



—BELMATT—  
HEALTHCARE TRAINING

## MARCH 2019 NEWSLETTER

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March 2019

## NEWSLETTER

Welcome to our March 2019 Newsletter. We have a lot happening at Belmatt. I have included some interesting articles published by our delegates and lecturers.

We will be running in-house and bespoke courses to support Advanced Practitioners in general practice and primary care. We are also developing a Children Safeguarding Level and telephone triage programme. This one day course will develop your skills in recognising safeguarding alerts that may arise during a telephone consultation. Our GP lecturer has extensive experience in primary care and will explore clinical decision-making skills, local resources available and collaborative working to keep children safe.

Contact us if you want to learn more. If you want to contribute to our monthly newsletter, email [jeshni@belmatt.co.uk](mailto:jeshni@belmatt.co.uk).

Watch our alerts for our latest mental health updates delivered by Dr Balu Pitchiah.

### Primary Care Courses

28 March 2019  
Clinical Examination Skills

4 – 6 April 2019  
Minor Illness Course

13 – 17 May 2019  
Minor Injuries

18 – 20 May 2019  
Managing the Sick and  
Injured Child

### Updates

23 March 2019  
Mental Health Update

30 March 2019  
Prescribing in Urgent Care

11 May 2019  
Minor Illness Update

6 July 2019  
Minor Injuries Update

## TEN TOP TIPS FOR EMOTIONAL WELLNESS

Modern life is full of challenges and change is constant. Emotional wellness contributes to an optimal state of mind that can perceive and cope with daily life, leading to happiness and fulfilment. It is priceless but many things that affect our emotions are not within our control. However, it is possible to learn and adopt habits and attitudes that foster wellness.

1. Have realistic Expectation of self and others.
2. Develop Goals and Plans that are realistic and set out to achieve one thing at a time.
3. Learn to accept changes in life and adapt.
4. Learn to manage Anger, Resentment and Disappointments better.
5. Surround yourself with positive thoughts and people.
6. Take control and responsibility for yourself.
7. Be nice to self and be your best friend.

It is often said that there is “No Health Without Mental Health”. We live in a time where we use our minds more in our day to day life, relationships and work places. Influence of external factors in the environment, substances and Stress impact our ability to use our mind effectively. Mental health is very important to us all. We want all people to be healthy in their minds as well as their bodies. Mental health is how someone is feeling in their mind. Good mental health is about feeling good about your life and being able to cope with problems when they happen. Good mental health is often referred to as mental well-being. A mental health problem is a problem with someone’s mind that makes it difficult for them to live a normal life. Mental health problems may be small problems or more serious problems. The problems may last for a short time or a long time. People with mental health problems can often live normal lives, have healthy relationships and gainful employment if they get the right treatment and support.

Mental health problems are common and can affect anyone irrespective of their social situation, intelligence or material wealth. Most available literature conclude that up to 25 percent of the population (1 out of 4 people) will experience a mental health problem at some time in their life. Although mental health problems are very common, the complications of common mental health issues can have serious effects on the sufferers and their families. It is known that people with mental health difficulties may have fewer qualifications and may find it difficult to find a job and keep it. They may earn less money and become homeless. Their behaviour can at times be challenging for people who care for them. People with serious mental health problems have difficulty in self-care and have serious physical health problems. They may not eat healthy and may be often overweight or underweight. They may also self-medicate with substances, tobacco, alcohol etc. Some people with mental health difficulties may have challenges in regulating their emotions and can have anger problems. Having mental health problems is upsetting for the person who is not well, their families, friends, carers and local communities. Mental health conditions are common but preventable. Please do not suffer in Silence. There is no shame in opening up. Identifying mental health problems and seeking help is the first step towards recovery. There is nothing to be ashamed of when someone has a “mind problem”. Speaking to a health professional is often the first step and specialist help is usually very effective in preventing complications of common mental health

**Dr Balu MBBS MRCPsych MBA**  
**Consultant Psychiatrist**  
**Drbalu.com**

# Heart Failure and Hypertension

Nadia Dallsingh  
Cardiac specialist nurse

Heart failure (HF) can be a very debilitating condition affecting more than 900,000 people in the UK annually. This is due to structural or functional abnormalities which impairs the pumping action of the left ventricle. As a result of this, patients may present with either left ventricular systolic dysfunction (LVSD), or HF with preserved ejection fraction (HFPEF). Evidence suggests that the majority of patients treated for LVSD, are commonly caused by coronary artery disease (CAD) and myocardial infarction.

Some causes of HF could be attributed to long-term or uncontrolled hypertension, valvular heart disease, chronic excess alcohol intake, viral infections and metabolic abnormalities such as diabetes. Hypertension is present in the majority of patients who develop LVSD, and the second most common attributable cause of HF together with CAD. A substantial proportion of patients develop HF with systolic blood pressure levels below the recommended target levels (140 mmHg or 130 mmHg for high risk), thus highlighting the importance for diagnosis and treatment.

Although early diagnosis and treatment of hypertension in the prevention of HF is crucial, it is equally important to control hypertension during optimal therapy for HF also. However, starting patients on a regime of standard medicines can bring about many challenges with common side effects, and sometimes serious allergic reactions. Angiotensin-converting enzyme (ACE) inhibitor is commonly used for hypertension and HF, which is associated with 30% to 40% of ACE inhibitor induced angioedema seen in emergency departments in the USA. Patients may also report ACE inhibitor induced cough triggered by bronchoconstriction due to increased bradykinin and other peptides in the lung. ACE inhibitor blocks the degradation on bradykinin and other peptides in the lungs.

