Capacity to consent: clinical complexities

Sir,

We were interested to read the timely article *Assessment of capacity to consent to medical treatment* by Ali and Hassiotis (p. M148, vol 67(8), 2006). We recently encountered a difficult case that illustrates the complexities in determining a patient's capacity to consent.

A 51-year-old woman with suspected pulmonary embolism was scheduled for a computed tomography (CT) pulmonary angiogram. She became agitated and paranoid, refusing to proceed despite explanation. Her paranoid behaviour continued including barricading herself in her room. Psychiatric assessment concluded she was appropriate, orientated with reasonable insight but had impaired short-term memory. She developed proteinuria, haematuria and pleural effusions. Differential diagnosis included systemic lupus erythematosus and a body CT was arranged. She refused investigation and treatment.

Did she have capacity to refuse? The Mental Capacity Act 2005 supports her refusal, she should be permitted to make unwise decisions provided the consequences are understood. A multidisciplinary approach involving psychiatrists, physicians and anaesthetists decided she was incapable of making the decision. On the grounds of common law principle, she was uneventfully anaesthetized for the scan. It revealed mediastinal lymphadenopathy, bilateral basal consolidation and adnexal cystic masses.

Assessing a patient's capacity can be difficult, and Ali and Hassiotis's article helps to clarify a complex topic. The College of Physicians and Surgeons of Ontario (2005) summarizes this:

'Capacity is not static – it can change over time and be different depending on the nature and complexity of the specific treatment decision. What is being determined is whether the patient has the ability to understand the nature and effect of the treatment being proposed, not the "global" capacity of the person.'

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College of Physicians and Surgeons of Ontario (2005) *Consent to Medical Treatment.* Policy #4-05. College of Physicians and Surgeons of Ontario, Ontario (http://www.cpso.on.ca/policies/consent.htm accessed 24 October 2006)

Supplements and injections for joint disease

Sir,

We would like to add preservative-free morphine with local anaesthetic to the list of drugs for joint injections for joint disease by Derrett-Smith and Beynon (p. 290, vol 67(6), 2006). The authors' pain clinic receives many rheumatological and orthopaedic referrals of patients with knee pain who have exhausted medical and surgical treatment; for these patients one of the authors (WdM) has 7 years experience of using 4 mg preservative-free morphine in 2 ml saline plus 3 ml 0.5% plain bupivicaine. Analysis of this has shown a negative response in a third, some benefit in a subsequent third, and good benefit in the remaining third for a few days to 4 weeks, possibly by morphine-6-glucoronide production (Gupta et al, 2001). Pre-existing inflammation increases the efficacy (Stein, 1995). No reduction in stiffness in the joint was seen.

Recently the authors have injected shoulders and in two cases the addition of ketorolac improved analgesic efficacy. At a cost of 78 pence per 30 mg ampoule of preservative-free morphine it is a relatively safe intervention and deserves wider use on its own part of a multimodal approach to joint pain management.

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Gupta A, Bodin L, Holmstrom B et al (2001) A Systemic review of the peripheral analgesic effects of intraarticular morphine. *Anesth Analg* **93:** 761–70

Stein C (1995) The control of pain in peripheral tissues by opioids. *N Engl J Med* **332:** 1685–90

Guidelines for chaperone use

Sir,

Sexual abuse of patients by physicians is an unacceptable and thankfully rare event. Yet there are regular stories in the press about unscrupulous doctors and the ordeals of their unfortunate victims. Sadly many of these stories are true and the number of doctors being struck off the medical register is on the increase as are the number of bogus claims in an increasingly litigious society. In 2001 the General Medical Council (GMC) published guidelines for the use of chaperones for intimate examinations. Guidelines for good medical practice have also been set by various Royal colleges and the Clinical Governance Support Team (2005). Even so, record keeping is poor and a significant misunderstanding as to the appropriate use of chaperones still exists among health-care professionals.

It is good practice for health organizations to offer all patients a chaperone wherever indicated. The authors surveyed trainee doctors within their hospital to assess their knowledge of chaperone guidelines. They found that the attitudes and behaviour of the majority of doctors were at odds with the recommendations of the GMC.

The authors feel that every organization that has direct contact with patients should have a chaperone policy in place for the benefit of patients, staff and doctors, in the form of leaflets, posters or verbal information. Doctors should be educated by the trusts during their induction programme, and key principles of communication and record keeping should also be emphasized. This will ensure that the patient–doctor relationship is maintained and act as a safeguard against formal complaints.

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Clinical Governance Support Team (2005) *Guidance on the Role and Effective use of Chaperones in Primary and Community Care Settings.* Clinical Governance Support Team, Leicester (http://www.cgsupport.nhs.uk/downloads/Primary_Care/Chaperone_Framework.pdf)

General Medical Council (2001) *Guidelines for Intimate Examinations.* General Medical Council, London (http://www.gmc-uk.org/standards/intimate.htm)