, and I doubt if he has conducted postmortem examinations on young people gored to death by feral animals. I have, and during six years in Papua New Guinea I learnt that pigs turn rapidly when injured and that a careless villager who hunts with only one spear is at grave risk. I used every possible opportunity to persuade young men to go pig hunting adequately armed. I found that telling humorous tales of pig sticking in medieval Britain was an effective way of conveying serious health education messages to them. Clearly Owen

remembers the article: I hope that should he ever go hunting wild animals he also remembers to keep both barrels of his shotgun fully loaded.

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- 1 Owen T. Handling scientific fraud. *BMJ* 1995;311:262. (22 July.)
- 2 Garner P. Avoiding injuries caused by pigs. *BMJ* 1989;298:848.
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New measures can help to measure economic "externalities"

EDITOR,—Peter Draper and Hugo Crombie ask whether the health sector can make a useful contribution to macroeconomic policy.¹ This marks an important divergence from the school of thinking that health matters should be treated in economic terms entirely as consumption with no (monetised) return on expenditure.

An economic framework which understands how health outcomes themselves feed back into the process of sustainable wealth creation offers a starting point. For the purpose of discussion, we have, for example, created a pilot index of sustainable economic welfare for the United Kingdom.² Starting from a standard measure of personal consumption, the index makes a series of adjustments for factors which relate to human welfare and environmental sustainability. While the index does not purport to establish a single number as "true" welfare, it does allow an important assessment of relative performance over time.

Applied to the British economy, the index shows a striking difference to trends in gross national product, the most cited macroeconomic indicator of progress. Gross national product per capita was 2.3 times greater in real terms in 1990 than it was in 1950, with an average year on year growth rate of 2.1%. In contrast, there was virtually no overall growth in the index per capita over the same period. In 1990 the index was just 3% higher than it was in 1950, with an average growth rate of 0.1%. The difference between gross national product and the index per capita was particularly great from the mid-1970s onwards. Whereas, over the first half of the study (1950-74) sustainable economic welfare rose broadly in line with gross national product, in the past 15 years it has fallen dramatically—

declining at an average rate of almost 5% a year over the 1980s.

The reason seems to be a rising toll of social and environmental costs that are increasingly reflected as real losses in terms of welfare. The "externalities" ignored by macroeconomics are coming home to roost. In short, for all its sophistication, macroeconomic policy still does little more than assume that if one key indicator of economic output (gross national product) goes up, sustainable welfare will improve. Health professionals have much to offer in the development of new indicators that can contribute to a more sophisticated debate on the part of economists and policymakers.

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BMJ should declare its own conflict of interest

EDITOR,—I have noticed that you encourage the declaration of conflict of interest and source of funding of authors of papers published in the *BMJ*. I am concerned, however, that the *BMJ* fails to declare its own conflict of interest created by carrying advertisements for pharmaceutical products when, in the same edition, papers are published on related topics.

On 26 November 1994 there was a large, glossy, two page spread for co-amoxiclav in the same edition as a review article on the diagnosis and management of sinusitis in which amoxycillin (with or without clavulanic acid) is recommended; on 7 January 1995 there was a two page advertisement for filgrastim only a few pages from a review article on bone marrow transplantation in which the authors indicate that such agents are useful to reduce neutropenia; on 8 April 1995 tinzaparin was advertised a few pages away from an article on recent advances in orthopaedic and trauma surgery, a serious complication of which is the development of deep venous thrombosis. These examples are from editions of the *BMJ* taken at random from the shelf of a hospital library, but similar examples may be found in virtually every edition.

I do not wish to imply that the authors of these articles were in any way biased towards any particular product, but I fear that the *BMJ* may be unduly influencing readers by coincidentally publishing such advertisements. Advertising is obviously a major source of income for the journal (£4368 a week for a two page display advertisement) and presumably is a cost effective way for pharmaceutical companies to influence the prescribing habits of doctors. I am concerned that the journal may be, unwittingly perhaps, aiding the industry in applying that influence.

The *BMJ* has a notable tradition, particularly in recent years, for being a little smug and rather holier-than-thou. Perhaps, before preaching at potential authors, it should take a look at its own standards, get its own house in order, and declare its own interest when carrying advertisements.

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** The longstanding policy of the *BMJ* is that the advertising department does not know which papers are going to appear in the journal and the editorial department does not know which

How pig sticking injuries occur