## **Hypertension to Heart Failure**

Increase in cardiac afterload in a hypertrophic myocardium together with increased peripheral vascular resistance, has an increased burden on the myocardium. Due to increased workload of the myocardium in HF, hypertension also contributes to ischaemia by increasing myocardial oxygen demand. Also, abnormalities in the electrolyte balance, water and neuro-hormonal activation plays a key role in the process from hypertension to HF. During hypertrophy and HF, there is an increase in activity of the renin-angiotensin-aldosterone system and B-adrenoceptor activity.

Angiotensin II is an important initiator of extracellular remodelling, which contributes to the pathogenesis of atherosclerosis and cardiac hypertrophy (Georgiopoulou et al, 2012).

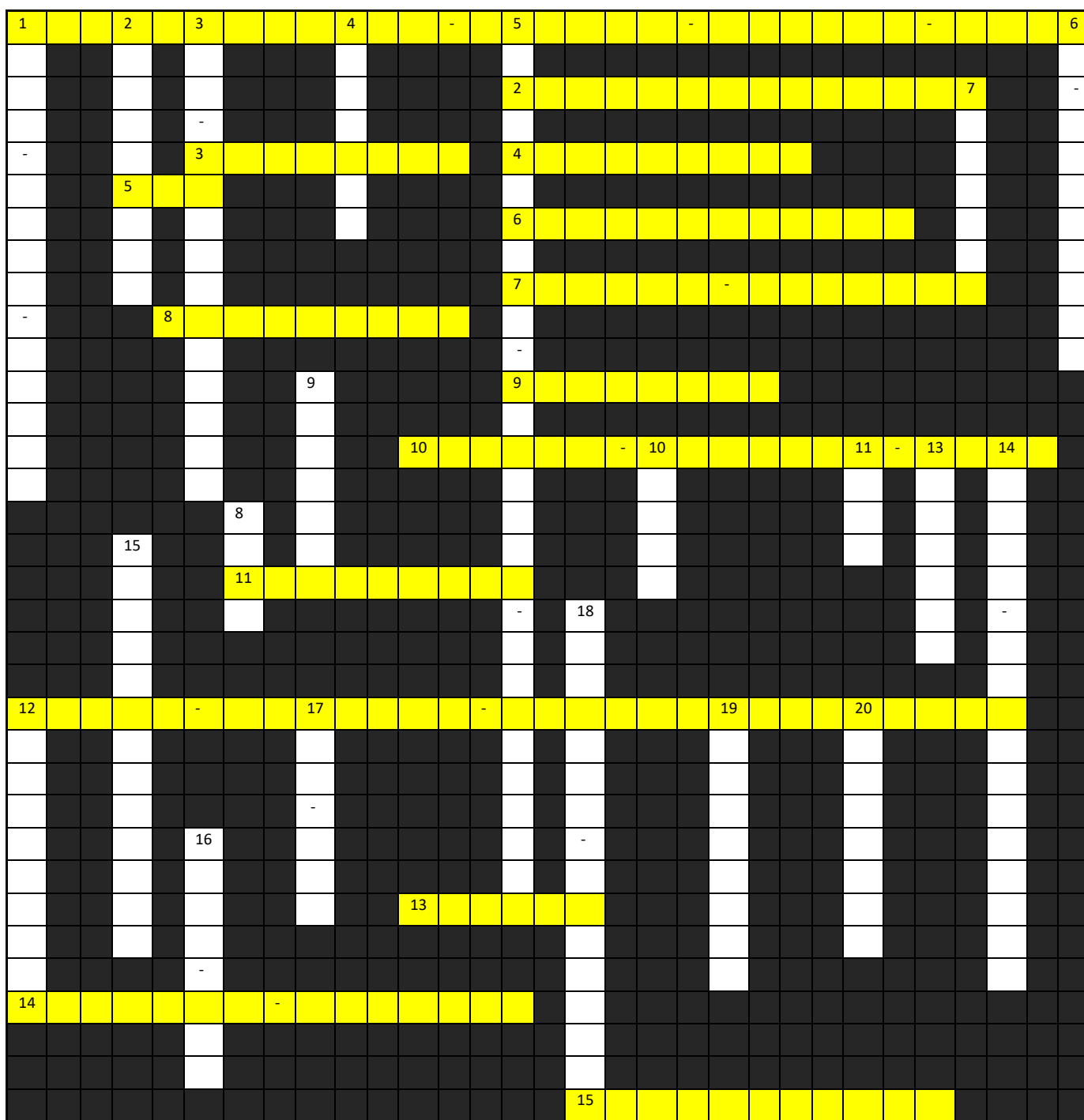
Early initialisation and titration of ACE inhibitor, together with beta-blockade and neuro-hormonal antagonist are recommended in the treatment of HF. ACE inhibitor stops the conversion of angiotensin I to angiotensin II. However, a substantial proportion of cases 30% to 40% of ACE inhibitor induced allergic reactions are seen in the emergency department in the US. Angioedema (AE) is characterised as either allergic AE (mast cell or immunoglobulin E mediated), or non-allergic AE (usually bradykinin mediated).

## **Conclusion**

While it is essential to treat HF promptly in the prevention of further impairment to systolic function, rigorous monitoring for allergies and side effects is paramount on initialising and titration of any medical therapy. Patients should be advised of the common side effects and allergic reactions, and what to do in an emergency in case of angioedema.

# ASTHMA CROSSWORD

Written by Ameet Gordhan



Across	
1	(4 words) All people with asthma (and/or their parents or carers) should be offered self-management education which should include a written:
2	Common symptom of asthma, but also of heart failure, COPD and PEs
3	Type of diagnosis that asthma is
4	Severe adverse effect of high dose inhaled corticosteroid treatment
5	Within how many days does a patient need to be seen by GP post discharge from hospital following an exacerbation of asthma?
6	Asthma is a combination of bronchial hyper-responsiveness combined with what type of condition?
7	Another term for asthma exacerbations (2 words)
8	Old adjective of asthma
9	Devices used to deliver medication directly to lungs
10	A patient self-administered tool for identifying those with poorly controlled asthma (3 words)
11	Normal breath sounds
12	Main preventer therapy in asthma (3 words)
13	To breathe with a whistling or rattling sound in the chest, as a result of obstruction in the air passages
14	Recommended for all patients with asthma - annual as a minimum (2 words)
15	Symptom of asthma describing heaviness, anxiety and shortness of breath
Down	
1	An option to show variation in obstruction in order to support the diagnosis of asthma (3 words)
2	Under what age is the use of the RCP 3 questions not supported to classify asthma control.
3,4,5	Three major reasons for uncontrolled asthma
6	Aim of asthma management (2 words)
7	Device used to increase drug deposition when used with pMDIs
8	A measure of the severity of airflow obstruction
9	One reason why many people with asthma get symptomatic in the summer
10	A symptom of asthma, however also a reflex action to clear your airways of mucus and irritants such as dust or smoke.
11	The class of drugs that should never be used alone for the treatment of asthma in children and adults.
12	Inhaler type which can describe amongst others the following: Accuhalers, Easihalers, Nexthaler, Ellipta, Spiromax, Turbohalers
13	Reasons which can cause asthma symptoms, flare ups and attacks - very important to know
14	One of the signs of uncontrolled asthma (2 words)
15	What cats and dogs shed, which causes symptoms in some people with asthma
16	One reason why many people with asthma get symptomatic in the winter (2 words)
17	One reason why many people with asthma get symptomatic in the desert (2 words)
18	Only LAMA currently indicated as add-on maintenance bronchodilator treatment in patients aged 6 years and older with severe asthma who experienced one or more severe asthma exacerbations in the preceding year (2 words)
19	Up to how long can an asthma attack last? (2 words)
20	Salbutamol or terbutaline

## Urinary Tract Infections

### Nutan Prasad, Nurse Practitioner Brent Urgent Care

The incidence of urinary tract infections (UTI) is highest in the females, as around 50% of women will suffer a UTI sometime in their life (NICE, 2015). Urinary tract infections (UTIs) occur more often in women than in men, at a ratio of 8:1 and approximately 50–60% of women report at least one UTI in their lifetime, and one in three will have at least one symptomatic UTI necessitating antibiotic treatment by age 24 according to Rann et al (2008).

The incidence of UTI increases with age and sexual activity (Scholes, 2002). Post-menopausal women have higher rates of UTIs because of pelvic prolapse, lack of oestrogen, loss of *Lactobacilli* in the vaginal flora, increased per urethral colonisation by *Escherichia coli* (*E. coli*), and a higher incidence of medical illnesses such as diabetes mellitus (DM) (Mohsin, 2010). Risk factors for UTI in sexually-active pre-menopausal women are the onset of symptoms shortly after sexual intercourse, the use of spermicides for contraception, taking on new sexual partners, the age of the first UTI, a maternal history of UTI and voiding dysfunction. Many other factors have been thought to predispose women to UTIs, such as voiding patterns pre- and post-coitus, wiping technique, wearing tight undergarments, deferred voiding habits and vaginal douching; nevertheless, there has been no proven association (Scholes, et al, 2002). Medical conditions such as pregnancy, DM and immunosuppression increase a woman's risk of UTI by facilitating the access of uropathogens overcoming normal host defense mechanisms. (Franco, 2005). Urinary tract infections are caused by the presence and multiplication of the microorganisms in the urinary tract. The most common causative organism for uncomplicated UTI is *Escherichia coli* (75-90 %), whereas remaining cases are usually due to gram-negative bacteria such as *Klebsiella* species and *Proteus* species (Mazzuli, 2012). It is more common in females owing to the length of urethra in females as they have a relatively short urethra hence allowing *E. coli* staph and enterococci to travel from the bowel (Addison et al, 2016 and Francis et al, 2014). However, men in comparison have a longer urethra and the antibacterial properties of prostatic fluid make urine infection less common in men according to Addison et al (2016).

The most common symptoms of a UTI are dysuria, urinary frequency, urgency; suprapubic pain and possible hematuria and the urine may have an unpleasant odour and appear cloudy (Franco, 2003). The age of the person experiencing the symptoms is relevant as cystitis is very common in the women of reproductive age. 50% women will be treated for symptomatic urinary tract of infection (UTI) during their life time, at menopause, and changes in urethral and vaginal epithelium may increase the likelihood of infection in some women. (NICE, 2015) although the difference between complicated and uncomplicated UTI is not always clear but it always helps in making out a working diagnosis and making clinical on its basis.

A usually uncomplicated UTI in a pregnant woman has an increased likelihood of progressing to pyelonephritis due to the relaxation of the ureteric sphincters. (Morris et al, 2014) Prompt and effective treatment of UTI is important during pregnancy because there is greater risk of complications from UTI (such as pyelonephritis and premature labour) Expert opinion in guidelines from the Scottish Intercollegiate Guidelines Network is that the urine should be cultured to test for cure. (SIGN, 2010).

In elderly women cystitis may be indicative of underlying pathology such as diabetes and they are also more prone to pyelonephritis. An increase in post void residual urinary volume (for example >50 ml) is an independent risk factor for urinary tract infection in post-menopausal women (Kodner, 2010).

It is difficult to make an accurate diagnosis of UTI in a women who are frail, elderly, or have a long term catheter. In these situations bacteraemia is often present but not related to the sign and symptoms, They may present with aching ribs, rigours, more confusion, and slightly increased temperature, for example 37.90 cent or above (NICE, 2014). Hence, "UTI symptoms vary in younger adult from mild discomfort to passing blood stained urine accompanied by loin pain and rigours: whereas elderly patient can present with offensive urine, new incontinence and confusion." (Armstrong, 2015). So in this



situation it is always better to take the patient's history of offensive urine, pain and discomfort when passing the urine, and pyrexia to develop a working diagnosis of the cause of infection. (Armstrong2015).

Diagnosing a patient with UTI should be initiated by a good history taking, using systemic structure as OPQRSTU mnemonic system (Bickley and Szilagi, 2015) as history taking plays a very important role in establishing the diagnosis of the patient. It is important for clinicians to check for the red flags such as unintentional weight loss, haematuria, and lower back pain especially over the age of 55, which could be an indication of bladder tumour or renal colic. (Hopcroft and Forte, 2014).

Clinical monitoring also involves the urine dipstick checking, using the re agent strip as a screening tool: mainly indicated in a woman with minimal symptoms of UTI (SIGN, 2012). Urinalysis, either by dipstick or microscopy, for the detection of pyuria, as a method for predicting a UTI has a sensitivity of 80–90% and a specificity of 50%, but it only detects those bacteria, which reduce nitrates to nitrites in the urine. Bacteria such as *Staphylococcus saprophyticus* lack that enzyme, which makes the nitrite test considerably less useful. Dipstick analysis for leucocyte esterase (the enzyme produced by neutrophils) is indirect and is the least expensive test that detects pyuria with a sensitivity of 72–97% and a specificity of 41–86%, as organisms other than uropathogens can also produce leucocyte esterase (Simerille, 2005).

More advanced investigations, such as cystoscopy, are advised in women over the age of 50 (Laurentschnik, 2006). Ultrasound of the kidneys, an intravenous pyelogram (IVP) and a computed tomography (CT) scan can help in detecting congenital structural urogenital anomalies

NICE (2014) states that in a woman with only slight or more symptoms and no catheter, a dipstick test can be used to determine leucocyte esterase and nitrites in urine. If these tests do not show positive results, then the diagnosis of UTI is unlikely. The presence of nitrites is positive with or without leucocytes, a UTI is very likely (Armstrong, 2015.) The key urine dipstick indicators for possible UTI are positive test for Leucocyte esterase and nitrites (Public Health England, 2014).

For the female patients with other negative outcomes except for leucocyte always consider for other genito-urinary causes which may include fungal infections, sexually transmitted diseases, threadworms, drug induced cystitis and dysmenorrhoea (NICE, 2013). Clinicians should consider non –urgent referral for bladder cancer in people aged 60 and over with recurrent or persistent unexplained urinary tract infection (NICE, 2015).

The management of acute uncomplicated lower UTI in women depends on the presence, or not, of haematuria. If the haematuria is present then the medical referral is required as there is strong evidence that antibiotic is effective in eradicating the bacteriuria and relieving UTI symptoms (SIGN 2012).

Simple analgesia such as paracetamol and NSAIDs can be ordered for pain relief if this does not prevent the individual from seeking appropriate medical advice. (SIGN 2012). Recent studies have shown that the number of antibiotic prescriptions issued for uncomplicated urinary tract infection can be reduced by symptomatic treatment with ibuprofen, reserving antibiotics for women who return with worsening or recurrent symptoms, and without an increase in symptom burden, recurrences, or complications. This treatment regimen can be discussed with women who are willing to avoid antibiotics or to accept a delayed prescription. BMJ, Gagyor: 2015).

According to Lifshitz, (2000) urine culture and sensitivity testing are the standard diagnostic investigations to detect the causative organism as this also helps with determining antimicrobial therapy. For treatment of acute urinary tract infection (UTI), NICE (2015) recommends nitrofurantoin 50 mg four times daily, or 100 mg (modified-release), twice daily and prescribe trimethoprim 200 mg twice daily for 3 days and a 7 day dose for complicated UTI's (BNF, 2017). The NICE CKS: 2015 guideline concludes that there is no difference between nitrofurantoin and trimethoprim when treating UTI'S. The guidelines also recommend avoiding the broad-spectrum antibiotics and encourage the use of narrow spectrum antibiotics. Nitrofurantoin is used for decades with minimal levels of resistance and is one of the first line choices of antibiotics used for the treatment of UTIs (NICE CKS: 2015). Safety

measures should be taken into consideration when treating the patient with nitrofurantoin, and should be avoided if the glomerular filtration rate is below 45ml/min/1.73 m<sup>2</sup> (MHRA, 2014), as this will potentially have adverse effects on the kidneys.

Trimethoprim is also commonly used as first line treatment. However, There are many medicines that don't mix well with trimethoprim. So need to make sure clinician is aware about the patient's history of taking these medicines before starting trimethoprim: an antibiotic called rifampicin, a blood thinner, such as warfarin, digoxin (a heart medicine), phenytoin (an epilepsy medicine), diabetes medicines called repaglinide and pioglitazone. ref (NICE, CKS, 2017). A recent case-control study among older patients has shown that taking an Angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin receptor blocked (ARB) along with trimethoprim-sulfamethoxazole (SMX-TMP; co-trimoxazole) is associated with an increased risk of sudden death. (Kauffman, 2015). Trimethoprim blocks the epithelial sodium channel in the distal nephron, reducing renal potassium elimination and can cause up to 80% of patients developing hyperkalemia. (Fralick, 2015) This reaction can occur rapidly and can be life threatening, especially in the outpatient setting, whereby sudden death potentially due to hyperkalemia could likely be attributed to heart disease when this might not be the case. Trimethoprim should be used with caution in pregnant women, as it is a folate antagonist. It is usually seen as safe in second and third trimesters but must not be given to pregnant women who have a folate deficiency or used trimethoprim in the past year. Cephalexin or amoxicillin is the alternative treatment (BNF, 2017). However, resistance to amoxicillin makes it less effective as an empirical treatment (CKS, 2015). Ciprofloxacin was also associated with an increased risk of death likely due to its ability to cause QT interval prolongation (adjusted odds ratio 1.29). No increased risk of sudden death was observed with amoxicillin, nitrofurantoin or norfloxacin. About 1-2% of pregnant women suffer an acute lower UTI (cystitis) or upper UTI (pyelonephritis), when the pregnant mother is very ill with acute pyelonephritis which then increases risk of preterm labour and even foetal loss. Hence, hospital admission is recommended for pregnant females who develop pyelonephritis. Sometimes, a continuous low-dose prophylaxis throughout pregnancy is required in some women with recurrent UTI. These women require renal tract ultrasound scans, and review by a nephrologist or a urologist postnatally.

Cranberry juice has been found to contain the substance that prevent the bacteria (particularly E. coli) from adhering to the uroepithelial cells on the wall of the bladder and urethra. No evidence has been found of efficacy in treating UTIs but it does appear to be evidence for benefit in preventing infections (Jepson et al. 1998, 2012), but this is not scientifically proven and more research is necessary on the subject. A study by (Maki et al (2016) carried out amongst 18 clinics and involving 373 healthy women in the US concluded that the consumption of a cranberry juice beverage lowered the number of clinical UTI episodes in women with a recent history of UTI as one UTI event was prevented for every 3.2 woman-years of the cranberry intervention. These results are to be considered with caution as the study excluded women who needed to take preventative antibiotics and others who may be at higher risk of UTIs, such as those with indwelling catheters, any problems or abnormalities of the urinary tract, those with sensory problems (spinal injuries), and those over 70 (thereby excluding many infirm people, care home residents, etc.). Manisha et al (2016) found that there was no significant differences among older women residing in nursing homes when administered cranberry capsules compared with placebo resulted in no significant difference in presence of bacteriuria plus pyuria over 1 year. Cranberry juice is a very high-sugar drink that also contains a lot of additives.

In fact, this study used a less additive-laden version with a shorter shelf life that is not commercially available. Therefore, people may need to individually consider whether the potential benefits of daily consumption of a high-sugar drink in the long term is worth it. Frazad et al (2012) undertook a double-blind randomized clinical trial, 58 type 2 diabetic male patients were randomly divided to receive 1 cup cranberry juice (CJ) or placebo drink daily for 12 weeks. Findings were that there was cranberry juice had a beneficial effect in reducing the risk of CVD in diabetic patients in CJ group and reinforces the notion that health benefits can be derived from consuming cranberry juice as an antioxidant-rich (e.g.,



flavonoid) food in type 2 diabetic patients. However, a recent study by (2017, unpublished) will be published on 1 July 2017 and may provide some interesting findings on the use of cranberry juice for urinary tract infections. Cranberry juice must be avoided in case of patient is on warfarin as it increases the prothrombin time. (BNF, 2015).

Patients are also advised to keep well hydrated because hydration helps in diluting the urine and flushing the bacteria from the bladder. Simple practices such as wiping from front to back after urinating or after bowel movement may help to prevent bacteria that are in the anal region from spreading to the vagina and urethra. Emptying bladder soon after intercourse and drinking more water may help as well to flush the bacteria. (Dason et al, 2011, NHS choices, 2014).

To conclude uncomplicated UTI in women is very common presentation in primary care centres. Most cases of UTI are easy to identify and treat, managing acute uncomplicated infections in women depends on the presentations, patient category, clinical judgement of the clinician and the plan of treatment/antibiotic duration depends on the patient's condition and severity of symptoms. Confirming the cause is important to ensure the best treatment.

However, with the rise in multi-resistant organism, the more challenging presentations require careful investigations, considerations and referrals to the specialist rather than prescribing the empiric.

## Exploring the concepts of Capacity and Consent

### Capacity/Competence

The starting point when discussing the medical treatment of competent adults comes from Lord Donaldson's judgment in *Re T (Adult: Refusal of Medical Treatment)*.<sup>1</sup>

"An adult patient who... suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered."

This case involved a woman who had been brought up as a Jehovah's Witness and, whilst not a practicing member of that religion, refused to consent to a blood transfusion. This statement makes the importance of consent in relation to the medical treatment of adults clear. Without such consent any form of touching, no matter how minor, will be unlawful and constitute both a criminal offence and a tort<sup>2</sup>.

Consent will be discussed later. However, capacity/competence to make decisions or consent to treatment is fundamental in healthcare as it also reflects respect for autonomy and choice in decision-making. Section 1(2) of MCA 2005 states that 'Any persons over the age of 18 can make decisions no matter how unwise and must be assumed to have capacity unless established he lacks capacity. Any consent given by a patient requires them to be competent.

There are four criteria that must be met in the assessment of competence. These are outlined in section 3 (1) of the Mental Capacity Act and are listed in Table 1.

#### **Table 1: Determining Capacity**

For the purposes of section 2, a person is unable to make a decision for himself if he is unable –

- a. to understand information relevant to the decision,
- b. to retain that information,
- c. to use or weigh that information as part of the process of making the decision, or
- d. to communicate his decision (whether by talking, using sign language or any other means).'

Hence, patients may have the capacity to believe their healthcare practitioner but still not accept their treatment recommendations as in the case of *Re C*.<sup>3</sup> and this was recently confirmed in the case of *Ms B v An NHS Hospital Trust*.<sup>4</sup> Unlike common law, section 2 of MCA introduces a two stage test for capacity which states: 'that a person lacks capacity in relation to a matter if at the material time he is unable to make a decision because of an impairment of, or a disturbance in the functioning of, the mind or brain and it does not matter whether the impairment or disturbance is permanent or temporary'. This allows that a wide variety of conditions are covered such as alcohol or drug misuse, delirium and concussion. Patients with these conditions do tend to commonly present in FCS, and therefore present a dilemma for HP providing treatment. Assessing patients and determining their capacity to make decisions especially in these circumstances can be quite difficult.

Section 2(3) of the MCA clarifies that a lack of capacity cannot be established by reference to a person's age, appearance, and aspect of behaviour or merely by the fact that they have a mental disorder. The principles for assessing capacity as outlined in the MCA (2005) is detailed in Table 2 below.

<sup>1</sup> [1992] 4 All ER 649

<sup>2</sup> The American jurist, Cardozo J, made a statement with similar meaning in *Schloendorff v. Society of New York Hospitals* (1914) 211 NY 125 at 129-130, when he said that: "Every human of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages."

<sup>3</sup> *Re C* [1994] 1 All ER 819, [1994] 1 WLR 290. Mr C a paranoid schizophrenic refused a lifesaving operation to remove a gangrenous leg. He was deemed to have capacity to support his refusal.

<sup>4</sup> *Re B* (consent to treatment: Capacity), *Re* (2002) EWCH 429 (Fam); (2002) 1 FLR 1090.

*Miss B* was a competent adult whose right to refuse treatment was sustained even though the decision might hasten her death.

**Table 2: Principles for Assessing Capacity**

Principle 1: Capacity should always be assumed. A patient's diagnosis, behavior, or appearance should not lead you to presume capacity is absent

Principle 2: A person's ability to make decisions must be optimized before concluding that capacity is absent. All practicable steps must be taken, such as giving sufficient time for assessments; repeating assessments if capacity is fluctuating; and, if relevant, using interpreters, sign language, or pictures

Principle 3: Patients are entitled to make unwise decisions. It is not the decision but the process by which it is reached that determines if capacity is absent

Principle 4: Such decisions must also be the least restrictive option(s) for their basic rights and freedoms

Principle 5: Best interests – anything done for or on behalf of a person who lacks capacity must be done in their best interest.

Hence, treatment provided to patients who lack capacity must be given in their best interests, as determined by the treating clinician. If, despite this, a patient who has been determined as having capacity still refuses treatment, then his or her decision should be respected<sup>5</sup>. In English law there is no mechanism by which a relative or friend can make the decision lawfully on an adult's behalf<sup>6</sup>. In relation to an adult with full capacity the guiding principle of self-determination applies. This is represented by the need for the consent of the patient in order for treatment to be lawful. A refusal of consent will be determinative unless there is a risk of harm being caused to others<sup>7</sup> in which case the principle of allowing treatment will be applied<sup>8</sup>

**Patients Rights**

The law places great importance on those of 'sound' mind being able to determine their own lives. A number of factors have influenced the development of patient's rights to self-determination, including the acceptance of the autonomous rights of patients and their consequent involvement in health care decisions. As early as 1914, Justice Cardozo stated that, "Every human being of adult years and sound mind has a right to determine what will be done with his own body: and a surgeon who performs an operation without his patient's consent commits an assault"<sup>9</sup> Other sources raising the focus of "rights" relating to health care include the United Nations Universal Declaration of Human Rights (1948) and the World Health Organization's Constitution that states:

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" (World Health Organization, 2006).

<sup>5</sup> General medical Council (1998) *Seeking patient's consent: the ethical considerations*. London.GMC

<sup>6</sup> The old *parens patriae* jurisdiction permitted the court to consent on behalf of an adult patient but this was abolished under the Mental Health Act 1959. Hornett makes it clear that a power of attorney could not be used to authorise proxy healthcare decisions, see S. Hornett, 'Advance Directives: A Legal and Ethical Analysis' in J. Keown (ed), *Euthanasia Examined* (Cambridge: Cambridge University Press, 1998), p.303

<sup>7</sup> Under the Public Health (Control of Diseases) Act 1984 it is possible to order a person who is suffering from one of a number of 'notifiable' diseases, including cholera, typhus and smallpox, to receive a medical examination if it is in the interests of the patient, the patient's family or the general public.<sup>59</sup>

<sup>8</sup> The full list of notifiable diseases is set down in s.10 and in the Public Health (Infectious Diseases) Regulations 1998, r.3 and sched.1

<sup>9</sup> *ibid*

The effect of the change in emphasis, to that of recognizing the rights of patients, firmly places them as active participants in the delivery of health care services (Deber, 2007). However, Melden (1977) and later Feldman (2002) argues that any person possessing a right must accept that it may have to yield to other considerations, whilst Dworkin (2005) states that self-determination free from the constraints of external influences is impossible. It could be argued, therefore, that the individual's right to choose not to have something done to him is stronger than the right to choose to do something. If this is the case then the guiding principle of self-determination will be of greatest importance when the desire of the patient is to refuse treatment.

## **Consent**

English law clearly states that the treatment of a competent patient is unlawful unless the patient consents to it<sup>10</sup>. Consent is the legal expression of the principles of self-determination and autonomy<sup>11</sup>. Hence, it is important to understand it from the outset as it is also important due to the way consent is essential to the protection of the patient's rights. Hutchinson (2005) reiterates that the provision of healthcare is based on consent, which in itself is a complex issue. There are no single acts of parliament that sets out the principles of consent, hence the courts through common law,<sup>12</sup> have established legal rules in the form of case law. As a result, legal principles have been established through the cases such as *Bolam v Friern Hospital Management Committee* [1957], *Re C (adult: refusal of medical treatment)* [1994], *Chester v Afshar* [2004] and *Chatterton v Gershon* [1981], which were heard in the High Court and have subsequently provided legal directions. There are also, other statutory provisions, which affect or impinge upon consent, Mental Capacity Act (2005), ECHR and the Mental Health Act (2007). There is a distinction between mental incapacity and mental disorder as defined in the Mental Health Act (MHA) (2007) which is discussed in Appendix 1 & 2. It also clarifies that someone unable to make certain decisions e.g. persons with learning disabilities<sup>13</sup> does not necessarily have a mental disorder<sup>14</sup>. Consent must be informed and this is always difficult especially in emergency or FCS. Jackson (2008) states that informed consent is commonly used to describe two legal duties; the duty to obtain the patient's consent before treatment and the duty to ensure that the patient has been adequately informed about the risks and benefits of their therapeutic options. Del Carman (2005) structured informed consent into five areas; disclosure, decision, understanding, capacity to give consent and voluntarism and this is discussed further in Appendix 3. Non-clinicians who use knives to inflict wounds on others may be found guilty of criminal charges. A clinician who does so will not be charged because of two crucial reasons. Firstly, they do not intend to cause harm and indeed are trying to attain a therapeutic benefit for the patient. Secondly; they obtain informed consent of the competent patient. Consent of the patient will prevent a doctor from being liable for the tort of battery and Lord Mustill showed this protection in *Airedale NHS Trust v Bland* when he stated:

'...bodily invasions in the course of proper medical treatment stand completely outside the criminal law. The reason why the consent of the patient is so important is not that it furnishes a defence in itself,

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<sup>10</sup> Re T (Adult: Refusal of Treatment) [1992] 4 All ER 649

<sup>11</sup> D. Feldman. (2000) 'Human Dignity and Legal Values – Part II' 116 LQR 61, p.67

<sup>12</sup> The essence of English common law is that it is made by judges sitting in courts, applying their common sense and knowledge of legal precedent to the facts before them. A decision of the highest appeal court in England and Wales, the Supreme Court of the United Kingdom, is binding on every other court in the hierarchy, and they will follow its directions. For example, there is no statute making murder illegal. It is a common law crime - so although there is no written Act of Parliament making murder illegal, it is illegal by virtue of the constitutional authority of the courts and their previous decisions. Common law can be amended or repealed by Parliament.

<sup>13</sup> Under Section 2A of the 1983 Act, learning disability is defined as a state of arrested or incomplete development of intelligence and social functioning and is not considered to be a mental disorder unless the disability is associated with abnormally aggressive or seriously irresponsible conduct

<sup>14</sup> Mental Disorder is defined in Section 1 of the Mental Health Act 1983 (as amended by Section 1 of the Mental Health Act 2007) as 'any disorder or disability of the mind'.

but because it is usually essential to the propriety of medical treatment' <sup>15</sup>.

Thus from common law, for public interest reasons, 'proper' medical treatment is outside the realm of criminal law. It is therefore the patient and not the clinician who is responsible for the decision to accept treatment and must accept any harm that results, provided that the treatment was properly administered, the harm was unavoidable and the patient was properly informed about the risk of it as outlined in Table 3.

#### **Making a health care decision**

To make a health care decision the individual must understand in broad terms:

The nature of the intervention

The purpose of the intervention

The risks and benefits of the intervention and of alternative interventions

The risks of not carrying out the intervention

A competent adult cannot be treated without consent; this protects the patient's autonomy and bodily integrity. Butler-Sloss LJ in *Re T* <sup>16</sup> clarifies this matter by stating:

'A man or woman of full age and sound understanding may choose to reject medical advice and medical or surgical treatment either partially or in its entirety, a decision to refuse medical treatment by a patient capable of making a decision does not have to be sensible, rational or well considered.' This respect for competent adults and patient autonomy is discussed in table 4.

#### **Autonomy**

The principle of respect for autonomy underpins the requirement for valid consent. Respect for autonomy is one of the four key principles developed by Beauchamp and Childress(2001) and acknowledges the right of persons to determine how to live their lives, make their own choices in life and reach self-fulfillment. Scanlon defined autonomy as: 'To regard himself as autonomous...a person must see himself as sovereign in what to believe and in weighing competing reasons for action'

Valid consent to treatment should be given voluntarily. Even if sufficient amount of information is disclosed to the patient, their consent will be invalid if anyone has pressurised them into choosing what they do <sup>17</sup>. In this respect coercion may vitiate consent. Coercion has been defined as:

'If one party intentionally and successfully influences another by presenting a credible threat of unwanted and unavoidable harm so severe that the person is unable to resist acting to avoid it. If the patient undergoes treatment in which they were coerced into the consent then the medical treatment given may be considered as assault and battery. Treatment in the absence of consent is discussed in Table 5.

#### **Table 5: Legal Accountability**

A clinician who treats in the absence of consent could potentially be liable for battery or negligence for acts done to an incompetent adult which normally require consent, if those acts were not consistent with their best interests (discussed in Appendix 7) and the *Bolam test* <sup>18</sup>, as modified in *Bolitho* <sup>19</sup>. In order to successfully prove negligent behaviour by a clinician, all of the following must be proven: firstly that the defendant had a duty of care. Secondly, that he breached that duty and thirdly, the breach caused the damage.

<sup>15</sup> *Airedale NHS Trust v Bland* [1993] AC 789

<sup>16</sup> *Re T* [1993] Fam 95

<sup>17</sup> *Re T* [1984] 1 All ER 1036

<sup>18</sup> *Bolam v Friern Hospital Management Committee* [1957] 1 W.LR 582

<sup>19</sup> *Bolitho v City and Hackney Health Authority* [1998] AC 232; [1997] 4 All ER 118

Hence, the law is quite clear that patients must be presumed competent unless proven otherwise and any treatment performed requires valid consent from the patient. These concepts which provide guiding principles in clinical practice will be discussed in more detail within the analysis of relevant themes found in the literature search.

### **The Mental Health Act 2007**

The Mental Health Act establishes a framework for the provision of medical treatment on an involuntary basis if necessary for those suffering from a mental disorder while the MCA 2005 provides a more general framework through which decisions may be made on behalf of adults who lack the relevant decision-making capacity. Mental health legislation was reviewed after enactment of Human Rights Act (2000) and Article 5 of the European Convention on Human Rights which recognizes that 'everyone has a right to liberty and security of person as demonstrated in the case of *Re (N) v. Dr M and Others*, a patient's refusal to consent to treatment would be upheld by the court unless medical necessity shown.<sup>20</sup> However, in *R (MH) v. Secretary of State for Health*<sup>21</sup>, the Court of Appeal held that the state had a duty to protect incompetent patients and Section 2 of the Mental Health Act (1983) was incompatible with Article 5(4) of the ECHR. It was this case and numerous others which highlighted incompatibility between Mental Health Act of 1983 and current legislature via: Human Rights Act 1998(HRA), European Convention for Human Rights ECHR, MCA (2005) and led to subsequent amendments and an amended Mental Health Act coming into force in 2007.

### **Mental Health Act 2007 and Mental Capacity Act 2005**

However, the present situation, in which an adult with capacity can refuse treatment for a physical disorder, but not (if detained) for a mental disorder needs to be clarified. In the case of *Re C (Adult: Refusal of Medical Treatment (1994))* the Court ruled that C, who had gangrene of one leg, had the capacity to decide whether or not to consent to amputation. Since he withheld his consent to this treatment it could not lawfully proceed, yet there was no requirement to assess his decision-making capacity with respect to treatment of his mental disorder, schizophrenia. He could be forced to have treatment for this under the MHA 2007, even though he might have had capacity to decide against it. The difference in criteria regarding consent for the two categories of health problem is of particular interest given that, in contrast to the gangrene, the schizophrenia was not thought to present any threat to C's life. Thus, when considering the treatment of physical disorders the decision of a capable adult must be respected, even if the outcome is likely to be his or her death. In the case of a mental disorder, the MHA 2007 allows treatment without consent, even if the risks (e.g. to health) of not having treatment may be less serious and even if the person concerned has the capacity to make the decision.

### **Appendix 3: What should the Informed Consent Process Discuss**

The 'prudent patient' test has gained support in the United States (US), Canada Australia and New Zealand . In the US case of *Canterbury v Spencer* risk must be disclosed:

<sup>20</sup> *R(N) v Dr M and Others*, Times Law Report, 12 December 2002;CA

<sup>21</sup> *R (MH) v. Secretary of State for Health*, Times Law Report, 8 December 2004, CA; [2004] EWCA Civ 1609



'when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego a proposed therapy.'

Correspondingly, in the case of *Rogers v Whittaker* from Australia, a risk was defined as material if:

'In the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is, or should reasonably be aware that their particular patient, if warned of the risk, would be likely to attach significance to it.'

As stated by Jackson (2006), the 'prudent patient' test has drawbacks, since it is impossible for a doctor to know exactly what a reasonable patient might want to know. There is a general lack of case law and available legal judgements in this area and perhaps the best way to determine what a 'prudent patient' needs to know is to seek guidance from other physicians and members of the multidisciplinary team.

In *Sidaway v Board of Governors of Bethlem Royal Hospital and Maudsley Hospital*, the Lords had marked differences in their approaches to determining the relevant standard of care for disclosure. Lord Diplock believing that a doctor's adequate disclosure of information prior to an operation should be based on the *Bolam* test. Whereas Lord Scarman (dissenting) thought that a doctor's duty to disclose arose from the patient's 'basic human right' to make her own decisions. In addition, he thought there was merit in the 'prudent patient' test. Lord Bridge felt that disclosure was 'primarily a matter of clinical judgement' (although felt that the medical profession was not free to set its own standards). Although authoritative, there was by no means a clear statement from the House of Lords in the judgement for the expected detail of disclosure of information to a patient.

In *Pearce v The United Bristol Healthcare NHS Trusts*, Lord Woolf MR, moved towards the 'reasonable patient test', when stating:

'a significant risk [is] which would affect the judgement of the reasonable patient.'

From this one can draw that the legal standard which probably is best suited to judge the adequacy of information disclosed during a consent process is whether or not it is sufficient for a reasonable and prudent person in the position of the patient to plan the future in a way that they would wish.

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## Belmatt Healthcare Training

Suite 570, 405 Kings Road

Chelsea

Sw10 0BB

### Contact Us

[www.belmatt.co.uk](http://www.belmatt.co.uk)

Email: [info@belmatt.co.uk](mailto:info@belmatt.co.uk)

Mobile: 0207 692 8709